Factors that affect the management capacity, leadership and employee performance in the Ministry of Public Health (MoPH), Afghanistan:

An embedded single-case study

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A thesis submitted in partial fulfilment of the requirements of Bournemouth University for the degree of Doctor of Philosophy

30/09/2020

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Abstract

Shaqaieq Ashrafi Dost

Factors that affect the management capacity, leadership and employee performance in the Ministry of Public Health (MoPH), Afghanistan.

Background: The importance of management capacity in the health sector has been increasingly recognised. The World Health Organization (WHO) (2008) has claimed that limited ‘management capacity’ in low-income countries is one of the main obstacles towards achieving goals. Afghanistan is identified as one of those countries (WHO 2018a). To achieve sustainability, the management and leadership capacity need improvement.

Aim: to explore the perceptions of directors and senior employees about the factors that affect the management capacity, leadership and employee performance in the MoPH, Afghanistan.

Methods: A mixed-methods case-study was carried out in 30 directorates of the MoPH, Afghanistan to explore capacity. Qualitative data were analysed thematically using NVivo, while quantitative data were analysed using descriptive statistics. Both followed by the analytic technique of explanation building using theoretical propositions.

Results: The hiring of directors in the MoPH was found to be affected by political influence. Many directors introduced to the system by politicians did not appear to have the capability to manage well. This set of conditions resulted in a reported lack of support for their employees and the absence of a healthy work environment. This is compounded by a resource shortage. It is evident that a strategic approach to capacity building is not in place with employees attending uncoordinated and often irrelevant training. Employees believe they are not treated consistently and fairly in all respects and this is further compounded by overly complex administrative systems. The socio-cultural influence is affecting transparency, accountability and increases the potential for corruption. Overall the findings suggest that management capacity is weak.

Conclusions: This study reveals management capacity in the MoPH needs a significant overhaul. The government should address political and socio-cultural influence, to allow the appointment of more competent and diverse people.

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Acknowledgement

I would like to take this opportunity to appreciate everyone who has supported me in completing this thesis. It is a pleasure to acknowledge first and foremost the support of my supervisors Professor Edwin van Teijlingen and Dr. Rachel Arnold. Completion of this thesis would not have been possible without your immense guidance. I would like to give my special thanks to my ex-supervisors, Professor Carol Bond, Professor Stephen Tee, Dr. Zoe Shepard and Dr Clare Killingback. My special thanks also go to Professor Sue Way for her wisdom and support.

I am thankful to my family; my husband Dostyar Dost and my loving children Armaghan Dost and Ali Arman Dost. Together, we passed all the ups and downs in many aspects of our lives. I am thankful for your tolerance. I hope my study can benefit you.

My appreciation also goes to all the participants in the MoPH who generously gave their time and took part in this study. All this would not have been possible without their cooperation. Special thanks to the Deputy Minister who helped this study to happen.

This thesis is dedicated to my homeland, Afghanistan.

پدر من !

اینک زمان آن رسیده است که بعد از سپری نمودن یک دورهٔ پراز فراز ونشیب ، رساله تهیه شده پروگرام دوکتورای خود را تحویل دهم. رسیدن به چنین موفقیت بدون حمایت پدربزرگوارم خواجه احمد اشرفی ممکن نبود. او درهرمرحله زندگی در راستای تعلیم و تحصیلم با فرهنگ و تضاد های فکری خانواده و اقارب نزدیک مان مبارزه نمود، هیچگاهی شکست را نپذیرفته و همیشه با قاطعیت وجدیت رزمید وبه من روحیه داد.

دیری نگذشت، آنهای که مخالف تعلیم و تحصیل دختر خانمهای خانواده ما بودند، درجای پا های ما قدم گذاشته ، راه ما را تعقیب نمودند، ودختران شان را جهت تعلیمات و تحصیلات عالی به شهر ها و ولایات دیگر ارسال نمودند. جای مسرت این است که دیگر هیچ دخترخانواده ما بخاطر تعلیم و تحصیل توهین وتحقیر نشده بلکه حمایت کامل فامیل های شانرا دارند. زیرا پدرم و من با همه موانع و مشکلات گوناگون رزمیدیم و راه را به نسل های آینده مان هموار نمودیم.

پدربزرگوارم ! اکنون آنها حقایق را درک نموده و به شما که سرمشق و الگوی خوب در خانواده ما بودید میبالند و افتخار میکنند. خداوند منان را سپاسگذارم که شما را در قالب انسان منحیث پدر برایم اعطا کرد. به هر اندازه ای که عمیق می اندیشم بیشتر از پیش به حیرت میمانم که چطور با خونسردی، بدون اینکه کسی را آزرده سازید یا درنگ و تردیدی داشته باشید، خواست های خود را که همانا تعلیم و تحصیل اولادهای خانوادهٔ تان بود برآورده می ساختید.

پدر مهربانم، مرا ببخش که در تمام زندگی برایت مایه مشقت و مبارزه بوده ام، ممنون احسان و فداکاری های تان استم . به داشتن چنین پدر افتخار نموده و همیشه دعا گوی تان میباشم. روحت شاد و یادت گرامی باد! سرنوشت پدرم و خودم ، سخن گاندی را به یادم میآورد که گفته است (تغییری را که در جهان میخواهی خودت باش). این همه آسان نیست اما ما آنرا انجام دادیم وفعلا دختر تان که همیشه با چالش های فرا راه زندگی مبارزه نموده برنامه دوکتورای خودرا به اختتام میرساند.

My father !

It is now time to submit my doctoral thesis, after going through many difficulties, ups and downs. This would not have been possible without the support of my father, Khawaja Ahmad Ashrafi. In every phase of my life, he strived with the culture and intellectual conflicts of our family and close relatives for my upbringing, but never accepted failure, and always gave me the courage to go for my education.

Not long afterwards, those who were opposed to the education of the daughters of our family stepped on our path and followed us. Slowly, slowly different members of our family started sending their daughters to universities, and to study in other cities and provinces. The good news is that now no other girl in our family is humiliated or has to fight for their education but have the full support of their families. Because we (my father and I) fought through all the different obstacles and difficulties. We paved the way for the future generations of our family.

My father! Now everyone realises the importance of education and are proud of you as a great example! We became role-models for our family and your wish about the education of your whole tribe is being fulfilled.

You were like an angel and I thank God that He granted you to be a human being for me; to be my father. I think about you deeply and I am more and more amazed at how calmly you continued fulfilling your desires for your children and other family members' education. Even when you were threatened and had warnings and bad behaviour from your family you went ahead without any hesitation, fear or doubt and without hurting anybody. You accomplished your aim.

Our life together reminds me of Gandhi's saying to “be the change you want to see in the world”. It was not easy for either of us, there were many challenges, but we did it and now, your daughter who you struggled for so much is completing her doctoral programme.

My dear father, forgive me for all the hardships and struggles you have had in your life because of me. I am always grateful for your sacrifice. I am proud of having such a father, and I will always pray for you. May your soul be happy and peaceful!

I cherish your memory!

Author's declaration

I, Shaqaieq Ashrafi Dost declare that this study, "Factors that affect the management capacity, leadership and employee performance in the MoPH, Afghanistan" is entirely my own piece of work. It has not been submitted in any previous application for a degree. All quotations have been distinguished by quotation marks and sources of information have been specifically acknowledged.

30/09/2020

List of abbreviations

AREU	Afghanistan Research and Evaluation Unit
ARTF	Afghanistan Reconstruction Trust Fund
BU	Bournemouth University
BUREC	Bournemouth University Research Evaluation Committee
BPHS	Basic Package of Health Services
CASP	Critical Appraisal Skills Programme
CBR	Competence Based Recruitment
CBHC	Community Based Health Care
CCCU	Canterbury Christ Church University
CPD	Continuous Professional Development
CSO	Central Statistics Organisation
CSC	Civil Service Commission
CIDA	Canadian International Development Agency
CINAHL	Cumulative Index of Nursing and Allied Health Literature
EC	European Commission
EPHS	Essential Package of Health Services
ERW	Explosive Remnants of War
GF	Global Fund
HMIS	Health Management Information System
HR/s	Human Resource/s
HRM	Human resources management
IANPHI	International Association of National Public Health Institute
IRB	Institutional Review Board
IJHPM	International Journal of Health Policy and Management
IT	Information Technology
JICA	Japan International Cooperation Agency
LICs	Low-income countries
LMICs	Low and midle-income countries
MD	Medical doctor
MEC	Monitoring Evaluation Committee

MBA	Master of Business Administration
MDGs	Millennium Development Goals
MMAT	Mixed Methods Appraisal Tool
MPH	Master of Public Health
MoPH	Ministry of Public Health
MOH	Ministry of Health
MoE	Ministry of Education
MSH	Management Sciences for Health
NGO/s	Non-Governmental Organisation/s
NCDs	Non-Communicable Diseases
PEPFAR	President's Emergency Plan for AIDS Relief
PDF	Portable Document Format
PIS/s	Participant Information Sheet/s
PAS/s	Participant Agreement Sheet/s
PRR	Priority Reform and Restructuring
PhD	Doctor of Philosophy
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDGs	Sustainable Development Goals
SMS	Senior Management Services
SPSS	Statistical Package for the Social Sciences
TA	Technical assistance
UN	United Nation
UNICEF	United Nations International Children's Emergency Fund
US	United States
USD	United States Dollar
UK	United Kingdom
USAID	United States Agency for International Development
UNFPA	United Nations Population Fund
UNDP	United Nations Development Programmes
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Chapter 1. Introduction

1.1.Overview

This thesis is based around a study of management capacity, leadership, and organisational performance. This first chapter starts with a description of the researcher's history and background and how this topic was selected. Next, the health system of Afghanistan and the Ministry of Public Health (MoPH) is discussed, followed by an outline of the bigger picture. Then the terms that are used in this study are defined followed by a description of the study's aim, objectives, and research questions. Finally, this chapter provides an overview of the overall content of this thesis.

1.2. The researcher

The researcher's history and background

I am an Afghan born in Kabul, the capital of Afghanistan. I was in class nine when the mujahidin increased their attacks on Kabul and their rockets killed hundreds of people. Therefore, my family and relatives decided to migrate to Baghlan province (my family's original hometown) where it was a little safer. After high school, I gained admission to the medical school in Balkh University. During my studies, the Taliban attacked Balkh twice and we had to escape back to Baghlan through the mountains. Our studies were interrupted by various political groups, not just the Taliban, who were fighting each other using different heavy weapons in the city with no regard for the safety of its citizens. Medical training is typically seven years in Afghanistan. When I was in the fifth year the Taliban captured Balkh and forbade females to continue their education. My family, therefore, sent me to the neighbouring country of Pakistan, to continue my studies. Unfortunately, I needed to start from scratch which I did not accept. Missing my college, I sometimes went to the Aga Khan University alone, sitting under a tree and staring at the university buildings, the teachers and students, envying how unknowingly lucky they were to have peace. I had never seen real peace in my life and all my student years passed in fear and under threat. In my mind Pakistan did not have greedy political parties operating for their personal benefit. I thought that all the misery in my country was

due to ignorance resulting in selfishness and greed. I believed that educated people should never take up arms even if they were right, but should solve problems by understanding and acceptance of each other. Slowly I became hopeless, thinking my five years' study had been wasted as nobody thought that one day the Taliban would fall. So, I started to teach immigrant Afghan children in Karachi as a volunteer, after which I was offered work in a primary school by an international organisation (Aga Khan Education Services). I was busy there when I unexpectedly heard that the Taliban regime had been removed and the universities had been re-opened for females. I immediately travelled to Afghanistan and re-started my education after three years' interruption. I, like other girls became classmates to boys who were in their second year when we were in our fifth. Many of my female classmates did not return; some had emigrated while others had married. We were also informed that some of our male classmates had been killed during the Taliban government and many others had left their studies as they did not think they were safe anymore. This may be a typical history of an educated Afghan who lived through this period.

How the topic was chosen:

After graduating as a medical doctor (MD) from Balkh University in 2004, I worked in Public Health in Bamyan; one of the most neglected provinces. I started as a midwifery trainer with an international organisation and was involved with the establishment of a provincial Community Midwifery Education Programme. Before I started my Masters programme in Public Health (MPH) at Bournemouth University (BU) in 2014, I worked for different health programmes, including the Community Based Health Care Programmes, Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). Over that period, I began to realise that effective management was one of the most important influencing factors in the success of an organisation.

I have witnessed the success and failure of many health organisations. Typically, in Afghanistan, health agency performance is assessed by the MoPH. When an agency is assessed as failing to manage health services properly, it is required to hand over their responsibilities to other, more successful, agencies. However, neither the MoPH nor the non-governmental organisations (NGOs) investigate the causes of failure or what could be done by the 'failing' agency to improve the sustainability of its

programme. I also observed how it resulted in higher costs, as transferring responsibilities from one organisation to another is time-consuming and costly.

During my work in the Afghan health system, the focus was always on the achievement of national health indicators and the effectiveness of health services. There was rarely any discussion around how effective management might contribute towards the achievement of national health-related goals. There were many issues in health management at both the national and provincial levels, which negatively affected health services; however, these were, rarely, if ever, given attention. For example, I never witnessed any policy discussion at management level to consider managerial effectiveness or improvements.

Travelling to provinces to visit the health facilities and provincial offices, I observed that staff often worked hard and indeed, they were champions in doing good work. However, they faced many challenges due to managerial issues at the national as well as the provincial level. Those managing the provincial offices seemed to lack the necessary human resource management (HRM) knowledge and skills, nor did they have a good understanding of national policies which affected their employees' rights. For instance, managers did not allow female employees to take their full maternity leave, even though this was their right. Moreover, senior managers did not appear to want to hear about management weaknesses and the problems this mismanagement caused.

It often seemed as if employees' wellbeing was not properly considered within the Afghan health management system. During my work experience, I do not remember anyone asking about our work environment or how management issues affected our work. Neither do I recall being asked for feedback on improving the management system to enable better performance. Taking even one day of annual leave (out of 24 days annually) was often problematic for employees. They were told that they were not interested in their job or that they had already taken too much leave. Why this was so, may have been due to the lack of knowledge of HRM or the lack of confidence in the human resource (HR) system accountability. Whatever the reason, employees faced negative consequences. For example, to avoid confrontation or being challenged in the office, staff preferred not to take annual leave. The situation was even worse in the national NGOs, where senior management appeared able to dismiss staff with impunity as there did not seem to be any rules or regulations to

protect staff, and managers were never challenged. Had there been a system or regulation by the MoPH as the leader of the health system, then these organisations might not have been able to terminate their staff without adhering to formal procedure as they were answerable for their actions to the MoPH.

A number of cultural and gender issues were also at play. For instance, when a person was working in a senior position and had authority, they would bring family members or friends into the office and provide jobs for them, even though they were often unsuitable for those positions, which affected service delivery. There was also a big difference between female and male salaries for staff in the same position, even if women were more competent and committed. Why did women receive less payment? The managers may have been influenced by their culture where men are supposed to be the breadwinners not the women, which is why it was acceptable for women to earn less for the same or equivalent work. Nobody knew, or seemed to care, how this undermined the female employees' hard work and adversely affected their motivation. It was disappointing, as there were many honest and loyal staff working hard with enthusiasm, but this was rarely recognised and appreciated by management. Even the annual appraisal system did not appear to benefit people who had worked well throughout the year. Again, this might suggest a lack of awareness on the management's part of their employees' performance and the motivational factors for productivity. If good performance had been acknowledged, then it would have been good motivation for employee performance.

During my work in public health, I began to understand how important managers' roles were and how their capacity, skills and commitment affected the whole organisation either positively or negatively. When the organisation was handed over from one senior manager to another, we often witnessed big changes in the performance of the entire organisation depending on the competence, commitment, and other characteristics of the new leadership. I had the experience of working for a strong and committed leader who had a very close working relationship with their employees, an understanding of employees' motivation and organisational performance. During this period, we, as employees of that organisation were proud to introduce ourselves as representatives of that organisation. We were confident in our organisation's achievement and reputation nationally. In contrast, I also experienced a weak senior manager, and the changes he brought had a negative impact, resulting

in distancing between top management and employees. Although this senior manager had a high and relevant health qualification, in this instance, personal commitment might have played an important role. We often did not meet the leadership for months, which meant that we were not fully engaged in decisions or asked to explain our performance, to show our creativity or to put forward suggestions for better services. This situation adversely affected the employees' motivation.

These observations about health management capacity and leadership were reinforced during my MPH programme. I studied how national goals were achieved in different countries and the way effective management and policy contributed to their success. Prior to this, I had thought that Afghanistan was the only country where everything had been destroyed by conflict and war. From reading reports from various low-income countries (LICs), I found that many countries faced a similar situation to that of Afghanistan. However, after establishing a new government, other countries such as those reported in studies by Turner and Short (2013) and Latifov and Sahay (2013) appeared to develop functional health systems. These studies showed that identifying the problems was a big step towards improvement. They sought solutions and undertook research on how to improve, for example, evidence-based practice in Indonesia, Malaysia, Thailand and Philippines (Turner and Short 2013) or how to improve strategic planning and policy-making capacity and how to incorporate electronic governance into the health systems in Tajikistan and Kazakhstan (Latifov and Sahay 2013). These inputs had a very positive impact on the national health system. It is questionable whether many of the health needs/gaps are recognised by the MoPH in Afghanistan, which lacks the necessary capacity to recognise the problems. Increased capacity would give managers the ability to identify the gaps in the health organisations and system. If there were competent senior managers, they might have the ability to provide an enabling environment to their employees and acknowledge good performance. A competent manager should be able to ensure of a HR system that handles the employees affair well which would be a good motivation for good performance. Undertaking my Master's programme, I found that management capacity and leadership could be part of the solution and it was this belief that made me choose to explore management capacity as the topic for my Doctor of Philosophy (PhD) thesis. I decided to focus on the MoPH because it leads the health system and all NGOs work in partnership with it, attending MoPH

meetings, task forces, working groups and workshops. As the person responsible for Mother and Child Health in my organisation, I regularly attended meetings in the MoPH regarding Mother and Child Health, Nutrition, Community Health, Immunisation, and Gender. The low capacity of the MoPH was discussed in the MoPH as well as in World Health Organization (WHO) documents, but these documents did not cite any relevant research. I hypothesised that if an NGO or a hospital capacity is low then it will affect the local population, but if the MoPH has low capacity then the whole country will be affected, because the MoPH coordinates the entire health system.

1.3. The health system in Afghanistan

Since the re-establishment of a health system (2001), the MoPH and partners have had significant achievements. One very significant achievement was to start the provision of the BPHS through the NGOs. This contributed to the improvement of the country's health status by expanding health services nationwide and prioritising health problems/needs (Newbrander et al. 2014). Similarly, the establishment of the EPHS (tertiary services) to complement the BPHS in the health system was another achievement by the Health Ministry and partners (MoPH 2005a). As a result, accessibility was increased; immunisation rates improved from 27 percent in 2000 to 68 percent in 2018. Skilled birth attendants increased from 12 percent in 2000 to 51 percent in 2018 and life expectancy at birth increased from 56 years in 2000 to 64 in 2018 (World Bank 2019). The accuracy of some of these figures are disputed, however there has been undeniable and significant progress over a very short space of time. BPHS and EPHS are described in Section 2.3.

The establishment of community midwifery schools in 34 Afghanistan provinces between 2002 and 2013 was a major achievement on the part of the MoPH (Turkmani et al. 2013) because when the Taliban government collapsed, maternal mortality was one of the highest in the world (Bartlett et al. 2005; Newbrander et al. 2014). Community midwives helped to address the needs of the predominantly rural community. More than 3,000 community and hospital-based midwives graduated between 2002 to 2013 and the programme was supported by the United States Agency for International Development (USAID), the World Bank and the European Commission (EC) (Turkmani et al. 2013). Quality was assured by an accreditation system (Currie et al. 2007). Afghanistan and the MoPH are also working on global

initiatives; Afghanistan has signed up to the Millennium Development Goals (MDGs) Declaration and the indicators for Afghanistan due to security reasons have been set for 2020. The country is also a signatory to the Sustainable Development Goals (SDGs) (MoPH 2015a).

However, for a young health system to flourish there is a need for many skilled and qualified people to work towards sustainability in the system. WHO (2018a) claims that, despite progress, Afghan health indicators remain worryingly high when regional and global comparisons are made and are in need of urgent attention. For example, the maternal mortality ratio is still 661 per 100,000 live births (MoPH 2017a). Pakistan, a country with generally poor health indicators, has a maternal mortality ratio of 178/100,000 live births (WHO 2018b), which is just over a quarter of that of Afghanistan. Communicable and non-communicable diseases also cause high mortality and morbidity and Afghanistan remains one of only three polio endemic countries globally (WHO 2018a).

One obstacle to national health improvement might be limited capacity at the managerial level in the MoPH (WHO 2018a). For this reason, WHO (2018a) prioritised health professionals' capacity building in its most recent strategy. The MoPH has also recognised the requirement for the improvement of capacity building particularly amongst both national and provincial level managers (MoPH 2015a). Capacity building was already recognised as a challenge in 2002 by the MoPH (2005b). Additionally, capacity building was identified as one of the most important steps in the government's National Development Strategy from 2008 to 2013 (Islamic Republic of Afghanistan 2008).

Donor resources from the international community are likely to decrease and inadequate financing is one of the main challenges for the MoPH (Feroz 2018), requiring the MoPH to focus on sustaining the health sector (Belay 2010). One of the main components to assure sustainability is capacity building within the MoPH, but despite almost 16 years of technical/financial support from partners to build capacity, it still falls short. Even before donor funding decreases, the country's health goals have been only partially achieved and services have not reached the most vulnerable populations (Trani et al. 2010).

Management capacity in Afghanistan is a phenomenon that is largely unexplored. No study was found to explore what factors affect leadership and management capacity

in the MoPH. Unless attention is paid to management capacity and leadership, change is unlikely to happen in the health system. It is, therefore, a crucial issue needing further exploration.

Issues of management and leadership are not unique in the MoPH; they are likely to be similar to other Afghan governmental organisations. For instance, studies found weak management in the Ministry of Education (MoE), reflected in the poor quality of services, political influence on admission to higher education and jobs and corruption (Giustozzi 2010). The government has also found ministerial fragmentation and ineffective management one of the primary challenges that affects the effectiveness of education and is a source of dissatisfaction in the general population (Islamic Republic of Afghanistan 2017).

Low and middle-income countries (LMICs) like Afghanistan, often have limited institutional capacity (WHO 2018a; 2020a). In addition, Afghanistan is a conflict-affected country. Countries that emerge from conflict generally have poor institutional capacity and this affects all levels of government, their authority, and ownership and these in turn cause weak governance (Sondorp 2016). These countries have the weakest health systems with low prioritisation of health needs (Martineau et al. 2017). This means that limited capacity in management and leadership is not a unique or specific problem for Afghanistan, but is a generic problem among LICs, especially among conflict-affected countries. Although extremely challenging, improving governance and institutional capacity in such countries is vital (Baltissen et al. 2013).

1.4. The MoPH-the case study

The MoPH was the focus of this study because it has the stewardship of the health of the nation and oversees all international and national NGOs, including the right to grant or withhold funds or terminate the NGOs contracts. Therefore, the MoPH requires the capacity to manage all health stakeholders and guide the health system by developing policies, strategic plans, and high-quality and evidence-based guidelines. With some of the poorest health indicators in the world, the MoPH needs to intensify its action to address the related-health problems. This major initiative requires qualified and competent people.

According to the MoPH organogram in Appendix 1 (MoPH 2016c), its services are carried out by 30 directorates; each responsible for one specific service. Eleven directorates report to deputy ministers, while 19 report to general directorates. General directors work directly under the three deputy ministers. Each general directorate has one to six directorates working under their control. There are three deputy ministers: - a Deputy Minister for Health Services Provision, a Deputy Minister of Policy and Planning and a Deputy Minister for Financing and Administration (Appendix 1, the MoPH organogram). The plan was to explore management capacity and leadership across all directorates in the MoPH. The MoPH is located in Kabul with provincial offices located in the provinces. The study was conducted in the headquarters, as the health system is centralised, and all instructions are issued from the capital to the provinces. All policies, guidelines and protocols are also developed in the Kabul MoPH and then implemented at national and provincial levels.

To explore issues of management capacity, it was decided to include all of the directorates, because they are responsible for the health system across the entire country. While general directorates as well as vice ministers /ministers play important roles in the key decisions with donors, international agencies and implementer NGOs, the directorates were taken in the study because their direct input provides guidance for the whole health system. They are responsible for specific services and develop policy and strategies for those services and provide guidelines and protocols. They also have the responsibility of monitoring and supervising those services. Considering the commencement of capacity building in the MoPH (Section 1.3), this study was designed to identify the factors that affect management capacity and leadership, whether they were affected by factors in the MoPH or whether the managers had low capacity from the outset and their capacity had never been developed in the MoPH.

Each directorate operates as a part of the MoPH, being responsible for specific objectives and services for the entire country such as the ‘Gender Directorate’, which is responsible for all gender-related affairs in the entire country. Directorates have the stewardship of health among all stakeholders (MoPH 2015a). To achieve those objectives, these directorates need to coordinate with NGOs who implement health services at national and sub national levels (MoPH 2016a, 2016b). The directorates’

main responsibilities are leadership, guidance, instruction, supervision, monitoring, evaluation, capacity building and mentorship of all health implementers (MoPH 2017a). Therefore, to successfully fulfil their critical responsibilities and achieve national goals, directorates need high capacity. The implementers' performance and services are affected by the MoPH directorate input. The country's health services are also affected either positively or negatively by the MoPH's performance.

Each directorate consisted of two groups of employees: the directors and their subordinates. The director is the head of the directorate and has an important management and leadership role, as well as being responsible for policy and decision-making. Along with their subordinates, directors develop objectives and need to ensure the objectives are implemented. To achieve those objectives, they need to develop short and long-term strategic planning and coordinate with other partners and implementers. Directors manage all activities in the directorates including HRM, supervision, monitoring, capacity building, mentorship, coaching, and finance (e.g. budget planning and expenditure in close coordination with the finance directorate). Another group that is included in a directorate is the employees who are subordinates to directors. These employees include heads of units, advisors/consultants, team leaders, officers and sometimes managers. These employees get their instructions from the directors, report to them and have their performance managed by them.

1.5. Big picture of low management capacity and leadership

Afghanistan is one of most conflict-affected countries in the world (Frost et al. 2016). Globally, there are many other countries such as the Cameroons, the Congo, the Democratic Republic of Congo, Liberia, Nepal, Sierra Leone, the Solomon Islands, Timor-Leste, and Yemen that are fragile and conflict-affected countries (World Bank 2014a). Prolonged conflict often weakens the state and its institutions. Poor institutional capacity typically affects all levels of government including health authorities (Sondorp 2016). The international community, including the World Bank, provides critical financial and technical support to help these countries increase their capability (Tang et al. 2005; World Bank 2014a).

There is literature indicating that LMICs suffer from low capacity in their health sectors (WHO 2007b; Adam et al. 2011). Despite low capacity being recognised as

one of the chief obstacles in LICs, there is no established strategic long-term framework to follow (World Bank 2014a). Potter and Brough (2004), who carried out a literature review of international community technical assistance and capacity building in LICs, argue that no significant changes have been seen and there is failure in recognising the real needs for building capacity. Many LICs lack the capacity to measure or even understand their own weaknesses and constraints, resulting in policymakers making decisions without any scientific evidence, which means all health-related decisions and plans are often based on their personal and political preferences. In these conditions even the simplest interventions often fail to achieve their goals (Potter and Brough 2004; WHO 2009).

Meanwhile, when there is not institutional quality, then there is not sustainable development (Baltissen et al. 2013). Literature from conflict-affected countries also demonstrates that typically after war, efforts and attention are mainly focused on the delivery and scaling up of services, but less attention is paid to the management and leadership capacity of the health sector (ter Veen and Sondorp 2013). The negative leadership practices of the health systems in LMICs negatively affect staff motivation and teamwork (Gilson and Agyepong 2018). These authors argue that leadership is necessary not only to guide and enable the different dimensions of the management system to work towards common goals, but also to enable the employees' learning, creativity and adaptive capacity. Therefore, Gilson and Agyepong (2018) argue that current efforts are not effective and it is essential to think differently about how to develop leadership in these countries. That is why a balance between health services, leadership and governance capacity building is suggested by ter Veen and Sondorp (2013). Scholars also claim that although considerable efforts have been made, there is no clear picture of progress or shortfalls in this regard (Catford 2005). One of the main things that can promote health system capacity is research, but unfortunately it is not promoted in LMICs (Martineau et al. 2017; Gilson and Agyepong 2018). Health policy and systems research was studied by Adam et al. (2011) in LMICs. They found an increase in publications in those countries but only 4% were led by authors from LICs. Despite improvements in the infrastructure of research institutions, minimal change has been seen in the level of experience of researchers within LIC institutions.

Potter and Brough (2004) suggest that effective capacity building in LIC is essential; they also argue that capacity building should promote independence, rather than dependence. Why should this study be done in Afghanistan? All the problems observed by the researcher in the Afghanistan health system and discussed in Section 1.2, echo the capacity and capacity building conditions found in many LICs. A study is needed to explore it. This would help to identify the factors that affect the capacity of the MoPH. This may also help the international community to identify the underpinning factors for low capacity in these countries and seek effective ways to help successful capacity building with sustainability.

1.6. Key terms used in the thesis

To clarify the focus of this study, it is important to define and locate key terms in the context of organisational management. 'Capacity' has been used for the individual in terms of individual capacity as well as for the entire management system. For the management system, the following definition was chosen:

> "(a) government's ability to marshal, develop, direct, and control its financial, human, capital, and information resources" (Ingraham et al. 2003, p.15).

It was chosen over others because this study explores the MoPH's capacity, as a governmental organisation responsible for guiding, developing and directing all other health stakeholders. Additionally, this definition includes controlling other organisational components (finance, HR, capital, and information technology (IT)), which is compatible with this study.

'Competence' is another key term used in this study. It includes characteristics, knowledge, skills and behaviour "that help an individual to contribute to or successfully engage in a role or task" (Seemiller and Cook 2014, p.77). Although 'competence' has been used synonymously with 'capacity' (Gargan 1981; Eisinger 2002), it has an individual rather than an organisational or management system focus. Leadership competence is very often studied together with other components of management capacity. Therefore, this informed the researcher's decision to include capacity instead of competence in the research question to develop a better understanding of the situation. However, more focus is given to the role of leaders within an organisation. In some studies, organisational capacity is synonymous with managerial capacity (Ingraham et al. 2003; Christensen and Gazley 2008), which

again links organisational capacity to individual capacity, as managers have the responsibility to guide the management system in an organisation. 'Competence' is used to indicate an individual's competence/ability, whilst 'capacity' is used to reflect an individual's ability or leadership, management, or organisational ability, which has a broader meaning.

The Black Box Model (Moynihan and Ingraham 2004) and the Leadership and Management Strengthening Framework (WHO 2007a) were used to study management capacity (Sections 2.5.1-2.5.2). In both, the terms of 'leaders and managers' or 'leadership and management' are not differentiated; therefore, in this study, leadership is considered part of management. Leadership has been given the central role in management as the leaders are specified in these frameworks to translate all other organisational components as the inputs into the outputs or outcomes of the services.

The MoPH is a governmental organisation, which allows the inclusion of literature that is related to governmental organisations. In some literature, terms such as 'public organisation', 'services', 'administration' or 'sectors' are used (Moynihan and Ingraham 2004; Andrews et al. 2006); others refer to 'countries' capacity' instead of 'government capacity' (Ulikpan et al. 2014). All these are applicable to this study as they are managed by the government and provide services for the public. Leaders are defined as individuals that influence a group of people to accomplish a common goal (Northouse 2019). In this PhD study, 'leader', 'manager', 'director' and 'head of the directorate' all refer to the same people who are responsible for the management of directorates in the MoPH. The discussion about terms and concepts will be expanded in Section 2.4.

1.7. The study's aim and question

The aim of this study was to explore the factors that affect the management capacity, leadership, and employee performance in the MoPH, Afghanistan. To fulfil this aim, the perspectives of the heads of directorates and employees, MoPH documents and archival records were explored. The findings may help the health ministry to consider those factors in their strategic plan and work on them towards improvement. This will also help the donors and development partners in their support of the MoPH. It is hoped that the findings of this study will provide significant information

for policymakers to improve the capacity of the MoPH and the success of the health system in Afghanistan. The research question is:

> *'What are the factors that affect the management capacity, leadership, and employee performance in the MoPH, Afghanistan?'*

The specific objectives to achieve the overarching aim were to:

1. obtain aggregate data about workforce investment such as qualifications, training, and capacity building in relation to directors.
2. collect data from 30 heads of directorates by self-assessment questionnaires to find out the factors that affect the management capacity, leadership, and employee performance in the MoPH.
3. collect data from senior staff/employees from all 30 directorates regarding the factors that affect the management capacity and leadership and consequently influence their performance.
4. review the key policies and strategies from the directorates to determine whether capacity building is considered and implemented.

1.8. Outline of the thesis

This thesis is presented in nine chapters (Figure 1.1). Chapter 2 presents the background of the study context and setting. The scoping review helped to define the area this PhD examines and informed the theoretical framework of this study. It played a significant role in selecting the case study design. Chapter 3 presents how the literature review was carried out and how its results helped to develop the theoretical study propositions. It informed what was already known about management capacity and leadership in LMICs and identifying the gap in knowledge that is addressed in this study. Chapter 4 discusses the methodology and rationales for selecting the embedded single-case study design, methods, data collection and analysis. The key findings of the four study methods are presented in Chapter 5. Chapter 6 brings together findings from all the methods in one single-case study. Chapter 7 presents the discussion of the findings, which explores and compares in more depth, with the theoretical proposition on management capacity and leadership. Chapter 8 discusses the study findings in relation to the literature and the new knowledge that this research contributes to the field of management capacity and leadership in LMICs. Based on the findings, it also suggests a revised framework

which may contribute to the studies in LMICs. Finally, Chapter 9 concludes the thesis with recommendations for further areas of research in the field and finally suggests potential solutions for the current challenges. References and appendices with the additional material to support the thesis are also provided.

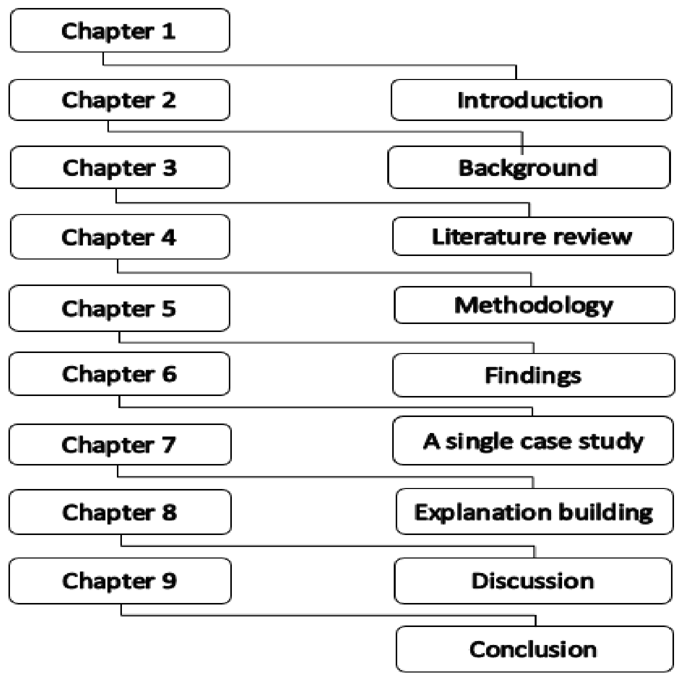

Figure 1-1 Overview of chapters in the thesis

Having observed the importance of management capacity during my work and gained some knowledge about it during my MSc. in Public Health, I chose management capacity and leadership as the topic of my PhD research. The topic of leadership/management capacity is neither easy nor simple. To carry out a rigorous PhD study around this complex issue required an in-depth exploration of the current situation and what is known about it, as well as developing a good understanding of all the relevant concepts, terms, and definitions. This needed a comprehensive literature review. The following two chapters discuss the background of the study context, setting, the scoping review and the systematic literature review.

Chapter 2. Background

2.1. Introduction

This chapter starts with a background discussion of Afghanistan as the study context and the MoPH as the specific setting of this PhD study. It uses a review framework to explain how the scoping review was carried out to establish the background and context. It examines key terms such as 'leadership', 'management' and their relationship with each other and 'leadership competence', 'capacity', and their related concepts. This includes an exploration of the theoretical context leading to a description of a leadership and management capacity model and framework, followed by a discussion of how the model, framework and concepts work in this study.

2.2. Afghanistan, the context of this study

Afghanistan is an ancient country with a rich history and an ethnically and linguistically diverse population (Islamic Republic of Afghanistan 2017). Due to its geopolitical landscape, it has always been either the 'hunting ground' for superpowers such as Greece, Great Britain, United States (US) and the former Soviet Union, or within their sphere of influence and intervention, such as fermenting inter-ethnic rivalries (Rywkin 2004; Barfield 2012; Lee 2018). The superpowers have always played political games in Afghanistan to their own advantages (Rywkin 2004). The country has been influenced in the last few decades by neighbouring countries and the US in establishing and continuing conflict and war (Barfield 2012; Lee 2018); as a consequence the demographics of Afghanistan have been disrupted.

The Afghan Central Statistics Organisation (CSO) is a governmental body and the only source of up-to-date demographic information. According to the CSO (2018), the total population of the country in 2017-18 was estimated to be 29.7 million, of which 15.2 million were male and 14.5 million female. Most (74.8%) live in rural areas and life expectancy at birth is 64 years (World Bank 2019).

Almost four decades of war have devastated the country and each month, an average of 100 civilians are victims of land mines and Explosive Remnants of War (ERW) (CSO 2018). Clean water remains inaccessible for an estimated 35% of the population and is a major contributor to a range of intestinal diseases and child

mortality (CSO 2018). It is also a proxy indicator for high levels of absolute poverty. Afghanistan's poverty statistics show nearly 40% of the population fall below the US Dollar (USD) 1.25/day global poverty threshold, with increasing rates in the past four years (CSO 2018). Decades of war coupled with a rising population have eroded Afghanistan's traditional systems for sustainable natural resource management. This dynamic has heightened the impact of natural disasters and contributed to deforestation, over-grazing, and food insecurity (CSO 2018). There are more than 2.5 million vulnerable persons living with disabilities, many of whom suffer from social, economic, and political marginalization (CSO 2018). Access to education, particularly for young women and girls, is affected by culture, politics and conflict. The potential of women to contribute to economic development remains severely restricted by structural barriers, cultural norms, and insecurity (CSO 2018). One in six women (17%) is literate, compared to nearly half of men, and just 15% of working age females are in paid employment (CSO 2018). An estimated 2.5 million Afghans are registered as refugees, and an estimated similar number are undocumented migrants, mainly living in Pakistan and Iran (CSO 2018). Decades of protracted conflict have resulted in severe social and ethnic rifts and weakened government institutions (CSO 2018). A similar level of neglect and destruction is evident in health care.

2.3. The Ministry of Public Health

The health system in Afghanistan was re-established after the fall of the Taliban regime at the commencement of the new government in 2001. The Taliban regime ruled from 1996 until 2001 (Rashid 2002; Lee 2018). Years of war had destroyed most systems and infrastructure and a devastated health system remained where the public sectors were mainly dysfunctional and the health services were delivered by national and international NGOs who often had their own areas of interest (Newbrander et al. 2014). At the same time, the country was lacking HRs, which was a crucial component for system development. Most of the skilled and /or well-qualified professionals had had to leave the country due to insecurity (Waldman 2002; Currie et al. 2007). In addition, Taliban did not allow women to be educated or take professional studies or complete their education (Waldman 2002; Rashid 2002). In order to re-establish the health system, and deliver a well-co-ordinated package of

health services nationally, the MoPH obtained financial and technical commitments from the international community (Smith et al. 2008; Feroz 2018).

Having the worst health indicators after the removal of the Taliban, the MoPH needed to rapidly expand health services throughout the country and to tackle the most urgent health problems for a majority rural population (Najafizada et al. 2014). Therefore, the BPHS was thought by the MoPH and partners to be an affordable and effective strategy to improve the population's health status (Palmer et al. 2006; Bayard et al.2008). However, given Afghanistan's and the MoPH's poor capacity (Section 1.3), the MoPH and donors decided to implement the BPHS through the NGOs. Therefore, they contracted out basic health services to national and international NGOs (Bayard et al. 2008). These contracts covered all 34 provinces either fully or as clusters of districts and were mainly funded by the World Bank, USAID, the European Union and the Asian Development Bank (Palmer et al. 2006). Three provinces are run by the MoPH itself with the government strengthening mechanism funded by the World Bank. A bidding process was established for NGOs who had to compete to provide health services in specific geographical areas of the country. In 2010, 60% of the health sector was financed by external donors (WHO 2010b); this was even higher in 2012, namely 75% (MoPH 2012). Currently the MoPH relies heavily on external sources (Feroz 2018; WHO 2018a).

The traditional role of the MoPH before 2001 was the provision of health services to the country. In this contracting process the MoPH took on the role of contracting with health providers. The MoPH had to deal with reviewing contract bids, monitoring and evaluation of the implementers' performance and establishing policies, strategies, and standards (Bayard et al. 2008). All these new responsibilities required different skills; as the MoPH authorities and senior employees did not have public health skills, this was a major challenge (Newbrander et al. 2014). To manage all these important responsibilities there was the need for high capacity while Afghanistan had just emerged from conflict and the government capacity was weak with limited availability of national expertise (Bayard et al. 2008; Newbrander et al. 2014). Contracting out is more likely to be adopted in countries where government capacity is weak. Therefore, to manage all the above-mentioned responsibilities, the MoPH and donors used donor-funded international advisors and spent heavily on expatriate technical assistance (Palmer et al. 2006; Newbrander et al. 2014) to

develop capacity in the MoPH and NGOs. The international community has had significant input for capacity building since 2001 (Dalil et al. 2014), and US$ 1.6 billion was spent on capacity building (MoPH 2016a), much of which has been to pay for technical assistance (World Bank 2012). Technical assistance was part of capacity building which involved hiring staff outside the structure of the MoPH to carry out its functions, and not only included international expatriates but also Afghans. In 2002–04 the government, with support from the World Bank and the Afghanistan Reconstruction Trust Fund (ARTF) initiated the Afghan Expatriate Program and Lateral Entry Program. The aim of these programmes was to attract competent Afghans and to facilitate Afghan professionals' return to the country (World Bank 2012). These programmes hired expatriate Afghans as senior advisers and in management positions with a salary two or three times greater than that of ordinary employees. However, these programmes provided mainly short-term inputs and did little to build longer term capacity (World Bank 2012). Meanwhile, such programmes were not included in the remit or structure of the MoPH and were found to undermine the overall reform effort.

The MoPH (2020) website indicates that their technical and financial partners include USAID, the World Bank, the EC, Japan International Cooperation Agency (JICA), Global Fund (GF), United Nations Population Fund (UNFPA), WHO, United Nations International Children's Emergency Fund (UNICEF) and the Canadian International Development Agency (CIDA). However, the timing and duration of their partnership and the type of their inputs are not described. Figure 2.1 provides an understanding of the donors and partners as well as the implementers working under the MoPH; the name order is taken from the MoPH website (MoPH 2020). The technical and financial partners provide inputs with the MoPH having the stewardship role working with implementing partners. Provincial health directorates are located in all 34 provinces working in partnership with NGOs based in these provinces. Provincial health directorates report to the central MoPH in Kabul. The MoPH and partners implement two standard packages of health services across the entire country.

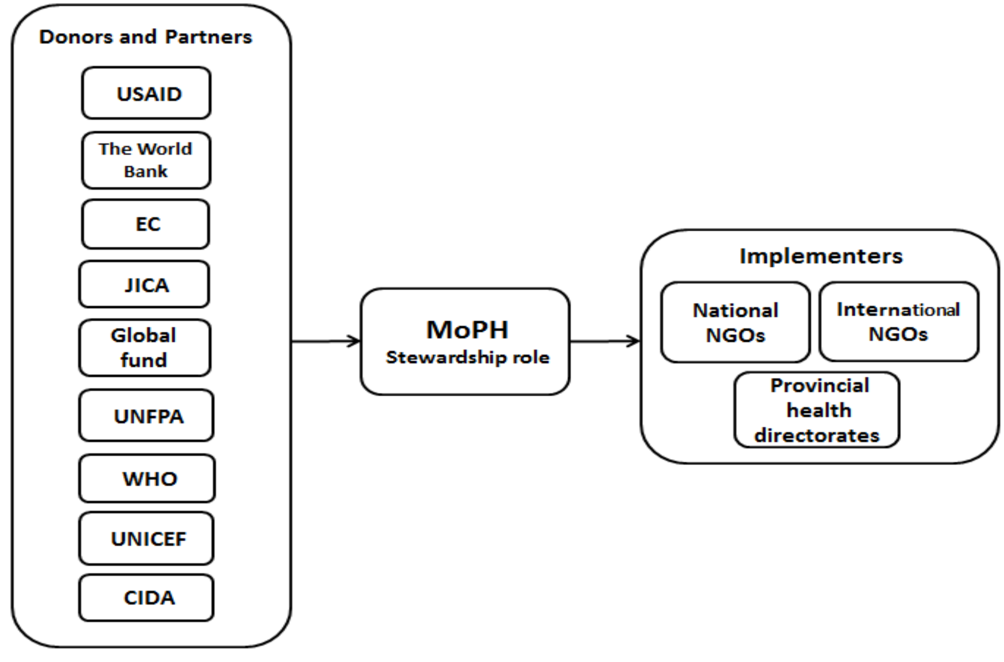

Figure 2-1 MoPH with donors, partners and health implementers

The BPHS provides key primary health services involving seven components of maternal and newborn health, child health and immunisation, nutrition, control of communicable diseases, mental health, disability, and provision of essential drugs (MoPH 2010). It defines each type of health facility (Health Posts, Health Sub-Centres, Basic Health Centres, Comprehensive Health Centres, and District Hospitals), its specific services, size of catchment, number of staff needed, equipment required and essential drugs for these services (MoPH 2010; Najafizada et al. 2014; Newbrander et al. 2014). The EPHS is a standardized package of hospital services defining staffing, equipment and drugs for all types of hospitals: district, provincial, regional and speciality (MoPH 2005a; Frost et al. 2016). The link between the BPHS and EPHS is the district hospital, which serves as the first referral-level hospital for primary care facilities (MoPH 2010).

The researcher had work experience in public health, but did not have the required knowledge about these health organisations, management and performance and the commonly used terms and concepts. Meanwhile there was the need to understand what was already known about the topic in other LMICs. Hence there was a need for a literature review and a scoping review. The scoping review is a part of systematic literature review that is explained in Chapter 3. Section 2.4 discusses the scoping review.

2.4. Scoping review

To carry out appropriate research it was necessary to be familiar with and have some personal insights and understanding of the relevant terms, definitions, and concepts of the topic. Therefore, an informal search was conducted, which was very helpful in designing the formal literature review. The initial plan was to include papers from LICs in the literature review because they would be the most relevant to Afghanistan. Initially the search used databases such as Complementary Index, Academic Search Complete, Science Direct, Business Source Ultimate, Education Source, Medline Complete, SocIndex with Full Text and the Cumulative Index of Nursing and Allied Health Literature (CINAHL) Complete. Unfortunately, very few papers were found and many of those were only partially related to the review topic. This meant that there were insufficient papers relevant to LICs to provide a meaningful examination of the topic. Therefore, in order to establish the current 'state of the science' on this topic a review framework was necessary to conduct a comprehensive review of those terms so that they could be used in a proper manner. It was therefore decided to include the terms 'leadership', 'capacity', and 'competence' from any type of country, including low-income, middle-income, and developed in order to establish if these terms were defined differently and used in different fields. In this case, it was decided to include literature from any subject disciplines such as business, management, health, industry, and marketing regarding the definitions of the terms. Relevant definitions from the United Nations (UN) agencies were also included such as: 'manager', 'capacity', or 'capacity building' since these agencies work in different fields in many LMICs providing technical inputs. The scoping review found that management capacity and leadership are complex topics encompassing many terms and concepts. To help clarify the focus of this study, each of these terms and concepts are defined below.

2.4.1. Definition of leadership

The term 'leadership' is defined differently by scholars. Veber (2002 cited by Mládková 2012) defines leadership as the creation of vision and activation of people to achieve that vision. Kouzes and Posner (2017) see leadership as the relationship between those who aspire to lead and those who choose to follow. However, Kouzes and Posner only highlight the relationship aspects and not the achievement or outcomes. DuBrin (2006) understands leadership as a dynamic concept for the

development of communication channels towards others, which influences the group in achieving goals. This definition indicates the importance of the communication role in leadership and in the fulfilment of the vision and goals. Northouse (2019) also defines leadership as a process where individual influence can impact a group of people towards accomplishing a common goal. However, unlike Veber (2002 cited by Mládková 2012) and DuBrin (2006) who suggest the creation of vision and communication as good influences, Northouse does not mention any action by leaders that can help goals to be accomplished. Sarros et al. (2014) understands leadership as embodying the values and creating an environment in which goals can be achieved. This suggests that creating an enabling environment is the responsibility of a leader in an organisation. As Nelson points out, leadership influences, motivates, directs and "lights the passion of the job within their subordinates" (2005, p.96).

As can be seen in many of the above definitions, with the exception of Kouzes and Posner's (2017), the aim of leadership is the accomplishment of a common goal. Different scholars suggest various influences that will help accomplish the common goal. The leaders are expected to create vision, activate people, develop good communication, create an enabling environment and motivate employees. All of these suggestions imply that leadership focuses on relationships and through relationships within the group, leaders help goals to be achieved. The leadership elements are one of the important focuses of the study; as explained below.

2.4.2. Leaders and followers

Many leadership theories have emphasised that leaders and followers are central to the leadership process (Shondrick et al. 2010). It means that in any leadership process the presence of a leader and followers is essential. Similarly, Howell and Shamir (2005) suggest that leadership does not exist without a leader or a follower. All leaders have a vision, they gather followers to fulfil that vision and achieve the result through teamwork with "their persuasive, exciting, and bold personality" (Creek and Lougher 2008; Johnson 2015, p.157). While leadership is adequately defined in the literature, the terms 'leader' and 'followers' within the leadership process are rarely defined. In addition, the link between the two roles has not been explored in depth.

In any organisation, employees are considered the most valuable resource and they are considered as the followers in the leadership process. To manage this ‘resource’ the role of leaders is important because leaders are the ones “who can motivate, inspire, cultivate subordinates to reach their maximum potential” (Nelson 2005, p.95) and provide a quality service. Another two terms that are used in this study are the management and managers. Management is used because it focuses on organisational performance and goals. This will help to explore the management capacity in an organisation. The manager’s term is used because managers are the ones who manage all the activities and performance in an organisation.

2.4.3. What is management/ a manager?

Management is concerned with planning, organising, directing or guiding and supervising/monitoring activities and aims to achieve the organisational goals and objectives in an efficient way (Gopee and Galloway 2014). It mainly emphasises on systems, controls, procedures and policies (VanVactor 2012). In management, people or the employees of the organisation are not the focus. The primary focus for management is the achievement of organisational goals. Managers are those who plan, organise, direct and control their employees (Johnson 2015). Based-on the above definitions, organisation is one of the responsibilities of managers, therefore, the skills that are needed for managers are organisational skills, which can help them to respond to issues and decide if any changes are required (Johnson 2015). In contrast, Gopee and Galloway (2014) suggest a more comprehensive definition, namely a manager is: an employee who is appointed to ensure that the objectives of an organisation are achieved efficiently and effectively.

Considering the above definitions for the managers and management, the argument presented here concerns how efficiently and effectively the objectives are achieved, which depends on the managers’ level of competence. Since managers require knowledge, skills and expertise to achieve the appointed tasks, they need to be knowledgeable, trained in policies and procedures, be analytical and change and action-oriented (Nelson 2005; Johnson 2015). This is because in an organisation it is the managers who decide, prioritise tasks and ensure that those tasks are performed by appropriate and skilled personnel. Furthermore, managers make plans, organise, direct or guide and supervise/monitor activities to achieve the organisational goals and objectives. However, in this study they are also considered as the leaders. The

question is how and why managers are considered as leaders , as explained in Section 2.4.4.

2.4.4. Relationship between leadership and management

Understanding the relationship between management and leadership varies among authors. Management and leadership are two different terms with their specific skills, however, they are the two necessary components and their balance in an organisation drives it to success (Nelson 2005; Johnson 2015). Some authors separate leadership from management, while others acknowledge leadership is a part of management. Ricketts argues that management involves activities that practice “executive, administrative and supervisory direction of a group or organisation” (2009, p.22), while leadership involves the individual influences to achieve goals. This means that leadership relationships have an important role. Kouzes and Posner (2017) also differentiate leadership from management arguing that in management most activities are about analysis, with the focus on objectives, while leadership activities require more creativity and focus on vision. Managers manage a task, but leaders lead the way to do the task (Nelson 2005). Managers plan, organise, direct, and control in an organisation while leaders focus on employees as important tools for success (Johnson 2015). This indicates that employees are valued by leadership. Veber (2002 cited by Mládková 2012) and Mládková (2012) agree that leadership is a tool used in everyday activities of management to achieve a positive outcome. However, managers are not always leaders (Johnson 2015). Johnson (2015) suggests, leadership qualities are one of the most important strengths that a manager should have for the sustainability and success of an organisation.

Competence and capacity are the other two terms/concepts that were linked to leadership and management. Consequently, their roles are discussed in the following sections.

2.4.5. Leadership competence

To fulfil leadership responsibilities, leaders require competence. Tabassi et al. (2016) argue that although in the twenty-first century, more attention has been paid to effective leadership than ever before, insufficient research has been conducted on leadership competencies including the quality of leadership in the area of sustainable development. Leadership competence includes three components: personality traits;

knowledge/skill; and behaviour (Cumberland et al. 2016). These authors combined knowledge with skill and assessed them with one unified tool. While Seemiller and Cook have used values and abilities to define competencies

> "leadership competencies are knowledge, values, abilities and behaviour that help an individual contribute to or successfully engage in a role or task" (2014, p.67).

They have not used the 'skill' as a competence element. While skills might be a critical element for a leadership role, leadership itself interacts with a group of people. For leadership, social relationships are important, which requires other skills (Johnson 2015). Lucia and Lepsinger (1999) have also used the term 'competence' in their three-tiered pyramid model to describe knowledge, skill, characteristics and behaviour as the required components to be effective on the job. They have put personal characteristics at the base of the pyramid. Knowledge and skills are placed at the mid-tier and behaviour have come at the top of the pyramid (Lucia and Lepsinger 1999) (Figure 2.2). In this model, personal characteristics are native talents or aptitudes showing how a person has the potential to acquire skills (Lucia and Lepsinger 1999). Personal characteristics are also shaped by culture (Tubbs and Schulz 2006) and different cultures value different characteristics (Kowske and Anthony 2007; Cumberland et al. 2016).

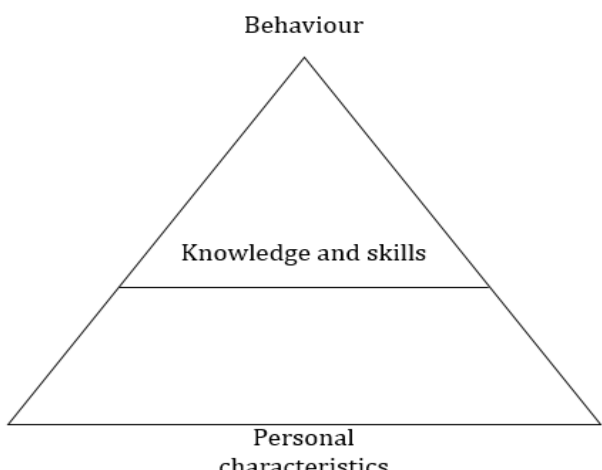

Figure 2-2 Three-tiered pyramid model for leadership competence (Lucia and Lepsinger 1999)

Knowledge is a complex process of remembering, relating or judging an idea or abstract phenomenon (Bloom 1956). A more recent definition of knowledge is by Seemiller and Cook (2014), who define knowledge as information that helps one to know and engage in an intended behaviour, which can include understanding models, practices, theories and processes. Skill defines an individual's ability to execute specific tasks that can be learned over time (Caligiuri 2006), while Seemiller and Cook (2014) interpret skill together with motivation as the ability to connect a person to engage in a particular behaviour. The final component, behavioural competence, is required to translate all those personality traits, knowledge and skills into action (Cumberland et al. 2016). Seemiller and Cook (2014) define behaviour as an effective engagement of competence. Knowledge is most pertinent to the role of leadership (Cumberland et al. 2016). This implies that leadership can be taught and can be learnt. It is particularly important in organisational management and is largely gained by education and training (Cumberland et al. 2016). Similarly, leadership training develops not only leadership knowledge but also skills and behaviour (Collins and Holton 2004; Littrell et al. 2006; Hendricks et al. 2010; Cumberland et al. 2016; Herd et al. 2016). This means that competencies like knowledge, skills and behaviour influence each other and cannot be easily separated.

Leadership knowledge and education have gained significant importance in recent years (McCauley et al. 2004; Pearce et al. 2006). Various studies have produced many reasons for this. Almost three decades ago Drucker (1992) identified that the age of work related-knowledge had started and was enhancing the contribution of skilled professionals. Current leadership development focuses on the individuals who occupy leadership positions and/or are considered to occupy such positions (Pearce 2007). Organisational performance is driven by knowledge acquisition, development and use (Lord and Shondrick 2011). Cumberland et al. (2016) introduce a leadership development framework, which includes approaches that help leaders improve the three competence components (characteristics, knowledge/skill and behaviour). Although this framework was developed for global leadership (i.e. those who lead organisations in more than one country), Thomas et al. (2014) suggest that the approaches of this framework are commonly shared between global and domestic leaders.

To summarise this section, as leaders influence the achievement of the organisational goals, their competences are found to be critical for the success of an organisation. Although different scholars have introduced different elements for leadership competence, this PhD study considers the elements of competence introduced by Lucia and Lepsinger (1999), containing personal characteristics, knowledge/skills and behaviour. Leadership competence is gained through relevant qualification. Therefore, to find out about the leadership competence in an organisation, leaders' qualifications need to be assessed.

2.4.6. Capacity: Definitions and synonyms

Capacity has a direct link to the performance of an organisation and consequently to the achievement of the organisational goals and objectives. This is why the terms 'capacity' and 'capacity building' became part of public or governmental services in the US in the 1980s (Gargan 1981). Capacity and capacity building have come to describe governmental work, to discuss public services or organisational performance (Moynihan and Ingraham 2004; Christensen and Gazley 2008; Andrews and Boyne 2010 and Björk et al. 2014). Capacity is not limited to a single academic community or discipline. It is being increasingly developed in fields such as business, non-profit management and public-sector management and administration (Christensen and Gazley 2008).

Capacity is, however, a difficult concept to define (Crisp et al. 2000). Different organisations and contexts give different meanings to and definitions for capacity (Goodman et al. 1998; Tang et al. 2005). The earliest definition of capacity in the literature is the government's ability "to do what it wants to do" (Gargan 1981, p.656). In this definition, Gargan used the term 'ability' as the synonym of 'capacity'. Later, Goodman et al. (1998) provided a more comprehensive definition of capacity as the ability to achieve key goals and objectives. They also used the term 'ability' to describe 'capacity'. Here, Goodman and colleagues link capacity to the achievement of goals and objectives, however, they did not consider how to efficiently and effectively achieve those goals. Perhaps the easiest definition of capacity is from Yu-Lee (2002) as 'the organisational ability to work'. A more expanded definition is provided by Ingraham et al. (2003, p.15):

> " ….. (a) government's intrinsic ability to marshal, develop, direct, and control its financial, human, physical, and information resources".

In this definition, the use of ‘marshal, develop, direct and control' demonstrates a systematic approach toward progress. However, it doesn't indicate the achievement or effectiveness of those efforts. This definition shows capacity as the ability to use resources in addition to the availability of resources themselves. It means that if managers are able, then not only can they use their existing resources properly but will also be able to gain more resources. For example, capable managers can raise funds easily and can utilise the available funds properly (WHO 2008).

After Ingraham et al. (2003), it appears that ‘ability’ is not used for the definition of capacity. Christensen and Gazley (2008) define capacity as the resources and conditions necessary to achieve organisational effectiveness. The term ‘conditions’ is a broad one, however, it includes those conditions that bring achievement to the organisation and the term ‘effectiveness' adds to its value. It is argued that the definition of capacity is dependent on differing natures and contexts. These terms provide a general definition for capacity rather than a specific one. Competence is another term used synonymously with capacity (Gargan 1981; Eisinger 2002). While discussing capacity in a health context, some authors have not defined what capacity really is and what component/s it consists of (Smith et al. 2006; Bowen et al. 2009; Lê et al. 2014). The easiest definition of capacity in regard to the health sector is the ability to carry out the stated objectives (Goodman et al. 1998). While the United Nations Development Programme (UNDP) (2009, p.53) defines capacity as:

> ‘‘The ability of individuals, institutions and societies to perform functions, solve problems and set and achieve objectives in a sustainable manner.”

Capacity and capacity building are used interchangeably in the management literature but are not typically differentiated and so these terms will now be explored.

2.4.7. Relationship between capacity and capacity building

Both capacity and capacity building are widely discussed in the literature as a necessary aspect for a good management system. However, the majority of papers do not differentiate between these terms. Many do not debate whether there is any difference between the two or not. Honadle (1981) has distinguished between the two, defining capacity as the means to performance and capacity building as the

efforts to improve performance. Studying capacity building alone, Smith et al. (2006) define it as the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. If both Honadle (1981) and Smith et al.'s (2006) arguments are considered together, then capacity itself is knowledge, skills, commitment, structures, system and leadership. Management capacity and leadership have an important role to play in staff and organisational performance. The term organisational performance is discussed below.

2.4.8. Organisational performance

Performance does not have a universal definition; however, efficiency and effectiveness are linked when there is a discussion about performance (Christensen and Gazley 2008). The performance of organisations can be assessed (Andrews and Boyne 2010). Different aspects can affect the performance of an organisation. One of the aspects that positively affects performance is organisational capacity. There are debates on the relationship between capacity and performance (Christensen and Gazley 2008). Capacity is closely related to performance but does not mean performance itself but is rather the means to perform (Björk et al. 2014). Björk and colleagues (2014) also argue that capacity to perform is different from the performance itself. Ingraham et al. (2003), describe capacity as the input and performance as the output (or outcome) of a management system.

Organisational performance also relates strongly to the leadership of organisations. Andrews and Boyne (2010) found that the leadership has a significant role in the performance of organisations because the leadership utilise the capacity of an organisation to perform and enhance the impact of capacity. Therefore, their commitment is important. Research found a positive relationship between the affective commitment and the leaders' performance (Preston and Brown 2004). Those who were emotionally attached to their organisations were more likely to work effectively and enthusiastically towards the organisational goals than the ones who had weak commitment.

The financial management system, the interest of different stakeholders and organisational characteristics are other aspects that can affect the performance of an organisation (Andrews and Boyne 2010). However, Andrews and Boyne have discussed the financial management system but not the shortage of resources or

funding, which may be a common challenge in LICs and can affect the organisational performance. A shortage of resources is a significant barrier because it affects employee performance and productivity (Turner and Short 2013; Mkoka et al. 2015). Different definitions and synonyms of capacity were provided above, however, there are many other concepts related to capacity that are necessary to understand in this thesis.

2.4.9. Dimensions of Capacity

Gargan (1981) argued that capacity is multi-dimensional but did not specify these dimensions. Additionally, Gargan's (1981) study was on governmental capacity, which comes under organisational capacity in today's research. It seems that in Gargan's time, capacity dimensions were undefined until later. In their study on community capacity, Goodman et al. (1998) suggested that capacity is multidimensional and introduced dimensions of capacity. Although some dimensions are different from those in management capacity, leadership, skills and resources were introduced as similar to the management capacity introduced in contemporary studies.

Different authors have suggested different dimensions to capacity. Similarly, different authors have named variables, elements or components to dimensions. Eisinger (2002) introduced elements to capacity, which included resources, effective leadership, skilled and sufficient staff, institutionalization and external linkages, while Ingraham et al. (2003) propose the four elements of finance, HR, capital and IT systems. Moynihan and Ingraham (2004) argue that leadership is not only a separate variable but also interacts with other capacity variables to perform. They argue that managers/leaders integrate all health management system variables; HR, capital, finance and IT in order to create and direct their organisational capacity.

Some scholars have given tangible and intangible or qualitative and quantitative dimensions to capacity. For example, a sufficient number of managers in an organisation can be tangible or quantitative, while the quality or knowledge of managers is intangible or qualitative (Eisinger 2002; Ingraham et al. 2003). Honadle (1981) argues that although the inputs in the form of resources such as personnel, information, community support and revenue show the capability of an organisation, real institutional strengths lie in less tangible abilities to attract and absorb the

resources. Honadle (1981) emphasises the knowledge and quality of management. From Christensen and Gazley's (2008) systematic review of the last four decades, it appears that scholars agreed that capacity is multidimensional and it is agreed that HR, capital, finance, IT with leadership are the five dimensions of capacity.

Different sectors focus on different dimensions of capacity. For instance, business focusses more on finance, while the public-sector administration focusses more on HR and management. Christensen and Gazley (2008) criticise the literature and argue that time should be used as a variable of capacity to describe how and when a change in processes and structure supports or hinders capacity or performance. Table 2.1 describes the dimensions of management capacity that are introduced by Christensen and Gazley (2008) in the context of an organisation.

Dimension	Structures, resources, functions	Strategies and processes
Human resources	Motivation (employee, volunteer, public service, etc.) Knowledge base	Training Planning, scheduling Managerial decisions
	Experience	Turnover
	Quality and quantity of personnel	Timing of decisions
	Leadership/management qualities	Internal policies
External	Relationships Trust	Public participation Linkages to external knowledge
	Contract management	Network processes, exchanges
	Regulatory/statutory environment	Collaboration and integration
	Government Structure	(of services, products)
	Level of autonomy	Competitor behaviour
	Client characteristics, behaviours	Demand for services, products
	Dominant logic (in inter-organisational relationships) Information (quality, quantity, nature, flow)	Market dynamics
Infrastructure	Computer, IT	Information exchange, communication systems
	Organisational culture Production system Combinative capabilities Research Organisational size Organisational structure Inventory	Integration of systems
Financial	Revenues Assets Financial planning, management systems Cost of labour	Capital investment

Table 2-1 Variables and measures of capacity (Christensen and Gazley 2008, p.275)

Table 2.1 shows the four dimensions including HR, external, infrastructure and financial. All four dimensions represent the componants of management capacity. Each of them has structure, resources and functions. Each of them has its particular

strategy and process to be carried out. In addition to the capacity dimensions, capacity levels are other terms that are introduced for the organisational/management capacity (Section 2.4.10).

2.4.10. Capacity levels: individual, organisational and system level

Capacity is not only introduced in the management system of an organisation but also introduced at different levels including organisation. For instance, Bowen and Zwi (2005) argue that capacity includes the expertise and resources at the individual, organisational and system levels. Accordingly, at the individual and organisational levels, the main capacity factors are skills, competencies, leadership, partnership and an appropriate workforce, organisational structure and good mobilisation and allocation of resources. Key capacities at the system level consists of policies, processes, politics and people. Nine elements of health systems have been recognised, which also covers individual and organisational capacity (Potter and Brough 2004).

1. Performance capacity
2. Personnel capacity
3. Workload capacity
4. Supervisory capacity
5. Facility capacity
6. Support service capacity
7. Systems' capacity
8. Structure capacity
9. Role capacity

Christensen and Gazley (2008) have indicated three main levels: individual, organisational and national. This is similar to that of Bowen and Zwi (2005), with the small difference of a ‘system’ level instead of ‘national’. Bowen and Zwi (2005) argue that the capacity required at the system level includes economic, politics, values and ideology. These four categories are achievable only if they are considered at the national level rather than at the individual or organisational level and that the variables can sometimes overlap between the levels of capacity. Although organisational capacity has been widely considered (Björk et al. 2014), the relationship between organisational capacities with individual capacity and their

interaction, has been insufficiently addressed even though organisations include individuals. Within this context, the capacity of individuals definitely affects organisational performance. This has instead been described as HR, which is one of the dimensions of organisational capacity. In some studies, organisational capacity is synonymous with managerial capacity (Ingraham et al. 2003; Christensen and Gazley 2008) because managers have the responsibility of guiding the management system in an organisation which includes finance, HR, capital and IT issues.

Andrews and Boyne (2010) found studies which have suggested that capacity has degrees and different degrees can influence the performance of an organisation. However, the degree of capacity was not discussed by other scholars of this review. Andrews and Boyne (2010) have not, however, described or elaborated on the degree of capacity. This potentially alludes to the notion that the better the capacity, the better the performance and the reverse holds true. Examples of this degree might be; lack of capacity, low capacity or high capacity. Christensen and Gazley (2008) also found that understanding the context in which the capacity and its meaning are used is important. For instance, 'production capacity' or 'transformative capacity' is recognised in the business contexts and literature. In contrast, 'collaborative capacity' or 'policy implementation capacity' can be seen in public and non-profit management literature.

Summarising this section, to study the capacity in an organisation, it is important to understand the capacity levels. It is also important to decide which levels need to be studied. Some studies may only need to assess individual capacity in an organisation, others the organisational capacity or sometimes there is a need for the assessment of the entire system. Studies also discussed which aspects of capacity need to be assessed at each level. Some literature use competencies to describe leadership quality, while others use the capacity to explain it. To avoid any confusion, Section 2.3.11 explains their similarities and differences and clarifies the use of each.

2.3.11. Competence versus capacity

Although competence is synonymous for capacity by some scholars (Gargan 1981; Eisinger 2002), leadership competence only focuses on the quality of leaders including characteristics, knowledge/skills and behaviour. It does not link to other organisational or managerial aspects such as resources or other supports. It has an

individual level focus not organisational or management. While capacity, as can be seen in Section 2.4.6, has an individual as well as managerial or organisational focus. It means that it covers the ability or the quality of individuals as well as the whole organisation such as capital, IT, HR and finance. Therefore, competence can be seen to be used at the individual level such as leaders' competence, whereas, capacity can define the quality of the entire management system. With the addition of an understanding about competence and capacity, it was also important to understand how they were assessed in an organisation by other scholars. Sections 2.4.12 -13 explain how competence and capacity are assessed.

2.4.12. Leadership competence assessment

As previously discussed, leadership competence consists of three elements: (a) personal characteristics; (b) knowledge/skills; and (c) behaviour, so, to assess competence in its totality each component needs to be assessed. Cumberland et al. (2016) found in their literature review that leadership competence is usually assessed using tools. They reviewed 98 research papers and book chapters on leadership competence assessment and their review focused on studies from the last 15 years. Few examples of tools were found that are used for the leaders/managers' competence assessment in health organisations. One such tool is the competence self-assessment inventory developed by (Management Sciences for Health (MSH) 1998). This tool was a questionnaire completed by leaders/managers themselves to assess their own qualities. Another was a competency framework developed by Senior Management Services (SMS) (2003) that is used in the related health organisations to assess the competence of health managers.

Cumberland et al. (2016) argue that the assessment of knowledge and skill is difficult. It might be the reason that few assessment tools have been identified, which seems to be a gap in knowledge and understanding. However, as mentioned above, leadership knowledge can be gained by education and training (Cumberland et al. 2016), so in order to assess leadership knowledge, the training and education that a leader receives can be assessed. To assess the leaders' competence, the qualification of leaders is assessed by the WHO's framework (2020a). This framework has already been used to evaluate managers' competence in health organisations (WHO 2009) to improve expected performance goals.

2.4.13. Management capacity assessment in an organisation

Organisations need to achieve their expected performance targets. To do this, they need to have the appropriate capacity. They need to assess whether they have the required capacity to fulfil their organisational goals. It is, however, difficult to measure or assess the capacity of an organisation (Crisp et al. 2000). Similarly, there is not a unified tool to measure the capacity of an organisation. Different frameworks and theories have been used for capacity assessment. Andrews and Boyne (2010) conducted an empirical study using the Black Box Model. They defined the management system as ''Capital management, financial management, HRM, IT management, and leadership''. Each has an important role in delivering high performance (Andrews and Boyne 2010, p.444). Hence capacity assessment includes the assessment of the whole management system.

Some authors, such as Lê et al. (2014), have carried out a capacity assessment based on the levels of capacity; individual, organisational and national. Others such as Mirzoev et al. (2014) have studied two levels: individual and organisational. Exploring capacity, according to the framework of Lê et al. (2014) would need more time. For example, the external linkages such as organisations that the organisation has a partnership with are fields that require assessment, which in turn needs more time. All these indicate that the assessment of the organisational capacity is difficult as Crisp et al. (2000) argued in the above. Some scholars such as Björk et al. (2014), have used managers' perceptions to assess organisational capacity. They argue that managers work in the centre of organisations and therefore have a better understanding of the obstacles they face and the problems to be solved.

To summarise this section, to study management capacity in an organisation, some have used management capacity frameworks, which includes the components of finance, capital, IT, HR and leadership. Some have used the capacity levels to study management capacity and finally some other have studied the managers' perceptions because managers are in the centre of an organisation and have an understanding of all aspects.

Culture was another concept that was found to be linked to leadership and capacity. Although it seems different from the above terms and concepts, from the review, it was found to be an important concept relevant to leadership and the organisational

achievement. To study the management capacity and leadership, it was necessary to have an understanding of the concept of culture. It is discussed below.

2.4.14. Leadership and culture

Culture is defined as:

> "shared motives, values, beliefs, identities, and interpretations of meanings of significant events that result from common experiences of members of collectives and are transmitted across generations" (House 2004, p.15).

Unlike all the definitions discussed above on leadership, Schein (2010) believes that leadership is the ability to step outside of the prevalent culture to initiate evolutionary changes, which are more adaptive. This definition is a little different from others in this review, in that it refers to achievement as a result of evolutionary change. Culture has been shown to be an important concept for leadership, although none of the definitions of leadership in section 2.4.1 considers culture. Delgado (2014) argues that cultural differences play a significant role in leadership effectiveness and criticises the implementation of leadership models from abroad without adapting them to local culture. He also claims that culture influences the ways in which people think about leaders and the privileges that are granted to leaders. Thus, leaders should adapt their behaviour according to context and culture and must know which traits or characteristics to develop (Kowske and Anthony 2007). This argument supports the Schein's claim that;

> ".. if elements of a culture become dysfunctional, it is the unique function of leadership to perceive the functional and dysfunctional elements of the existing culture and to manage cultural evolution and change it in such a way that the group can survive in a changing environment"(Schein 2010, p.22).

'Managing cultural evolution' means adapting behaviour according to the context. According to Schein (2010), it is the leaders' roles who bring changes in those cultures in an adaptive and appropriate way; or those might be the missing elements to be discovered by the leaders. Mládková (2012) argues that leaders are those people that emerge in a critical situation. They need to adapt their competencies according to the context they work in; otherwise, they will not be successful leaders and will face obstacles when they are not aware of the context and culture, they work in.

Having understood the related terms and concepts around the management capacity and leadership, now it would be more helpful to see those concepts in an interrelated link within a framed-theoretical context. Section 2.5 will help clarify their positions and how they link to each other in the context of an organisation.

2.5. Theoretical Context

An extensive examination of the literature indicates there are many theories concerning leadership that have been introduced by a variety of different authors (Burns 1979; Mládková 2012). Amongst them are two relevant theoretical models that consider management capacity and leadership strengthening. The first is the 'Black Box Model of management capacity' (Moynihan and Ingraham 2004) and the second is the 'Leadership and Management Strengthening Framework' developed by WHO (2007); both of which are described below. The literature review also discusses two other frameworks from Burgess (1975) and Christensen and Gazley (2008). However, the Burgess Framework (1975 cited by Gargan 1981) was criticised as being theoretical rather than descriptive. Meanwhile, it does not seem to have been used in later studies, as no study about capacity in this review has cited or mentioned it. The framework described by Christensen and Gazley (2008) is not an original one, neither was it used in the management capacity by others. Conversely, the Black Box Model and the WHO frameworks have been used by many studies to assess management capacity. Therefore, these two frameworks are considered in this literature review.

2.5.1. Black Box Model of management capacity

The majority of studies use four dimensions (finance, HR, capital and IT) for management capacity. The Black Box Model added leadership to the other aforementioned dimensions to propose five dimensions of management capacity: finance, HR, capital, IT and leadership (Moynihan and Ingraham 2004).

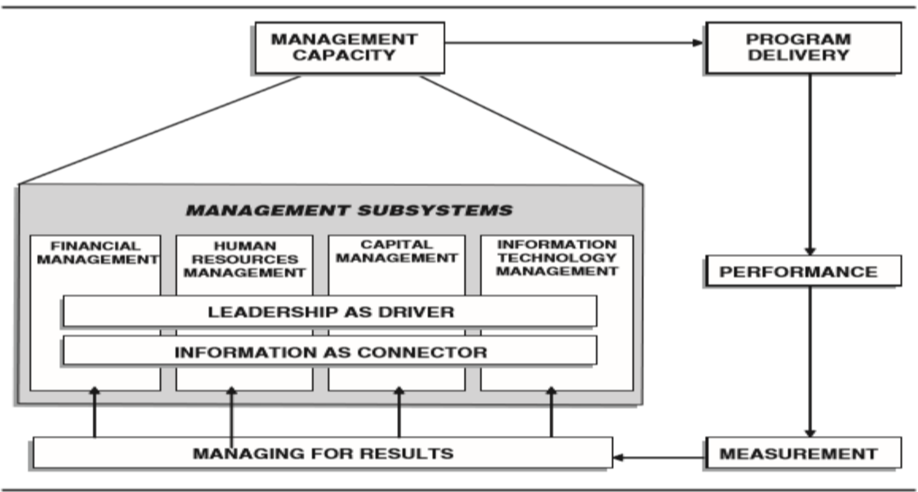

Figure 2-3 The Black Box Model of management capacity (Moynihan and Ingraham 2004, p.429)

It is arguable that managers/leaders can be included in the HR dimension consisting of all staff including managers and heads of departments; however, leadership has purposefully been placed in the centre of the Black Box Model. The ‘subsystems’ term used in the model are those components that have come as four dimensions of capacity in other studies. Moynihan and Ingraham (2004) argue that leadership should be located at the heart of the Black Box of capacity (Figure 2.3), claiming that leaders find ways to integrate management subsystems to achieve organisational goals.

Many studies have applied the Black Box Model when they have described organisational capacity and its dimensions (Christensen and Gazley 2008; Andrews and Boyne 2010; Björk et al. 2014). By this model, the organisation is viewed as a black box where the integrative role of managers uses and transforms inputs such as HR, finance, capital and IT into the output and organisational outcome (Björk et al. 2014). This means that leadership acts as a standalone variable. In the Black Box Model, the discussion’s point and focus is on the role of leadership and the integration of the other four dimensions by leadership for a better performance, as other terms in the diagram (Figure 2.3) such as 'Information as connectors', 'measurement', 'managing for results' and 'programme delivery' are not described in detail.

2.5.2. Leadership and Management Strengthening Framework

This framework was developed by the WHO after an international consultation on strengthening leadership and management in LICs (WHO 2007a). It was then introduced for strengthening management capacity and leadership (WHO 2009).

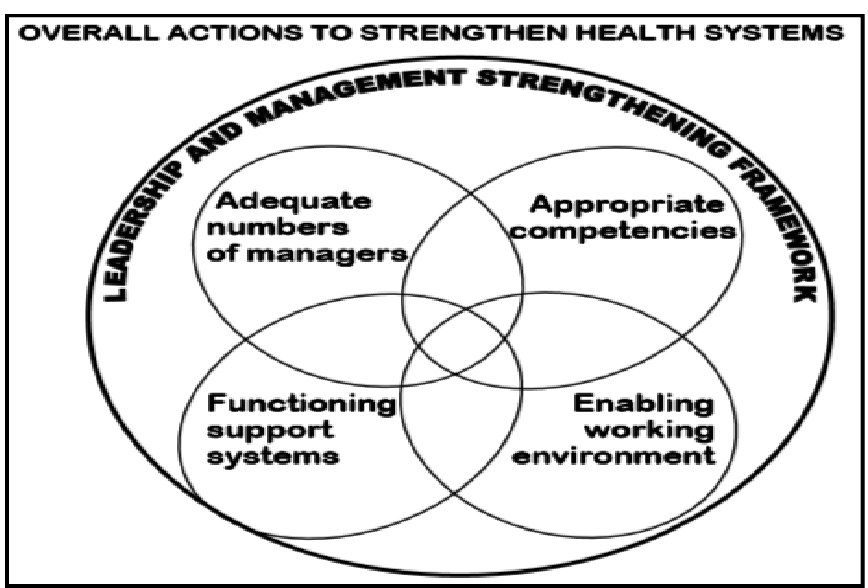

Figure 2-4 Leadership and Management Strengthening Framework (WHO 2007a, p.11)

To develop the framework, management issues were brought together and then the lessons learned were shared and discussed (WHO 2007a). Though the framework is developed for LICs, it may also be relevant to other countries (WHO 2020a). Although it is not mentioned how it may be relevant to other countries, it is apparent that all four dimensions can be assessed. This framework (2007) contains four main components: adequate numbers of managers, appropriate competencies, enabling working environment and functioning support systems. The WHO (2020a) describes all elements of each dimension in its website, which makes the assessment easy. Table 2.2 is used to show some of the examples of each of the dimensions' elements introduced by the WHO on its website.

Number and distribution of managers	Appropriate competencies	Management support systems	Enabling working environment
• Managemen t/leadership • Staffing levels • Workload indicators of staffing needs	• Use of competency models/ Frameworks	• HR • Financial resources • Information system • Drugs and supplies • Equipment, vehicles and buildings • Procurement system • Time management • Knowledge management	• Rehabilitation of the workforce • Creating a positive work climate • How to motivate staff • Identifying factors for job motivation • Developing a salary policy • Individual coping strategy when staff is underpaid • Chief Executive Officer online motivation; needs, rewards, reinforcements, expectations

Table 2-2 Examples of elements of each dimension of WHO's framework (2020a)

2.5.3. The Black Box Model versus Leadership and Management Strengthening Framework

The Black Box Model has been used in multiple contexts such as social services, schools, housing, libraries and the environment (Andrews and Boyne 2010), but no paper in this review was found using this model in a health context. In contrast, the WHO framework (2020a) was developed specifically for management capacity and leadership assessment in the health context. The WHO framework dimensions are different from those of Moynihan and Ingraham (2004), although some dimensions can be related to dimensions in the Black Box Model. For example, the number and distribution of managers can be included in HR. Some other dimensions like finance

in the Black Box Model cannot be included in the WHO's framework (2007). However, finance has been included in the management support system of the WHO framework (WHO 2007). The WHO framework has introduced the elements of each dimension clearly (Table 2.2), while these were not introduced in the Black Box Model, which may create confusion because different assessors will use different elements. A WHO report (2009), is an example of three case studies in Ethiopia, Ghana and Tanzania for the assessment of the capacity of government health officials, using the WHO framework. There is one main similarity between WHO (2007) and Moynihan and Ingraham's theories (2004), and that is the management capacity and leadership by which the organisational goal (s) can be achieved. Leadership is recognised as the driver of other dimensions in Moynihan and Ingraham's model (2004). At the same time, the WHO framework (2007) also covers all aspects of management and leadership.

The Black Box Model (Moynihan and Ingraham 2004), and the Leadership and Management Strengthening Framework (WHO 2007a) both suggest that the assessment of management capacity and leadership is to be undertaken using a case study approach. This is because a case study provides a more detailed picture of a situation (Yin 2013). This approach uses all types of evidence including documents, observations, interviews and surveys (Gillham 2010). This was one of the reasons that case study was selected to do this study, the detail is explained in Section 4.3.

2.6. How the reviewed concepts and frameworks work in this PhD

Reviewing the terms, concepts and the two theoretical frameworks helped to elaborate their importance and links to each other and how each of them is placed within an organisation. As a result, the following points guided this PhD study:

- Leadership and management are considered as complementary elements.
- Management system includes capital, finance, HR, IT and leadership dimensions.
- Leaders are located at the centre of management capacity.
- Competence is crucial for the critical role of leaders.
- Qualification of leaders/managers can help to measure competence.
- Ensuring an enabling working environment is the responsibility of leaders.
- Leaders need to manage the organisational culture.

- Leaders need a functioning support system.
- For good performance, an organisation needs capacity and to assess its capacity.
- Organisation needs to provide capacity building.

2.7. The scoping review summary

All the reviewed research papers about management capacity were carried out in governmental and public contexts. ‘Organisational capacity’ is synonymous with the term management capacity (Gargan 1981; Moynihan and Ingraham 2004; Andrews and Boyne 2010; Bryan 2011; Björk et al. 2014). Most papers discussed capacity in governmental organisations; a few studied the capacity of local governments (Gargan 1981; Andrews and Boyne 2010). Most of the reviewed literature and research was carried-out in high-income countries, e.g. US scholars. Gargan (1981) and Moynihan and Ingraham (2004) have played important roles in developing the concepts of capacity and its dimensions and frameworks.

It seems the scholars have slowly reached one unified idea about management capacity. They accepted leadership as a dimension of the management system, which has a significant role in the integration of other dimensions in an organisation to transfer inputs into outputs (or outcomes). The importance of managers/leaders in organisational capacity has become more evident in recent decades (Ingraham et al. 2003; Moynihan and Ingraham 2004; Christensen and Gazley 2008; Andrews and Boyne 2010). Researchers have discussed the important role of every dimension of the management system; finance, HR, capital, IT and leadership. However, what would happen if the leaders and managers lacked capacity, or possessed lower capacity or their capacity was affected by factors was not discussed in these papers.

The decision to focus on management capacity and leadership was informed by the Black Box Model and WHO framework (Moynihan and Ingraham 2004; WHO 2007a). Leadership is a common theme in both and is located at the centre of the management and organisational capacity. Whilst the other components, such as finance, IT, capital and HR are important, leadership capacity is seen as the critical component of the management system (Andrews and Boyne 2010). Leadership improves the service delivery and consequently maximises the impact of the management system’s effectiveness (Gargan 1981; Moynihan and Ingraham 2004;

Christensen and Gazley 2008; Björk et al. 2014). Indeed, resources such as finance, IT, HR and capital availability cannot be effective unless there is leadership competence to use those available resources (Ingraham et al. 2003). Leadership qualities are instrumental in turning a poorly performing organisation into a top performer (Joyce 2004). In contrast, performance failure has also resulted from:

> “a lack of leadership in driving performance improvement (more) than from weak organisational structures and processes” (Andrews et al. 2006, p.289).

However, it is important to evaluate whether managers have capacity, which has been adversely affected by other factors and is therefore not used due to obstacles, or whether they possess lower capacity or lack of capacity altogether. According to Andrews and Boyne (2010), governments have responded to managerial capacity as a challenge but the impact of their work on the organisational outcome is limited. Although capacity and its important role in management and managers’ work has been extensively studied worldwide (Andrews and Boyne 2010), fewer research papers were found on factors that affect the managers’ capacity.

Earlier studies had focussed on the definition and nature of capacity itself (Gargan 1981). Subsequent studies searched and suggested dimensions for capacity (Goodman et al. 1998; Ingraham et al. 2003). Over the following decade or so, management capacity and leadership frameworks were developed (Moynihan and Ingraham 2004; WHO 2007a). In these frameworks, leadership was placed at the centre of management capacity in an organisation. This study attempts to discover which factors affect the management capacity, leadership and their employee performance.

Chapter 3: Literature review

3.1. Introduction

A literature review was carried-out to identify the contribution of leadership competence to organisational performance in LMICs. It helped to establish what was and was not already known on this topic. The importance of the literature review is ever more recognised in health and social care (Aveyard 2014).

To answer the specific question, only the literature related to health were considered. Research papers from LMICs were included, as they have their own relevant factors and underpinning determinants. As management capacity and leadership of the MoPH was the topic of interest, literature from health-related organisations was thought to be helpful. The plan was to only include papers from the overall management of health organisations and not clinical or management of health facilities or hospitals. Following a comprehensive literature search, it became apparent that articles, particularly about LMICs were scarce. Instead, papers related to health were included whether from entire organisations, health care services or hospitals.

From the informal search and review of relevant papers, the current literature shows that there is a substantial knowledge gap on this topic. Consequently, this research topic has not been considered in depth. Therefore, it was decided to include articles that addressed the research question either partially or completely. The aim of the literature review is to explore leadership competence specifically related to the leaders' abilities but no other aspects of support in the organisations. However, in the preliminary search, leadership competence was found to be associated with many other management aspects, such as management support, HR or financial support. Therefore, any aspect related to leadership that caused success or failure in an organisation, hospital or health facility was included in order to provide a broader picture around this topic. Table 3.1 presents a summary of the review framework. The research question was;

'*How leadership competence contributes to health organisational performance in LMICs?'*

Literature review framework
LMICs
Related to health
Health organisations, health system, health facilities or hospitals.
Leadership competence/capacity

Table 3-1   Summary review framework

3.1.1. Search strategy

The search strategy consisted of four components to retrieve the literature:

- The literature was searched from nine databases including Complementary Index, Academic Search Complete, Science Direct, Business Source Ultimate, Education Source, Medline Complete, SocIndex with Full Text, Cinahl Complete.
- Websites were searched for grey literature on leadership competence (e.g. WHO website)
- Direct contact with authors – this is sometimes called snowballing (Aveyard 2014). The authors of studies which met the study criteria was contacted.
- The reference lists of studies which met the inclusion criteria were hand searched

In order to capture all important terms, the Thesaurus.com website was used to help identify potential search terms, which are also recommended by (Aveyard 2014). The main terms (‘leadership’, ‘competence’, ‘contribute’, ‘performance’, ‘health and LICs’) and their alternatives were entered into Boolean operators for search. As explained in Section 2.4, before doing a formal search for literature, a preliminary search of the literature from developed and LMICs was done. This suggested that the factors affecting the work of health managers in LMICs were different from those in developed countries. The WHO also reports low management capacity in LMICs rather than developed countries (2008). Therefore, the search strategy included the

terms LMICs but not developed countries. It was also decided to put the term ’health’ in a separate row of Boolean operators, because in the informal preliminary search most of the papers were related to fields other than health, such as engineering (i.e. mechanical capacity) though the term ‘health’ was combined with other terms such as ‘health leadership’ or ‘health managers’. Table 3.2 demonstrates the search terms and their alternatives.

Search terms and alternatives	
Search term 1:	leadership OR leader* OR ‘’senior manager*’’ OR ‘’health manager*’’ OR manager* OR director* OR executive*
Search term 2:	competence* OR knowledge OR qualification* OR skill* OR characteristic* compatibilit* OR abilit* OR aptitude OR capability OR efficienc*
Search term 3:	contribute* OR influenc* OR add* OR grant* OR affect* OR suppl*
Search term 4:	performance* OR ‘’organisation performance’’ OR ‘’health achievement*’’ OR achievement* OR success* OR ‘’service improvement*’’ OR ‘’good service*’’ OR failure OR breakdown OR collapse* OR defeat* OR fail*
Search term 5:	Health
Search term 6:	developing countr* OR Asian countr* OR African countr* OR lower income countr* OR LIC* OR third world OR 3rd world

Table 3-2 Search terms and alternatives

The limiters selected for the search were peer review (for research articles), publication date, source type (journal papers) and language.

3.1.2. Inclusion and exclusion criteria

To obtain clear findings and avoid an abundance of irrelevant literature, inclusion and exclusion criteria were determined. For the publication date, two matters were considered; to achieve a sufficient number of papers in this review, and to obtain the most recent papers that consider leadership in a changing world. Effective leadership is a dynamic concept, which in the twenty-first century is receiving significant attention in order to understand and influence its impact (Andrews et al. 2006; Tabassi et al. 2016). This review limited its focus, therefore, to recently published papers in order to consider contemporary findings of leadership in LMICs. Studies published prior to 2000 do not reflect contemporary thinking.

The researcher's ideas were informed by the wider theoretical and research literature from both developed and LMICs. However, the principal focus was studies on leadership competence conducted in LMICs because of the cultural, economic and political similarities as well as similar challenges and solutions. In other words, studies that have access to huge funds/resources are not generalisable to environments with significant resource constraints. Moreover, LMICs are mostly supported technically and financially by international agencies and NGOs are involved in implementation (WHO 2015). All these factors make comparisons difficult with developed countries, so they were not included in the literature review.

Most UN agency reports have something about leadership. For instance, the WHO reports/policies have always discussed leadership, particularly in LMICs. It was, therefore, decided to include grey literature. The qualitative method research and reviews were included to address the review question. Table 3.3 displays the inclusion/exclusion criteria for the review question.

Inclusion and exclusion criteria	
Inclusion criteria	Exclusion criteria
Leadership competence in health organisations/system/hospital and any other health centre Leadership/management at the national and provincial level Research papers from 2000 to September 2016 Research from LMICs Grey literature Qualitative research papers	Leadership in other fields such as business, education etc. Papers prior to 2000 Studies from high-income countries

Table 3-3 Inclusion and exclusion criteria

3.1.3. Data extraction and studies synthesis

A total of 2121 studies were identified through all search strategies. Applying the limiters, 727 papers remained. Applying the inclusion and exclusion criteria, 686 papers were excluded because they were mainly not research papers, were from non-health fields, were duplicates, and were relevant to developed countries. The remaining 41 papers were screened against the inclusion and exclusion criteria for full text assessment from which 30 more papers were excluded because they were irrelevant to the review question, duplicates or training materials. Finally, 11 papers were included in the review, which had been published between 2004 and 2015 (Figure 3.1).

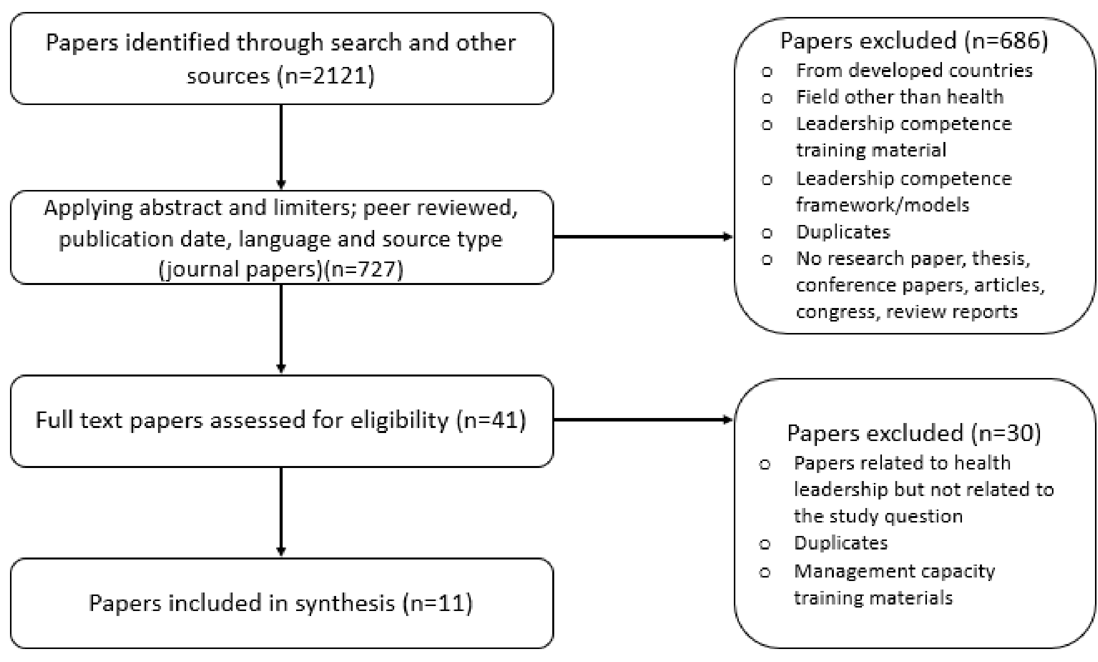

Figure 3-1 Summary of the literature retrieved for review and synthesis

The included papers were assessed for the quality using appraisal tools and the result of the quality appraisal is reported in Section 3.1.4. A thematic approach was used, to sum up, the findings of all the literature. In the findings section of the papers, the data were highlighted and annotated, then the extracts about each theme were grouped together electronically then these groups, as themes, were named. The appropriateness of names was checked for the relevant themes and if they were the proper representative of their included data. The papers' design, methods, aim, main findings, limitation, sample size, analysis, ethical consideration and contexts are summarised in Table 3.4.

3.1.4. The quality of the included papers

The quality of the papers mentioned above, were assessed using the Critical Appraisal Skills Programme (CASP) (2019). It is widely used and acknowledged as a good quality resource (Aveyard 2014), however, this tool addresses particular types of studies, not all studies. For instance, it does not have a tool to appraise mixed-methods studies. The two mixed-method studies were therefore assessed with the Mixed-Methods Appraisal Tool (MMAT) – Version 2011 (Pluye et al. 2011).

Based on the appraisal tools, the literature was assessed as follows: eight papers were of excellent quality with few limitations (WHO 2009; Nankumbi et al. 2011; Latifov and Sahay 2013; Turner and Short 2013; Ulikpan et al. 2014; Mkoka et al. 2015; Mirzoev et al. 2015; Chanturidze et al. 2015). The study of Kolehmainen-Aitken (2004) was categorised as of good quality. Asante et al. (2012) and Jacucci et al. (2006)'s studies were categorised as fair as they did not mention how the participants were selected for interview and how the literature was retrieved and analysed. Appendix 2 illustrates the quality assessment of the included papers.

The WHO report (2009) was assessed as if it was a qualitative study but this had limitations, as the reporting of ethical approval and the researcher's role would not be expected in a report format. However, the University of Canberra (2020) suggests that grey literature needs to be assessed using the same critical appraisal tools. Three studies, (Asante et al. 2012; Jacucci et al. 2006; Kolehmainen-Aitken 2004) did not mention ethical considerations. This is because of the word limitations of journals or because of the country of origin of the study, and different ethical practices in different countries or organisations. The type of study can be another issue: in literature reviews, for instance, the data are analysed, which have already been gathered.

Despite the limitations identified, no paper was excluded. As Noyes (2010) argues that even if the quality of papers is slightly lower than the gold standard, they can still provide valuable insight. The studies of Kolehmainen-Aitken (2004), Asante et al. (2012), and Jacucci et al. (2006) were, therefore, included as they were relevant to the study question and based on the Aveyard (2014)'s argument suggesting that if they were removed then the study would miss some important information. This is perhaps more acceptable when the papers are from LICs, as resources are limited, and research is not common although the findings must be read with caution given the methodological weaknesses. Research is often undertaken under difficult circumstances and there is a shortage of evidence in those countries.

3.1.5. Data extraction and studies synthesis

In total, 11 papers were retrieved for the review. Among those papers, two were mixed-methods (Nankumbi et al. 2011; Latifov and Sahay 2013), one was a case study (Latifov and Sahay 2013). One was a qualitative literature review

(Kolehmainen-Aitken 2004); the eight remaining papers were qualitative. Among the eight qualitative studies, six were case studies. One of these was a report of a study in three LICs (WHO 2009). This report was included because it was directly related to the review question. Three studies were on the capacity of the ministry of health (MOH), two (including the WHO report) were on management capacity, two were on health systems and the four remaining were conducted in health care services and hospitals.

The two mixed-method studies (Nankumbi et al. 2011; Latifov and Sahay 2013) had reported the quantitative findings thematically together with the qualitative data. In this case, all the papers were synthesised in the same manner and the findings were reported together.

The selected studies were from Ethiopia, Ghana, the United Republic of Tanzania, South Africa, Indonesia, Mexico, Malaysia, Thailand, the Philippines, Tajikistan, the Solomon Islands, Kazakhstan, Kyrgyzstan, Mongolia, Turkmenistan, and Uzbekistan, located in the four continents of Asia, Africa, Australia/Oceania and North America.

The participants in these studies were predominantly health managers and health workers such as midwives and nurses and studies were conducted in health care services and hospitals. Whereas, policy makers, health managers and national leaders were the participants of the studies conducted at the MOH and about the health systems (Latifov and Sahay 2013; Chanturidze et al. 2015; Mirzoev et al. 2015).

Besides interviews (individual, pair or group) which was the most common method, the studies included a wide range of data collection techniques including document reviews, observations, participants' observations, reviews of published and grey literature and disk and report reviews. For the quantitative data collection within the mixed-method studies, database analysis and questionnaires were used (Nankumbi et al. 2011; Latifov and Sahay 2013).

The description of data analysis varied among studies; Kolehmainen-Aitken (2004) and Jacucci et al. (2006) did not mention the analysis at all. Nankumbi et al. (2011) carried-out descriptive analysis both for qualitative and quantitative using a framework, SPSS (Statistical Package for the Social Sciences) tool was used for quantitative analysis. Turner and Short (2013) used thematic analysis using NVivo

and then analysed the findings using a theoretical framework. Mkoka et al. (2015) utilise a qualitative content analysis. Mirzoev et al. (2015) used a framework approach for analysis assisted by NVivo software, while Ulikpan et al. (2014) and WHO (2009) used a comparative analysis. The WHO also carried-out analysis based on the WHO framework used by Asante et al. (2012). Chanturidze et al. (2015) used a capability assessment model. Latifov and Sahay's (2013) analysis was an iterative and ongoing process.

No	Author/date	Methodology /Study design	Study methods	Ways papers retrieved	Aims	Main findings	Data analysis	Sample size	Study limitation	Ethical consideration	context/settings
1	Nankumbi et al. (2011)	Mixed -method	Qualitative Quantitative	Database search	To evaluate the impact of introducing PEPFAR (President's Emergency Plan for AIDS Relief) clinical services into government clinics.	Capacity building increased leadership and empowerment which in turn increased efficiency and the quality of services.	Descriptive analysis using a framework	Qualitative: Six Quantitative: not mentioned	Small sample size, clinics from one project.	Yes	Government clinics Kampala, Uganda
2	Mkoka et al. (2015)	Qualitative	In-depth interview Document review Observation	Database search	To explore the perspectives of health workers and managers on factors influencing working conditions.	Governance-related factors affecting health workers' performance.	Qualitative content analysis	22	The study done in one district	Yes	Health care services Kongwa district, Tanzania
3	Turner and Short (2013)	Qualitative	Semi-structured face-to-face interviews (individuals, pairs, group interviews)	Database search	To explore the barriers and enablers of evidence-based practice change at the hospitals.	Lack of knowledge and skills, beliefs about consequences, perceptions of feasibility, social issues like hierarchy and leadership, and resourcing issues were the factors influencing the evidence-based practice.	Thematic analysis using NVivo and theoretical framework	179	The planned number of staff were not interviewed	Yes	Hospitals Indonesia, Malaysia Thailand Philippines

No	Author/date	Methodology /Study design	Study methods	Ways papers retrieved	Aims	Main findings	Data analysis	Sample size	Study limitation	Ethical consideration	context/setting
4	Kolehmainen-Aitken (2004)	Literature review	Review	Database search	Assess impact of decentralization one demand side of HR equation, and contributing factors	Three issues need urgent action: (1); availability of HR policy, planning & management skills, (2) equity in staffing & (3) motivation.	Not mentioned	N/A	No explanation literature retrieval & analysis	Not mentioned	(Health system) South Africa, Ghana, Indonesia, Mexico
5	Jacucci et al. (2006)	Case study	Interviews, direct and participant observation, physical artefacts and documentation	Database search	To develop a theoretical concept of local sustainability in order to contribute to the discourse on the sustainability of information system in LICs.	Local sustainability is a continuous-change process where the local organisation proactively reinterprets its own way of working.	Not mentioned	Not mentioned	Data analysis not described & no number of interviewees	Not mentioned	Hospitals South Africa

No	Author/date	Methodology /Study design	Study methods	Ways papers retrieved	Aims	Main findings	Data analysis	Sample size	Study limitation	Ethical consideration	context/settings
6	Mirzoev et al. (2015)	Case study	In-depth interviews, document and observations of policy events (qualitative)	Contacting author	Set conceptual framework to understand/assess MOH capacity to conduct health policy processes	Framework to understand the capacity to conduct health policy processes	Framework approach assisted by NVivo.	37	Focussing on one context	Yes	MOH Tajikistan
7	Asante et al. (2012)	Case study (using the WHO framework)	Desk review of both published and grey literature and discussions with key individuals	Database search	Describe status of health management and leadership capacity and to analyse issues affecting performance of managers.	Capacity of managers was weak and many other issues such as lack of support, weak work environment and socio-cultural factors affected the leaders' work.	WHO framework	Not mentioned	Describe status of health management and leadership capacity and to analyse issues affecting performance of managers.	Not mentioned	Leadership capacity in the health sector Solomon Islands

No	Author/date	Methodology /Study design	Study methods	Ways papers retrieved	Aims	Main findings	Data analysis	Sample size	Study limitation	Ethical consideration	context/settings
8	WHO (2009)	Case study (using the WHO framework)	Desk review, interview	WHO website	To obtain information on the management and leadership issues and aims to provide an overview of managers as part of the health workforce.	Lack of data on managers &management development strategies in policy documents. Skills and competencies managers are not regulated by clear job descriptions and clear performance ; no national training plans for them.	WHO framework and comparative analysis	Not mentioned	Participant numbers not mentioned.	Not mentioned	Management capacity Ethiopia, Ghana, United Republic of Tanzania
9	Chanturidze et al. (2015)	Case study	Capability assessment model	Contacting author	To highlight the need to strengthen managerial capacity in the health system.	HR development worked effectively where enabling environment and political will were present.	Based on institutional capability assessment model	28	Not mentioned	Yes	MOH Kazakhstan

No	Authors/date	Methodology /Study design	Study methods	Ways papers retrieved	Aims	Main findings	Data analysis	Sample size	Study limitation	Ethical consideration	context/settings
10	Latifov and Sahay (2013)	Case study	Qualitative and quantitative; interviews, reports review, observation, and analysis of databases	Contacting author	To find components of health info infrastructure to shape transition to "action-led" systems from "data-led" systems.	Five facets to help transition; data, software, capacity, policy and info, and communication technologies. External and internal elements identified to help the transition.	Iterative process	Not mentioned	Sample size for qualitative +quantitative not mentioned	Yes	MOH Tajikistan
11	Ulikpan et al. (2014)	Case study	Qualitative; multi-case study design; document review, interview and participant observation	Contacting author	To assess the development of Central Asian Post-Soviet countries in health since the Soviet Union collapse.	Development was different due to politics and governance. 3 countries showed improvement; in 2 management culture and opaque management processes hinder development.	Comparative analysis	11	Limited published literature constrained the cross-country comparison	Yes	Health system Kyrgyzstan, Mongolia, Tajikistan, Turkmenistan, Uzbekistan

Table 3-4 Characteristics of the included studies in the literature review

3.2. The literature review findings

Thematic analysis identified six key themes influencing the contribution of leadership competence to the performance of organisations in LMICs. These were: 1. supportive leadership and working conditions; 2. leadership knowledge and skills that impact on performance; 3. dual role of health managers; 4. political/socio-cultural and leadership; 5. managers' attitudes, transparency and commitments; 6. low management/leadership capacity in LMICs.

3.2.1. Supportive leadership and working conditions

All studies, mentioned above, show that managers' support played a significant role in improving staff productivity and consequently the performance of the organisations. Where there was poor staff achievement, it was shown that the staff were not supported by managers to do their best. Employees' work was not supervised, monitored and properly appraised (Kolehmainen-Aitken 2004; WHO 2009; Asante et al. 2012; Mkoka et hal. 2015). Whilst many employees were not satisfied with their working conditions they were continuing in their jobs due to family or financial demands (Kolehmainen-Aitken 2004). In such work environments, staff were demotivated (Mkoka et al. 2015). There was no compensation for their extra work and no system providing incentives for good performance (WHO 2009). The poor work environment/conditions negatively affected staff morale and performance (Kolehmainen-Aitken 2004). Typically, there was no effective communication system between the managers and their staff to help them share their concerns and complaints (Mkoka et al. 2015).

In contrast, where there were supportive managers, there were good working environments and a culture of support and acceptance of challenges (Jacucci et al. 2006; Nankumbi et al. 2011; Turner and Short 2013; Mirzoev et al. 2015). Staff were motivated, there was an improved working environment, increased job satisfaction and decreased staff turnover (Jacucci et al. 2006; Nankumbi et al. 2011). This appeared to increase the employees' productivity and service quality.

The management support system was also found to be important for managerial work (WHO 2009; Asante et al. 2012; Latifov and Sahay 2013; Ulikpan et al. 2014). In poorly performing areas, it was found that managers had no or limited autonomy and authority in their work (Asante et al. 2012). There was poor supervision and

monitoring of the managers' work (WHO 2009). The managerial role was not clearly defined, with everyone having their own definition, which was very broad from chief director to supervisors. Many managers did not have job descriptions and their performance was not assessed (WHO 2009; Asante et al. 2012; Ulikpan et al. 2014).

3.2.2. Leadership knowledge and skills affect performance

The studies suggested that managerial training provided new management knowledge and skills. It improved leadership and managerial work and indeed an increased empowerment of the leadership was evident (Nankumbi et al. 2011; Asante et al. 2012). Managerial knowledge and skills were found to be fundamental in achieving better outcomes (Turner and Short 2013). Management knowledge helped the managers to provide enabling environments and make proper decisions towards organisational goals (Nankumbi et al. 2011b; Chanturidze et al. 2015). Managers that were competent had a good understanding of the organisational vision and worked appropriately (Jacucci et al. 2006). They also had the ability to determine and fill any gaps.

In comparison, managers/leaders who did not have managerial training were found to be unable to manage properly; they were weak in staffing, administration and personnel affairs (Kolehmainen-Aitken 2004; Chanturidze et al. 2015; Mkoka et al. 2015). They were not able to create enabling environments for staff and could not cope with additional complexity (Kolehmainen-Aitken 2004). In some LICs, managers' training did not meet acceptable standards and there was an absence of any system to accredit the training programmes (Kolehmainen-Aitken 2004). Manager selection in the hospital environment was typically based on their clinical background, not their management qualifications (WHO 2009). Managers who did not have the ability to use the internet, a computer or the English language, were found to be unable to promote evidence-based practice and provide quality services (Latifov and Sahay 2013; Turner and Short 2013). Many managers did not have financial and HR management skills (WHO 2009; Ulikpan et al. 2014), which caused delays in grants and underspending of allocated budgets (Asante et al. 2012). Due to inefficiencies in management, countries faced a chronic shortage of funds and this was a potential contributory factor to the decline of health indicators (Ulikpan et al. 2014).

3.2.3. Dual role of health managers/ clinical background

In the countries studied, professionals with clinical backgrounds are given management responsibilities without having the knowledge, skills and training for this role (Kolehmainen-Aitken 2004). This limited their use of health data to monitor progress (Asante et al. 2012) and was found to be the biggest obstacle to managerial effectiveness (WHO 2009). They were found to spend much of their time on clinical delivery while less time managing services and planning (Asante et al. 2012). In some countries, even the time allocation for these two responsibilities was not clearly determined (WHO 2009) and due to staff shortages, managers had to give most of their time to clinical work.

3.2.4. Political/socio-culture and leadership in the health system

Political and socio-cultural aspects were further characteristics, which negatively affected leadership (Ulikpan et al. 2014; Mirzoev et al. 2015). For instance, respect for elders meant younger managers avoided challenging the work of an older employee or a colleague in a higher position (Asante et al. 2012). The converse was also true in that junior employees had to accept what the senior employees said or did even if it was wrong (Turner and Short 2013). Gender discrimination was apparent in the health sector (Asante et al. 2012; Turner and Short 2013), with the gender distribution of managers being biased in favour of males (WHO 2009). Political interference was found to be a factor affecting hiring decisions (Kolehmainen-Aitken 2004; Ulikpan et al. 2014). Other socio-cultural characteristics, such as punitive management, nepotism and favouritism based on kinship also negatively influenced managerial work (Asante et al. 2012; Ulikpan et al. 2014).

3.2.5. Managers' attitudes, transparency and commitments

Studies revealed that unprofessional behaviour and conflicting attitudes in line managers negatively affected performance (Kolehmainen-Aitken 2004; Mkoka et al. 2015). The transparency and accountability of the management system affected staff performance (Ulikpan et al. 2014; Chanturidze et al. 2015; Mirzoev et al. 2015; Mkoka et al. 2015). It was also apparent that people were promoted without formal appraisal being undertaken (WHO 2009). Consequently, donors were reluctant to commit funding unless governments improved their accountability, transparency, financial management procedures, governance and a special effort to eliminate

corruption (Ulikpan et al. 2014). Leadership, political willingness and commitment were, therefore, fundamental for any improvement in the situation (Jacucci et al. 2006; Latifov and Sahay 2013; Ulikpan et al. 2014; Chanturidze et al. 2015) as managers/leaders may have the capacity but not the willingness or commitment to achieve the goals of the organisation (Mirzoev et al. 2015).

3.2.6. Low management/leadership capacity in LMICs

The studies indicated that the leadership capacity of the MOH to deliver high-quality health services in each of the LMICs were found to be low (Kolehmainen-Aitken 2004; Nankumbi et al. 2011; Latifov and Sahay 2013; Ulikpan et al. 2014; Chanturidze et al. 2015; Mirzoev et al. 2015). Most of these countries were not progressing towards their health targets and did not have effective performance, with weak leadership capacity being one of the main contributors to failure (Kolehmainen-Aitken 2004; WHO 2009). It was argued that HR and planning capacity are mostly found to be weak in these countries (Kolehmainen-Aitken 2004; WHO 2009). Working conditions/workforce crises were also found to be a key challenge in many LICs, affecting the health systems' ability to provide quality services.

3.3. Discussion

The aim of this literature review was to explore the importance of leadership competence in an organisation and the question was ' *how leadership competence contributes to health organisational performance in LMICs*'. The literature demonstrated that health leadership and management capacity were considered weak in LMICs. They lacked the ability to manage the health system properly and this consequently affected the performance of health services in those countries. In some countries where the MOH was the health system leader there appeared to be limited management capacity (Section 3.2.6.). Many of the themes were linked to each other, e.g. leaders/managers who did not receive management training were more likely to be inefficient managers and lack the skills to support employees to do their work. These findings support the findings of other related studies in LMICs. Management capacity was found to be weak in the health projects in India, China and Vietnam, there was no proper planning of resources, including HR to support implementation (Martineau et al. 2015). Inadequate management was also a problem in a health-

related programme in Kenya (Abuya et al. 2010). Lack of transparency in funding management, limited managerial authority, an inability to respond to change and ineffective communication mechanisms were all factors affecting the implementation of programmes in this country.

In addition, from reviewing research papers in LMICs, it seems that political issues have a very negative effect. This means that not only did political influence fail to bring about improvements in these countries but was also a big obstacle towards improvement. When a research paper is on an issue or problem in a low-income country, it often shows the country of study has passed a war or internal conflict and that war has resulted in the destruction of that country. This is true mainly in countries located in Central Asia (Latifov and Sahay 2013; Ulikpan et al. 2014 ;Mirzoev et al. 2015). However, the research from Asante et al. (2012) in the Solomon Islands also indicates that they have also experienced recent conflict. The war has ruined many aspects of their life and had very negative effects on their society, economy, education, health, infrastructure as well as HR shortages and low-quality management training.

The findings suggest that the leadership competence is particularly affected by political and socio-cultural issues where the countries have experienced war or internal conflict (Asante et al. 2012; Ulikpan et al. 2014; Mirzoev et al. 2015). This was because the political people and the favouritism and kinship had influenced the work environment and the system. This in turn had affected the leaders' commitment to the organisation's performance. These findings support other studies in LMICs. Arnold et al. (2015) studied the culture of a maternity hospital in Afghanistan, which has had a long history of war over several decades. There was a punitive system. Staffs were frustrated and demotivated by the unsupported working conditions. They also found that the hospital culture had very negatively affected the work of staff due to nepotism and cronyism (Arnold et al. 2015).

This review suggests that the countries who had experienced conflict remained highly dependent on external funding. The MOH was donor driven and capacity building was coordinated by the donors, which were found to be weak. The capacity building in those countries was not effective and was found to undermine progress (Asante et al. 2012; Latifov and Sahay 2013; Ulikpan et al. 2014; Mirzoev et al. 2015). This might be one of the reasons that the leaders' competence was low

because their training and capacity building was neither need based nor coordinated. The review found that leaders were not able to manage their financial responsibilities, which caused delays in getting further funding. This supports the previous findings that financial issues were the biggest cause of delays in African and Asian countries, compounded by a lack of technological skills, management skills and competencies (Akogbe et al. 2013).

Other studies, which found the leadership capacity weak, did not include the impact of cultural issues on the employees work and health services. For example, Mkoka et al. (2015) found that the management capacity was weak but gave no indication if cultural or political issues affected their capacity. In other studies; such as the study of Turner and Short (2013), the culture had both positive and negative effects on organisational performance and development. Senior staff had created an encouraging work environment to promote evidence-based practice, which had helped junior staff to use their new knowledge and skills. The cultural negative effects, however, were that junior staff had to follow the way the senior staff worked and could not challenge them even if they were wrong (Turner and Short 2013).

This review has attempted to explore the leadership and management role in health system functionality and in organisational performance. The studies from Abuya et al. (2010), Akogbe et al. (2013), Arnold et al. (2015) and Martineau et al. (2015), whilst useful in providing further context, sought to examine the challenges for implementation in health-related services but not the health leaders/managers' roles. Interestingly, they also found that ineffective management influenced programme implementation, although this was not the primary focus of their investigation. This review's aim was to explore the contribution of leadership competence to organisational performance in LMICs, but no research was found that studied leadership competence alone. Leadership competence was examined along with other factors that affected the managers' work such as the availability of management training, quality of training received, the culture in the work environment, the role of politics, the economy of the country, the support system for leadership and the health system structure. All these aspects were affected negatively by the war and conflicts in the studied countries. Therefore, this review added a new

insight that leadership competence is affected by many issues including political and socio-cultural issues that are the result of years of war and conflict.

3.3.1. Strengths and limitations

The included studies have used different methodologies, which make direct comparisons difficult. The quality of the papers varied even though they were peer reviewed. Two papers did not describe the methodology well but they were very relevant to the topic of this study so they were included (Asante et al. 2012; Jacucci et al. 2006). A further limitation of this review would be the inclusion of grey literature from the WHO.

The strength of this review is the inclusion of literature from different LMICs in Africa, Asia, Oceania and North America. This may increase the international applicability of the findings of this review in all LMICs. This review has focused on recently published papers in order to consider contemporary findings of leadership in LMICs. This was a broad review. Besides the exploration of a specific question, this review investigated the many different concepts and definitions that may be used in the topics around the management capacity and leadership. This helped in the understanding of management capacity components and the unique importance of the leadership. The wide-ranging literature review also resulted in the discovery of the two main frameworks on management capacity and leadership; the Black Box Model (Moynihan and Ingraham 2004) and the Leadership and Management Strengthening Framework (WHO 2007a). These two frameworks are applied in the current study.

3.4. Conclusion

This review attempts to identify what is already known about leadership competence and its contribution to the organisational performance of health systems in LMICs. There is limited literature in relation to LMICs. However, a consistent theme is that management capacity appears to be weak in many LMICs and leadership competence is poor. The findings suggest that managers do not get adequate training on important aspects of management, which impacts negatively their capability and work. Consequently, they do not create supportive and enabling work environments for employees, which in turn limits the performance of staff and health organisations. Whilst it is a complex picture involving many other socio-cultural, political, economic, systemic and structural factors, improving leadership capacity is an

important part of the solution towards greater health system effectiveness. The findings of this review suggest that war is a significant contributing factor to low management capacity in many LMICs. It was found that many of these countries had past war and conflict experiences. Those countries that had recently experienced war were more likely to be affected by the political and socio-cultural influence and these influences had negatively affected the management capacity. Another new knowledge was about the capacity building in those countries. One of the reasons for low management capacity was the donor-driven capacity building, which was found to be ineffective because it was not coordinated, need-based or systematic and this has been an obstacle to progress in those countries. Whilst more research is clearly needed to assess the impact of leadership, as well as its relationship with other factors in performance, policymakers in LMICs, as well as the international community, should perhaps take note of these emerging trends in their consideration of how to strengthen management systems and improve the performance of health organisations.

3.5. Theoretical propositions developed from this review

The following propositions were developed from the literature review. They were used to examine and explain what factors affect the management capacity, leadership and the employee performance in the MoPH, Afghanistan:

1. There is a strong relationship between managerial support and employee performance;
2. The management support system affects the work of managers;
3. Managers who have managerial training can manage well;
4. Political and socio-cultural influence affect leadership;
5. The lack of transparency and accountability and corruption of the management system affect staff and organisational performance.

The researcher understands that the MoPH staff, including managers, do not have a dual role, which is why the ’dual role’ was not included as a proposition. Theoretical propositions are described in Section 4.16.

Chapter 4: Methodology and Study design

4.1. Introduction

The aim of this study was to determine 'What factors affect the management capacity, leadership and the employee performance in the MoPH of Afghanistan?' This question was refined by reviewing the current literature, which explored the relationship between leadership competence (knowledge, skills, experience and personal characteristics) and organisational performance. The literature review suggests that leadership competence has always been studied within management capacity (capital, finance, HR, IT and leadership) in LMICs. This informed the researcher's decision to use the broader concept of management capacity in this study instead of leadership competence in isolation. The literature review brought to light the importance of leadership competence when examining other components of management capacity. The use of management capacity allows the inclusion of all factors, including leadership competence, that can affect employee performance. The literature review helped formulate the theoretical propositions used to explore the research questions of this study. The reviewed concepts, frameworks and propositions helped with the design of the study, including choosing the case study approach. This chapter sets out and justifies the choice of approach and its applicability to the study's aim. It also sets out the research design.

4.2. Methodology/philosophical view

The research methodology details important boundaries in which the research is framed. As Brown (2006, p.12) points out:

> "methodology.... is the philosophical framework within which the research is conducted or the foundation upon which the research is based".

It helps the researcher demonstrate how the research was undertaken using care and methodological awareness (Yin 2013). This chapter also describes how the research was conducted in an ethical way and how the quality indicators of the case study approach, including validity and reliability were addressed. It demonstrates how the methodological design ensured the quality of the data produced. The methodology is concerned with the philosophy of methods and as such, encompasses epistemology

and ontology (Jupp 2006). The ontology, epistemology and methodology are central features of social science research; they provide shape and definition to an inquiry (Popkewitz et al. 1979). "Epistemology is concerned with the nature and forms of knowledge" (Cohen et al. 2007, p.77). Epistemological assumptions are concerned with how knowledge can be created, acquired and communicated (Scotland 2012). It includes the following questions:

> "What is the relationship between the knower and what is known? How do we know what we know? What counts as knowledge?" (Tuli 2010, p.99).

While "ontology is the study of being" (Crotty 1998, p.10). Ontological questions in social science research are relevant to the nature of reality (Tuli 2010). Research philosophy deals with the source, nature and development of knowledge (Bryman and Bell 2015). To conduct research, researchers have their own assumptions and beliefs, which include one of the four main research philosophies; pragmatism, positivism, realism and interpretivism (Saunders et al. 2012). The chosen philosophy helps determine the research strategy. As a PhD student, the researcher believes that there are many ways to understand the world and one way might not be enough to understand the entire picture of all phenomena. The assumptions in this research may be influenced by previous lived experiences, when the researcher used different methods to understand the situation in the health facilities of her organisation. Scholars have pointed to the fact that research philosophy is impacted by practical implications (Research Methodology 2019). The philosophical assumption in this research is inevitably impacted by the researcher's practice and background.

Realism is based on the assumption of a scientific approach to the development of knowledge (Novikov and Novikov 2013). While interpretivism refers to diverse approaches, including constructivism, phenomenology and hermeneutics and these are approaches that reject the objectivist view (Collins 2010). Positivism is based on the ontology in which the world exists, independently of human's knowledge of it. In contrast, interpretivism is based on the ontology in which reality is subjective, and the social life is interpreted by humans as social actors according to their beliefs and values (Tuli 2010). These two together come in the pragmatic perspective, which is followed in this study because taking a pragmatic position can help to improve communication amongst the different paradigms, which in turn attempts to advance knowledge (Tashakkori and Teddlie 2016). Pragmatism helps to combine different

approaches to achieve a positive and fruitful outcome (Hoshmand 2003). It is indeed a bridge between two conflicting philosophies of positivism and interpretivism (Darke et al. 1998; Johnson and Onwuegbuzie 2004). This approach presented the researcher with a useful middle position (philosophically), which offered to combine the strengths of two opposite epistemological assumptions and select a mix of methods that could help better explore the study aim.

In pragmatic research both qualitative and quantitative approaches are combined in one study, drawing on different research paradigms (Daymon and Holloway 2011). For pragmatic research, completing the research and achieving the desired goals in a pragmatic and practical way is important, regardless of their ontological and epistemological base or whichever methods or research strategy are used (Daymon and Holloway 2011), which fits this PhD study very well. No matter which approach is used or which ontological and epistemological view the researcher has. “A pragmatist is interested in the practical consequences of, or workable solutions to problems” (Johnson and Onwuegbuzie 2004, p.16).

4.2.1. Methodological consideration

To achieve the objectives of the research, it was necessary to first explore different paradigms to find out which would be suitable for this research. Initially, the plan was to carry-out the study with a mixed-methods design. By using mixed methods, the research question (Section 1.6) could be answered through the distribution of questionnaire surveys and in-depth interviews. Then it was recognised that there was a need for further information to address the complex situation. To study the complex situation in depth, there was a need for additional data collection techniques. Mixing different approaches would provide opportunities to obtain the answer to the research question.

The researcher’s decision to use a questionnaire to explore the managers’ perceptions regarding their responsibilities and their employee performance was informed from the literature review. To find-out about the capacity of managers as well as the investment of the MoPH in capacity building, the managers’ personal records were the best source to gain this information. The data about organisational capacity building in relation to leadership and management could also help in the understanding of the leaders' qualifications relevant to the field.

There was also a need to explore the employees' perception regarding the support they get from leadership/management and what factors affect their performance. The interview was the best method to explore the employees' perceptions as it helps to understand the feelings of the participants and their thoughts in depth (Gerrish and Lathlean 2015). A document review was another qualitative method needed to find whether the MoPH has considered the capacity building needs of employees, especially the leaders, to enable them to fulfil their roles. The Ministry's documents, such as policies and strategies, will show whether the MoPH has identified the problem and developed a plan to address it. Quantitative methods are concerned with numbers and measurement while qualitative methods are concerned with words and meanings. Having the pragmatic view and the need for the use of different quantitative and qualitative methods requires a paradigm, which can allow the inclusion of these different methods. The researcher's decision was well informed by a comprehensive literature review, which demonstrated that a case study mixed methods approach, would be the best design for exploring the management and leadership in an organisation. Section 4.3 explains how and why a case study was selected.

4.3. Case study: rationale and types

A case study approach is appropriate for a study that focuses on one thing and explores it in detail (Thomas 2015). This is exactly the aim of selecting the case study as the design of this study. Thomas (2015) has selected the word 'thing' because this 'thing' can be a person, a family, an organisation, a county or many other things. The special strength of case study is being able to use a variety of evidence, which is not usual in other methods (Yin 2013). This is important and useful when the aim is to do in-depth research into complex situations. A case study involves a detailed and intensive analysis of a single case (Bryman 2015). According to Stake (2005), a case study is concerned with the complexity and particular nature of a case. Management capacity and leadership in the MoPH as the unit of analysis is complex and needed an intensive analysis. This is because, after 16 years of financial investment by the international community, the management capacity remains low and the reasons were not known by the MoPH and partners. Gerring (2004, p.341) suggests that a case study is "best defined as an intensive study of a single unit with an aim to generalise across a larger set of units". Through the study of the

management capacity and leadership of the MoPH, understanding will be gained about the entire health system of Afghanistan because the MoPH has the leading responsibility for the health system. Piekkari et al. (2009, p.569) define case study as:

> "a research strategy that examines, through the use of a variety of data sources, a phenomenon in its naturalistic context, with the purpose of "confronting" theory with the empirical world".

Moynihan and Ingraham (2004) and the WHO (2009) recommend a case study in their management capacity assessment models as the best strategy to assess leadership and management capacity. All the above-mentioned advantages of the case study informed the researcher's decision to change to a case-study design, which is still a mixed methods design by nature using a variety data collection methods.

There are different types of case study introduced by different authors, each of which has a specific aim. To use the appropriate type for this PhD, the researcher needed to evaluate the suitability of all those types. The section below discusses the selection of the appropriate type of case study to be used.

4.3.1. Types of case study

Robert Stake and Robert Yin are the two major champions of case study research, but each adopts different approaches. Their different approaches stem from their different paradigms. In total, seven types of the case study are introduced by Stake (1995) and Yin (2013). The suitability of all seven types was assessed for the current study. The three case study types of Stake (1995) were not applicable to this research as the 'Intrinsic' type represents other cases, which are already carried-out. It doesn't deal with the primary study. The 'Instrumental' type is interested in defining a theory using a case, which means that the case is of secondary interest. The 'collective' type contains multiple cases to define similarities and differences amongst different cases. The four remaining types of case study are introduced by Yin (2013). 'Exploratory', which is linked to the exploration of a situation in which an intervention is evaluated. The 'Descriptive' type defines a phenomenon or intervention, the 'Multiple cases' helps to explore differences within and between cases. The 'Explanatory' type, which is used to answer a question relevant to a real-life intervention that is too complex for other strategies such as surveys (Yin 2013). It is used to explain the cause and effect.

The 'Explanatory' type was best fitted to the question of this current study. This was because the researcher sought to explain how and why a complex phenomenon came about (Yin 2013). The complex phenomenon in this study was the management capacity and leadership in the MoPH and this study involved a question to explore. The question was ‘what factors affect the management capacity, leadership and the employee performance in the MoPH?’, which attempts to explore the phenomenon in a real-life situation. Having a question is a must in an explanatory type. This study is a single case and does not aim to describe a situation or explore a situation rather its aim is to discover the causes and effects of the current situation of the MoPH.

This study’s aim (Section 1.6) is to find out the underpinning factors that are responsible for the current situation and this is the aim of the explanatory type. Its answer would explain presumed underlying relations in real-life interventions (Baxter and Jack 2008). The explanatory type was selected, which was introduced by Yin (2013). His books are important resources to other case study researchers (Gerrish and Lathlean 2015) and many researchers/authors cite his work rather than to introduce a new definition or explanation. For instance, Gerrish and Lathlean (2015) has cited the Yin’s case study definition or provided the data collection methods that were introduced by Yin. Therefore, Yin’s books are cited more in this chapter rather than other authors who themselves have cited Yin as a credible source.

After the selection of the case study and its type, it was necessary to specify the unit of analysis to determine what exactly needed to be explored in this research. Section 3.4 explains what the case is to be analysed.

4.4. What is the case?

According to Miles and Huberman (1994, p.25), a case is:

> “A phenomenon of some sort occurring in a bounded context. The case is, in effect, the unit of analysis”.

The most common usage of the term is ‘case study’ together with a location with emphasis on the intensive examination of that location (Bryman 2015). Although a case is not a methodology, there is extensive attention to the process in which data are collected and analysed (May 2011). Determining the unit of analysis can be a challenge (Baxter and Jack 2008), however, questions such as: do I plan to analyse an organisation or a person and so on can help. Thus, different authors suggest

different ways to bind the case into a unit of analysis. Baxter and Jack (2008) suggest boundaries in case studies, which are similar to the establishment of inclusion and exclusion criteria in other studies. Not only do boundaries show the sample, but they also indicate the breadth and depth of the study. The time and place are suggested by Creswell (2018) to be determined, similarly to Yin (2013). Stake (1995) further argues that time and specific activities are important. It seems that time is considered important by all the above-mentioned authors in terms of case study boundaries. Miles and Huberman (1994) propose the definitions and context of a case need to be determined.

Binding the case helps to determine the scope of the study data collection (Yin 2013). This makes it easier to be concise and to decide which data are to be collected and which not. For this research to be concise and to be specific about the data to be collected, the researcher assessed the boundaries suggested by Miles and Huberman (1994), Stake (1995), Creswell (2018) and Yin (2013). Time was the boundary suggested by three of these scholars except Miles and Huberman (1994). The place was another aspect taken into account by these scholars, and Table 4.1 summarises context and time of this PhD study. To answer the study question the researcher decided to include four sources; the directors, the senior members of staff, the MoPH relevant documents (policies and strategies) and the archival records of directors (Section 4.7).

Locality	**Context**	**People/sources**	**Time**
Kabul, Afghanistan	30 directorates of the MoPH	• Directors • Senior members of staff • Documents • Archival records	(Sep/2017- Jan/ 2018)

Table 4-1 The boundaries of case study

A case study can involve a number of different designs, so, there was a need to assess the appropriateness of each design to the aim of the study. Section 4.5 describes why and how the embedded single-case design was selected.

4.5. The study design

Yin (2013) argues that the conduct of a case study with a formal design makes the study stronger and more straightforward in terms of process; referring to four designs:

1. Holistic single-case design
2. Embedded single-case design
3. Holistic multiple-case design
4. Embedded multiple-case design.

The selection of the design was easy, as the study question helped in the selection of the study design. It was initially proposed to focus only on the Maternal, Neonatal and Child Health Directorate, which was supposed to be carried out by a holistic single-case design. The holistic single case is of a holistic nature without subunits. However, by selecting only one directorate it would be more difficult to keep the identity of the leadership anonymous. This was particularly important when the aim of the study was the exploration of the management capacity and leadership. In addition, focussing on a single (holistic) case study design has a very high risk if the participants decline to participate. Therefore, it was decided to include 30 MoPH directorates in the study to make sure potential identification was less of an issue as well as to increase flexibility if any directorates declined to take part. In this case, the embedded single-case study design was employed. The MoPH was counted as one single case and the directorates were the embedded units of the case that enabled the researcher to explore the study question (Section 1.6). When within a single case, attention is also given to subunits, this is called embedded case study (Yin 2013). These subunits provide important opportunities for extensive analysis which in turn enhance insights into the single case. However, there is one main pitfall about the embedded case study if more attention is paid to subunits and failing to return to the larger unit of analysis (Yin 2013). The multiple case studies (holistic and embedded) were not applicable to this PhD study as it explores factors that affect the MoPH and

the MoPH was with a holistic nature. The difference between a multiple (or collective) case study and a single-case study with embedded units is in the number of cases. In a multiple case study, several cases can be analysed to find out the similarities or differences, but in a case study with embedded units, only one single extreme/critical case is analysed and understood (Baxter and Jack 2008). Yin (2013) argues that a single-case study is appropriate where it represents a critical and unique case. The MoPH was considered a critical case due to its critical role in the health system of Afghanistan. This was particularly important as there is only one MoPH in the country having the stewardship role at the national level. The next section gives explanation about the study context.

4.6. Study Context

The unit of analysis was management capacity and leadership in the MoPH (Table 4.1). According to the MoPH organogram (MoPH 2016c), in Appendix 1, there were six general directorates, under which 19 directorates worked. The remaining (n=11) directorates work directly under the deputy ministers. The 30 directorates were included because they work directly in partnership with the implementer NGOs, provincial Public Health directorates and other key stakeholders. Each one has responsibility for specific service. Thus, the Pharmacy Directorate is responsible for all pharmaceutical affairs in the country. Their inputs provide guidance for the entire health system. The MoPH and partners implement the standard packages of health services across the whole country. One of the most important aspects was to specify which methods would be included in the study that could answer the research question. Section 4.7 justifies the inclusion of each method.

4.7. Data collection methods

Typically a case study uses multiple sources, which is a good strategy to enhance study credibility (Patton and Patton 1990). Baxter and Jack (2008) see each data source as a single piece of a puzzle, contributing to the understanding of the case. Six methods commonly used in case studies are introduced by Yin (2013):

1. Interview
2. Document analysis
3. Survey
4. Archival records

5. Observation
6. Participant observation

To increase credibility, archival records, questionnaires, semi-structured interviews and document analysis were used.

4.7.1. Archival records

Archival records were used as a method to collect historical data about workforce investment in the MoPH. After explaining the study's aim to the relevant department and presenting the study approvals, the researcher requested information about the people who were working as the head of departments. The aim was to obtain the data relevant to capacity building and capacity investments for the leaders and whether leaders had the training and qualifications that would help them fulfil the tasks that are required from their roles. Considering confidentiality, the relevant department provided the personal information needed about the targeted directors rather than providing their personal files. In this case, a list was given to the relevant department requesting specific information. Each of them was included for a specific reason, which is discussed below:

- **Qualifications and educational achievements**

Qualification and highest education degree were included if they were considered by the Ministry for the position of directors. From the literature review (Section 3.2.2), it was found that knowledge was an important element of leadership competence, which can be acquired by enhancing qualifications through higher studies. Within this context it was important to explore if qualifications are one of the criteria used in the selection of the directors in the MoPH.

- **The training that the directors received**

The training that the directors received was explored to learn if the capacity building needs of directors are being addressed. This included any kind of short-term training, organised or conducted by any sources that could improve their competence so as to more effectively fulfil their responsibilities.

- **Capacity building provided to directors**

Capacity building by the MoPH was included in the study to assess whether the MoPH is making an important contribution to the capacity building of employees, especially those who were hired in the vital roles and responsibilities of directors. This contained the short-term courses and workshops or higher education degrees such as master's or PhD programmes.

- **Directors' study subject**

Directors' area of studies was explored for two reasons; the first was to investigate whether qualifications of directors are relevant to their jobs, which is not always the case in Afghanistan. The second reason for this was to explore if they have gained higher education with any management-related subject. The literature review demonstrated that managers without management training were not able to manage the employees and organisation properly (Turner and Short 2013; Chanturidze et al. 2015). The subject of Public Health was also considered important. This was because the MoPH, as the name describes, focuses on Public Health which means that the scope of the MoPH is to work on Public Health of the country.

- **Salary category**

This was included to assess whether salary levels were related to their qualifications or years of experience. A good salary will attract qualified people to an organisation, while a low salary causes unqualified people to fill positions rather than qualified.

- **Position title**

This was included to find out if the people who were working as the head of directorates all had the same position titles, or if they had different positions and what was the difference or the criteria.

- **Appreciation letters**

Appreciation letters are awarded to the employees in the context of Afghanistan who have outstanding achievement and/or creativity. Some of these appreciation letters

include an increment of the employee's salary. This is also an indication of the acknowledgment of a good performance. This is in turn a good support and motivator to the employees who have done a good job. Appreciation letters were included to explore whether the director's creativity and accomplishments are acknowledged by the MoPH leadership. This was counted as a good motivation and support by the MoPH leadership. Motivation definitively affects their performance (Bradley et al. 2013).

4.7.2. Survey

In this method, a questionnaire was used to collect both qualitative and quantitative data. Structured questionnaires were used because it enables questions to be organised and to obtain responses without being face to face with each respondent (Walliman 2018).

The questionnaire was developed in a manner to achieve the relevant objectives of the study. Leadership competence and management capacity questionnaires and self-assessment checklists have been developed and used by several organisations. 'Assessing an Organization's Capacity in Health Communication' and 'Management and Organizational Sustainability tool' by MSH (2010), 'SMS competence framework' (SMS 2003), and a competence self-assessment inventory developed by MSH (1998) were assessed to determine if they could be useful for developing a questionnaire. Not only did they include the questions required in this study but also, they helped in developing questions providing ideas about questionnaire formats, structures, order.

The survey was used to investigate the directors' perception of the management capacity in the MoPH, which also includes the directors. Beside the questionnaire, the interview was also assessed to see if it can be used for the directors. To explore directors' competence, previous research used self-assessment questionnaires rather than interviews (Björk et al. 2014). This is because it would be more comfortable for the managers to complete a self-assessment questionnaire rather than to talk in an interview about their competence, performance, relationship with their employees and support to their employees. This, therefore, informed the researcher's decision to use a questionnaire to explore the managers' perceptions.

For a better engagement of the participants, formatting and structuring of the questionnaire were other matters that required consideration. The questionnaires of MSH (2010) and SMS (2003) were helpful in the structuring/ formatting of the questionnaire. The question/answer format and the type of questions were matters that needed to be considered, which would make it interesting for the participants to follow. The developed questionnaire included both open-ended and close-ended questions. The close-ended questions consisted of:

1. Multiple choice questions
2. Dichotomous questions
3. Rank order questions (Forced preference rank order)
4. Rating scale questions

For instance, some questions were developed in the type of multiple choice with the provision of checkboxes to be checked by participants. Dichotomous questions were developed with ‘Yes’, ‘No’ and ‘Other’ boxes to be crossed. Some other questions required scoring by the participants from 1 to 4 and instruction were provided. Other questions needed to be sequentially ranked by participants from high to low (Appendix 14).

Some of the terms used needed to be defined in the questionnaires to be clear to participants. For instance, the term 'initiative' was defined in brackets as 'a new plan or process to achieve something or solve a problem'. Another term that needed definition was internal communication. Although the research question (Section 1.6) is a single question it includes the elements of ‘management capacity’, ‘leadership’ and ‘employee performance’, all of which needed to be addressed. Meanwhile, the study’s question was informed by theoretical propositions from the literature (Section 3.2). To make sure every proposition was followed appropriately in the questionnaire, the questions were developed under six main sections as below.

A. Managers’ support and personnel’s performance
B. Management support system
C. Management training
D. Leadership/management capacity
E. Socio-cultural/political effects on leadership

F. Management system transparency and accountability

The first proposition was about the managers' support and personnel's performance. Therefore, the attempt to include questions that could address the link between the manager's support and the employee performance was considered. Question 14 is a good example to address this proposition among other questions: "How often is the personnel performance appraised?".

For the second proposition (management support system), questions were developed that could address whether and how the directors got management support (from their managers and higher authorities of the MoPH). So, question 22 "Are you given the authority you think is required for this (your) position?" was one of those questions to address this proposition. The same attempts were carried-out for every proposition.

4.7.2.1. Pilot testing of the questionnaire

Pilot tests are carried-out before the implementation of the survey to assess if problems exist that need to be addressed (Lavrakas 2008). To carry out a reliable study, a good quality questionnaire needed to be produced. Before starting data collection, therefore, the questionnaire was tested. Pilot testing involved checking the structure and formatting of questionnaire, the clarity of instructions, the order of the questions, the understandability of terms and sentences, the timing of its completion (van Teijlingen and Hundley 2005). The questionnaire was tested by five professionals either currently working with or having previously worked with the MoPH. These professionals were provided with questionnaires in both English and Dari and asked to complete the one with which they were comfortable. The following questions were asked once the questionnaire had been completed:

- How long did it take you to complete the questionnaire?
- Did you experience any confusion with any question which you think needs more clarification?
- Are there any changes you would recommend in this questionnaire, e.g. structure, response format?
- Are there any other important aspects you think should be considered in the questionnaires (English or Dari version)?

The main comments received were about the response format, rewording text and defining some terms. Based on the comments, the questionnaire took 20 to 42 minutes to complete. With consideration of the comments, the questionnaire was amended and finalised. For instance, one of the questions was to ask whether the initiative of staff is rewarded. The recommendation was to add a definition for the initiative so that the meaning was clear for participants. I, therefore, added a definition for it. Checkboxes were also suggested so these were added in front of each question. The questions about the directors didn't have an instruction so '*please answer the following questions about yourself*' was added.

One of the main considerations about survey was to know which delivery mode would achieve the best response rate. Personal delivery can help the respondent to overcome the difficulties and answer all the questions, thereby ensuring the response rate would be high (Walliman 2018), but time and geographical aspects can be restrictive. Electronic delivery is quicker and cheaper (Clark et al. 2015). It is also recommended by Clark and colleagues for the questionnaire reminders, which increases the response rate. The questionnaires were distributed firstly by email with all the required information about the study; this helped the targeted people to review them. After that most of the targeted people were met to discuss the study and answer any questions. An email reminder was also sent to the targeted participants. Telephone calling was another method that was helpful in reminding the participants and increasing the response rate. This was in agreement with Stafford's argument that telephone calls significantly increase the response (1966).
The questionnaire was provided in English (Appendix 14) and Dari (Appendix 15). They were distributed and collected before the semi-structured interviews in order to inform them (Section 4.9). It contained 44 questions and was distributed to the heads of the directorates.

4.7.3. Semi-structured interviews

Interviews in case studies are fluid rather than rigid and are one of the most important sources of case study research (Yin 2013). The key feature of the interview is its flexibility as it allows a good understanding of participants' perspectives (Daymon and Holloway 2011).

The interview questions were developed based on the findings of the literature review (developed propositions) and the questionnaire findings. There were five theoretical propositions (Section 3.5), so the design aimed to address each proposition with a few questions. Additional questions ensured the research aims were fully addressed. For instance, for the first proposition which was 'manager's support and employee performance', so questions were included, which could explore this. One of the questions was 'What motivates you to do your best in your work? And are there any things that demotivates you?' The second proposition was about 'the management support system'. A general question was asked first, 'Do directorates here receive enough management support needed from higher levels? If the respondent was comfortable then a specific question was asked about their own directorate. This was similar with every proposition.

The interview can be formal or informal (Daymon and Holloway 2011); in this study, the formal approach was chosen using semi-structured interviews. These are also called focused interviews because they focus on the topic area. They decrease the time-consuming nature of interviews but are not meant to be followed strictly; they also aim to gain a deeper understanding of the perspective of the participants (Daymon and Holloway 2011; Bryman 2015). Interviews can be face-to-face or online (Daymon and Holloway 2011). Some researchers argue that online interviews are better than face-to-face, especially, in regard to the safety of the researcher and participants. Since it also depends on the context of the study, the researcher opted to conduct the interviews face-to-face as the internet facilities were sometimes weak and/or the participants did not have access to the internet due to a lack of electricity at the MoPH.

4.7.3.1. Interview test/rehearsals

The aim of the interview test was to pilot the interview guide and develop interview skills (Gerrish and Lathlean 2015). To make sure good quality interviews were carried out, three pilot interviews was done with two senior members of staff in the MoPH but were not included in the study, although one of them was at the same level as the interviewees, he was from the general directorate not from target directorates. They were at the same positions/levels that the targeted participants were. Interviews were exactly the same as the real interviews. They were conducted

in the MoPH and were recorded and transcribed. The pilot interviews were useful as they produced the following learning points:

- To be familiar with the questions and make sure that they were as clear and understandable as possible for the participants.
- Reminder to introduce oneself and the study project if necessary, although this was already provided in the Participant Information Sheet (PIS).
- To remember that the voice is recorded, and to ensure that confidentiality and anonymity are maintained.
- Three recording mediums were used to assess which was the best; computer, Samsung Galaxy S5 and a tablet. The computer proved less successful, as the recorded voice was very low and difficult to understand. The Galaxy S5 was better, but the tablet provided the best audio recording.
- Transcribing took longer than originally thought.
- While transcribing, it was recognised that some points mentioned by participants needed clarification during the interview, therefore probing skills needed to be developed.

Having considered and addressed each of these issues and after discussion with supervisory team, data collection proceeded to the participant interviews.

Semi-structured interviews were conducted with one senior member of staff from each of the targeted directorates in the MoPH meeting rooms. They continued until the data was saturated by 12 interviews (detail of saturation is described in Section 4.10). There were 15 open-ended questions (Appendix 16) and the interviews took from 42 minutes to one hour and 11 minutes. The language used in the interview was Dari, preferred by participants helping them to speak comfortably.

The interviews were audio recorded after the provision of study information and informed consent had been obtained. In each interview, two recording mediums were used in case one failed. The interview data were stored as audio records and transcribed (Saldana 2011). Audio recording is known as the best way to ensure that the participants' words are accurately recorded. This also allows the interviewer to maintain eye contact and pay attention to what the participant says and helps the researcher to maintain a good relationship with the participants while they talk.

However, audio recording needs participants' permission first so that participants' autonomy and decision-making are respected. As soon as the interview was completed the transcript was written. The transcripts were written by the researcher in Dari. Due to financial constraints, it was decided to translate only one of the interview transcripts. The one translated transcript was a way to cross check coding by supervisors and the quality of the analysis. All transcripts were coded in English. The coding process and the development of themes were also assessed by one of the supervisory team in the database.

4.7.4. Document review

The fourth data collection method was a document review, which is a systematic procedure for reviewing or evaluating documents (Bowen 2009). Because of their overall value, documents play an explicit role in case study research (Yin 2013). The document review was carried out to determine whether leadership capacity and capacity building were included in the MoPH policies and strategies. Consequently, they helped to examine, whether the planned activities for capacity building were being implemented. The document review was carried out alongside the other methods. Yin (2013) discusses two kinds of biases in relation to documents. One is biased selectivity, where the collection of documents is incomplete. Another is reporting bias, which can be committed by the author of a document. Many MoPH documents were accessible through the MoPH official website but to minimise the bias and to not miss any important documents, the documents were requested from the related department after presenting the research approvals. A total of 85 documents were provided in a folder by the relevant directorate. They included draft versions, duplicates (in three languages), and from different years. To avoid being overwhelmed and to enable an in-depth analysis, criteria for inclusion and exclusion were set.

4.7.4.1. The rationale for the inclusion and exclusion criteria

The aim of the document review was to analyse the MoPH documents that could provide information on the MoPH capacity and capacity building planning in the last years and whether those plans were implemented. This was to assess whether the finding of the documents corroborated with the findings of the other study methods regarding management capacity. Typically, national MoPH policies and strategies

are the documents that can provide such information. Indeed, these documents form the framework at the national level for all other MoPH documents including concept notes, statements, guidelines and frameworks. All MoPH activities need to be consistent with these policies and strategies. Therefore, the policies and strategies were included in the study but no other documents. Anything is discussed in policies and strategies will be found in other MoPH documents and similarly aspects that are not discussed are unlikely to be in other documents. These documents were issued in English, Dari and sometimes in Pashto. To not miss any documents, all three languages were included.

After the re-establishment of the health system in 2002, there was a significant shortage of capacity (MoPH 2005b), but after one decade and following the huge investment in the capacity building of the MoPH; it was expected that there would be a greater capacity. Therefore, it was decided to include policies and strategies that were endorsed from 2013 onwards. All the documents from before 2013 containing drafts, duplicates, and concept papers were excluded.

Inclusion criteria	**Exclusion criteria**
From 2013 onwards	Before 2013
In Dari / English/ Pashto	Draft version
Final (Approved) version	Without a cover page to show the date and other important information. e.g. which policy or strategy it is.
Policy (principles for reaching its long-term goals)	Ending by 2013
Strategy (sum of actions to be taken to achieve long-term goals.)	Other MoPH documents such as concept notes, statements, guidelines, frameworks

Table 4-2 Inclusion and exclusion criteria for the documentary analysis

Amongst the documents, there were those that started from the contents or forward page and lacked a cover page to indicate the content, date and department. These were considered as the indications of drafts, so they were excluded. The final

versions of documents were included. Typically, all the important documents of the MoPH are signed by the Minister or Deputy Ministers when they are finalised and are then ready for implementation. Therefore, they were included as the final versions. Figure 4.1 illustrates how the targeted documents were retrieved.

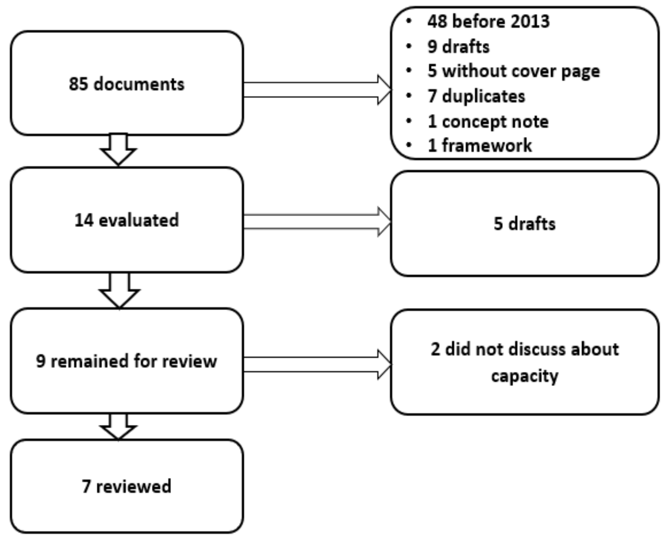

Figure 4-1 How the targeted documents were retrieved

From 85 documents, 71 documents were found to have been published before 2013, or were drafts, duplicates, concept notes, frameworks and/or lacked a cover page. There were 14 documents identified that would be subject to evaluation based on the set criteria. Five more documents were excluded due to being incomplete as they lacked the signature of the Minister or the Deputy Ministers of the MoPH as an approved document for implementation. At the end of the process, nine documents remained and were subject to review; two of them, 'National Pharmaceutical Quality Assurance Policy 2015' (MoPH 2015h) and 'Prison Health Services Strategy 2.0, 2015 (MoPH 2015i) did not discuss anything regarding the capacity, capacity building, competence or capability in the MoPH. The seven remaining documents were reviewed for evidence of reporting on or addressing the leadership capacity or capacity building issues (Appendix 17).

4.8. Summary of methods

Table 4.3. summarises the methods, sources that were used for each method, sample size and the rationale for using each method.

Methods	When	Who/what (data source)	Sample size	Rationale
Archival records	Sept. 2017-Jan. 2018	Aggregate data on capacity and capacity building	Records of about 30 directors	Assess investment in capacity building e.g. qualifications, awards, training.
Questionnaire	Sept. 2017-Oct. 2017	Heads of directorates	24 out of 30 completed	Determine the perception of leaders on factors that affect management capacity.
Semi-structured interview	Nov. 2017-Jan. 2018	Senior members of staff	Until saturation (12)	Determine perception of senior staff on factors affecting managerial capacity & employee performance.
Document review	Sept. 2017-Jan. 2018	Policies, strategies	7	Assess strategies & policies that promote /inhibit capacity building in the MoPH.

Table 4-3 Summary of methods and when they were carried out

4.9. Preparation of documents and translation

Although the official languages in Afghanistan are Dari, Pashto and English, Dari is the predominant language in government offices and English is used in all official correspondence and emails. All the documents were developed in English and then as Regmi and colleagues (2017) argue the questionnaires, PIS and PAF were translated into Dari. All study participants were provided with both the Dari and English versions of the PIS and PAFs. The participants were also provided both English and Dari versions of questionnaires and could complete whichever version they wanted. The interviews were all conducted in Dari as this was the participants' choice.

4.10. Data collection

After obtaining ethical approval from BU and the MoPH Institutional Review Board (IRB) Afghanistan, data collection started on 10th September 2017 and ended on 7th January 2018. Data collection was conducted sequentially. It started by distributing the questionnaires, then semi-structured interviews were conducted after compiling the results of the questionnaires. The archival records and document review were carried out concurrently. The sample size of the research was an important issue to be determined while designing the study (Section 4.11).

4.11. Sample

Sampling is “the process or technique of selecting a single sample, representative of the population from which it is taken for the purpose of determining parameters or characteristics of the whole population” (Singh 2016, p. 89). For quantitative studies, the number of participants is important to increase the generalisability of the study (Aceijas 2011). For qualitative studies, the sample size is often small, but the detail and in-depth analysis are important (Hewitt-Taylor 2011). However, for the case study, a case cannot be a sample, but it is an opportunity to study an issue within a bounded system (Baxter and Jack 2008). These boundaries indicate the breadth and depth of the study (Baxter and Jack 2008; Yin 2013). In a case study, the sample size may be small, however, a case study is concerned with the depth and richness of data rather than the quantity (Yin 2013).

Generalisation in case study research is about the theoretical proposition, not about populations (Hartley 1994). The goal is not a statistical generalisation, but analytical generalisation, which allows the researcher to move beyond the boundaries of the case and its setting and be applicable to other situations (Yin 2013). In analytical generalisation, a previously developed theory is used as a template with which to compare the empirical results of the case study (Darke et al. 1998; Yin 2013). In this study theoretical propositions were used to increase the generalizability of the study. They were developed from the literature review. The study results were examined with the propositions, the similarities and differences were compared, and the analysis involved asking what was similar to, what was contradicted, and why. This is discussed in Chapter 6.

4.11.1. Study participants

It was the researcher's responsibility to make sure the right people are included in the study who can provide the right information to address the study question. The question of the study helped the researcher in the selection of study participants. The research question determined that different methods needed to be utilised regarding the selection of participants from the directorates of the MoPH. In those directorates, there were mainly two groups of employees.

The directors who are the policy makers in their directorates and are responsible for strategic planning and making sure that policies are implemented. They have an important role in hiring the directorates' employees and deciding how to use the employees' skills, abilities and experience. They receive inputs such as financial and technical support from the management system and utilise them through the employees.

Another group of staff in those directorates are the employees or senior members of staff who work under the directors and receive guidance, instruction and support from them to perform and achieve the organisational goals. Their performance is monitored and supervised by the director. The factors that affect the performance of directorates are well known by these two groups of employees (the directors and the employees).

The researcher's rationale for selecting these two groups as the study participants was:

1. Heads of directorates who are directly involved in the daily activities and processes of the directorates. They also occupy supervisory and responsible positions. They were included in this study because they have a central role in the management system.

2. Senior members of staff or employees work under the direct supervision of the heads of the directorates and their performance will be directly affected by them. Senior members of staff were selected because they were more experienced among all other staff in these directorates and had greater insights about the relevant directorates. The employees were included in this study as their performance is linked to the management system.

To gain access to the participants, the list of directorates along with contact addresses including email address and mobile numbers of the relevant directors was provided by the General Directorate of Policy and Planning after demonstration of ethical approvals and explanation of the study's aim.

4.11.2. Sample size of the survey

The sample size was determined based-on the number of directorates in the MoPH. According to the organogram approved by the Minister (2016c), there are 30 directorates indicating a relatively small population size. In this case, the total population sampling was the most applicable sample to choose. It is a type of purposive sampling technique where the entire population that have a particular set of characteristics is chosen to be examined (Singh 2016; Laerd Dissertation 2019). The targeted sample of this study therefore was the total population, the 30 directorates of the MoPH.

4.11.3. Sample size of the interview

Semi-structured interviews were carried-out with the most senior member of staff in each of those 30 directorates until the data were saturated. Employees of each directorate were asked to introduce a few of the most senior employees in their directorate. The employees provided their names with their contact address, then an email was sent to them separately. The directorates were selected using purposive sampling. Data saturation addresses whether a study is likely to have achieved an adequate sample for content validity (Francis et al. 2010). However, making the decision that the appropriate sample size has been attained and the data reached to saturation is difficult. In this study, the themes were created by the eighth interview. After eight interviews, there were some new information, but these came under the already created themes rather than constituting a new theme. Therefore, interviews were stopped after the 12th interview. Francis et al. (2010) claims that the saturation occurs when no new themes emerge in the last two or three interviews. This was followed in this study.

4.11.4. The sample size of the archival records

The archival records sampling was based on the number of directors that were included in the study which was 30. For a total sample the information about those 30 directors was sought from the relevant department.

4.11.5. The sample size of the document review

The sample size of the document review was dependent on the results of inclusion and exclusion criteria (Section 4.7). The inclusion and exclusion criteria were applied, and nine documents were initially selected for review. Two, however, did not discuss capacity and capacity building so, the seven remaining documents were selected for review.

4.12. Ethical considerations

Ethical approval was obtained from Bournemouth University Research Evaluation Committee (BUREC) for this current study (Appendix 4). As this research was planned to be conducted in the MoPH, Afghanistan, the study protocol along with other required documents was submitted to the IRB of the MoPH and approval was obtained (Appendix 5).

Ethical considerations are more important in a society like Afghanistan where after decades of war people find it hard to trust and confidentiality is not respected. In practice, ethical consideration required greater awareness and care on the part of the researcher to safeguard participants' anonymity and confidentiality. I was really careful about ethical considerations and fortunately, strict compliance created more trust amongst the participants, which in turn encouraged their disclosure of information. This study took nine principles into account as shown below. The application of every single principle and how it was applied to each method is explained under each principle.

1. Autonomy

Respect for individual autonomy means that they have the freedom to decide whether to participate in the research or not (Robichaux 2017; Kyegombe et al.2019). This principle was applied to the survey and interview. All the research participants had complete autonomy to decide whether to participate in the research or not. There was no force or pressure on any group to participate. For the survey, out of 30 directors, 24 agreed to participate, three directors didn't agree to participate, and two of the directors had only been in their post for a few months. After consulting the supervisory team, it was decided to not include them. One director position was vacant during the research time. For the interview participants as well, it was for

them to decide whether to help or not. To gain access to the most senior members of staff, employees of each directorate were asked. The employees provided two or three names of senior members with their contact address, then an email was sent to them separately. The research was explained and the PIS was shared with those who replied and were willing to participate. To ensure the autonomy it underlies the need for informed consent (Canterbury Christ Church University (CCCU) 2018), which is described below.

2. Free and informed consent

This principle was applied to the survey and interview. One of the main responsibilities of a researcher is to provide enough information to potential participants to enable them to decide whether to take part to the study or not (Kyegombe et al.2019). A PIS including a summary of the project was provided to participants. It was emphasised that they could make a free and voluntary decision and were able to withdraw at any time up to the point where the data was processed and became anonymous. To help the participants take an informed decision, all documents were provided in two official (formal) languages (Dari and English). As the study included two groups of participants for the interviews and questionnaires, each group was provided with their relevant specific information sheet (Appendices 6, 7, 8 and 9). Simple language was employed to make it accessible and understandable to every reader. The PIS and Participant Agreement Sheet (PAS) were shared with the research supervisory team for comments and revision. These documents were also reviewed and assessed by BUREC.

Participants were encouraged to ask further questions and were provided with the research team contacts if they had further concerns about the research. The purpose, nature and timing of the research were explained. The methods that were used for data collection from participants were clearly described as well as the possible benefits and harms of the study. The PIS also explained to participants what would happen to their data and what the outcome would be. Many participants were met face to face if they had any concerns or questions. If they were willing to participate, they completed and signed the PAS (Appendices 10-11). Data collection was started after the PAS was signed by the participant.

3. Veracity

The researcher is required to provide true information to participants and obtain informed consent (CCCU 2018). Meanwhile, the researcher's claims need to be accurate and the information taken from participants must be conveyed truthfully and accurately (Mathison 2005). In practice, in addition to the formal responsibility for the veracity, because the participants trusted and shared their perceptions, problems, hopes and wishes for improvement, the researcher felt personally responsible to convey exactly what they shared. This principle was applied to all four methods used in this study. To fulfil the veracity, the researcher has tried her best to convey the data accurately. For instance, many times the researcher has gone back to the codes, transcripts or filled questionnaires to make sure that the sentences that are reported in the thesis are the same as the participants have indicated. This was the same with the document data as well as the archival records. The data were checked several times in the original source to ensure accuracy. The supervisory team have also regularly assessed that the findings are reported accurately.

4. Respect for vulnerable persons

Some research may include vulnerable people who need special consideration (DeRenzo and Moss 2006; Ognibene et al. 2012). The participants of the survey and interview were the directors and the senior members of staff who were mature, educated and had the ability to confidently make decisions for themselves. However, all principles were carefully considered and whilst all participants seemed capable of providing consent, the researcher was sensitive to any individuals who may have shown vulnerabilities. Also, the interview participants were supposed to talk about the management capacity and their directors during their interview. In this case they were counted as vulnerable people if the information they gave was disclosed to a higher authority or their bosses and their career could be in danger. Therefore, this was considered throughout the research.

5. Privacy, anonymity and confidentiality

Each individual is entitled to privacy and confidentiality and anonymisation protects confidentiality (Ognibene et al. 2012; Kyegombe et al.2019). Confidentiality and anonymity must go hand-in-hand when dealing with the data provided by participants. Anonymisation is the removal of any personal identifier from data, to make it impossible to relate the data back to the participant. While:

> "Confidentiality means (1) not discussing the information provided by an individual with others, and (2) presenting findings in ways that ensure individuals cannot be identified (chiefly through anonymisation)" (Wiles et al. 2008, p.418).

Privacy means that each person has the freedom to decide the time and circumstances under which they share information (CCCU 2018). The interview participants of this study required strict privacy. Interviews were conducted at times and locations that the interviewees requested. For other methods of the study, there was a flexibility in terms of time. For the survey, participants were emailed the questionnaires and provided with a long span of time to complete them. They were then given the option of returning them to the researcher by email or if they wanted to complete the questionnaires in hard copies that the researcher would then collect. Privacy was strictly followed for the data collected through documents, archival records and the emails that were provided by related departments. The PIS provided to survey and interview participants with a full explanation of what would be done with the data they provided. It clearly stated the protection of participant confidentiality and anonymity. These were also strictly followed for the documents and archival records as it was important to not only protect the participants' anonymity, privacy and confidentiality but also to protect the people or departments whose names are mentioned by the participants or in the documents or archives. In the archival records although the information was related to individual director these data did not specify any name or identifier. This was the same in the document method. Data were used to show the general condition about the capacity in the MoPH, no individual or department name was used.

All the data were anonymised by coding so could not be connected back to the individual. The coding or anonymisation list was kept separately from the data. To maintain anonymity, all the identifiers such as participants' names,

department/directorate or place of work were removed from the data. Instead of the participant’s name, the relevant code was used in the research report. While reporting case studies, anonymity is required when it deals with a controversial topic (Yin 2013), however, on other occasions, it is not appropriate because important background information will not be provided and explanation of the case becomes difficult (Gerrish and Lathlean 2015). The unit of analysis-management capacity and leadership in the MoPH, was decided not to be anonymised, because based on Gerrish and Lathlean's argument above, the background of the case can be discussed. However, the list of participants’ codes was integrated with the report while the participants’ particular contribution or point of view was anonymised. In order to safeguard participants’ anonymity, the researcher faced some limitations. There were instances of evidence for some claims, but in order to prevent identification of the directorate, they were not used in the report.

6. Justice and inclusiveness

Justice involves fairness and equity for all participants in research (Robichaux 2017). Consideration of this principle was required in all the included methods. Fortunately, this research involved the minimum burden of taking 30-60 minutes for the interview and questionnaire participants. This research may not include any immediate benefit for the included participants. However, if there are benefits, they will benefit all the participants and other employees similarly. The participants of this research were all treated the same. The same questionnaire was distributed to all directors with a single email, attachments and instruction text. They were given the same span of time. This was the same in the archival records method. Similar personal information was asked and collected for all directors. All the documents were assessed similarly against the inclusion and exclusion criteria. Interview participants were all asked the same interview questions and all other procedures were similar.

7. Harms and benefits

One of the responsibilities of a researcher is to assess the possible benefits and harms that can be caused by the research to the participants and other people with an

emphasis on minimising harm and maximising the benefit of research (Ognibene et al. 2012) as below;

a. Minimising harm (Non-maleficence)

This indicates the duty to avoid, prevent or minimise harm to others (Kyegombe et al.2019) and the research participants should not be exposed to any unnecessary harms. The MoPH has been defined as a fragmented institution (Islamic Republic of Afghanistan 2017; Feroz 2018), and management capacity and leadership was therefore a potentially sensitive topic to study. The researcher realised that this responsibility should be taken seriously to prevent not only the participants but also the people who the participants talked about from possible harm. Assessing the situation, the researcher concluded that the possible harm to participants might affect their jobs and careers. It was therefore decided to take extra precautions to protect participants' anonymity and confidentiality. The questionnaire was sent to participants by email and they were encouraged to return the completed questionnaires to the researcher's email address. For the interviewees, the interview was carried out in the MoPH, but in a separate meeting room where the interviewees were comfortable and far away from disturbance or identification. The interview location was not important for some participants and neither was it an issue for the interview to be carried out in the office where other colleagues were present. Nevertheless, the interviewees were encouraged to have the interview in a separate meeting room, in order to protect them from possible harm. As there were few female participants amongst the interview and survey participants no gender identifier was included in order to reduce the risk of identification.

b. Maximising benefit (Beneficence)

The principle of beneficence enforces a duty to maximise net benefits (Ognibene et al. 2012; Kyegombe et al.2019). The aim of research should be to generate new knowledge that can produce benefits for participants themselves and for others in society. The research benefits were assessed at the preliminary stage. The study would benefit the MoPH because the study's aim was to explore and identify the

factors that affect the management capacity and leadership in the MoPH, Afghanistan and the employee performance. Therefore, this research was believed to benefit the MoPH and consequently the Afghanistan health system. The findings of the research can also benefit the LMICs as this research was carried out in light of the literature that was conducted in those countries. This would be considered the researcher's duty to convey the results to the relevant stakeholders and the international community in a timely manner and expand the produced knowledge actively. This would be possible through publications of the PhD results in the relevant journals and through national and international conferences and meetings. This was the concern that the findings of the study needed to be reported in a manner that should not harm anybody. So, it was attempted through the reporting to show that the aim is to share the findings for improvement not to blame any person, group of people or organisation.

8. Health and safety issues

Health and safety considerations are important in all research (Ognibene et al. 2012), but these were heightened in this study, given the risks to security in Afghanistan. There have been many suicide attacks on government buildings in Kabul. Moreover, MoPH is located beside the US embassy and the international airport, these two places are one of the main targets for Taliban. It was important to consider the health and safety risks for both the study participants as well as the researcher. A full risk assessment was undertaken prior to the commencement of field work and the risk assessment was subject to continuous review. In order to manage and minimise the risk, consideration was given to training in risk management, safety during fieldwork and monitoring information outlets to gauge the degree of threat at any one time. Fortunately, the researcher has a family home in Kabul, which was a safe base. The researcher attended the risk assessment workshop provided by BU and risk assessments were completed before the commencement of the research and in the middle of the research and approval was gained. This was also monitored by BUREC during the study (Appendix 12). The advice of the Ministry's security advisors was sought to comply with local rules and regulations. The news was regularly accessed for updates about the security situation in the locality. The phone and emails of participants were obtained to maintain contact with participants when travel needed

to be avoided for reasons of safety. To minimise personal security risks to participants, they were interviewed in their own place of work in the MoPH, but in separate meeting rooms where their confidentiality could be maintained and without attracting attention to their participation in the study.

9. Data storage

Data storage was also ethically considered as it directly linked to the participants' anonymity and confidentiality. Data storage through databases is discussed by scholars at greater length and in greater detail in case studies than in other paradigms (Yin 2013). The two main roles of databases in the case study are to retain the evidence for later analysis and to allow the inspection of the study evidence (Yin 2013). However, besides the above two roles, databases can practically play a significant role in data security.

Two databases were used, including one software and one hardware; the questionnaires, the archival records (personal information), documents, and interview's transcripts and audios were stored in NVivo. The questionnaires were kept in NVivo as it included some qualitative data. The electronic data were stored in a password-protected computer at the university and the hard copies of research papers and materials were stored in the locked filing cabinet at the university. NVivo was used as a master database. Not only were the research data stored in NVivo, but also many of the relevant literature and useful material relevant to the study were kept in it, which was accessible and less time-consuming (Appendix 13).

To summarise this section, in practice, in this study, different methods needed ethical considerations. As the archival records included personal information about the directors, this created more ethical concerns to be considered by the researcher and the relevant department who is responsible for keeping the employees' information confidential. However, the good point of this method was the researcher was able to provide her email address to the responsible person and the information was provided by email to the researcher. This helped the reduction of risk of data of being exposed to irrelevant people. However, storage of these data was important to make sure they are confidential, and their privacy is maintained. The use of email helped to maintain confidentiality for the survey participants as it was safer and less accessible

than paper copies. Storage of the questionnaires, anonymity, confidentiality and veracity were the most important aspects to be considered for the survey method among others.

Ethical considerations were a little easier in the conduction of document review. This was because the documents were downloadable from the official website of the MoPH which indicates that there is not any concern about confidentiality and anonymity from the MoPH side. This might be available on the websites to help public accessibility to these policies and strategies for better awareness. However, there was a need to consider other ethical aspects that were required. For instance, veracity was important in the document review, by conveying the information truthfully and accurately. Participants' autonomy and informed consent were important issues to be considered for the interview method, particularly with regard to the audio recordings, transcripts and their analysis. The principle that was one of the most applicable aspects to interviews was the health and safety consideration.

The quality of research is a critical issue, here all the relevant quality measures introduced by Yin (2013) were strictly considered. Section 4.13 describes the quality considerations in detail.

4.13. Research quality

Yin (2009) suggests that internal validity, external validity, reliability or replicability are the key quality criteria for case studies. Consideration of the quality of research was very important as research informs the action and contributes to developing knowledge so all of Yin's criteria were carefully considered and applied where appropriate. 'Singularity' means the study of one single or particular case. The singularity of case studies is said to cause bias and lack validity, reliability and generalisability (May 2011). However, Simons (2009) sees a case study as a valuable and valid tool because its aim is 'particularisation'. 'Particularisation' is the process of presenting a rich picture or description of a single setting, contributing to the knowledge of a specific topic. It seems that the scholars who have many years of experience with case study methods, count the 'singularity' and 'particularisation' of a case study as its strength, not a weakness. Stake (2005), as a strong defender of

case studies, argues that singularity is a strength that enables the researcher to focus on the particularity and complexity of a single case.

The critical role of generalisability of the case study is through sharing lessons learned (Yin 2013). Four tests were introduced by Yin (2013) for the assessment of quality in case studies. They are widely used in all social science methods and have served as a framework for assessing other quality case studies. These tests were used in this study as the framework for quality appraisal. Besides the tests, there are several tactics introduced by Yin (2013) for dealing with those tests and the phases of research to be used while undertaking case studies. Table 4.4 shows four tests along with tactics and the phases introduced by Yin for the quality of case study. It also discusses how it was applied to current research. The applicability of those tests to this study are detailed in the sections below.

Tests	Case study tactic	Phase of research in which tactic occurred	Actions taken
Construct validity	Use multiple sources of evidence	Data collection	Archival records, document review, questionnaires and interviews were the multiple sources used
	Establish a chain of evidence	Data collection	Evidence was sought in different sources
	Have key informants review draft case study report	Composition	The review of the summary report was shared with participants
Internal validity	Do explanation building	Data analysis	Collected data were compared with the theoretical propositions using explanation building as an analytical technique.
	Address rival explanation	Data analysis	Data of this study were assessed versus the rival explanation
External validity	Use theory in single-case studies	Research design	Theoretical propositions were used in the study design
Reliability	Use a case study protocol	Data collection	Study done based on protocol; • The same questionnaire was completed by all participants • Same questions were asked to all interviewees • Same personal information was sought from all participants
	Develop a case study database	Data collection	Study relevant materials were stored in proper databases

Table 4-4 Criteria for the quality of case study (amended from Yin 2013, p.45)

4.13.1. Construct validity

Construct validity is the degree to which a test measures what it is planned to measure (Crocker and Algina 2008). To increase the construct validity of the case study (Table 4.4), three techniques are introduced by Yin (2013), which are applicable during data collection and composition. Those three techniques were carried out as below to address the construct validity;

Use multiple sources of evidence: As explained in Section 4.2.1, there was a need to review documents over and above the qualitative and quantitative mixed-methods studies. As the study plan was to address the factors that affect the management capacity and leadership. It was also recognised to explore the leaders' qualifications and any capacity building which they had received. All this was possible through the MoPH archives. As a result, the decision to use a case study allowed the inclusion of the document and archival records review in addition to the interviews and questionnaires. These various sources were complementary and contributed to the picture (Yin 2013) while no single source of data has any major advantage over the others.

Establish a chain of evidence: A chain of evidence increases the reliability of the information because it allows the reader to follow the derivation of any evidence from the research question to the case study conclusion (Yin 2013). In this study, it was ensured that all the data collected from different sources were stored in the databases, to ensure they were shown in the findings. It was also important to demonstrate how the coding process and the development of themes were developed and how they became the basis for the conclusions of the study. In each of the processes, the data were cross-checked by one of the supervisory team to make sure that the conclusions of the study were based on the data that was collected. For instance, the researcher was asked to provide references to a claim in the previous chapters to show the linkages.

Have key informants review draft case study report: One of the emphasises that Yin (2013) placed for the quality is the review of the findings report by the participants. Sharing the interpreted report was difficult and ran the risk of the participants either rejecting the findings, requesting changes or expressing concerns about the contents. Nevertheless, it was decided from the design stage of this PhD study to share the findings with the participants especially when their data is interpreted and analysed by the researcher. All 12 interviewees were given the draft of the interview findings in November 2018 by email if they were willing to review and provide their comments. Seven participants replied to the email commenting that they agreed with the content. One of them provided feedback that it would be better if the researcher can provide their own recommendations for the improvement. These emails had included the researcher as well as one of the supervisory team.

4.13.2. Internal validity

Internal validity refers to "the extent to which the ideas about cause and effect are supported by the study" (Walliman 2018, p.104). For the internal validity of this case study, two issues needed to be considered (Yin 2013); the use of explanation building and the use of rival explanations. When designing the study, it was important to select an approach which would help the data to be analysed properly. This would help to be concise and on track in the data analysis. At the same time avoid missing findings from the data (Yin 2013). The theoretical propositions had already been developed from the literature review and explanation building was identified as the best means of developing and explaining the findings versus the developed propositions. Explanation building is an analytical technique, its aim is "to analyse the case study data by building an explanation about the case" (Yin 2013, p.14). The collected data were analysed versus the theoretical propositions. How the explanation building was used is explained in Chapter 7.

Another issue was to ensure that the results or conclusions that were developed from the collected data were correct and therefore it needed to be established whether other factors could lead to the same results. For this, rival explanations are introduced (Gillham 2005; Baxter and Jack 2008), where the researcher attempts to collect evidence about possible 'other influences'. Two rival explanations were

addressed and explored during the data collection. Rival explanations are defined in Sections 4.17.

4.13.3. External validity

External validity refers to "the extent to which findings can be generalized to populations or to other settings" (Walliman 2018, p.104). In case studies, generalisation is about theoretical proposition rather than the populations (Hartley 1994). This means that by the application of theoretical proposition the research can be generalised to other population and settings. As a key marker of research quality, external validity was considered during the study design. For the external validity of single-case studies, Yin (2013) introduced a previously developed theory to be used for analytical generalisation. The literature review helped in developing theoretical propositions and these propositions were used in the study design and used as a template with which the findings of this study were compared, in order to increase the generalisability. Theoretical propositions are explained in Section 4.16.

4.13.4. Reliability

Reliability will increase when errors and biases are decreased (Yin 2013). Yin introduced two ways to increase the reliability of case studies; the use of case study protocol and the use of a well-developed database. The protocol was developed at the start of the study (Appendix 3). This helped each step through the study to be determined and to be on track, which in turn helped to minimise errors and biases. NVivo was used as the study master database, which was an easy way to have access to the study data and other relevant materials. The details of database and data storage are explained in Section 4.12.

4.14. Data analysis

Gillham (2005) finds the analysis and presentation of case study a 'formidable task' but does not describe it with detail. Though they have named theories and provided appropriate explanations for the analysis no explanation was given. Data analysis in case studies is explained by Yin (2013) with detail, they suggests four general

strategies for data analysis in case studies: 1. relying on theoretical propositions, 2. working on data from the ground up, 3. developing a case description and 4. the examination of plausible rival explanations. The applicability of these four strategies was assessed in this study as below.

1. ***Relying on the theoretical proposition:*** in this strategy, theoretical propositions lead case study. The case study objectives and design are based on these propositions, which reflect the research question (s). In this study, to find out about the topic, a literature review was carried out at the start of the study, which was a good opportunity for developing theoretical propositions. This strategy was followed because of the pre-existing theories aid precision. The question and objectives of the research were developed based on the theoretical propositions and they helped to organise the entire analysis (Yin 2013). They also prevented bias that may occur with other strategies because each step of the research was based on these propositions, so they helped the research to stay on track.
2. ***Working on data from the ground up:*** this strategy is in contrast with the first strategy, so it cannot be carried out at the same time with the first strategy. In this strategy, the researcher needs to pour through the data to notice a pattern or find some concepts. This strategy was not applicable as the theoretical proposition strategy was already chosen and the study design and objectives were based on the first strategy.
3. ***Developing a case description:*** in this strategy, the case study is organised according to a descriptive framework. It can be used as an alternative when the researcher has difficulties with the first and second strategies. This strategy was not applicable to the researcher's study as the aim of this research was not to match or describe the findings of the case study with a framework. The aim was to address the study's question.
4. ***The examination of plausible rival explanations:*** this strategy generally works in combination with the other three strategies mentioned above for data analysis as it tests and defines the plausible rival explanations (Yin 2013). It helps to find out if there are ''other influences'' possible for the current situation. This was of interest for the researcher to explore if there is another factor or factors that can affect the MoPH performance, particularly if they

cannot be under the control of the MoPH. In this case, this strategy was a good opportunity to find-out about those factors. Therefore, it was considered to be included especially when it increases the internal validity (Baxter and Jack 2008).

Choosing the 1st and 4th strategies (theoretical propositions and rival explanations), offered the following benefits, which were also claimed by Yin (2013): first a focused analysis; secondly, exploring rival propositions provided an alternate explanation of the case; and thirdly, confidence in the findings increased as the rival propositions are addressed. Both theoretical propositions and plausible rival explanations are detailed in Sections 4.16 - 4.17.

Within the analysis strategies for case studies, five analytic techniques were introduced by Yin (2013). 1. Pattern matching; 2. Explanation building; 3. Time-Series analysis; 4. Logic Models; and 5. Cross-case synthesis. Amongst all the techniques, explanation building was chosen to be used as the analytical technique. This was selected because the explanation building is applicable in the explanatory case studies and the explanatory type was used in this study. Meanwhile, this technique compares the findings of the case study against the initial explanatory propositions, which were already developed in this study. In this case, this technique was the most applicable technique to choose. Other techniques were not applicable to the current study.

<table>
<tr><th>Method</th><th>Sources</th><th colspan="2">Data analysis</th></tr>
<tr><td>Archival record
(quantitative)</td><td>Personal information of directors</td><td>Descriptive statistical analysis</td><td rowspan="6">Comparing findings with theoretical propositions and rival explanations through the analytic technique of explanation building</td></tr>
<tr><td>Document review
(qualitative)</td><td>Policies
Strategies</td><td>Thematic analysis using NVivo</td></tr>
<tr><td rowspan="2">Survey
using questionnaire
(quantitative)</td><td rowspan="2">Directors</td><td>Statistical analysis using SPSS</td></tr>
<tr><td>Thematic analysis (manual)</td></tr>
<tr><td>Interview
(qualitative)</td><td>Senior members of staff</td><td>Thematic analysis using NVivo</td></tr>
</table>

Table 4-5 Data collection methods and their analysis

The first technique was not applicable as this study does not involve predicted findings. The third and fourth techniques were not applicable as the aim of the study was not to analyse the time-series nor to explore the events. The single-case study was used in this research while the fifth technique was applicable for the multiple case studies not for single-case studies. Table 4.5 describes each single data collection method and its analysis in the current study.

4.14.1. Analysis of quantitative data

Quantitative analysis is carried out with the use of SPSS software using descriptive statistics (Gillham 2010). In the descriptive statistics, the data are described. It summarises the numerical data (Gillham 2010; Singh 2016). The questionnaire included both quantitative and qualitative data. Qualitative data were analysed thematically, described in Section 4.14.2.

In total 97 variables were developed. The ‘analysis' and ‘graphs' options within SPSS were used for analysis. Under the ‘analysis' option in SPSS, ‘descriptive statistics' and ‘multiple response' options were used. In the ‘descriptive analysis' option, the ‘frequencies' option was used. Many other options are not applicable when the total population is included in the study. For instance, the 'Confidence intervals' can only

be used when a sample size from a total population is included in the study, not the total population. The findings of qualitative and quantitative data of questionnaires were reported together in Section 5.3. The findings of archival records were described in Section 5.2. The questionnaires and archival records findings were then reported in combination with the findings of other methods in Chapter 6 as a single-case study.

4.14.2. Analysis of qualitative data

The qualitative data included the interview data, documents and the qualitative responses from the questionnaires. Thematic analysis was used to interpret the data. It was used as a method for identifying, analysing, and reporting patterns within the data (Braun and Clarke 2006). Unlike quantitative studies that start when the data collection ends, the qualitative study's process is a continuous process. After transcribing, the first interview data were entered into NVivo. For the interview and documents reviews, NVivo was used for data analysis, while the qualitative data, using questionnaires, were analysed manually. NVivo is an analytical software package that is used for qualitative data analysis. The qualitative data analysis in this study was informed by the Braun and Clarke (2006) utilising the process of dividing the thematic analysis into six separate steps. Appendix 18 demonstrates a sample of the thematic analysis in this study. Below is the description of all phases of the analysis and how they worked in this research.

Phase one: familiarizing with data

This phase starts when the data have already been collected, with some thoughts and knowledge of the collected data (Braun and Clarke 2006). Practically, three important activities were found helpful in this phase; carrying out transcription by the researcher, reviewing of transcripts and noting down the important points. Transcription of the data was helpful for familiarisation with the data, as was having conducted the interview. Notes were taken during the reading phase to help for systematic coding in the second phase. For the documents and qualitative responses of questionnaires, note-taking was the same as for the interviews described above.

Phase two: generating initial codes

This phase includes the production of initial codes from the data (Braun and Clarke 2006). Data were analysed deductively. The theoretical proposition guided all the data collection processes and finally, the data were analysed versus those theoretical propositions. In the deductive analysis, the theory is examined and confirmed based-on the observation/findings. The interview data and documents were coded using NVivo, while the coding of the qualitative data of the questionnaire was carried out manually. Two main folders by the name of 'Interview' and 'Documents' were created in the NVivo database for the interviews and document review coding processes. While the coding folder for the qualitative data of questionnaires was created in a computer. In this phase (2nd), 381 codes were generated from the interview data, 49 codes from the document review and 208 from the qualitative data of questionnaires were generated. Figure 4.2 demonstrates the generation of the initial codes in the 2nd phase.

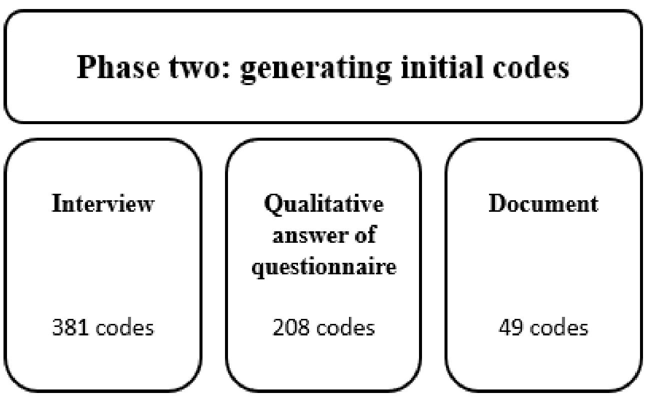

Figure 4-2 Generating initial codes

Phase three: searching for themes

This phase involves sorting the different codes into potential themes (Braun and Clarke 2006). In the interview folder, four subfolders were created by the name of each phase commencing from phase two as the first phase was familiarising with data only and the fifth phase was the last subfolder because phase six is the reporting phase. The same procedure was performed for the document review and qualitative data of the questionnaire. The initial themes that were created in this phase (3rd) were 13 in the interview folder, four in the documents folder and eight were created in the

questionnaire folder. Figure 4.3 demonstrates the themes contained in the third phase.

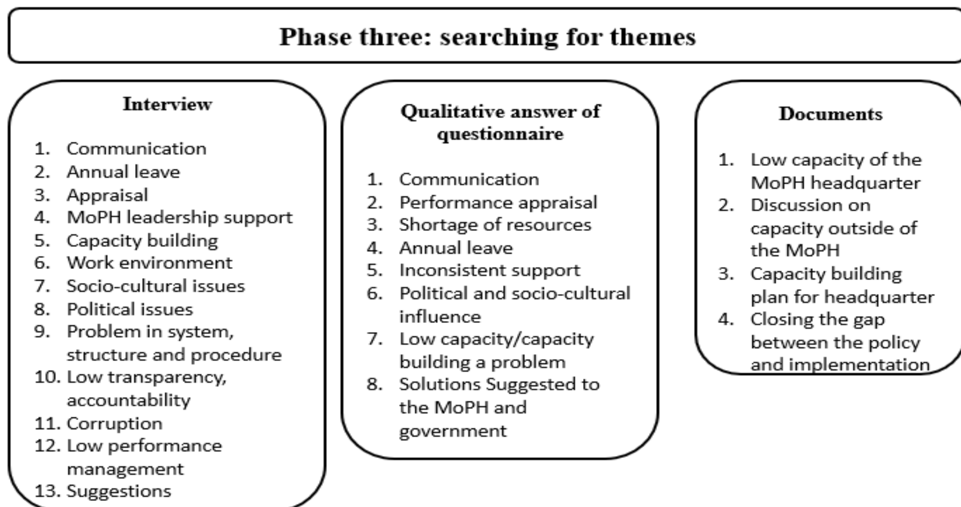

Figure 4-3 Searching for themes

Phase four: reviewing themes

This phase involves the refinement of the candidate themes (Braun and Clarke 2006). The candidate themes were assessed to come-up with potential themes. In the interview folder, some themes had codes that were not easily distinguished from the codes in another theme. For instance, the theme of 'Socio-cultural issue' and 'Political issues' included many codes that were coherent with each other. In this case, both themes needed to be collapsed into each other. In the document folder, the theme of 'Closing the gap between the policy and implementation' was not supported by other data, therefore, it was discarded. In the qualitative answers of questionnaires folder, themes of communication, performance appraisal, shortage of resources and annual leave that are categorised as the supports that the employees need in an organisation. They were therefore collapsed in the 'Inconsistent MoPH support' theme. These resulted in the creation of five potential themes in the interview folder, three potential themes in the documents folder and five themes in the folder of qualitative answers from the questionnaires. Figure 4.4 demonstrates reviewing themes in phase four.

Phase four: reviewing themes

Interview

1. No enough support
- The managers' support, the employees' performance
- Inconsistent leadership support
2. Uncoordinated capacity building
3. The political and socio-cultural negative influence
4. Lack of transparency, accountability and corruption
5. Change is demanded

Qualitative answer of questionnaire

1. Inconsistent support
2. Low capacity/capacity building, a problem in the MoPH
3. Political and socio-cultural issues
4. Lack of transparency
5. Suggested solution

Documents

1. Low capacity of the MoPH headquarter
2. Discussion on capacity outside of the MoPH
3. Capacity building plan for headquarter

Figure 4-4 Reviewing themes

Phase five: defining and naming themes

This phase begins when satisfactory themes of the data are on hand (Braun and Clarke 2006). One theme in the interview folder consisted of two subthemes. This was because it was recognised among the data that there were two types of supports; one was from the directors to their employees. Another was from the MoPH leadership to the directorates including the directors and employees; therefore, these are reported separately in the thesis. This was the theme of 'Insufficient support', which included the sub-themes of 'The head of directorates' support, the employee performance' and 'Inconsistent MoPH leadership support to directorates'. The themes in the folders of qualitative answers of questionnaires and documents did not include sub-themes.

The themes and subthemes were assessed based-on whether they were good representatives of the data included within them. For instance, in the document folder the theme of 'Discussion on the capacity outside the MoPH' seemed confusing because it was not clear who is included in the 'outside the MoPH', while the discussion was about the people who were implementing the health services in the field, so 'implementers' was the best term to be used here as 'Implementers' capacity' which was a good representative of the data in the relevant theme. Same issues were assessed in other themes. Figure 4.5 demonstrates defining and naming

themes.

Phase five: defining and naming themes

Interview

1. Insufficient support
- The head of directorates' support, the employee performance
- Inconsistent MoPH leadership support to directorates
2. Uncoordinated capacity building
3. The political and socio -cultural negative influence
4. Inconsistency due to lack of transparency and accountability
5. Change is hoped for

Qualitative answer of questionnaire

1. Inconsistent support
2. Low capacity/capacity building, a problem in the MoPH
3. Political and socio-cultural issues
4. Lack of transparency
5. Suggested solution

Documents

1. Low capacity of the MoPH
2. Implementers' capacity
3. Capacity building plan

Figure 4-5 Defining and naming themes

Phase six: Producing the report

This phase involves the final analysis and writing of the findings report (Braun and Clarke 2006). The data of each method were analysed and reported separately in Chapter 5. The qualitative part of the questionnaires is reported in combination with the quantitative questionnaires and the interviews, archives and document's findings are reported separately in Chapter 5. Then the findings from every method were combined and presented as one single-case study in Chapter 6. Data triangulation and convergence are very important in case studies and have been counted as the best advantage of multiple sources used in case studies (Yin 2013), so Section 4.15 describes why the convergence of multiple evidence is the best advantage of the case study.

4.15. Triangulation in the case study

Triangulation from multiple sources is needed to understand reality (Axinn and Pearce 2006). The conclusion of a case study that is based on several sources of information will be more convincing and accurate (Gerrish and Lathlean 2015) and will be rated high-quality. The important point here is the data are collected from

multiple sources, but the aim is to corroborate the same phenomenon. Yin here uses the 'convergence of evidence' term in their book published in 2009, however, it is not described instead this is described well in their book published in 2013. This means that if multiple sources are used to explore about one phenomenon and they follow a similar convergence then the findings of this study are more convincing. This is because multiple sources provided multiple measures of the same phenomenon. That is why it strengthens the construct validity of the case study with multiple sources of evidence (Yin 2013). Yin counts the data triangulation the best advantages of the case study design. To address triangulation; document review, semi-structured interview, questionnaires and archives were used to explore the same phenomenon (Figure 4.6).

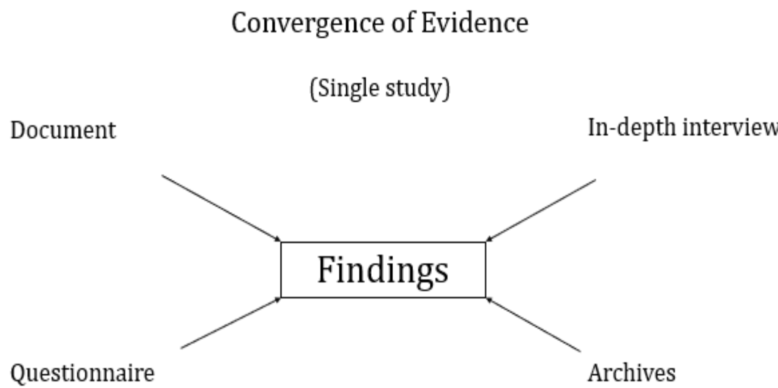

Figure 4-6 The study convergence of evidence

In terms of triangulation, some other important points are there to be considered when doing a case study. Using multiple data collection techniques needs to be carried out properly (Gerrish and Lathlean 2015). If any of these techniques is used improperly, the convergence line will be lost among the data. Pilot studies are other ways that are helpful. The interview and questionnaires were both piloted exactly as the real data collection until the researcher became confident about them. The researcher already has experience similar to the documents and archives review before so there was not an issue of concerns about them.

4.16. Theoretical propositions

Theoretical propositions help to focus data collection, determine the direction and scope of the study and form the foundation for a conceptual structure/framework (Miles and Huberman 1994; Stake 1995). They guide what needs to be examined (Yin 2013). Propositions are generated from literature, personal or professional experience and theories or generalisation from empirical data (Baxter and Jack 2008). Like hypotheses in quantitative studies, they are an educated guess to the possible outcomes of research studies. The propositions in this study were developed based on the literature (Section 3.5) and led to the development of a conceptual framework for this study. The following propositions were used to examine and explain what factors affect the management capacity, leadership and the employee performance in the MoPH:

1. There is a strong relationship between managerial support and employee performance
2. The management support system affects managers' work
3. Managers who have managerial training can manage well
4. Political and socio-cultural influence affect leadership
5. The lack of transparency and accountability and corruption of the management system affect staff and organisational performance.

The use of theoretical propositions may include three main shortfalls: 1. The development of theory needs more time (Eisenhardt 1989). 2. It requires a long way to go to develop the research design, which should be based on theory. 3. In some topics, if the existing knowledge is poor and the literature is not enough then the literature cannot provide a conceptual framework (Yin 2013).

4.17. Rival explanation

Examining plausible rival explanations is one of the four general analytical strategies for case study data analysis. It defines and tests the rival explanations and is used in combination with the other three strategies; theoretical proposition, working on data from the ground up and developing a case description (Yin 2013). In this study, this strategy was combined with the theoretical proposition strategy.

The rival explanation is the evidence about the possible 'other influence' that has caused the result (Baxter and Jack 2008; Yin 2013). This means that for a study if the

rival explanations are accepted it means that there are other influences rather than the factors that the findings of the study demonstrate. Inversely, if the rivals are rejected this means that they are not the influence for that situation. The real-world rivals are emphasised to be considered in the research (Gillham 2005) and indeed consideration of them increases the internal validity of the study and the confidence in the findings (Baxter and Jack 2008).

When rival explanations are accepted in a study then their types need to be defined. According to Yin (2013), rival explanation includes six types: the ‘direct rival', where an intervention other than the target intervention accounts for the results; the ‘commingled rival', where other interventions and the target intervention both contributed to the results; the ‘implementation rival' where the implementation process accounts for the results; the ‘rival theory' where a different theory explains the results better; the ‘super rival' where a force larger than, but including the intervention, accounts for the results and finally, the ‘societal rival' where social trends, rather than any particular force or intervention, account for the results (Yin 2013, p.141).

Two rivals were formulated in this study and both were accepted as influences in the current situation besides the factors that were found affecting the management capacity and leadership in the MoPH. They are discussed in Sections 8.3.1 and 8.6.1.

4.18. How the model and framework fit in the PhD case study

Section 2.6 discussed how the reviewed terms, concepts and frameworks work and were used as guidance in this study. This chapter elaborates on the applicability of each number of Section 2.6 in the current case study.

1. Leadership and management are considered as complementary elements.

With the guidance of the study framework (Section 2.6), this PhD research does not only separate the management and leadership in the MoPH but also combines them, which suggests that both are the necessary assets and complementary elements in the MoPH. Leaders/managers are those who have important roles in the management system of each directorate and are the heads of directorates.

2. ***Management system includes capital, finance, HR, IT and leadership dimensions.***

In this study the MoPH management system includes the dimensions of capital, finance, HR, IT and directors. The directors as the leaders integrate other dimensions of the management system and transfer them to the organisational outputs as their services. This PhD study explores these dimensions in relation to the management capacity.

3. ***Leaders are located at the centre of management capacity***

The study locates leadership at the centre of management in the MoPH. In the leadership process, two types of people are involved (Section 1.4). The head of directorates as the managers have the responsibility to develop the required policies, organisational plan and organise activities. They need to direct and control performance by their supervision and monitoring. At the same time, they need to develop and maintain a strong relationship with their employees.

4. ***Competence is crucial for the critical role of leaders.***

Leaders are those who get the most out of all other dimensions (HR, finance, capital, and IT) of the management capacity. That is why 'competence' is nominated as one of the four components of the WHO framework (2007). The need for competence in directors is taken into account in this study as other dimensions require a leader/manager who is competent enough to be able to fulfil this critical responsibility.

5. ***Qualification of leaders/managers can help to measure competence.***

The directors' competence is assessed in the MoPH to make sure of the availability of competent leaders and managers. To find out about the directors' competence, the study framework suggests the assessment of qualifications. Therefore, the directors' qualifications and capacity building/training were assessed.

6. ***Ensuring an enabling working environment is the responsibility of leaders.***

An enabling working environment is another element in the framework that is required for the success of the MoPH and this is the responsibility of directors in each directorate. They are required to create a supportive and enabling work

environment, develop a good communication system, motivate employees and inspire employees to perform well and achieve the organisation's goals.

7. Leaders need to manage the organisational culture.

According to the study framework, the MoPH directors are expected to manage the organisation's culture in a way that benefits themselves and their teams. It promotes the good performance among employees and helps achievement of the MoPH goals.

8. Leaders need a functioning support system.

Functioning support systems is designated as one of the essential elements of the study's framework. Besides competence to achieve the MoPH's goals, directors need proper support from the higher levels or the authority of the MoPH.

9. For good performance, an organisation needs capacity and to assess its capacity.

Beside the MoPH directors' competence there are needs for management capacity. It means every component of the management system in the MoPH needs to have the required capacity. Capacity in the MoPH, according to the framework is considered an input for the performance and performance is directly linked to MoPH capacity.

10. An organisation needs to provide capacity building.

The framework suggests that the higher the capacity, the more efficient and effective the performance will be in an organisation. Therefore, the MoPH as an organisation needs to ensure efficient and effective performance through providing capacity building in every aspect.

4.19. Summary

Methodology chapter first introduced the researcher's philosophical view, i.e. pragmatism using multiple qualitative and quantitative approaches to explore the study question in a complex situation. After evaluating different approaches embedded single case study was selected as the best choice for the study. One of the important issues to be considered in the study was the quality of the study, so the Yin's framework was followed for the study quality. Ethical considerations were a critical concern in the study context because decades of war and conflict have increased vulnerability in the country. Therefore, it was attempted to make sure every single ethical issue was recognised and addressed. The case study approach

allowed for the use of multiple approaches of document, interview, archives and surveys to explore the same phenomenon. However, the important issue was whether the findings of these methods corroborate with each other or not. All these sources are triangulated to provide multiple measures of the same case and they corroborated the same findings. Among many authors, Yin had described a comprehensive analysis of case studies. Quantitative data was decided to be analysed descriptively in SPSS. Qualitative data were analysed thematically as outlined by Braun and Clarke (2006). NVivo was used to assist with the qualitative analysis.

This was also important in the preliminary stage of the study to include the methods that can answer the research question and to address all elements of the question. Figure 4.7 illustrates how the question's elements were addressed by all of the methods that were used.

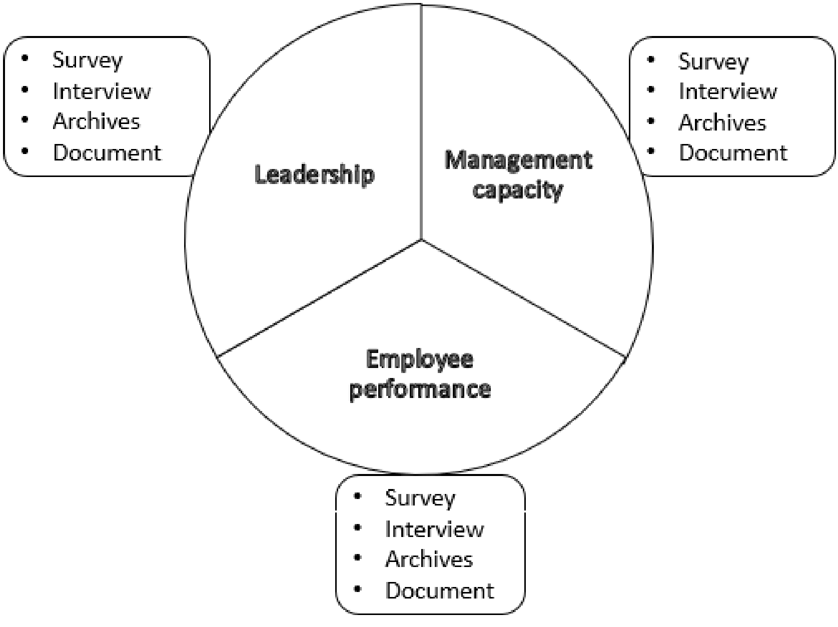

Figure 4-7 Demonstrates that the question's elements were addressed by the methods used

Chapter 5 discusses the findings of all four methods included in this research.

Chapter 5. Findings

5.1. Introduction

This chapter presents the findings from all four methods; interviews, documents, archives and survey. The first findings below were generated in the archival study.

5.2. Archival records analysis findings

The archival records of the MoPH were used to explore investment in building leadership capacity. The record's last revision date was not indicated in the provided sheet. Some of the required information was missing and the reason for this was not provided. For instance, the pay grade of one director was missing. As explained in Section 4.7, the MoPH was asked to provide information about a list of items. Below are the findings from provided archives.

Qualifications and the last educational degree

It was assessed whether the qualification degree was considered by the Ministry as an important criterion for the position of the heads of directorates. Out of 30 heads of directorates 16 had bachelor's degrees, 13 had a master's degree and one had less than a bachelor's degree, and the subject of the degree was missing in the provided sheet for one. The information about the directors' qualifications contradicted those provided by the directors in questionnaires. This was discussed with the responsible person in HR department who explained that the information is updated when the directors provide updates about themselves. If the directors did not do so, then there was no other mechanism to update records, suggesting a deficit in the system of HR.

Directors' study subject

The subject of study was explored to find out whether directors' qualifications are relevant to their jobs and whether they have gained qualifications in any management-related subject. As Table 5.1 demonstrates only six directors have studied Public Health, one has undertaken management and business studies, one has studied government management.

Subject of study	**Number of directors**
Clinical/medical (curative)	14
Stomatology	1
Prosthodontics	1
Public Health	6
Management and business	1
Government management	1
Engineer	1
Computer science	1
Economy	2
Pharmacy	1
Anthropology	1

Table 5-1 Directors' study

Some of the directors' qualifications are relevant to their job, for instance, a director who has the qualification in economics is the director of finance. The director with the engineering qualification has the responsibility for the MoPH construction. The director who studied pharmacology is responsible for the pharmacy. The directors with a medical background are the heads of different directorates. However, most of the qualifications that the directors had were not relevant to their responsibilities nor related to managing a Public Health system. Public Health would be important as the health system of Afghanistan focuses on it. However, 14 directors studied clinical education but have never studied health management. Health management includes topics such as human resource management, performance management, strategic planning, progress monitoring, problem-solving, recognition of the gaps and filling those gaps and these are not taught in medical studies.

- **Position title**

Archival data suggest that heads of directorates had four different titles. Table 5.2 demonstrates 25 of them had the director's title. One was given the title of member, which is not a typical title in Afghanistan, but another title was not mentioned for member, nor was it mentioned if they were volunteers. The directors' position titles were a little different from those in the organogram of the MoPH that was approved by the Minister. In the Ministry's organogram all heads of directorates are shown as directors. While in the provided form, five titles were other positions rather than directors.

- **The salary category**

The salary grades were assessed if they were linked to the director's qualification or years of experience. The pay grade of directors ranged from two to four - two is the higher salary and four is the lower salary. Table 5.2 illustrates that 25 out of 30 heads of directorates who had the title of director were entitled to a 'two' payment grade.

Title	Directors (n=30)	Payment grade
Director	25	2 [1 was missing]
Head of unit	3	3
General manager	1	4
Member	1	4

Table 5-2 The title and salary category

The payment grade of one director was missing in Table 5.2. One of the directors who possessed a master's degree had a payment grade of four, while one of the directors who had a qualification degree of lower than bachelor was on grade two. However, the later director was at this position for 16 years, this is strange as no directors have been in the director position for so long a period of time. This was also assessed to find out if the pay grade is related to work experience. The director who

had three years' experience was on pay grade two, which was the same as the directors who had 30 and 13 years of experience, all of whom had the same degree.

- **Appreciation letter**

Typically, appreciation letters are awarded by the organisation to those who have shown outstanding achievement or creativity. This indicates that the ones who have done good jobs are supported and motivated. This consequently promotes good performance in an organisation.

Appreciation letters awarded	Number of directors
0	15
1-4	11
9-16	3

Table 5-3 Appreciation letter awarded to directors

The findings regarding appreciation letters that the directors had was notable. Table 5.3 shows that most directors have never received any appreciation letter. Whilst one who had only been director for two years had been awarded 16 letters. This poses a question of how it is possible to get 16 letters in two years but checking this director's experience suggests he had seven years experience, he might receive those letters during those seven years. There were many other directors in the list who had never received any letter in the past two to three decades. The award distribution may be an indication of inconsistent support to the directors, which may support the interview findings about the MoPH leadership's lack of consistent support for the directors.

- **Directors' training and the capacity building that the MoPH provided**

Although the information about the training that the directors have received and the capacity building that the MoPH had provided to directors was requested from the

relevant department, these records were not available. It was explained that when the employees, including the directors, attend training the related directorate is not informed. So, it was told that although the MoPH has sent some directors for higher education such as master's degrees, the record was not available. This indicates the lack of a recording system regarding the capacity building. This may cause the misuse of training opportunities by people. This supports the interview findings that some people repeatedly attended trainings while others never attended because there was no recording system to show who had attended which training (Section 5.4.2).

5.3. Survey analysis findings

The questionnaire used in the survey included qualitative and quantitative data (Section 4.14.1). For better understanding quotes from the qualitative data have been used to illustrate the findings. Subsections have been added to clarify different parts of the survey findings. Before describing the findings, Table 5.4 summarizes the demographics of the survey questionnaire respondents.

Highest degree of qualification	6 (25%) Medical Doctor 17 (70.8%) master’s degree 1 (4.2 %) Other but not specified
Gender	21 (87.5%) Male 3 (12.5%) Female
Marital status	21 (87.5) Married 3 (12.5%) Single
Age (in years)	3 (20-30) 9 (31-40) 11 (41-50) 1 (50 and above)
Years in the health field	3 to 32 years
Years in the current position	1 to 16 years
Number of people with additional responsibility besides MoPH job	4 (see below)
Hiring mode	65 % - candidate competition 13 % promoted on getting master’s degree 35 % recommended by MoPH higher levels 12 % promoted 4 % appointed by the President of Afghanistan

Table 5-4 Characteristics of questionnaire respondents

The reason for the hiring mode and the higher percentages in the table is that, some people had selected two or three options instead of one. For instance, one person, after getting a master’s degree had been promoted to a higher position, meanwhile this candidate was recommended by a higher level of the MoPH. Amongst three single directors, two of them were female and both had master’s degrees. Besides their responsibilities in the MoPH, four directors worked respectively as an academic in the medical university, as a mother, as a practitioner in a private clinic and as a

functionary for a social and cultural organisation. In total, 24 out of 30 questionnaires were filled by the directors. Ten of the participants had been working as a director for two years, which indicates a big change in the key positions at one point in time, which might be due to political changes, as this equates to the years that the national unity government was formed (Figure 5.1).

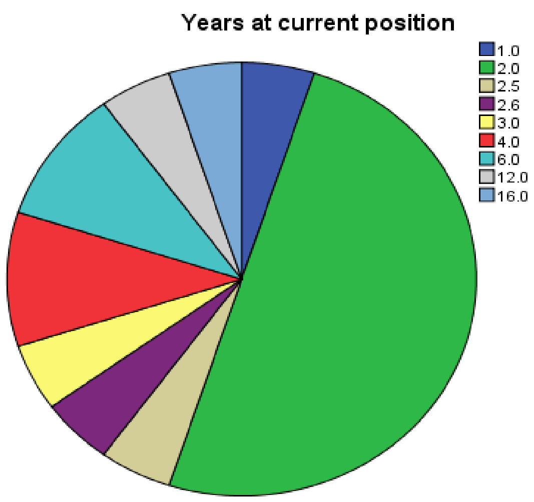

Figure 5-1 Years that directors spent in current position (researcher)

Lack of support

Survey participants (directors) were asked about the support they had to carry out their jobs. Different concerns were raised by directors. Frequent power cuts were a problem, which adversely affected their work. There was a shortage of financial, human and office facilities such as computers, heaters or air conditioners. Three out of 24 said about the physical workspace as an issue because they lacked a separate meeting room or felt that their office was overcrowded. More than half (56.5%) claimed that they had a shortage of staff. Staff were not well-paid and they were not provided with enough facilities in the office to be comfortable. Staff were not paid overtime for their extra work. There was a lack of capacity building and job security. Management was another issue. Top management allocated extra/ad hoc assignments with tight deadlines with less acknowledgement of good work. A few directors were unhappy with what they considered to be unprofessional treatment by their line managers.

Employees' concern is another important issue that requires support by the management, however, from the below quotes, it seems that the employee's problems and concerns were not taken seriously. Some of the directors stated that there were no concerns from staff, while others stated that staff had already accepted conditions. As in the following quotation.

> "*All matters are clear in the job description and the applicants have already accepted all the conditions*" (Participant 2).

The directors explained that employees had concerns about the ad hoc assignments that they were given by the MoPH leadership. A few directors said that they tried to convey the employees' concerns to the higher-level management as below;

> "*The staff raise concern over the ad hoc assignment usually given to them by the MoPH leadership and I try to make sure their concern is heard"* (Participant 3).

The concerns of employees appear not considered by the donors or the MoPH management. As one of the directors has shared the concerns but they were ignored as the below quote.

> *"The concerns of employees about capacity building was raised to donor and the MoPH leaders but it was ignored"* (Participant 5).

Above quotes show that the employees' concerns are not always heard by directors, the MoPH leadership and donors. In fact, 71% of staff had raised concerns about their work environment.

Communication

The survey included some questions about the internal communication such as how they communicate with their employees and what are the benefits of communication. The findings of managers' communication with their staff demonstrated that it benefited staff as well as directors. For the staff, it provided a friendly environment and teamwork while keeping staff on track with organisational priorities. This also helped to share information with staff and use staff abilities, which in turn provided encouragement and motivation as well as improving their trust and confidence. For the directors, communication helped proper monitoring and mentoring of their employees in the directorates through which they could understand their directorates achievements and challenges. Communication with staff also facilitated them to

discuss the issues and gaps and jointly find an on-time solution helping them in achieving their directorates targets. However, some directors saw communication only as a means to control staff as indicated in the quote below:

> "*Communication ensures that personnel are on their duties and the personnel know that they are under control*" (participant 2).

Meetings were the most frequently used means of internal communication at 91.7%, followed by email use with 87.5%. Face-to-face communications and telephone/mobile were each 83.3%. Social media such as WhatsApp was also used for group communication with 4.2%. Communication with staff was described as daily, weekly and biweekly.

Employees' appraisal

The survey included questions about how the employee's performance is appraised and whether it benefits their performance. Regarding the benefits of appraisal, two opinions existed amongst directors; 91% of directors responded that appraisal benefits the organisation's progress. Some were happy with the benefits of appraisal, including staff salary increments, motivation and encouragement. Good work would be appreciated while those who had weak areas would be provided with training. In such cases, the organisation would benefit. The remaining 9% of directors did not believe that appraisals were helpful to the MoPH, because they claimed they were not based on the evidence.

> "*…because the appraisal is not an evidence-based assessment. Often, all employees get the score of excellent, and their weaknesses are not revealed. In this case, the result is not correct*" (Participant 4).

Other directors understand that favouritism, nepotism, kinship, cronyism were obstacles for the appropriate implementation of appraisals. As discussed below, the socio-cultural issues have influenced the system and the directors are not able to eliminate it from their work environment;

> *"Due to personal and social relationships in the country you cannot score one or appraise him honestly, so it is not working. If you appraise him badly then he will be your enemy forever"* (Participant 5).

Personal and social relationships are very important in Afghan society. This relationship even comes into the workplace and affects the organisations performance. The above quote indicates that the personal relationship affects the appraisal system and hinders its proper implementation.

Annual leave

The questionnaire contained a few questions about employees' annual leave whether they take their annual leave. In total, 79.2 % reported that staff take their annual leave, while 8.3% indicated that staff did not take their annual leave in order to receive their full salary. The reason was provided in a short sentence. *"Because of low government salary"* (Participant 7), 12.5% (three participants) chose the 'other' option by which they reported that most staff do not take their leave to get their salary and overtime.

> *"when the employees don't take annual leave, then they are entitled to overtime pay. On this basis, they are less likely to take their annual leave"* (Participant 12).

The ordinary employees in the governmental organisation do not have enough salary. Decades of war has also affected the economy of the country and the MoPH is mostly funded by external donors.

Low capacity in MoPH

Capacity building was one of the main issues that the director's perspectives illustrated. These perspectives came under management support in the questionnaire. Low capacity was reported to be a problem in the MoPH and was described as needing a serious change. According to the survey, 95.8 % of the directorates needed capacity building, 56.5% had taken finance-related training. Among directors, 54.2 % had faced problems in preparing budgets. Nearly two-thirds (65.2%) needed finance training out of 23 participants. Information about one participant was missing. Amongst directors, 67 % had HR related training and 62.5% had undergone training in management such as financial management. The training that most directors felt they needed was financial, HR, project, time, Public Health and data management. Some needed training in procurement, capacity building planning, staff

retention and leadership. Few needed trainings in policy and planning, monitoring/evaluation, HMIS (health information management system), systematic thinking and health strategies in post-conflict countries. One of the reasons for the low capacity of directors in the MoPH was indicated as below;

> *"Due to low salary in government organisations appropriately qualified people are rarely interested to work with government so, most of the people who are with less knowledge and experience join the ministries"* (Participant 9).

Health professionals who are well qualified try to find jobs in the UN agencies and NGOs because they have good financial packages for their employees. In contrast governmental organisations have low salary. Another commented that there were many people in the MoPH, and that the government had spent a lot on their capacity building, but no changes had been seen in their performance.

Directors' support to employees

The directors reported that the support they provided to their staff included encouragement, monitoring, supportive supervision, fair treatment, opportunities and providing an environment conducive to good performance and achievement. They appreciated the staff's good work and delegated tasks. In total, 87.5% were well-informed about the education of the people they supervise. Three –quarters (75%) were well-informed about the professional backgrounds and job descriptions of people under their supervision and advocated for them where appropriate. Only 66.7% knew the work plans of the people who were under their supervision. The findings suggest that 75% respected staff and their contribution and treated them consistently. Good work by staff was praised mostly in the staff meeting (79%); others encouraged good work verbally (75%) or provided an appreciation letter (75%). Staff promotion was 71% competitive (through applications and candidates' competition), while 76% based on performance appraisals (based on their appraisal records).

Further support the directors need

One question asked the directors to list any further support they needed to achieve their directorate's goal. Financial support was listed by most participants; an increment of staff/qualified staff and capacity building were both at the second level of needed support. Five participants needed more staff while five others needed qualified staff. This raises a question as to whether the directors have any authority in the selection of staff in their own directorate because one of the directors had written in the questionnaire that they, as the head of the directorates should be consulted in the hiring or promotion of staff in their directorates. Most directors (91.7%) responded that they are given the authority that is required in doing their roles, but some needed more. However, this was also found from the questionnaires that staff were hired or promoted in their directorate while directors were not aware or not informed; this may be an indication of the limited authority of directors in their own directorates but this might not be realised by directors. Leadership support (financial and technical) and consistent support was the third support asked by the directors. Other resources and equipment in the office was the fourth needed aspect that the directors needed to reach their directorates' goals. Physical space, having more authority and increments of staff salary were the three more supports that three participants needed for better performance. Below quotation is cited for physical space.

> *"There is no suitable space in terms of physical structure; the crowd of people also causes work problems. In the office where, technical work is to be carried out, technical meetings are also held, and this disturbs other staff members who are not in the meeting"* (Participant 4).

Participants were asked to list five supports that they need to help them achieve their organisational goals. The example below is representative of all the other answers given for this question;

> "*1. Increment of the staff members*
> *2. Enough budgets*
> *3. The hiring of qualified staff to fulfil their position requirement*
> *4. Capacity building of staff*
> *5. An increment of staff salary (their employees)"* (Participant 23)

In addition, another participant asked for legal support instead of hurdle support. However, it is not noted what they meant using "hurdles".

> "*1. Training*

2. Leadership Support
3. Legal support instead of hurdles
4. Sufficient authority and less interference
5. Low political pressure" (Participant 5)

A few respondents insisted that there were no problems in their directorates, as all kinds of support exists.

"In this office, attention is given to the work quality and we do not face any challenges" (Participant 21).

Political and socio-cultural issues

Political and socio-cultural issues were explored among the directors to find if these issues have negative effects on the achievements of the targeted directorates. Only 22 of the 24 directors answered the question of whether socio-cultural aspects existed and affected leadership work. Nepotism, favouritism and cronyism were the issues most commonly rated by directors at 80%, 70% and 50 % respectively. Fifteen directors denied that discrimination existed in the MoPH, while eight claimed that discrimination existed and affected leadership work. One did not answer the question. Political interference/powerful people pressure, specifically in the current government, was the issue that caused the most discrimination, as the following quote illustrates:

> *"Our current state of affairs lies on the political and other discriminations, employment of people is on the basis of political pressures"* (Participant 6).

Although findings suggest that political discrimination caused unqualified people to be hired in the MoPH, it appears from the citation below that people are frightened to raise their voice about this political negative influence.

> *"Political interference in the hiring of unqualified people in the programmes is a big issue. We cannot detail about because it is very political"* (Participant 19).

The above citation shows that people are frightened to speak out against political interference. This may be because there are people from different political parties who may not trust each other. It was found by survey that political groups do not support each other, which is worsening the problems in the MoPH. This may be

because each political party unfairly supports their own members in the MoPH and tries for their political aims. In this case this would be a disadvantage for the organisation. These political groups refer to the Government President and the Executive President political groups described in Section 5.4.3.

Obstacles in reaching goals

In a question, a list of obstacles towards the achievement of the organisation's goals was provided in a table and the participants were asked to choose among them (Table 5.5). In total, 20 out of 24 participants reported obstacles towards achieving their goals; the remaining four did not answer this question. Shortages of resources were rated by most directors (85.7%), followed by political interference (81%), which adversely affected the directors' work. The latter is illustrated by the following quote:

> *"Avoid excessive pressure of parliamentarians which are the obstacles in reaching our goals"* (Participant 11).

Intimidation/pressure from those in power, scant support by management, cultural issues and corruption were other options that were selected by many directors as obstacles (Table 5.5). And some mentioned that this has to stop: "*Corruption should be eliminated in all departments"* (Participant 11). Family issues were the least identified obstacle for directors towards the organisational goals. Three more obstacles were added under the 'other' option, including complicated procedures and discrimination, insecurity and directorates having the same objectives.

- *"The complex and cumbersome process of the existing administrative system*
- *Failure to impose the laws and regulations on all individuals consistently.''* (Participant 4)
- *"The existence of parallel offices with similar objectives*" (Participant 8)

Table 5.5 shows the obstacles that the directors faced.

		Per cent of Cases
Obstacles	Politics/political issues	81.0%
	Cultural aspects	52.4%
	Inadequate management support	61.9%
	Shortage of resources	85.7%
	Corruption	52.4%
	Low transparency	38.1%
	Low management knowledge	52.4%
	Family issues or other personal issues	28.6%
	Intimidation/pressure from Powerful people	66.7%
	Insecurity	4.8%
	Offices with the same objectives	4.8%
	Complicated procedures and discrimination	4.8%

Table 5-5 Obstacles faced by directors

Participants were asked to provide their ideas about the solutions for the top obstacles that they were facing in reaching their organisational goals. Striving against the interference of political pressures, powerful people and other socio-cultural influences was suggested by most participants to be the best solution.

Change wanted

Directors were asked to indicate what further support they needed for the achievement of their goals, as well as to share their suggestions for solutions to existing problems and challenges if any. The Directors suggested that the MoPH leadership needs to treat and support all directorates similarly. The support that the directors asked for included financial, more staff and follow up of the tasks allocated to them. The directors also recommended the MoPH to evidence transparency.

‘Evidence transparency’ may mean that the MoPH needs to improve transparency in the system and procedures. Participants also suggested to eliminate corruption and support the implementation of laws consistently for all. Simply that the: *“Law should be implemented consistently on all citizens*” (Participant 24). Effective communication was another aspect that the directors asked for. It was proposed that the Minister conduct annual meetings with all directors to discuss the issues and improve coordination. The directors also suggested appropriate structures and policies/strategies based on the national context. Directorates needed technical support and they wanted good work to be acknowledged. They also asked the competent people to be hired as the following quote illustrates:

> “*Employment of individuals should be on the basis of merit, regardless of ethnic, linguistic, religious or other issues*” (Participant 6).

Many directors highlighted the need for better accountability and responsibility by the government. It was suggested that the government should improve facilities in the MoPH to attract well qualified people. The capacity of weak employees should be built up and failing employees should be fired and well-qualified people should be hired.

> “*An evolution is needed in the employment of people in the MoPH. Some people, despite the spending of high cost for upgrading their capacity, still do not see any change in their performance, or do not have the suitability of the task they are responsible for. Such type of people should be assigned to the responsibilities that they have the ability to do, preferably working in the factory”* (Participant 4).

This quotation indicates a frustration, it also shows that there are people with very low capacity and even the capacity building programmes are unable to help. Such people it is suggested, are not suitable for their jobs. Some directors are not happy with the current situation in the government. They ask the government to provide security and a peaceful environment and seek solutions for challenges.

> “*To solve the current problems, we need to have good governance, managed and developed political parties, responsible and accountable government to provide a peaceful environment for people and society”* (Participant 1).

All problems were described as being caused by political and socio-cultural issues; hence the government was asked to fight against them and not allow political pressure and interference in the health system.

> *"The government can stop the interference of politics in the MoPH if it develop and implement the law"* (Participant 4).

Although the survey participants were directors and perhaps many of them were introduced by politics, they were frustrated by the political interference in the MoPH and wished for the elimination of this interference.

Summary of the survey findings

To summarise, the questionnaire suggests that there were many factors that affected the work environment of the directors and their employees such as shortage of electricity, finances, HR, capacity building, physical space and other resources and equipment. There was no job security policy for employees including the directors. Directorates had been given ad hoc tasks with tight deadlines with little acknowledgement of good work. Some directors were not happy with how they were treated by their line managers. The findings indicate that employee concerns were not considered important. The communication of the heads of directorates with their employees shown to have positive effects on the heads as well as on the employee performance, however, there were some directors that saw communication as only the means of employees control. Regarding appraisal, different ideas existed. Some were happy that it brings encouragement while others commented that it makes employees happy due to their salary increment but not engage employees to work as it is not evidence-based. Annual leave was another issue that the directors had different ideas about. Most indicated that employees take their annual leave while others mentioned that because of the low salary they are not willing to take their annual leave. The directors themselves believed that there is low capacity among directors. Almost 96 % of directors indicated they needed capacity building because they were facing problems in their daily office management activities. Another factor was that because of the low government salary, people with a high capacity are not interested to work in the MoPH. Many other people's capacity had not increased

despite the money that had been spent on them. It was suggested those kinds of people be terminated from their positions. The main obstacles of directors in reaching their goals were shortage of financial and human resources, political and powerful interference and pressure on the MoPH. Inadequate management support rated as the third obstacle. Cultural aspects, corruption, low transparency, and low management knowledge represented other obstacles that were selected by directors. The best solution that was suggested by most directors was to strive against the political interference and pressure and to eliminate socio-cultural influence from the MoPH. Transparency in the system and the elimination of corruption were also demanded. The government was asked to seek solutions for all challenges and provide a peaceful working environment.

5.4. Interview analysis findings

The interviewees were the senior employees working under the direct supervision of the directors in all directorates. A brief profile of the interviewees is detailed in Table 5.6:

Code	Job title	Years in current position	Years in health	Highest Degree	Previously been director
1	Senior advisor	2	11	Bachelor	Yes
10	Senior advisor	2	10	MD	No
11	Senior advisor	1	10	MSc	Yes
12	Senior advisor	6	33	MD	No
2	Senior advisor	1	15	PH Specialist	Yes
3	Consultant	9	9	MSc	No
4	Consultant	4	17	MD	No
5	Senior advisor	5	12	MD	No
6	Manager	7	22	MSc	No
7	Senior advisor	5	14	MSc	No
8	Team leader	12	12	MSc	No
9	Senior advisor	2	16	MPH, MBA (Master of Business Administration)	Yes

Table 5-6 Demographic characteristics of interviewees

Four of the interviewees had already worked as directors, mostly in the same directorates, but it was not explained why they might have lost their positions. Perhaps their positions were filled by those who were introduced by political parties. Out of 12 interviewees, only one was female.

Five themes were derived from the interview data:

1. Insufficient support
2. Uncoordinated capacity building
3. The political and socio-cultural negative influence
4. Inconsistency due to lack of transparency and accountability
5. Change is hoped for.

The 'Insufficient support' theme includes two subthemes described below. Figure 5.2 outlines the developed themes and related subthemes.

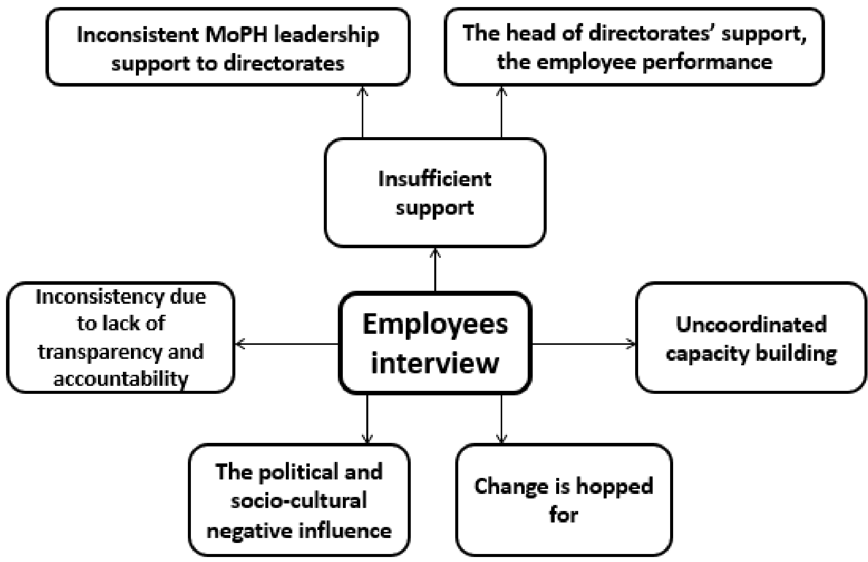

Figure 5-2 Employees interviews themes and subthemes

5.4.1. Insufficient support

This theme is used to refer to all types of support (provision of the right conditions) that the employees need to perform well to achieve the organisational objectives. Two main kinds of support were noted; one was the support that was provided by the directors to their team members in a directorate. Another kind of support was provided by the MoPH leadership to the directors and their directorates to help them

achieve their goals. For this reason, the theme was divided into two related subthemes; ‘The head of directorates’ support, the employee performance’ and ‘Inconsistent MoPH leadership support to directorates’. Each of the subthemes is explained below.

Figure 5-3 ‘Insufficient support' theme and subthemes

5.4.1.1. The heads of directorates’ support, the employee performance

This sub-theme explores the directors’ support to their employees within a directorate, which is vital in enabling them to work effectively. It describes the employees’ perspectives on the way they were managed by their directors, their performance, their communication and work environment. Directors as the line managers have a direct role in the employees’ support through the appraisal system and annual leave within a directorate. Therefore, the appraisal system and annual leave are included in this theme becide others.

Many directorates were managed by directors deemed by some interviewees to be competent with the appropriate knowledge and skills, and most have higher education qualifications.

> *“In the last ten years, apart from a few……. directorates are being run by efficient directors who are key people and are the right people in these positions”* (Interviewee 4).

However, most interviewees were pessimistic about the management of many of the directorates. The Unitary Government was blamed for the fact that the key positions were divided amongst different tribes and political parties. This allows people to be placed in the director’s positions without considering their merit.

> *“Merit-based selection is not considered in the government. Due to political influence in the MoPH, the management of important departments is given to people who are incompetent and the work of staff who work in those departments is affected by their mismanagement”* (Interviewee 2).

Delegation of tasks and performance management of employees are one of the significant tasks of managers that need specific skills. It was perceived that the employee performance was not managed well by directors, which may indicate that they were lacking this skill.

> *"Directors who are brought in directly [introduced by politician without competence-based recruitment] have low capacity; they are not open-minded and do not have a good understanding of their context. They are not able to identify which staff should be given which role, and which staff might be more useful in which responsibility so different dimensions of staffs' capacity is not recognised well*" (Interviewee 10).

One of the skills that is required for a manager to run an organisation successfully is problem-solving. Some believed many problems would be solved if only directors were competent.

"*if the directors were competent then half of all problems would be solved"* (Interviewee 4).

The implication was that interviewees believed the directors were not able to solve the problems in their organisation.

Performance appraisals

The appraisal system is a tool for ensuring that employee performance is monitored properly. Discussions of the appraisal process revealed a high level of dissatisfaction and negativity. This included problems with line managers, staff and the appraisal system itself. The appraisal was seen as a formality. Line managers and the HR personnel who were assigned to appraise staff members were perceived as not having the required capacity to judge properly. The appraisal was a new concept in the Afghanistan health system. People are deemed as not having enough experience to do it correctly and professionally. Therefore, it was thought that it neither motivates staff nor benefits their development or career.

The structure and design of the current appraisal system is perceived by participants as problematic. Interviewees described the appraisal form as having only five steps

within one specific position by which the salary can be increased. After taking those five steps there is no chance for any other incentives until the employee's position is changed. Furthermore, the skills stated in the appraisal forms described by interviewees were not measurable in the MoPH such as understanding English or computer. Consequently, staff members were not motivated. Favouritism/personal interests was another issue affecting performance appraisals mentioned by many employees. Below is an example:

> *"To be honest, the appraisal is a formality; line managers look at the employees and fill in the form. It is not based on performance indicators; it is based on connections and friendship"* (Interviewee 9).

Appraisal satisfied employees but it did not engage them in their work. Poverty also affected the appraisal system because sometimes managers had to give good appraisal scores to their employees so that their salary would be increased at least 1000 (= £9.90) Afghani per month. However, the salary was not increased parallel to the market currency rate. In addition, employees also thought that the appraisal system was not managed well. From the quotation below it seems that the importance of appraisal systems is not well understood by managers nor by employees.

> *"When there is not a plan, nor objectives, how can the appraisal be assessed? At the end of the year employees rush, fill in the forms themselves, score themselves, then obtain a signature from their line managers. This is not beneficial. Cheating themselves, cheating the system"* (Interviewee 1).

Annual leave

Annual leave is another support that employees need, which can affect their overall performance. There was a culture of not taking annual leave. Different reasons were pointed out for this. Many of the employees were very busy in the office.

> *"I am interested in taking my leave, but there is too much work in the office. Last year, I planned to take at least ten days, but at the end of the year we were so overloaded with so much work that I couldn't take leave"* (Interviewee 10).

Many staff members are low-paid and receive lunch and transportation costs provided by the MoPH. This stipend enhances their salary and if they are not at work, they do not get this extra money. Consequently, the majority of employees prefer not to take leave in order to receive a higher financial package for the days that they worked. Another reason is that if people take leave then it is nice to go away, but this costs money. Only a few wealthy people can take leave to travel to neighbouring countries for pleasure. When a person takes leave, they usually stay at home. The perspective in this case is not to take leave and be in the office. Therefore, annual leave is only taken for emergencies such as sickness or moving home. The majority of employees never take their annual leave for pleasure.

Another reason staff do not take their leave is that in some directorates employees were unaware of the annual leave policy. While another issue with the directorates about annual leave was the lack of a proper plan for the staff. In this case, when an employee was asking for annual leave, it was rejected by the line manager saying they currently had too much work. Some senior staff members were not interested in taking leave, worried that in their absence something might go wrong. The opposite also exists. The annual leave policy was followed by some departments but not by others, which resulted in the misuse of annual leave by taking more leave than the employees were entitled to;

> *"The system is not transparent; everyone takes as much leave as they want. Some directors have brought positive changes by creating an annual leave database, but not others"* (Interviewee 1).

Last year compensation was provided for those who had not taken their leave; compensation means that when people do not take their annual leave, they are paid extra at the end of the year.

The work environment plays a substantial role in the employee performance and productivity. Motivators and demotivators were identified in the workplace as well as the employees' communication and the balance between their personal and official life;

Communication

Four main issues were discussed by interviewees about communication: official communication in the office, the general communication system in the MoPH, internet and electricity, which are also a communication medium and the way directors speak to their employees. The general communication system, internet and electricity will be discussed in Section 5.4.1.2. as these are the responsibility of the MoPH leadership rather than the heads of directorates.

Most of the participants were happy with communication in their office. Although from the below citation it seems that this is not the same in all the departments.

> *"There is no problem with communication in our department. Unlike in other departments, even the lower positions have access to the head of the department to communicate. Teamwork is very good in our department; there is no limitation to any kind of communication"* (Interviewee 12).

The effectiveness of the morning department meetings was appreciated by some participants. Email and face to face were the most frequent means of communication. Mobile/telephone and group meetings were also used. Some of them also used Google group, Skype, Viber, messages, and group chat for easy and efficient communication. However, some managers were not conducting meetings and it was perceived to be due to their lack of confidence. This was believed to be affecting the performance of their employees because it prevented employees from sharing and discussing their performance, challenges, problems and other office affairs. The internal communication among the head of directorates and their employees was affected by the lack of internet and general communication systems in the directorates located outside the MoPH headquarters. This was attributed to the unavailability of their directors in the office. Employees were not aware of their directors' official travels and nor did they know about plans or decisions. In some directorates, the only communication medium used was face to face.

Leaders' treatment

Leaders' treatment was another matter that affected communication; with employees reporting unprofessional treatment by the heads of some departments. It was found

that the culture of not being confident in front of the departmental heads was apparent and employees did not have the confidence to raise all the issues that they wanted to discuss with their heads.

> *"It takes an employee five-ten minutes to decide to enter the head's office. From a list of suggestions, they cannot even talk about some of them. Skilled managers have reduced this mindset, but in some directorates, it continues"* (Interviewee 7).

Employees are the very important source of an organisation. They need to be respected, no matter at which level or position they are. Disrespect to employees by managers shows their misuse of power. Another view about the unprofessional treatment of head of directorates in some directorates was:

> *"Although this has been changed, dictatorships still exist in some directorates. Employees are not confident to talk in front of their head. They fear being insulted or disrespected in front of others by their heads"* (Interviewee 1).

The unprofessional treatment and insults by the heads of directorates is not acceptable, again, this may show misuse of power. The subject of communication was also important. For instance, if an employee wanted to take leave, they said that it was difficult to talk to their head because the head was unhappy to approve the leave application, saying there was too much work to be done. While the leaders' professional treatment and support of staff provided encouragement, confidence and employees motivation, unprofessional treatment demotivated staff and negatively affected their morale. Unprofessional treatment was stated as being perpetrated by managers who lacked sufficient capacity and had been introduced through political divisions. The directors who were thought to have low capacity had the feeling of being threatened by their employees. This indicates that such directors were more worried and concerned about their jobs rather than about promoting creativity and appreciate the good performance in the directorates.

> *"Such people are afraid and in fear of being dismissed. This is because their degree of competence and qualification is lower than that of their subordinates, they think they will take their place. These thoughts cause*

> *unnecessary and nonsensical conflict and contradictions in the office* (Interviewee 2).

Meanwhile, such directors were thought to paralyse their department affecting the employee performance and the working environment and creating stress for employees as the below quote indicates.

> *"Staff need to share their ideas very carefully and some of them prefer not to share their ideas at all because they think it will create conflict and bias and will affect their career. They will be dismissed by their managers"* (Interviewee 2).

The above quote illustrates that the directorate misses out on creative ideas and problem- solving as the staff cannot share their ideas confidently, which can be a big obstacle towards success.

Motivators and demotivators

The motivators and demotivators in the work environment varied between interviewees (Table 5.7). For most interviewees, the scope of their role and good teamwork were common motivators. The scope of their job was related to their field of work. For example, if they were working for maternal health this was a motivator. However, political influence was the highest demotivator, which prevented merit-based selection and resulted in incompetent people being appointed as line managers who were not able to create a more enabling work environment. Other demotivators were all mentioned the same number of times as below.

Motivators	**Demotivators**
Good work environment	Insecurity
Good teamwork that the employees had created	The political influence which prevents merit-based selection in the MoPH
Scope of job (e, g working for mother and child health)	Discrimination and inconsistency in the way staff were treated by directors
Subject/field of job (e.g. health economy)	The pressure in the work
The employee's experience, which can help them to perform well.	Having two supervisors
Having experience that can benefit the health system	Limited resources and lack of space
Good treatment by the directorate head	Partners (other departments) who have the same objectives work slowly which can be as obstacles for progress
Working in a unit with transparency	Not taking annual leave
Working with the government in the MoPH	No/low support of the MoPH leadership
Working in a higher position	Managers' low capacity
Receiving good financial package including salary	Varying capacity and commitment among employees in the same office
Interviewee's suggestions accepted by their director	Bureaucracy
	Outmoded auditing system
	Job insecurity
	The MoPH leadership superficial/low attention to some fields such as health monitoring at the national level.
	Employees work wasted; implementation halted
	Work overload and unfairness in workload distribution
	Donor interference and partiality

Table 5-7 Employees' motivators and demotivators at work

Work-life balance

Different reasons negatively affected the work-life balance of employees. Many staff were overloaded with office work and had to do work at home.

> *"Our head relies more on me and always gives me more tasks besides my planned tasks. Therefore, other staffs are free, and I have to work more. I try hard, but my work is not finished at the office, therefore, I take my work home and do it at night"* (Interviewee 1).

In some directorates, it was pointed out that the directors stay late; when they stay on to work some staff have to stay with them. Employees including directors also sometimes work on the weekends without any compensation. In many of the directorates, tasks were not delegated properly and fairly, which affected some of the staff members who were working well.

> *"I think there is a need for more work in this matter. In Afghanistan the harder you work, the more work is given to you, and how much you escape from work, that much work is given to others"* (Interviewee 10).

Staff members on higher salaries were expected by the MoPH leadership to work unofficial overtime although employees' higher salary was said to be because of their skills, knowledge and capacity, not for working extra hours.

In summary, to perform well, employees need their direct line manager's support at first. It was deemed that low capacity of management affected the managers' support of employees and consequently their performance. Employees felt that their skills and knowledge were not recognised properly. Their appraisal was a formality and affected by favouritism, in this case, their performance was not monitored well. Due to different reasons, annual leave was not taken by employees and employees were only happy with the communication system in the directorates. The unprofessional treatment of some directorates' heads was another issue that affected employee performance. An overload of work was another significant issue in many directorates that affected the employees' motivation and performance. Staff were motivated by the scope of their roles and the teamwork they had created in their directorates, despite suffering from political interference at the same time.

5.4.1.2. Inconsistent MoPH leadership support to directorates

'Inconsistent MoPH leadership support to directorates' is a sub-theme to the 'Insufficient support' theme. It describes the perspectives of the employees/the senior staff in the directorates about the support that the heads of the directorates get from MoPH leadership to manage their directorate and achieve the desired goals. There were different opinions about whether the directors get the support they needed; some interviewees believed that the leadership of the MoPH was supportive when the directors can provide a good justification for their suggestions.

> *"Directorates who exert themselves and demonstrate their creativity get the support of the leadership. The leadership is ready to provide support if we present them with a logical rationale and good justification. But if we do not provide them with good justification, then our suggestions are rejected"* (Interviewee 5).

Getting support was also dependent on the directors' capacity, hard work and commitment. It was suggested that even if the directors with low management skills were given better support, they would not be able to do a proper job.

> "*The authorities' support differs from one directorate to another, depending on the capacity, hard work and commitment of directors. Sometimes we feel that some directorates do not exist. Are you there? Yes, we are"* (Interviewee 7).

The support was described as better than that of previous Minister however still not satisfying and not enough for department requirements. The MoPH leadership support was encouraging. However, they were described as very busy. The leadership support was deemed by some participants of being unfair due to ethnicity and lingual bias. So, these participants described the leadership support as a mere token;

> *"In my opinion, support is token. Ethnicity and lingual issues have affected everything - this happens in the MoPH as well. There is unfairness regarding support"* (Interviewee 12).

Inter-ethnic rivalries are one of the results of decades of war in Afghanistan and every ethnic group unfairly supports their own members, and this has affected the country. The leadership support was also dependent on their background and area of interest. Employees also thought that the directors were not given the authority that they need in their roles.

> *"Directors do not have the authority to decide on even small issues. If an employee does not work properly, the director is not given this authority to decide about him/her"* (Interviewee 5).

Contradictory thoughts were expressed regarding the directors' authority. Some directors were thought to have limited authority, others were complaining that some directors hire all the employees from their own tribe. This may be related to the skills of directors or may be related to their political power and which political person is supporting them. However, this is an indication of a lack of a standard policy.

To achieve set targets, the directors and their teams need proper procedures and systems in place. The complicated procedures and systems in the MoPH are one of the biggest problems causing significant delays in work. Work that was supposed to be done in a few hours was taking days and sometimes by the time it was completed, the work was either too late or useless. The bureaucracy was one of the issues perceived to affect even the work of highly qualified people. The auditing system was another system that complaints were made about.

> "*One of the reasons that most of the ministries are underspent and the work is delayed is because of their fear and anxiety of the audit, because the audits in Afghanistan are not modern and not professional [giving unnecessary comments]"* (Interviewee 6).

The entire MoPH system was described as old-fashioned and in need of modernisation and is a significant issue, which demotivates employees.

The structure of the MoPH was another problem. Different departments had the same objectives. For example, there were several directorates in the MoPH responsible for the hospitals. These directorates did not have specific objectives. This caused some departments to be overloaded with work, but some departments had much less to do,

which was defined unfair. Some departments were mostly busy with work while some were mostly busy with going to training courses. Another complaint was that on many occasions, employees were expected to do more than they were capable of, or they were expected to do extra work *ad hoc* or that they were not supposed to do. It was suggested that the structure and system should be revised, and each department should be objective driven, and work according to their specific objectives and be evaluated accordingly, otherwise, it adversely affects the system.

Some other issues that were identified by the employees' interviews was that many staff, including the heads of departments, were working very hard beyond their official time, but effective work was rarely achieved. Additionally, some departments worked hard on projects but when they were finalised or achieved a good result and ready to be implemented or expanded, these projects were stopped, and all the work was wasted.

> *"There is no time management; workflow does not exist, and procedures should be easy. There should be creativity. People work a lot, but effective work takes less. This is a big problem"* (Interviewee 10).

Some procedures and systems such as CBR (Competence Based Recruitment), PRR (Priority Reform and Restructuring) were established to ensure people were hired based on their merit, knowledge and experience; however, these systems were described as not being beneficial because they were not implemented properly because of political influence.

> *"We have had some nominal procedures such as PRR, CBR and so on, but unfortunately, the people who really deserve to enter the system are not supported. It is only by chance, if one or two people are given support"* (Interviewee 11).

Another problem with the system was about their applicability, as some introduced systems were not applicable for the MoPH and needed to be adapted to better serve the needs of the Public Health service. These kinds of systems were a disadvantage for the employees.

> *"The civil service reform in HR is not applicable to Public Health. Currently, the specialists in hospital work as grades five or six, which is for a 12-pass person (high school graduates) or ordinary worker"* (Interviewee 6).

A good system of communication was another support that the directors and their team needed for good performance, but this system had problems. Interviewees were not happy about the general communication system in the MoPH. They reported that the MoPH did not have its own email account, that the whole of the MoPH used Gmail accounts and that there was no communication database. Electronic data governance was another need in the MoPH according to interviewees.

> *"Currently, we do not have the internet, which is a challenge for the communication. Another challenge is that we in the MoPH do not have our own specific account - everyone uses Gmail"* (Interviewee 10).

There were complaints about the lack of internet and electricity. Most of the directorates were located in the headquarters building, however, due to a shortage of space some directorates were placed at other locations in Kabul. The complaints about the lack of internet and electricity was common in those directorates located outside the MoPH headquarters. The communication channel in those directorates was rather more unofficial; 'WhatsApp' was used rather than face-to-face communication. WhatsApp is commonly used in the personal and social matters but due to lack of internet in the office, staff were using their mobile internet by sending messages to each other. The lack of internet and a general communication system had affected the internal communication among the head of directorates and their employees.

Another issue was job insecurity. There was no system under which the directors' nor employees' jobs were secured. Employees, including directors, feared dismissal and this caused distraction from their work objectives and generated considerable concern about their jobs and positions.

> *"Sometimes the directors, to save their position or show their creativity to the authorities, expect their personnel to work beyond their ability. When the staff cannot fulfil those expectations then the heads hold grudges against them"* (Interviewee 6).

Some directorates in the MoPH were described as being donor driven. The argument here is that donors interference prevents the MoPH from becoming self-sufficient and developing its autonomy. It was stated that sometimes things approved by the Minister were rejected by the donors. Sometimes the treatment by donors demotivated the employees and prevented them from taking ownership. There was a comment that: *"the MoPH should really have stewardship"* (Interviewee 8). The interviewee means that the MoPH does not really have the stewardship.

Interviewees also suggested that a person who worked very well was treated the same as the person who didn't work well or lacked commitment. Consequently, a system of rewards and sanctions was suggested to be more effective for those who did not achieve.

The two-tier system of employment created further problems amongst staff. Besides the ordinary staff in the MoPH, a consultancy system was created in the MoPH by donors. There were people hired as consultants at a higher salary and with more benefits than ordinary MoPH staff. This strategy negatively affected teamwork and the work environment. Staff were treated differently by their managers; comparisons of capacity between the two groups affected staff morale and caused jealousy. There were many differences between these two systems in appraisal, annual leave, salary, benefits, incentives, opportunities and development, although the consultancy system employees had less job security. The hiring system was not seen as transparent. The recruitment exam was reported as a formality, although all recruitment procedures were based on standards. Nevertheless, the preferred or targeted person was ultimately employed.

> *"In a department which has seven people; from the project manager to the guard, everyone belongs to one tribe and even from one geographical area, which is shocking. The HR role is symbolic"* (Interviewee 7).

Besides external interference from Parliamentarians for example, the MoPH leadership and people in higher positions were said to bring people into the health system unfairly. For instance, someone in a senior position from a different ministry calls a senior person in the MoPH, because a vacant position has been announced.

‘Ahmad’ is my cousin; please hire him for that position they say. Then he is hired because the person in the senior position orders or recommends that person to the selection committee.

> *“…of course, the people who are brought in are incompetent and are not committed. They do not work properly”* (Interviewee 5).

Some employees felt that the system was not transparent, and this is why staff at the same levels differ in their capacity and commitment. 'Highly competent' people were thought to be a threat for directors. In this case, the directors were perceived being unwilling to hire such people. HR situation was thought to be a big challenge:

> *“The current HR situation is a big challenge; it makes the socio-cultural problems worse and makes political issues more complicated in the MoPH”* (Interviewee 3).

There was not a good system in place for people who wanted to apply for posts announced by the MoPH. Materials, including policies, were not accessible to everyone who wanted to take the exam, neither did the MoPH website have enough capacity to include all those materials. Generally, the key for any exam in the MoPH was only available in the MoPH. This system was said to be unfair to people outside the MoPH.

To summarise this subtheme, directorates were getting support from the MoPH leadership, but this was not enough and sometimes was not consistent among the directorates. The use of support was also said to be dependent on the directors' capacity and commitment. The procedures and system were complicated, which caused delays in the work. The structure of the MoPH was another problem and many directorates had the same objectives, which caused overloading in some of those directorates. There were procedures and systems that were created for better work but were not helpful because they were either not applicable to Public Health or were not being implemented properly. There was not a system under which the directors and the employees be assured of their job security. Neither the interviewees were happy with the communication system in the MoPH affected by the shortage of

electricity and internet. The hiring system was not transparent causing incompetent people to enter the system.

5.4.2. Uncoordinated capacity building

This theme is used to refer to all aspects that are related to capacity/capacity building at the MoPH and the factors that affect them. First, there is a strategy/plan developed by the MoPH for capacity building, but no one had implemented it:

"The MoPH had developed a training plan but it has not been fulfilled" (Interviewee 4).

This might be the reason that no achievement was gained in capacity building and employees were not happy with its achievement as below.

"There has not been any achievement in capacity building in the last 16 years in the MoPH" (Interviewee 12).

Capacity building was not coordinated and was not based on employees' needs. Much of the training was irrelevant. People were attending the training even when it was not relevant to their field, which was why the training was not beneficial in the end. Discrimination and unfairness were other issues stated. In some directorates a lot of training was attended by the directors; when they were busy or attending other training, then they sent their favourite people. In order to attend training, having connections mattered.

> *"A person in one directorate has been to training more than 20 times in one year, while at the same directorate, at the same level, another staff member has not once been to training in several years"* (Interviewee 4).

People who attended training are paid a stipend (per diem) so they benefit financially. Going abroad counted as another benefit. Getting a training certificate was another advantage. Senior staff were described as attending training repeatedly,

which was regarded as unfair and shows a lack of accountability by managers in regard to their employees.

> "*Recently there have been complaints in one of the departments where senior staff repeatedly attend training that they have already attended; they do not let other employees attend*" (Interviewee 6).

Few directorates were described as having training plans based on needs and content which was consistently implemented among staff members. Staff who worked well in the office were missing opportunities because if they were sent for training then the work in the office was not done properly. This is a disadvantage for such employees who need to be appreciated by being providing with opportunities to develop.

> "*…. why couldn't we go to that training? Because of the work that we can do, others cannot. That is why we were told to stay in the office and other people were sent, while I needed that training - it was related to my job*" (Interviewee 2).

Misconceptions in the MoPH were another reason, which caused people to miss out on opportunities. There was a general misconception in the MoPH that advisors do not need training because they are deemed to know everything, hence, they were not given the opportunity. Participants had different comments about the qualifications and higher education of directors. Generally, qualifications and higher education were seen to bring more benefits to the directors. It was stated that more than 50% of the MoPH staff were not Afghans, they were foreigners, but now most of them are internal who have done their master's degree. They can do all kinds of work. However, the institution they graduated from was seen as important.

> *"……. Some universities may produce graduate students, but any changes are unrecognisable in those students and in their practice. However, some universities produce very competent and capable graduate students. When they enter the system, the effectiveness of their work is really recognisable in the system"* (Interviewee 1).

However, there were also different ideas about the qualifications; bureaucracy and complicated procedures were developed, which influenced people who were already

very well qualified in the MoPH. Qualifications were also affected by the existing culture. People with high qualification degrees were failed in the MoPH because they wanted to bring changes. However, other people were resistant against changes as is mentioned in below quote.

> *"People who are highly educated have grown up in this environment where they are influenced by the culture of their environment. Additionally, qualifications have failed in the MoPH, because resistance exists"* (Interviewee 6).

This means that unless people in the MoPH are willing to change, qualifications do not help. People were rarely described as possessing both the art as well as the science of management in the MoPH. Some managers who were highly qualified were described as not having management experience. Conversely, people who were experienced were defined as not having management qualifications, therefore, in both cases they were described as not being successful in their roles. The directors' qualifications, which were not related to their roles, were unhelpful. In this case employees suggested that those managers get training which may help them to do their jobs properly.

> *"If their education is not related to their job, then it is not useful. Instead, it is better to attend short-term training related to their roles, such as communication training, or accountability, how a director can be accountable. This simple training would be more beneficial for a director who might have come directly into their role"* (Interviewee 10).

Fake certificates were common. A few interviewees pointed-out that people who had fake certificates were not able to manage well. It was not mentioned where it was common and how the fake certificates are gained.

In summary, under this theme, it was found that the strategic plan for the capacity building was not being implemented at the MoPH. This caused employees to have the opinion that nothing had been achieved in the last 16 years in capacity building. There was a lack of coordination in capacity building. Furthermore, the development opportunities were misused and were not fairly used, which is not appropriate and helpful for the progress of an organisation. Employees including directors themselves were often attending irrelevant and repeated training. There was also discrimination

and unfairness in attending the training where having connections mattered. Participants believed that qualifications had a positive effect on the work of directors, but some also believed that the qualities of the Universities they graduate from were important. Other participants perceived that qualifications are influenced by bureaucracy at the MoPH. They meant that even if the directors with high qualifications when they join the MoPH, the bureaucracy that exists in the MoPH prevents them from achieving good work. It was also described that even directors with high qualifications were influenced by the family, society and culture. If knowledge and experience were together their benefits were high but if the qualification was not related to the job then it didn't provide any benefit. Relevant short-term training, however, was considered to be more beneficial.

5.4.3. The political and socio-cultural negative influence

This theme explores the political and socio-cultural aspects that negatively affected MoPH performance. The findings suggest that political parties are predominantly divided along ethnic lines with linguistic or regional links. When one of the political parties was named, everyone knew which tribe was mostly included in that party. Therefore, when a ministry belonged to a political party most of the employees were from that specific tribe. This issue not only made it difficult to separate the political issues from the socio-cultural issues but also these two aspects were found to be more twisted in the context of Afghanistan. Therefore, both are brought together under a one-unit theme.

It seems apparent from the data that all the interviewees were frustrated by the current situation of socio-cultural and political issues at the MoPH. The political situation was blamed for worsening political interference in the MoPH. The present government is divided between the Government President and the Executive President who are from different ethnic groups and represent different political parties. All government functions, including all the key positions in the Ministries, have been divided between them. Consequently, only political connections were considered. People who were related to these two political groups were placed in the key positions and other competent employees were not given a chance to be employed in those key positions.

"Before, political interference was occurring in other ways, but now the two-tiered Government [contains the Government President and the Executive President] has made our problem even worse. When a person from leadership is fired due to inefficiency, the other person who takes over is from the same political party. Merit, knowledge or management skills are not considered" (Interviewee 4).

In this case, technical professionals who didn't belong to any political parties perceived that they were not supported and not offered opportunities. They felt threatened and faced obstacles and were unable to develop their careers. Their knowledge and experience were not used properly. Interviewees described that the MoPH was under pressure from politicians and parliamentarians to hire their preferred people, regardless of whether they were competent or not. Parliament was said to always break the law and even interfere in the hiring and firing of people in the lower positions and was deemed to influence the MoPH performance as the priority was political rather than public benefit as below.

"Political interference has taken root in the MoPH. Politicians are destroying the health system of Afghanistan because it runs for the benefit of politicians rather than for the benefit of the public" (Interviewee 2).

Proper attention was not paid to Public Health problems due to their link to powerful people. Powerful people were the owners of these projects and were resistant to bring changes.

"There are too many problems in Public Health. People who are powerful won the contracts; people who are powerful are the implementers, people who are powerful are the decision makers, so when weaknesses and gaps are reported, they are considered superficially" (Interviewee 3).

The health services are implemented through the BPHS and EPHS packages in the country by different national and international NGOs (Section 2.3). The contracts are signed between the MoPH and those implementing NGOs. The MoPH has the authority to grant the contracts to the implementers. However, the decisions for granting the contracts needs to be mainly based on their performance. There are set criteria to make sure the contracts are granted to the right and suitable implementing

NGOs. However, from the quotes cited above it seems that the process is not transparent as these projects were run by powerful people and the decision makers while the decision makers are government authorities such as the MoPH leadership. The same problems existed in the private sector and the below quote indicates that these sectors were influenced by powerful people and the MoPH was not able to solve those problems.

> *"The MoPH is not able to make a decision about them, because those people have influence and do not want their reputation to be ruined. The MoPH cannot stand against them to solve the problems"* (Interviewee 3).

The term 'mafia' was used by some participants who said that they are dealing with a mafia. They did not say what they meant by the mafia and who they were. They might be the powerful people who were winning the public service contracts and running the private health sectors. People were described as caring about their political allegiances and supporting them unfairly in the MoPH.

> " *…people who come from political parties, for them political aims and benefits are more important than the aims and benefits of the whole of Afghanistan"* (Interviewee 11).

Political influence was described as less in the MoPH than in other ministries, where the situation was described as even worse. Socio-cultural aspects were other issues that the MoPH was struggling with. Without relationships and connections, getting support was seen as impossible. Different socio-cultural issues were said to exist extensively; though they were known as corruption.

> *"When we say we are drowning in corruption, it is nothing but these matters; favouritism, nepotism, kinship, personal interests, friendship, political partnerships, family members"* (Interviewee 10).

The findings suggest that people in the MoPH create jobs for their own favourite people, but it was not specified who does this. This is a type of betrayal which might not be acceptable in any organisation because it destroys the organisation.

> *"We have cases where a special job description is developed for a particular person. There are special candidates to be hired"* (Interviewee 9).

People have to have connections to be hired, to be appraised well, to get training and to be promoted. From the below quote, it seems that directors have an important role in allowing and creating socio-cultural issues in the MoPH.

> *"During your research, pop up to all the departments and find out when the head of the department was assigned as director and after that, how many of his political party members, tribe and family members are hired in that department. Without much effort, you will find out the reality straightaway"* (Interviewee 11).

Directors were thought by interviewees to be influenced by their environment, family, and ethnic culture. Interviewees thought this was caused in some directorates because all employees were from one tribe, or all of them were classmates or friends. Friendship was a very important matter in the MoPH. Many people were hired and supported due to friendships. Other cultural issues that existed in the MoPH were gender discrimination and bureaucracy which are described in the related sections. Each of them, in turn, affected performance in the MoPH.

In summary, this theme suggests that socio-cultural and political issues have extensively influenced the performance of the MoPH. Employees were frustrated with this situation. Powerful politicians and the government were blamed for interfering in the hiring system of the MoPH. The key positions are filled for political reasons, not based on merit. The socio-cultural issues such as favouritism, nepotism, and kinship existed and negatively affected the MoPH performance. Socio-cultural and political issues were promoted internally by the directors and other key positions in the MoPH through their unfair support to their political allegiances. These issues, in turn, influenced the transparency and accountability in the MoPH and consequently, the inconsistent treatment among the employees was promoted. This is detailed by the following theme.

5.4.4. Inconsistency due to lack of transparency and accountability

This theme was used to explain the lack of transparency and accountability that resulted in inconsistencies and the corruption that affected the management capacity, leadership and the performance of employees. This theme is distinct from the above

theme (Section 5.4.3) as this theme describes the lack of transparency and accountability and inconsistency regardless of their causes, though the main cause was perceived to be the political and socio-cultural issues. There was a lack of transparency and accountability in all procedures and systems. The findings also suggest that corruption existed in the MoPH. Employees were not treated consistently in all aspects.

> "*Opportunities should be fairly awarded to all staff members who deserve them, but managers always consider their own tribe. Staff members are not considered consistently"* (Interviewee 11).

There were many examples of lack of transparency in training opportunities, which was a big disadvantage for the employees, especially those who were working well.

> "*Some staff are mostly involved in training and development, while others are mostly involved with things which are related to work in the office"* (Interviewee 10).

There was also a lack of transparency from donors, for example employees had to keep the donors happy to have their training approved. Donors are expected to bring positive changes as they have come to help the MoPH to get rid of all unsatisfactory situations. However, it seems from the findings that the donors are also involved in the current situation of the MoPH as the next quote indicates.

> *"If the donor does not provide a letter, then the employee cannot attend training, and this is the donor's wish; here friendship works"* (Interviewee 8).

The findings suggest that females were discriminated against and were not treated equally compared to their male colleagues. They were paid less than men; and did not get the same overtime as the men. The hiring system also lacks transparency and accountability. Some departments were seen as ones that outsiders cannot enter. There were groups that supported people related to the group to get into the system. The selection process was described as below:

> *"A directorate plans to announce a vacant position. A panel is determined for the selection. The director introduces a person to the panel and gives them the task of helping his specific person (one of the candidates). Now the person who is on the panel has the job of guiding that specific person for the*

> *relevant exam questions and providing them with the relevant material. This is not a good culture - we may miss some competent candidates here"* (Interviewee 7).

Some directorates were described as lacking any achievement or progress, participants, therefore, questioned why the leadership was keeping such directors. Employees were working without having proper objectives, plans or job descriptions. *"Some directorates just exist; they are hibernating"* (Participant 7). Interviewees claimed that support was provided to incompetent people rather than to those who were highly competent, transparent and honest. There was enough resource, but they failed to reach the public.

> *"In many cases, there are enough resources and even more than enough, but they do not reach the public. They evaporate from the system and go into the pockets of those responsible "*(Interviewee 2).

From the quotation above the employee has the perception that corruption existed in the MoPH and that people misuse the public resources. Corruption was also perceived to exist in procedures and systems that were created to improve transparency and accountability but conversely cause and promote a lack of transparency.

> *"When such incompetent directors slip through filters like CBR, it indicates that there is huge corruption in the system. However, no one can raise their voice about those directors"* (Interviewee 11).

Political influence was not only blamed affecting the system and procedures including the hiring system but also blamed for all those disturbances and corruptions in the MoPH. The below quote indicates that political issues have a critical role in the performance of the MoPH.

> *"Unless political influence is gotten out of the offices, it will continue to play a role in all this embezzlement, theft of public property, misuse of public resources in procurement and purchases, in conversions and promotions and we cannot expect an ideal organisation"* (Interviewee 2).

In summary, the findings indicate that there is a lack of transparency and accountability in all the systems and procedures. Corruption also appears to exist as the interviewees pointed strongly to it. All these caused the staff members to be treated inconsistently and unfairly in the provision of opportunities

5.4.5. Change is hoped for

Interviewees were asked to share their suggestions for solutions to the problems and challenges they discussed during their interviews. This theme relates to interviewees' suggestions for the improvement of the MoPH performance. Eradicating political interference and promotion through merit were the two matters that were emphasised first and foremost. The senior staff interviewees recommended that incompetent people be fired, and that promotion should be based on skills, experience and competence not on connections and relationships. In the below quote a meritocratic system was proposed, unaffected by political and socio-cultural issues.

> *"Priority should be given to technical knowledge and technical knowledge should have authority. Priority should not be given to political connections, family connections, ethnic connections and friendships. A resource is needed to be on the ground in order to act on it, with commitment, a friendly approach and honesty"* (Interviewee 2).

Here, the interviewee wishes for the availability of an honest agency who can work on demolishing all these connections and show a strong commitment to the MoPH. It was suggested that the MoPH be a neutral ministry unaffected by political parties and to be managed by health professionals, not by politicians. Interviewees recommended that the tribal, regional, lingual, gender bias and other socio-cultural issues become an agenda and the work should be done on them. Parliamentarians interference in hiring and firing of the MoPH staff should be based on standards not on personal interests.

> *"Work needs to be given to the right people; this is our main problem - that the right work is not given to the right people"* (Interviewee 4).

Political influence caused people in the ministries to be employed without considering their suitability for the position. This resulted in other problems in the MoPH by which employees were not happy.

Transparency and accountability were other suggestions put forward. All the procedures such as the hiring system, appraisals and promotion were expected to be transparent. The quote below indicates that employees were frustrated from the lack of transparency.

> "*The thieves and people who commit corruption should be identified and removed from the system"* (Interviewee 2).

Another common suggestion was on the system and procedures to be simplified and restructured. Consistency amongst staff on capacity building and other opportunities was another aspect which demonstrates that employees are frustrated from unfairness and inconsistency. "*Rules should be implemented in the same way for everyone*" (Interviewee 1). Commitment, specifically the directors' commitment to their jobs, was another issue that was suggested for the improvement of health services. This was because it was found that directors were supporting their own political party's aims rather than the national aims. That is why the main recommendation to the office heads concerned reducing nepotism and political party support. It was suggested that all staff members should be supported consistently and provided with the same opportunities including capacity building. Whilst the delegation of tasks should be fairer without considering connections and relationships.

> *"My suggestion to my head would be, do not be nepotistic and do not support your own political parties unfairly. Value meritocracy instead and then see how it will benefit your directorate"* (Interviewee 11).

There was also a suggestion for the heads not to expect more from staff than their ability allowed. Some surprising suggestions to the related directors were mentioned below, which support the claims above that the managers lack the capacity that is required to do in their positions and employees are aware of this. This may create a demotivation for employees.

> *"It would be very helpful if our director attends basic management and leadership training and build his own capacity first to learn how to deal with staff and how to manage the office"* (Interviewee 10).

The above citations demonstrate that the employees believe that their head of directorates needs to improve their ways of working including their capacity.

5.4.6. Summary of interview findings

The interviews indicate that overall management capacity as experienced by the senior staff was as insufficient to address the significant challenges the country is facing. There appears to be a number of reasons for this. The Unitary government has a policy of dividing positions in ministries between them and due to this policy suitable candidates cannot be considered in the position of directors. Many directors introduced into the system by politicians were not able to manage well. They were not able to support employees in achieving good performance and provide them with a healthy work environment. Consequently, employees become demotivated which in turn affects their performance. Directorates were supported by the MoPH leadership, but the support was not enough nor was it consistent enough to all directorates. Interviewees were happy with the communication in their own directorates but neither from the general communication system in the MoPH nor from the shortage of electricity and internet, which was an obstacle for proper communication. Unprofessional treatment of some directors was another cause affecting communication among employees. The HR system had many problems and very basic procedures were not working as expected, such as the hiring system. Complicated systems and procedures were other problems that affected performance at the MoPH. Political and socio-cultural influences were rooted in the whole system, affecting performance at the MoPH. There were nepotism, favouritism, kinship, cronyism and political party relationships that affected transparency, accountability and caused corruption. These aspects also caused inconsistency and unfairness amongst employees, which had adversely affected their capacity development. All these aspects affected the employees' motivation, work environment and performance.

5.5. Document analysis findings

Documents were provided by the related directorate in a folder named 'Strategies and Policies final-PD'. It included 85 documents (Section 4.7.4). The 'PD' might be the abbreviation for the department, 'Policy Directorate'. Although the folder had the word final on it, most documents were incomplete drafts. For instance, some started from the table of content or some had missing sections. In some documents, the word 'draft' was written. The final versions of most of the documents were not available. For instance, the draft of 'Nursing and Midwifery Strategy' document was available, but the final version was not available. There were many such examples. Although many documents were incomplete, they were available in Portable Document Format (PDF). This is odd as typically complete documents are converted into PDF version. All this demonstrated that the organisation document keeping is not considered important and they are not maintained at the required standard. The documents listed below were included in the review:

1	Community-Based Health Care (CBHC) Strategy 2015-2020 (MoPH 2015g)
2	Communication Strategy for Public Relations 2016–2020, (MoPH 2016b)
3	National Health Strategy 2016–2020 (MoPH 2016a)
4	National Health Policy 2015-2020 (MoPH 2015a)
5	National Health Promotion Strategy 2014-2020 (MoPH 2014b)
6	National Strategy for Prevention and Control of Non-Communicable Diseases (NCDs) 2015-2020 (MoPH 2015j)
7	National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy 2017-2021 (MoPH 2017a)

Table 5-8 The MoPH documents reviewed

Unlike the interview and survey methods that aimed to answer certain questions, the focus of the document review was to find-out about the capacity and capacity building of leadership and whether they are implemented. From the documentary

analysis, three themes were developed (Figure 5.4).

Low capacity of the MoPH	Implementers' capacity	Capacity building plan

Figure 5-4 Document review themes

5.5.1. Low capacity of the MoPH

This theme refers to the information in the documents that acknowledges that there is low capacity in the MoPH. Among the documents three of them discussed low capacity in the MoPH; the MoPH Policy 2015-2020 (MoPH 2015a), the Communication Strategy 2016-2020 (MoPH 2016b) and the MoPH Strategy 2016-2020 (MoPH 2016a). The capacity building of the MoPH has commenced since the re-establishment of the health system of Afghanistan in 2002.

> *"There has been a mixed impact on the capacity building since 2002 both nationally and within the health sector*" (MoPH 2016a, p.21).

In the MoPH Strategy a review about the capacity building was cited, (2007 cited by MoPH 2016a), which mentions that despite spending US$ 1.6 billion on the capacity building since 2002, less has been achieved than expected. It means that low capacity still exists in the MoPH. Both donors, as well as the Government, are dissatisfied with this. In the MoPH Strategy (MoPH 2016a), it was stated that technical assistance in the MoPH is donor-driven, and has been uncoordinated and lacked a systematic approach. Another point related to capacity building was that donor support for the capacity building had mostly focused on the individual and on specific technical issues. Less attention was paid to MoPH governance and the functioning of the MoPH as a state institution as below.

> *"In health most donor support for capacity building has been for developing the capacity of individuals and for specific technical subjects. There has been very little support for strengthening the capacity of the MoPH in governance and the functioning of the MoPH as a state institution"* (MoPH 2016a, p.22).

The same was indicated in the MoPH Policy (2015a). In the review cited by the MoPH (2007 cited by MoPH, 2015a), it was also found that MoPH central management was not able to transfer the knowledge and skills related to governance and Public Health to provincial management because they themselves lack such capacities.

> *"..central level cannot transfer skills and knowledge related to governance and Public Health if it is itself not effectively demonstrating such capacity"* (MoPH 2016a, p.14).

In the Communication Strategy 2016-2020 (MoPH 2016b), slow and ineffective communication among MoPH departments is discussed. It states that the MoPH does not have its own server and intranet which affects communication and coordination.

> *"Inter-organizational communication in the MoPH is slow and ineffective. The MoPH does not have its own server and intranet, and communication with the provinces is slow and erratic, suffering from weak coordination and liaison capacity at both the central and provincial levels"* (MoPH 2016b, p16).

The second point that was discussed about capacity by this document was the low capacity in the MoPH, while there were high expectations and public needs.

> *"….a mismatch between the public high level of needs and expectations and the low capacity of the MoPH"* (MoPH 2016b, p.15).

This theme suggests that among the seven included documents of the MoPH there was the three that recognised the low capacity of the MoPH. There has been US$ 1.6 billion spent on capacity building, but the achievement was not as expected. The coordination about the capacity building in the MoPH was found to be the responsibility of donors, which was seen as weak and lacked a systematic approach. The slow and ineffective communication system was also found affecting the coordination and the capacity of the MoPH. People in the central MoPH were not able to transfer skills and knowledge related governance and Public Health to provincial staff because they did not have the capacity themselves.

5.5.2. Implementers' capacity

This theme describes the information about the implementers' capacity and capacity building indicated in the targeted documents. Implementers are people who implement the health packages (BPHS and EPHS) in the country and belonging to the national and international NGOs and the MoPH. Six out of seven documents discussed the low capacity of implementers at provincial level and had described a plan to build the capacity in the provinces. These included the capacity of health care providers, community health workers and volunteers, health facilities including hospitals, private and public services. Of these six documents, three indicated the low capacity of the MoPH itself in the capital as described in the above theme. The remaining documents did not discuss the MoPH's capacity in the capital, they discussed the low capacity at the provincial level as below;

> *"There is inadequate capacity at the subnational level in health. Therefore, while waiting for changes in the wider context, the Ministry headquarters level will transfer skills and knowledge related to governance and management and plans towards*" (MoPH 2015a, p.14).

The above citation shows that the MoPH has recognised the inadequate capacity at the subnational level but not at the national level. While in Section 5.5.1, it was found that the MoPH in the centre was not able to demonstrate skills and knowledge to transfer them to the provincial levels (MoPH 2016a, p.14). Another document sees the implementers' capacity building is essential in the success of the strategy implementation as below.

> *"At provincial level capacity building is essential in the successful implementation of this strategy"* (MoPH 2015j, p.18).

However, this document does not discuss the importance of national capacity and capacity building and whether they will affect the implementation of the strategies. Having the stewardship role, another directorate aims to develop standards, protocols and many other things to develop the capacity of implementers.

> *"As the steward of RMNCAH services in the country, the RMNCAH Directorate sets policy, strategy, and standards, develops clinical protocols and guidelines, monitors the quality of services and the capacity of implementing partners*" (MoPH 2017a, p.52).

This theme indicates that most of the MoPH documents recognized the low capacity at the subnational/provincial levels and plans were being developed to improve it. However, the documents also show that the central MoPH does not have the capacity to transfer the skills and knowledge to the provincial staff raising the question of how they can improve the capacity at the provincial level.

5.5.3. Capacity building plan

This theme is used to refer to all the capacity building and capacity improvement plans in the MoPH indicated in the documents. Short and long-term capacity building plans were stated as being developed. Capacity development needs were described as having been identified in different ways. Staff appraisal was proposed as one of the ways that would support development as quoted below.

> *"Capacity development needs will be identified through a number of ways including annual staff appraisal"* (MoPH 2015a, p. 18).

This was reiterated in other documents; CBHC Strategy (MoPH 2015g), National Health Policy (MoPH 2015a), MoPH strategy (MoPH 2016a) and RMNCAH (MoPH 2017a) stated that capacity would be built on leadership and management which would, in turn, promote transparency and accountability.

> *"Over the next five years, the MoPH is determined to build institutional, governance, and human resource capacity. Enhance MoPH managers' and leaders' capacity through institutionalization"* (MoPH 2016a, p.12).

The MoPH intended to build institutional governance and HR capacity as well as to strengthen the communication system.

> *"The implementation plan stresses the need to assess communication capacity and strengthen it as needed, enhance internal communication systems, and develop guidelines for MoPH quality control and coordination of communication"* (MoPH 2016b, p. 8).

In addition, there was a plan to reduce bureaucracy to a level where it no longer affects the MoPH capacity. The MoPH had also the plan to take over the leadership

and coordination of TA activities to ensure they are strategically targeted and are fully in line with health policy priorities.

In summary, the MoPH documents are not maintained well and it appears that they are not considered important because they were not organised and had missing documents. The document review demonstrates that the low capacity of implementers at provincial levels is recognised in most of the included documents. The low capacity of the MoPH in the capital is recognised only by a few documents. However, these documents contained the main documents of the MoPH; national health policy and strategy. All other MoPH documents need to be aligned with these two documents. However, the findings show that other documents are not concerned about the MoPH capacity and capacity building in the headquarters. Different strategies were made in these documents to build the capacity. However, during the data collection of this PhD research from September 2017 to January 2018, no reported improvement was found in the MoPH in the capital, though many of these documents are in the implementation process from 2015 to 2020. Another point that was noted was since 2002 capacity building has been in the plan, but no document reported any achievement or any evaluation of capacity building activities. It seems that all the plans about capacity building remains on the paper only with no evidence that they have been implemented.

Chapter 6. The single-case study

6.1. Integration of the findings of all methods in one single-case study

This chapter provides a single narrative for this case study. The findings from each specific method are presented separately in Chapter 5. This chapter goes one step further by presenting the agreements or disagreements in the findings from each of the four methods and how they jointly address the research question; *"What are the factors that affect the management capacity, leadership and employee performance in the MoPH, Afghanistan?*"

The document review method (Section 5.5) explored only capacity and capacity building of leaders in the MoPH and whether they were implemented. The same with the archival study; which aimed to record the directors' workforce investment including their qualifications, training and capacity building. For instance, the findings in the archival records was unlikely to include a finding related to political and socio-cultural influence. This is the benefit of a pragmatic philosophical assumption that allows the desired goal of the study to be achieved no matter which method or approach is taken (Tashakkori and Teddlie 2016). The pragmatical assumption helped this research to combine two different philosophical assumptions of positivism using archives and questionnaires and interpretivism using interviews and documents to advance the knowledge and achieve the outcome.

In answer to the research question, six factors were derived through four data collection methods: (1) General issues of capacity; (2) Leadership capacity and capacity building; (3) Political and socio-cultural influence; (4) Lack of transparency, accountability and corruption; (5) Not enough support; and (6) Change is hoped for.

6.2. General issues of capacity

The first factor that affects the management capacity, leadership and performance is related to an uncoordinated capacity building system. The findings from all four methods suggest a problem in the capacity building. A lack of coordination was found in the capacity building in the archival records as the information about the

capacity building was not updated in the archives (Section 5.2). The directors who reported a master's degree in the questionnaire were still listed as having only a bachelor's degree in the records (Section 5.2). There were no other means for archives to be updated except if the directors themselves informed the relevant department of any changes such as getting a master’s degree or promotion. The coordination of capacity building was found from document review to be the responsibility of the MoPH donors. Coordination was reported to be weak and lacked a systematic approach (Section 5.5.1). The interview findings show that there was not a strategic plan in the MoPH regarding capacity building, that was why there were no indications that capacity had improved in the last 16 years in the MoPH (Section 5.4.2). The same was found in the document that the MoPH and donors were not happy about the capacity building (Section 5.5.1). From the questionnaire, it was found that the capacity building was not enough for directors and their employees (Section 5.3). Lack of coordination was highlighted as causing the development opportunities being misused as some staff attended irrelevant training or attended the same training repeatedly while other staff had never been to any training. Favouritism and connections were found to be the reason opportunities were not provided fairly and consistently to employees (Section 5.4.2).

The findings from all the methods indicate that capacity building was not seen as important enough in the entire organisation. As in archives, no record was available to demonstrate what has been done for the capacity building of directors and other employees and what capacity building each of them needs. In this case, no gap can be recognised, and no proper plan can be made. The same was shown by documents, different strategies were introduced to build capacity. However, during the data collection, no record of improvement was found in the MoPH in the capital, although many of those documents cover the implementation process from 2015 and 2016. Since 2002 gaps related to capacity building was discussed and the plans about capacity building were introduced but no records or documents indicate any achievement. It seems that all the plans about capacity building remained on paper and have not been implemented.

6.3. Leadership capacity and capacity building

The second factor that affects the management capacity and the employee performance is related to directors' capacity and capacity building. The leadership capacity was found by all four methods to be low. Starting with the findings of interviews, which suggest that due to the policy in the Unitary Government, merit cannot be considered properly in the hiring of directors. Many directors introduced into the system by politicians were not able to manage well. They were not able to support employees and provide them with a healthy work environment. The apparent lack of a healthy work environment has resulted in the demotivation of the employees and has affected their performance. This helps explain why interviewees proposed that managers need to attend the required training to be able to manage the office (Section 5.4.1.1). This is supported by the archival records that the directors who held these positions had different degrees of qualification or experience. The responsibility of the entire directorate was also given to people who had an education of 15 years including the 12-year school (Section 5.2). The appropriateness of the subject of study was also not considered for the people who were appointed to manage or lead directorates in the MoPH. Eight out of 30 directors appeared to have studied Public Health and management, but most studied the subjects, which didn't include anything related to management, leadership, strategic planning for an organisation and understanding of the country's health.

The document findings also recognise the low capacity of the MoPH and despite a huge amount of money invested, the capacity had not improved much. Documents also suggest that the MoPH in the capital was not able to transfer the skills and knowledge to others in the provinces (Section 5.5.1). The survey findings suggest that the directors believed that there is low capacity among directors. Almost 96 % of directors needed capacity building because they were facing problems in their daily management activities. Another reason was due to the low salaries, people with low capacity joined the MoPH. Interviewees also perceived that many people's capacity cannot be built even after spending a lot of money. In this case, it was suggested by interviewees that those types of people should be terminated from their positions (Section 5.3).

6.4. Political and socio-cultural influence

The third factor that affects management capacity, leadership and performance is related to the political and socio-cultural issues. The interview and survey findings demonstrate that the political and socio-cultural influence was a substantial factor affecting MoPH performance negatively and was rooted in the entire system. Political interference was found in the survey as the second top obstacle for directors in reaching their organisational goals after the shortage of resources identified as the first obstacle (Section 5.3). Socio-cultural issues were another obstacle in the survey that negatively affected the leadership. Corrupt practices such as nepotism, favouritism and cronyism existed in the MoPH (Section 5.3), which coincided with the same as in the interview findings. Almost all interviewees were frustrated by political and socio-cultural influence. They believed that these issues have ruined the health system. The MoPH was under pressure from politicians to hire certain people who were thought to be not competent. In this case, technically capable people who did not belong to a political party were not supported in their career development and their knowledge and experience were not used (Section 5.4.3). The political and socio-cultural influence was also blamed in the survey that enables unqualified people to enter the system (Section 5.3). These issues were promoted from inside the MoPH. People who were introduced into key positions such as directors by the politicians were supporting their members of the political party or their ethnic group unfairly (Section 5.4.2.2). The best solutions indicated by most directors in the questionnaires for the obstacles was to strive against the political interference/pressure and to eliminate socio-cultural influences from the MoPH (Section 5.3). This was the same demand from the interviewees who stated that priority should be given to knowledge, skills and experience instead of political or any other connections (Section 5.4.5).

The findings in the interview and survey demonstrate that participants were frustrated by the political and socio-cultural influences in the MoPH and their negative impacts. The political interference and their negative impacts are not likely to be recognised in the documents of the MoPH. The ministry is unlikely to record and acknowledge anything that goes against its own policy.

6.5. Lack of transparency, accountability and corruption

The fourth factor relates to a lack of transparency and accountability. The findings from the interview and questionnaire show that a lack of transparency and accountability existed in all procedures and systems. The findings from these two methods also suggested that corruption existed in the MoPH. The interview findings provided more details concerning these challenges. The socio-cultural and political influences were blamed for the lack of transparency and accountability that affected the employee performance. Employees were inconsistently and unfairly treated in the provision of all kinds of opportunities including career development (Section 5.4.4).

Lack of transparency and corruption were introduced as the obstacles by directors in questionnaires in reaching their organisational goals (Section 5.3). Although the aim of the document review was only to explore capacity and capacity building, it was found in the documents that the improvement of leadership and management capacity will promote transparency and accountability (Section 5.5.3). This shows that the MoPH is aware of the lack of transparency and accountability besides the low capacity in the MoPH. Interview findings show that the NGOs contracts in public and private sectors were always won by powerful people. These are contracts to implement the BPHS and EPHS in the whole country. The implementers were the ones who were policymakers, who were decision makers, and this prevented the problems from being tracked down and solved in those particular sectors. The hiring system was another system where procedures were not transparent (Section 5.4.4).

The findings of the lack of transparency, accountability and corruption in the interviews and surveys were in agreement. These were also found in the document review.

6.6. Not enough support

6.6.1. Low management support

The fifth factor that affects management capacity, leadership and employee performance is related to the low support that directors and employees get. The

findings from the surveys and interviews about the shortage of support were in agreement. The factors specified by directors in questionnaires affecting their work environment and performance were shortage of electricity, shortage of finance and HR, shortage of capacity building and physical space and other resources and equipment (Section 5.3). Shortage of resources was selected by directors as the top obstacle in reaching their organisational goals (Section 5.3). This was similar in the interview findings. Interviewees were demotivated by the limited resources and physical space and a shortage of electricity and poor internet access. The further main support that the directors needed to achieve their organisational goals were; financial, qualified staff, capacity building, consistent support and other resources including more equipment in the office (Section 5.3).

An appropriate communication system was another support that was needed by both the directors in the questionnaires and the employees in the interviews. Participants in the interviews and surveys were happy with communication in their directorates (Sections 5.3 and 5.4.1.1). The internal meetings and the use of different methods of communication in the directorates were appreciated by senior employees in the interview. This was the same in the survey questionnaire, where the communication of leaders with their employees had positive effects on both the performance of leaders as well as the employees. Communication, however, was only used for controlling the staff in some other directorates rather than for other benefits. This internal communication was neither common in the directorates that were located outside of the MoPH building. This is described in the below lines. Neither the directors (in the questionnaire) nor the employees (interviews) were happy with the general communication system of the MoPH because of the shortage of electricity and internet (Sections 5.3 and 5.4.1.1). The shortage of internet was more common in the directorates that were located outside the MoPH headquarters and this caused them to use more unofficial ways of communication such as WhatsApp. They were essentially not aware of the regular activities of each other carried out in their directorates.

The unprofessional treatment was found in the surveys as well as in the interview findings. It was found from the interviews that unprofessional treatment still existed in some of the directorates, which affected the employee performance as they were careful in sharing their ideas (Section 5.4.1.1). The same complaints were found in

the questionnaires where some of the directors were not happy with their line managers' treatment. Many directorates were given ad hoc tasks with a tight deadline and with little acknowledgement of the good work (Section 5.3).

The inadequate and inconsistent support of the MoPH leadership was suggested by the findings from both the questionnaires and interviews. However, it was more obvious in the questionnaire as the directors are the front-line people who deal with the MoPH leadership rather than the employees. From the questionnaire findings, inadequate management support was rated by 61.9% of directors as one of the main obstacles towards their organisational goals. Consistent support from the leadership was the demand of directors to reach their goals (Section 5.3). However, the interview findings also suggest that leadership support was provided when the directors have logical justification for their suggestions. It also depended on the directors' capacity, hard work and commitment on how to use the provided support (Section 5.4.1.2). There were directors deemed by participants in the questionnaires and interviews who were not able to use the support they had (Sections 5.3 and 5.4.1.2). The archival records concurred as they showed that half of the directors had never been awarded any appreciation letter while three directors were awarded appreciation letters frequently, namely between nine and 16 times (Section 5.2). This finding suggests one of the two issues. Either the good work is inconsistent among directors, which supports the findings of the interviews (In this case, the use of support depends on the directors' capacity and commitment), or their good work is not supported consistently and appreciated by the MoPH leadership.

Information about the system, structure and procedures were expected to be gained from the surveys and interviews. The findings in both of these methods support each other. The problems in systems, structure and procedures in the MoPH were factors that affected the management capacity and the performance of directors. Job insecurity, complicated and time-consuming procedures, parallel directorates with similar objectives were the examples that were generated from the questionnaires (Section 5.3). Interview findings highlighted issues with bureaucracy, auditing, old fashion systems, job insecurity, directorates with similar objectives, ordinary and consultancy jobs, complicated procedures and existence of some systems such as CBR, PRR that were not useful in the MoPH and some were not applicable in the Public Health (Section 5.4.1.2).

The exercise of authority is another important aspect that directors need to make improvements on. Most of the directors in the questionnaires were happy with the authority given to them, but the evidence also shows that managers wanted to have qualified and skilled staff in their directorate, but staff were hired or promoted in their directorate without the directors' knowledge (Section 5.3). This might be the indication of limited authority as some other directors demanded more authority in questionnaires. It was also evident from the interview findings that the directors were not able to make decisions about their staff, for instance, to change their position or to promote them (Section 5.4.1.2). This indicates a limited authority of directors in their own directorates, but this might not be recognised by some of them.

6.6.2. Relationship between support and the employee performance

The factors that affect the management capacity and leadership are described in the above sections. This section attempts to describe how the employee performance was affected by those factors. The findings from all the methods suggest that the employee performance was negatively influenced by the factors that the management capacity and leadership were affected by.

The appraisal system is the system through which the performance of employees is monitored, their strengths and their developmental needs are recognised. Regarding the benefits of appraisal systems in the employee performance, two different ideas are evident in the questionnaires. Some were happy thinking it brings encouragement while others commented that it makes the employees happy and increases their salary but does not motivate them to work as it is not evidence-based. Neither the procedure was followed in regard to appraisal. The socio-cultural issues were also found in the questionnaire to be an obstacle for the directors in the proper fulfilment of appraisal forms (Section 5.3). The interviews demonstrate that interviewees were not happy with the appraisal system seeing it as a formality and based on connections. As implementing an appraisal system was a new idea in Afghanistan it was not completed professionally, and the line managers did not have the capacity to fill it. In this case, the performance of employees was not assessed properly, and their strengths and weaknesses were not revealed. The employee performance was neither

recognised in the directorates where the heads were introduced directly by the politician. The employees’ specific skills and abilities were not recognised by their heads nor were their heads able to know which responsibilities could be given to which employees. This situation demotivated employees (Section 5.4.1.1). From the archival record analysis, it was found that most of the directorates were managed by people who had clinical/medical knowledge and skills. The subject of their qualification didn't include knowledge about the employees' management and how to use the employees' skills and specific expertise in a directorate. Only eight directors had qualifications in Public Health and management (Section 5.2).

Employees' annual leave was another issue that the directors had different ideas about in the questionnaire. Most indicated that employees take their annual leave while others mentioned that because of the low salary they were not willing to take their annual leave (Section 5.3). It might be the indication that most of the directors did not see a problem with annual leave because they didn't recognise the underlying cause of why the employees did not take their leave. The findings from the interviews suggest that problems concerning annual leave suggested that employees either did not take leave due to different reasons or if they did take leave faced challenges (Section 5.4.1.1). It indicates that there was not a proper system for the employees' annual leave as others were taking more leave than they had a right.

The inadequate communication system was found in the questionnaires; documents and interviews to affect employee’s performance; was described above. The MoPH did not have its own server and communications database. The slow and ineffective communication among the different departments affected employee performance (Section 5.5.1). Some directors used internal communication as a means of controlling employees rather than using it to encourage better performance, which demonstrates a failure in the establishment of a trust in those directorates (Section 5.3). This supports the findings from interviews suggesting the unprofessional treatment in some directorates and its negative impact on employee performance. These were in directorates where the heads were deemed to not be open minded. To avoid conflict or to not be dismissed by the heads, employees preferred being very careful in sharing their ideas and sometimes keeping silent was the best choice for them (Section 5.4.1.1).

Political and socio-cultural influences also had a significant impact on employee performance as this situation has created a lack of transparency and accountability. Employees are treated inconsistently in the provision of all kinds of opportunities including development opportunities. There was a huge difference in the capacity and commitment of employees due to the lack of transparency in the hiring processes. The career of employees who did not have any link to any political party was affected negatively. Their knowledge and skills were not used properly even if they were skilful and competent. Some employees were given more tasks than others and when they were not to finish the given tasks at the office took them home to finish. Employees who worked well were missing some opportunities because they had to stay at the office and work, while others were attending their training (Section 5.4.1.1).

Problems in the structures, systems and procedures were other issues that affected the employee performance. For instance, there was a big difference between the opportunities for the ordinary employees of the MoPH and those employees hired as consultants by donors. This caused discrimination, jealousy and demotivation among employees (Section 5.4.1.1). The findings from questionnaires and interviews suggest that there was a lack of job security in the MoPH, which caused the employees to be stressed and distracted from their office objectives (Section 5.3 and 5.4.1.1). Directorates with similar objectives were another issue found in both the questionnaires and interviews that affected the employee performance. Some directorates were overloaded while some had less to do (Sections 5.3 and 5.4.1.2). Some employees were expected to work at the weekend, till late night or from early morning but they were not compensated. Sometimes they were expected to do ad hoc jobs with a tight deadline and when they were not able to do all this work then they faced criticism from their directors (Section 5.4.1.1).

The findings from questionnaires and interviews also found that in doing their jobs, employees were faced with shortages of resources and equipment in their offices, limited space for their work and meetings and they didn't have basic facilities such as heaters to work comfortably in the office. They were also provided limited capacity buildings, low salaries that are not adequate and were not paid overtime for their extra work (Sections 5.3 and 5.4.1.1). Despite all the mentioned shortages, a few directors indicated in their questionnaires that they did not have any challenges and

were provided all the required support. These kinds of directors may not care about the challenges that the employees face. They are perhaps not able to recognise all the challenges, or they are supported inconsistently while most of the others had these challenges. The findings from the questionnaire indicated that the employees' concerns about their work setting were not considered as important as they were not solved. Although some directors tried to convey their concerns it was useless. Some other directors thought that the employees had already accepted the work condition when they applied the job, which seems irresponsible (Section 5.3). As one of the heads of directorates' responsibilities is to provide a good work environment for the employees.

6.7. Change is hoped for

Finally, the sixth theme is the suggestions that the directors as well as their employees had for the improvement of the performance in the MoPH. First the shared recommendations that were wished by both the interview and the questionnaire participants are reported and then the specific recommendations are taken from each method.

Eradication of political interference and meritocracy were the main recommendations that the participants wanted. Transparency, accountability and the elimination of corruption were the other main aspects that were asked by the participants. Consistency (consistent support and consistent implementation of rules, regulation and laws) was needed by the head of directorates in the questionnaires and the employees in the interviews. Simplifying procedures, systems and structures were other suggestions to improve the performance of the MoPH. Policies and strategies were asked to be based on the Afghanistan context. Socio-cultural issues needed to be put on the agenda in the MoPH and then be worked on (Sections 5.3 and 5.4.5).

There were also some specific recommendations from the directors. They asked for good governance, responsible and accountable government to work for peace and seek solutions for problems and stop the political parties from unnecessary interference. The directors also asked for good communication by the MoPH leadership and acknowledgement of their accomplishments. They also asked for capacity building (Section 5.3). The specific recommendation from the employees to

their head of directorates were to avoid nepotism and support the team consistently. The directors were also asked to not give tasks to employees that is above their ability. They were also asked for a good commitment. Some participants asked their heads to attend the basic training of management and leadership (Section 5.4.5).

6.8. Summarising the case study

In this case study of the MoPH, management capacity and leadership are low. Although since 2002 a vast amount of money has been spent on capacity building in the MoPH, little has been achieved. Analysing the findings of the methods draws a picture of the factors that together affect the management capacity and leadership in the MoPH which in turn affects the employee performance. Figure 6.1 demonstrates those factors affecting the MoPH performance. Each of those factors are linked to the relevant sections in the below paragraphs.

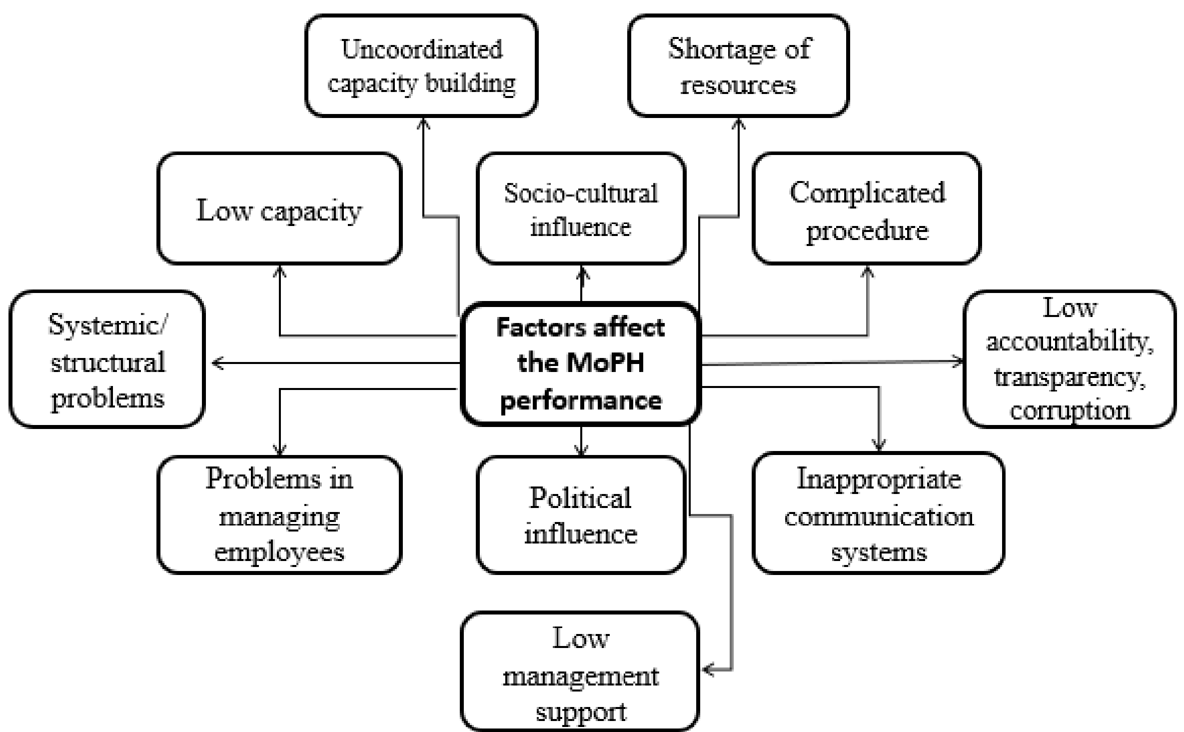

Figure 6-1 Factors affecting the MoPH performance

Many issues were identified that affect the leaders' capacity to manage well in the MoPH. The current political situation has increased the political influence on the MoPH and caused incompetent people to be employed; merit was rarely considered

in the selection of directors (Section 5.4). The subjects that many of the directors studied did not include any training in the management of an organisation or strategic planning for the health of a country. The shortage of resources (Section 5.6.1) was another main obstacle towards achieving goals. Socio-cultural issues (Section 5.4) from outside and inside of the MoPH negatively affected the directorates' accountability. Corruption, low transparency, and low management knowledge (Section 5.5) were also selected by directors as the obstacles towards their goals. HR management seems weak and the procedures were defined as complicated (Section 5.6.1) and lack transparency including the hiring system.

Low capacity of the MoPH (Section 5.2) is recognised in the national policy and strategy of the MoPH. Strategies have been suggested for capacity improvement but those strategies and plans rarely enter the implementation process. No achievements were found in the documents about the capacity and capacity building. Lack of coordination on capacity building (Section 5.2) caused the misuse of development opportunities; employees attended the irrelevant and unnecessary training. The system and structure had their own problems that created obstacles for achievement (Section 5.6.1). Directors need adequate and consistent support from the MoPH leadership (Section 5.6.1). They also need an appropriate communication system for proper coordination (Section 5.5).

The employee performance was negatively influenced by the factors that affected management capacity and leadership (Section 5.6.2). All of these aspects affected the work environment. Employees were not treated consistently and fairly. They were facing a shortage of resources. In some directorates, employees treated unprofessionally by their head of directorates, this caused them not to actively participate. The lack of an appraisal system caused the employee performance not to be monitored properly. Good work was rarely recognised. Employees had different capacities and commitments at the same levels. All these issues demotivated employees and affected their performance.

Comparing the findings from all four methods, there was some contradictions in the findings about the appraisal system, annual leave, and the qualifications of directors as follows; the findings in the questionnaires suggest that most of the directors thought that employees took their annual leave while the findings from the interviews suggest that taking leave was easy but for different reasons employees

were not taking leave. Perhaps most of the directors meant that employees did not face any challenges in taking leave from their side, but they had not recognised why employees did not take leave. A minority of directors commented that employees were not taking leave because of the low salary which concurred with the employee interviews.

There was a discrepancy about the qualification degrees of directors in the archival records and the filled questionnaires. The reason was that the directors were expected by the HR department to inform them about the updates and there was not any other means of updating the archival records. Another discrepancy was about the appraisal system between the findings from the interview and questionnaire. All the interview participants were not happy with the appraisal system while most of the questionnaire's participants were happy as they have commented that appraisals makes the employees happy and increases their salary. The minority of directors also commented that the performance appraisal made the employees happy but did not engage them to better work; in this case, it didn't benefit especially when it is not evidence-based. This means that the majority of directors thought the appraisal made the employees happy, so it is beneficial, however, the question was about the benefit to their work not to their personal benefit. Overall the findings from all four methods support each other.

Chapter 7. Explanation building

7.1. Introduction

This chapter reports how the evidence of this study was compared with the propositions that were developed at the earlier stage of the study. If the evidence supports the proposition, then the proposition remains the same. If the evidence shows a difference, then the proposition is changed, and a revised proposition is presented based on the evidence of the current study. Explanation building was used as the analytical technique to compare the collected data with the theoretical propositions. To maintain transparency and credibility, the explanation process was carried out step by step through the following iterations amended from (Yin 2013). Figure 7.1 illustrates the process of movement from theoretical statement to explanation.

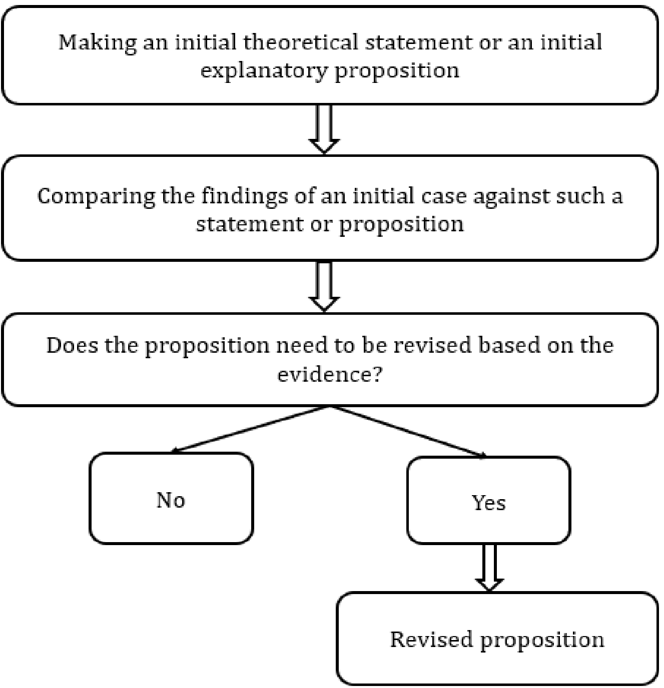

Figure 7-1 Iterative nature of explanation building (amended from Yin 2013, p.149)

7.2. The theoretical propositions that developed and used in this study

The analytical strategy of this study was the use of theoretical proposition, which was developed from the literature review. Five propositions were developed as below.

1. There is a strong relationship between managerial support and employee performance.
2. The management support system affects the work of managers.
3. Managers who have managerial training can manage well.
4. Political and socio-cultural influence affect leadership
5. The lack of transparency and accountability and corruption of the management system affect staff and organisational performance.

Study proposition 1: Managerial support and employee performance

Comparing the evidence against the proposition:

The findings contained evidence of a strong relationship between managerial support and the employee performance, which supports proposition one. However, in proposition one the managers' support is not linked to the managers competence. While this study revealed an obvious link between the managerial competence and their support to their employees and their performance. The findings suggest that managers who really were experienced, knowledgeable and able to manage well, were able to provide a better working environment and support the employee performance.

In many directorates, however, many participants believed that managers who were introduced directly into their positions were not able to manage well. Such managers were perceived to have low capacity and were not able to provide a supportive working environment that can help the employees performance. These kinds of managers were not open minded and did not have a good understanding of their context. They were not able to recognise the specific skills and abilities of their staff members and be creative in achieving their directorate's goals. This also prevented the employees' progress. In addition, their performance was not appraised properly or systematically to benefit their career development. All these issues led to demotivation and disappointment for employees.

Does the proposition need to be revised, based on the evidence?

The findings entirely support the proposition that there is a strong relationship between managers' support and employee performance. However, the evidence adds some additional points to the proposition, that the managers who are not competent cannot be supportive. This is because such managers are not able to recognise the employee's skills, specific abilities and creativity to use them effectively. All these affect the employees' motivation and performance.

Revised proposition: Managers with competence; good experience and skills are able to support their employees properly, while the managers who are not competent are not able to support their employees as required. Consequently, employee performance and progress are affected by their mismanagement.

Study proposition 2. The management support affects the work of managers

Comparing the evidence against the proposition:

The findings suggest that the managers performance is affected by the management support system, which supports proposition two. To achieve their organisational goals, directors needed resources such as financial and HR but there was a shortage of resources. However, the findings of this study also discovered the link between the managers' competence and being provided with the required management support. Participants thought that support depended on the directors being creative and explaining their rationale and justification for ideas. It also depends on the directors' competence, hard work and commitment to get the support and use it effectively. Whereas, in proposition two, the relation between the managers competence and getting the management support was not discussed.

Does the proposition need to be revised, based on the evidence?

The evidence shows that management support affects the work of managers. However, this also depended on the managers' capacity, hard work, commitment and ability to gain and utilise the support. Therefore, this needs to be added in the proposition two because it was found that if the managers were not competent, then even if there was enough support, they were not able to utilise it.

Revised proposition: The management support affects the work of managers; however, it also depends on the competence of managers to gain the available support and to use it effectively.

Study proposition 3. Managerial qualification/training matters in support

Comparing the evidence against the proposition:

Evidence in this study indicates that managerial qualifications and training helps managers to support their employees properly. This supports proposition three. However, the findings also suggest that higher education is only beneficial if it is gained from a good quality university. This perspective may be because participants claimed that MoPH employees had gone abroad for higher education but on their return, they could not see any improvements. By this, participants thought they had studied at low standard universities. The findings suggest that if the art and science of management are combined, then it would benefit more. This was clarified as if people in the MoPH had experience, they did not have its knowledge while people who had the knowledge, they did not have the experience. Neither was successful, and people who had both knowledge and experience together were rarely seen. If the managers' qualification were not relevant to their work, or if they attended irrelevant, unnecessary and repeated training these were unlikely to be beneficial.

Does the proposition need to be revised, based on the evidence?

This proposition needs to be changed. Although evidence strongly demonstrates that managerial qualifications/training positively affected the competence of managers and helped them to manage well. It is also evident from the data in this study that the quality of the training and the quality of university the managers obtained their degrees from was important. It was helpful if qualifications were combined with experience. Other evidence shows that if the qualification or training was not relevant to the role, then it would not be beneficial.

Revised proposition: Managerial qualifications and training benefit the managers' competence and help them to manage well, however, managerial qualifications is more beneficial if it is gained from a qualified university. It also benefits if it is

combined with experience. The relevancy of qualifications to the managers' roles is also important.

Study proposition 4. Political and socio-cultural issues affect leadership negatively

Comparing the evidence against the proposition:

The findings suggest that political and socio-cultural issues negatively affect the leadership performance supporting proposition four. The findings contained evidence of vast political and socio-cultural issues in the MoPH which negatively affected leadership work. Political connections, kinship, nepotism, favouritism and cronyism existed extensively, which influenced procedures and systems in the MoPH. Key positions were divided between political parties regardless of their competence and merit. There were deals for political benefit in the MoPH, rather than for public benefit. Ethnicity, language and gender discriminations in favour of men were other issues that existed. Directors were described as influenced by their environment, which affected their work in the MoPH. All the above issues caused discrimination among staff members, which in turn caused inconsistency and unfairness.

Does the proposition need to be revised, based on the evidence?

This proposition does not need to be revised because the evidence strongly supports the proposition. Leadership/management performance is negatively affected by political and socio-cultural issues. These issues affect procedures, systems and all other organisational aspects which in turn affect organisational performance.

Study proposition 5. The lack of transparency, accountability and corruption affect performance

Comparing the evidence against the proposition:

The evidence in this study supports proposition five. The findings suggest that there was a lack of transparency in all procedures and systems. All kinds of opportunities were provided to staff inconsistently and unfairly such as training opportunities, performance appraisals, salaries and annual leave. The recruitment system was one

of the main aspects that was described as not transparent. Many of the heads of directorates were said to be hiring people from their own tribes, which shows a lack of accountability. It was found that in many directorates, employees did not have proper plans, objectives, job descriptions and many directorates did not have proper achievement and progress. Evidence also showed corruption in the Public Health and private sectors' contracts owned by parliamentary lawyers and powerful people. Lack of transparency, accountability and corruption had affected the directors' performance.

Does the proposition need to be revised, based on the evidence?

This proposition does not need to be revised. It is supported by the current study. Lack of transparency, accountability and corruption affected all procedures and systems negatively including the recruitment system, contracts, opportunities and all other aspects, which consequently affected the performance of directors and employees.

Based on the explanation building techniques, propositions 1, 2, and 3 were changed while propositions 4 and 5 remained the same without any changes.

Chapter 8. Discussion

8.1. Introduction

This chapter discusses the findings of the study using four research methods on factors affecting the management capacity, leadership and employee performance in the MoPH, Afghanistan (Section 1.6).

The findings presented in Chapter 5, resulted in the following six overarching themes: (1) General issues of capacity; (2) Leaders' capacity and capacity building; (3) Political and socio-cultural dynamics; (4) Lack of transparency, accountability and corruption; (5) Insufficient support; and (6) Change is hoped for. After discussing the key themes in the light of the literature, the strengths and limitations of the study will be addressed followed by the researcher's reflections.

8.2. General issues of capacity

The findings in this study indicate that capacity is something well beyond mere qualifications and training. It also includes important systemic, cultural, financial and developmental dimensions. The results of the investment in capacity and capacity building were issues that neither the directors nor the senior employees were happy with (Section 5.5.1). The findings suggest that the absence of an implemented strategic plan in the MoPH on capacity building (Section 5.4.2) was also considered to be a key reason why capacity had not improved in the last 16 years. Furthermore, it was not needs-based and consequently employees were attending irrelevant and repeated training.

Interestingly, the MoPH and its partners were well aware of the low capacity within the organisation. According to internal documents (MoPH 2015a, 2016a), this was linked to the fact that TA was donor-driven and was neither systematic nor coordinated. This resulted in haphazard and uncoordinated attempts to address the problem but which also, ironically, maintained the problems associated with low capacity. Capacity problems in the MoPH also seem to stem from a focus on individuals or specific technical subjects rather than on the wider governance of the MoPH and institutional processes (MoPH 2016a). A clear example was the lack of (1) a functional information system on training; (2) a standard training centre; (3) a monitoring and supervision system of training programmes; and (4) post-training

follow-up. Although the MoPH and partners had developed a strategic plan and policy (MoPH 2014a) to tackle the above mentioned challenges, a carefully review of ministry documents by this researcher suggests the policy does not appear to have been implemented. The plan indicated that the MoPH were to take the lead in capacity building coordination and establish a resource centre (Section 5.5.3). However, no evidence was found in this study to show that these objectives had been achieved.

This has serious implications because to achieve the health-related goals, the MoPH needs to have the necessary capacity to be effective. Studies reveal that governments with low management capacity are shown to be inefficient and ineffective and unable to adapt to the complexities within their environment (Andrews and Boyne 2010). The level of capacity is also a substantial determinant for service quality (Ingraham et al. 2003). Low management capacity in LICs has been a critical obstacle for making major progress and achieving health-related goals (WHO 2008).

Interestingly, in the most recent documents, such as the MoPH National Policy and MoPH National Strategy (MoPH 2015a, 2016a), a review was cited from Michailof (2007) about the failure of capacity building in the MoPH. These national documents are important because they are the main national strategy of the MoPH and set the direction to which all other policies must be aligned. Michailof's (2007) review was commissioned by the World Bank, which has taken responsibility for capacity building coordination in the MoPH since 2001. This review appears to be the only document in the MoPH that seeks to address its capacity building issues and it is surprising that after twelve years the MoPH is only now paying attention to the failure of capacity building.

This thesis highlights that during the intervening years little work has been done to address the failures in capacity building (Section 5.5.3). Michailof (2007) indicated that since 2001 the international community has invested around US$ 1.6 billion on capacity building. However, even with dedicated funding spent on the MoPH capacity it remains under developed. As previously indicated, Michailof (2007) argued that capacity building was donor-driven and not needs-based, with the donor taking the coordination responsibility on TA from 2001 on the understanding that the MoPH leadership did not have sufficient capacity to manage it themselves. The donors believed that the TA was the only option to manage the huge aid flows, even

though there were lessons learned from African countries suggesting that the TA approach to training local staff was not successful and that governments of those countries had had to continue relying on the TA for upwards of 30 years. The donors ultimately accepted that their coordination was insufficient, which has affected TA effectiveness in the MoPH (Michailof 2007).

Michailof (2007) also indicated although their salary and benefits were high, the quality of the foreign TA personnel was low, and their skills were inadequate. This resulted in a lack of sensitivity to the local culture, which impacted on capacity building. At the time of the review (2006-2007) the MoPH had pointed-out the inappropriateness of the TA design, which they argued would not be successful. Nevertheless, the donor advocated for it to continue. The review by Michailof (2007) concluded that for TA to work three coordinated actions were required by donors: (1) address the weaknesses in the TA projects; (2) integrate the TA with practice; and (3) undertake TA according to the HR needs assessment. This raises the question as to what has been achieved by the donors and the MoPH since the review in 2007 identified the weaknesses, failures and the necessary actions. The findings of this PhD research in Section 5.5 show that the same failures and weaknesses that were detailed by Michailof (2007) are still present. This would suggest a failure both by the MoPH and the donors. Indeed, when the donor assumed responsibility for TA on the basis that the MoPH capacity was too poor to manage it, then this begs the question as to why it failed if the donors' capacity was deemed to be higher. The donor was there to support the MoPH financially and technically and help them develop a strategy to build Afghan capacity as rapidly as possible. The MoPH and the Government of Afghanistan had put their trust in the hands of donors but after nearly two decades the MoPH capacity remains inadequate and this constitutes harm to the MoPH, to the whole health system and to the health of the entire population.

What is interesting about Michailof (2007)'s review is that it also provided evidence showing that TA does not work in dysfunctional environments and organisations without an effective structure, where the needs are greatest. The decision to apply the same model in Afghanistan when it was known to have failed in similar low-income African countries with a similar background seems negligent. Donors are typically well-placed to learn the lessons gained from one country to another and to avoid such failures. It seems more effort should have been made to have first assessed and

determined the best ways by which the capacity could have been built-up in the MoPH. The literature indicates that other countries such as Tajikistan (Mirzoev et al. 2015) and the Solomon Islands (Asante et al. 2012) have had similar experiences to Afghanistan with capacity building donor-driven rather than needs-based, uncoordinated and have been similarly unsuccessful. These all echo the study of Martineau et al. (2017) who found services that can be uncoordinated in conflict and crisis affected settings. But the similarities do not stop there, these countries, like Afghanistan, have also experienced armed conflict and their economies were heavily reliant on external donor support.

The World Bank has supported the Afghan ministries for capacity development since 2001 (World Bank 2012). Capacity development initiatives included different short-term programmes such as CBR, PRR and a Management Capacity Programme. Targeting the senior levels of the ministries, the aim was to improve performance by dealing with common functions including financial management, HRM, policy and regulatory design and administration. However, surprisingly, this technical support did not include on the job training or capacity building and what activities were included in it and what activities the expatriates actually undertook were not described. Unfortunately, by contacting the MoPH, the researcher was not able to obtain any records which explained the programme details. Another document described the capacity budget spent on some departments such as Reproductive Health, Policy and Planning and HMIS, while less attention was paid to other departments (Dalil et al. 2014). Again, the details to see what the activities for capacity development in these departments are not provided; neither do they link to World Bank capacity building or any other programmes. This begs the question as to whether the budget was spent in Reproductive Health included the midwifery trainings in the CMEPs in the country. It would be a good achievement if the CMEPs were part of the capacity building budget as the World Bank is one of the main financial supporters of CMEPs. Unfortunately, the World Bank report (2012) as the capacity provider of the MoPH includes many problems such as inadequate funding, logistical problems, participants' weak applications and the design of these programmes. However, no specific information was found about the MoPH except a graph illustrating that only one person was included from the MoPH in the Management Capacity programme (World Bank 2012) which does not seem to be enough. At the same time, due to political policy, when the president of Afghanistan

is changed then all the key positions are changed in the ministries and this definitely happens in the MoPH too as illustrated in Figure 5.1 that 10 directors were hired in one year, which indicates that the previous directors were terminated from their posts. If this is the case, then those who received capacity development were either no longer in the MoPH or were in other positions where what they had learned from capacity development was not relevant. However, an independent evaluation of technical assistance and capacity building by the World Bank to ten conflict-affected countries including Afghanistan (World Bank 2014a) suggested that the World Bank capacity building strategies should be well adapted to fragile and conflict-affected states (World Bank 2014a). This source added that the World Bank should monitor the risk and always be ready for the risk and promote sustainability through predictable, programmatic budget support and developing a more realistic long-term framework in order to help the World Bank to be more responsive to the special needs and priorities of these countries.

Part of the problem appears to be the failure of the system to use evidence derived from research into health systems and policy. According to Mirzoev et al. (2015), although capacity in health policy processes is known to be weak in many LICs, evidence from research in these fields is often ignored. At the same time research on capacity development in the LMICs is limited and this causes the lack of knowledge about the capacity building in these countries (Catford 2005; Adam et al. 2011). This echoes the findings of this study. This PhD study found little if no research evidence has been used to support leadership and management capacity development in the MoPH or in the Afghan health system as whole. Such evidence might help build capacity by including it in the MoPH agenda for action, as well as by the international community. During this study, the researcher searched for research papers published on management capacity and leadership in the MoPH or in other Afghan public institutions in general. When this PhD programme commenced in 2016, no paper was found on management capacity and leadership in Afghanistan. In January 2020 the researcher updated as follows:

- Searched the MoPH new and old websites (MoPH 2020), there was not a single research paper on the new website even under the publications title. The old website of the MoPH, included the Public Health research and Ghazanfar Medical Journal (GMJ) page, which is a peer reviewed journal publishing

research papers since 2017 and belongs to the MoPH. There were research papers but not any papers on this topic.

- Searched the WHO (2020b) website (Afghanistan page and regional website) as WHO claims that the management capacity is weak in the MoPH. No research paper was found on this topic.
- Searched the World Bank website (2020) and although low capacity is mentioned, there is no indication that any research has been carried-out on management capacity and leadership since 2001.
- Afghanistan Research and Evaluation Unit (AREU) (2020) is an independent Afghan research agency that publishes research papers in six themes including Governance and Political Economy in Afghanistan. However, their research has focused on different aspects of sub-national governance. Under this theme 127 research papers were placed. The research reviewed the titles of all 127 papers to assess publications on management capacity and leadership in the MoPH or similar topics. Some topics were found on the governance or government, but none related to management capacity and leadership. For instance, the study of Ayobi and Rahimi (2018) arguing that the constitutionally-mandated administrative institutions are not yet established in Afghanistan. This was discussing the system but was not relevant to management capacity.

Research evidence is one of the foundations for development and progress, but despite millions of dollars being spent since the re-establishment of the health system in Afghanistan in 2001 (MoPH 2015a), evidence-based practice has not been actively promoted. The Afghanistan Public Health Institute in the MoPH has been involved in over 100 research projects and trained health professionals in research methodology (The International Association of National Public Health Institute (IANPHI) 2020). There has also been a yearly health research results conference organised by the MoPH for the last 8 years. However, there is no research culture evident in the MoPH and what little research has been conducted is mostly carried-out either by donors or with the support of donors, which does not develop the skills and capacity required for an evidence-based health system. Perhaps if the use of research had been promoted since 2001, the situation in the MoPH could have been improved. The MoPH current national policy document (MoPH 2015a), for example, has only one

research citation, which indicates that the research that has been done is not being translated into practice. The promotion of research in the Afghan health system was discussed in a conference conducted in the London School of Hygiene and Tropical Medicine in the United Kingdom (UK) in 2018 by the current Afghan Minister of Health and his team (Feroz 2018). They claimed that research capacity is a problem at the country level as well as the community level, but they didn't indicate that there were plans to promote research. It is argued that many organisations want to help conflict-affected contexts but there is a limitation of evidence that can guide effective interventions (Woodward et al. 2016).

Perhaps more encouragingly, the low management capacity in LICs is well recognised by the WHO, which is why they have been keen to promote their management capacity framework (2020a). However, there was no evidence to date that this framework was being used or supported within the Afghanistan health system. The WHO (2014) stated five years ago that its local personnel capacity was weak in Afghanistan, which may suggest that local WHO staff were not sufficiently competent to help the MoPH. This may be the reason why, despite acknowledging weak capacity in the MoPH in 2010 and 2014 (WHO 2010a, 2014), the WHO's support is not found in its documents. However, WHO's plan from 2018 is to support the health sector with well-functioning institutions, national and local capacity, planning and HR development (WHO 2018a).

8.2.1. The MoPH taking control

In more recent years, the MoPH has sought to take-over the leadership for capacity building to ensure it was needs-based, strategic and in line with the priorities of the Government (MoPH 2015a, 2016a, 2016b). The fulfilment of these aims was to be effective from 2015 through to 2020. However, from the data collected in the last quarter of 2017 no significant changes were identified, with little progress in handing responsibility over to the MoPH. It is appropriate for the MoPH to take-over capacity building coordination and seek new ways which are sensitive to the local environment and which can be effective and sustainable. Its staff could assess and implement methods by which capacity building could be an integrated part of its strategic tasks and be led, implemented and monitored by the MoPH, in a sustainable and affordable way. However, this is dependent on adequate numbers of qualified

and competent staff who are equipped with up-to-date knowledge about capacity building techniques, with a good understanding of the wider Afghan context.

Change can only be brought about by people who are sufficiently competent and possess the necessary dynamic leadership skills to implement new systems and not repeat the failures of the donor-led system of the past. In Kyrgyzstan and Mongolia shifting the aid from donor driven to country-led played a significant role in the development of health planning and the promotion of capacity building (Ulikpan et al. 2014). This is an important lesson for Afghanistan to learn. It is therefore clear that the international community, including the WHO, need to find new ways to cooperate with the MoPH to grow management and leadership capacity. Strengthening the local institution's capacity will help them to coordinate, which in turn re-enforces their ownership and sustainability (Martineau et al. 2017). Without capacity, further improvement is unlikely to be possible (Andrews and Boyne 2010).

To summarise this section, capacity building in the MoPH is a complex issue and due to the shortage of documents and records, gaining insight into it is challenging. However, one thing is evident: capacity in the MoPH is low and the achievements do not match the expectations of the MoPH and donors. From all the data collected, the accessed documents of the MoPH as the recipient of the capacity building, from the World Bank as the provider and coordinator, and from independent evaluations in the MoPH, it is obvious that capacity building and technical assistance in Afghanistan has had many problems. The World Bank is now in a position where it should have gained considerable experience of providing capacity building in low-income conflict-affected countries for many years and should use all the lessons learned. Capacity building programmes need to be adapted to the needs and priorities in Afghanistan and other conflict-affected countries.

8.3. Leadership capacity and capacity building

As discussed in Section 2.5, this thesis is theoretically framed around the 'Leadership and Management Strengthening Framework' (WHO 2007a) and the 'Black Box Model of management capacity' (Moynihan and Ingraham 2004) in both leadership is a central component of management capacity. The WHO Framework includes leadership competence as necessary for the success of the organisations and suggests that the academic certification and qualifications of the workforce are an important

measure of the competence of managers (WHO 2009). This is exactly the same with proposition three, that 'managers who have managerial training can manage well'. This Section discusses whether the findings regarding the leadership capacity and capacity building support the proposition.

Unfortunately, this PhD study found that the selection and appointment of the directors within the MoPH was largely based-on political affiliation to the Government rather than on merit. The quality of universities was another aspect pointed-out by the interviewees that people in the MoPH had graduated from the universities that were not of good quality. This was because they had not brought any positive changes since their appointment. To compound the problem, the in-service training provided for managers was often seen as irrelevant, unnecessary and not based on their needs, which they explained did not benefit or enhance their competence.

The findings in this study indicate that the MoPH acknowledged themselves that less attention was paid to the capacity of the MoPH in governance and the functioning of the MoPH as a state institution (Section 5.5.1). However, their response in providing short-term training and workshops was uncoordinated and not needs-based (MoPH 2014a).

8.3.1. Possible factors for low capacity among directors

WHO, as the technical lead partner, indicated the obstacles in the Afghanistan health system:

> "…lack of national capacities for health planning and management, especially in the areas of governance, health care financing, human resource development, for monitoring, evaluation and analysis of the health situation" (WHO 2010a, p.10).

Similarly, the documents revealed that the central MoPH was not able to transfer skills and knowledge about governance and Public Health to the provincial employees (Section 5.5.1). However, the underlying factors have not been investigated either by the MoPH nor by the technical partners to find-out why capacity is low.

The findings from this study demonstrate the irrelevancy of qualifications as the underpinning factor. The HR policy and criteria have been set for the selection of each postition including the position of directors since 2005 (Civil Service Commission (CSC) 2005). The criteria determined by the Government for the position of directors are cited as below;

1. “A minimum bachelor's degree certificate.
2. At least three years' work experience.
3. The ability to provide advice on the policy plan of the relevant office.
4. The ability to lead and control the administration.
5. Have reputation and competence” (CSC 2005, p.30).

However, having a bachelor's degree alone, as a criterion for a director’s position seems insufficient, for a director who leads a directorate that has the guiding and supporting responsibility of a specific service across the entire country with a population of almost 30 million (CSO 2018). Subjects studied by directors ranged from medicine, economics, stomatology, prosthodontics, and computer science with little in terms of academic background in health policy or management. Few had studied Public Health or management-related subjects. This demonstrates the irrelevancy of the directors’ qualifications. When most of the directors have not studied Public Health and governance then what relevant knowledge can they transfer to others and how can they analyse the health situation? Stomatology or prosthodontics is of little help in Public Health governance. Therefore, the relevancy of qualifications needs to be added into proposition three.

The findings show that there were some directors who were medical specialists. However, they were unable to provide supportive working conditions for employees. As a result, employees in their directorates were not happy with the work environment. This means that being a clinical specialist does not include the necessary skill sets to manage the department successfully. If the heads of departments had received some management training in addition to their specialist training, they would be able to manage more effectively. Hence, the interviewees suggested that the directors were better-off attending relevant short-term courses (such as learning how to deal with employees) rather than study subjects that were not relevant to their jobs (Section 5.4.5). This suggestion was commonly spoken

about amongst the employees whose directors had a bachelor's degree with a medical subject but no management-related subject.

Previous research reveals that health managers who have a solely clinical background often lack the knowledge and skills of HRM or Public Health planning. Asante et al. (2012) found those with a clinical background often lacked interest in progress monitoring and data management. Similar studies found such directors were unable to undertake appropriate HR and financial management or create a supportive and enabling work environment, creating a substantial obstacle in managerial effectiveness (Kolehmainen-Aitken 2004; WHO 2009; Bradley et al. 2013). Unfortunately, it seems that this problem is not recognized in Afghanistan. Since the criteria by CSC (2005) not only for the MoPH but for all the organisations is likely to impact the whole public system.

Similar issues arise from the duration of experience in health management for the role of director, which is determined to be at least three years. This seems a rather inadequate level of experience given the decision-making and policy-making demands. A director, with a predominantly clinical background, is unlikely to be able to advise on a complex policy plan or have sufficient insight into the Public Health related issues, or health leadership or management skills. In other settings, literature shows such managers were not able to overcome the complex health situation (Andrews and Boyne 2010). Typically, in Afghanistan those who are trained and work in a clinical context are not expected to be aware of population data for the country or of wider Public Health issues, unless they have undergone specific Public Health training.

The ability to lead and competence are two other criteria for the selection of directors within the MoPH cited above. Presenting a bachelor's degree would be easy for almost all the employees but assessing leadership skills and competence are not easy. This may be the cause of low competent directors in the MoPH, implying that the interviewees thought that people who are introduced/recommended by politicians for the position of director do not merit it. However, no document was available to provide information about how the leadership ability and competence were assessed among the candidates for the directors' position.

Another common problem in Afghanistan is that the concept of lifelong learning is not common. Once people have graduated, they rarely attend conferences or receive updates related to their professional qualifications. This is very different from other countries where lifelong learning, or continuous professional development (CPD), is an accepted principle of good practice with professionals working hard to keep up to date in their profession. This is reinforced by a range of professional and governmental policies that require members of particular professions to engage in continuous professional development in order to maintain acceptable standards of practice.

In Afghanistan, over the last decade, having a master's degree has become more popular in the MoPH. Many employees try to gain their master's degrees. Unfortunately, few were able to fulfil the requirements from reputable universities, but many were willing to gain their master’s degree regardless of the quality or how much it benefited their knowledge and skills. This is unfortunately not recognised by the MoPH. After the re-establishment of the health system in 2002, the MoPH started from zero. It needs more qualified people to succeed. However, this adds to the complicated situation of the MoPH when the quality of employee qualifications and training are not considered important. The findings from this research suggest that because the key positions were filled by people who had a post-graduate level qualification yet, have not brought effective change to their directorates. It is evident that the MoPH needs more competent people, who can recognise and meet the requirements of the managerial role and be able to deal with complex situations. It is the Government’s and the MoPH's responsibility to assess whether the quality of the universities and their qualifications are acceptable and appropriate, i.e. are able to fulfil organisational needs. A good quality university is where participants gain new ideas and new health system models. The qualification programmes are also generated to meet the needs of the population (Groves et al. 2011). Unfortunately, the findings suggest that the MoPH is still working with the old system and is far away from modernisation (Section 5.4.1.2).

When managers enter the system in the MoPH, it is important that they receive training and support based on their needs. Training will help the managers who do not have Public Health or management qualifications. The literature shows that relevant in-service management training improved leaders empowerment and led to

the success of programmes (Nankumbi et al. 2011). However, the findings from this research suggest that there is no systematic or needs-based training in the MoPH. The quality of training programmes is poor and neither monitored nor supervised (MoPH 2014a).

Kolehmainen-Aitken (2004), carried-out her literature review from many LICs, she criticise governments for not taking responsibility for the accreditation of training programmes and certifying graduates' qualifications. An accreditation system did not seem to exist in the MoPH for relevant training/workshops, nor for the graduate programmes to assess whether they are appropriate and acceptable for the fulfilment of national needs.

This is similar to the findings in other LMICs. Despite different training opportunities, the MOH staff in Tajikistan did not get benefit because training programmes were neither well-coordinated nor needs-based (Mirzoev et al. 2015). Neither was it beneficial to the health-care system of the Salomon Islands (Asante et al. 2012). Caligiuri and Tarique (2009) count such short-term training programmes among 'low contact activities' and argue that they are not as effective as 'high contact activities'. They define 'high contact activities' as short-term international assignments, membership on a global team or meetings held in an international location. Although the research of Caligiuri and Tarique (2009) is aimed at global leadership, it is also relevant to domestic leadership. It may not be possible for the MoPH to provide leaders high contact activities, but the international community can help in this regard. A coordinated and needs-based training strategy is urgently required in the MoPH.

The literature shows that managers who had graduated from low-quality universities or did not have management-related education or training were associated with weak administration systems in LICs, were not able to cope with complex situations (Kolehmainen-Aitken 2004). Whereas relevant education and needs-based training were shown to improve skills, knowledge and competence of managers, which leads to improved performance (Nankumbi et al. 2011), especially, when it was of good quality, updated and aligned with the cultural context.

The findings also suggest that besides the directors' competence, their willingness and commitment played an important role in their performance. Their contribution to

their job was negatively affected by their commitment to their political and tribal aims. This was because their attention and unfair support were focused more on their political or tribal members. Such issues undermined their commitment to their responsibilities and to the national aims. The literature states that willingness and commitment had an important role to play in the leadership contribution (Jacucci et al. 2006; Ulikpan et al. 2014; Chanturidze et al. 2015; Mirzoev et al. 2015), especially " at the core of the success is the willingness to improve'' (Jacucci et al. 2006, p.235). The managers/leaders may possess competence but may not be willing to contribute due to various reasons (Mirzoev et al. 2015), whereas commitment is critical for the success of an organisation (Ferguson et al. 1999).

In this study political and socio-cultural commitment, such as kinship and favouritism, appeared to undermine the commitment towards the national health goals in the MoPH and the health system in Afghanistan without the directors recognising this. Leadership willingness and commitment were, therefore, fundamental for any improvement in the situation and determination to achieve goals (Jacucci et al. 2006). The low willingness and commitment of directors may be linked to their capacity. Smith et al. (2006) defined capacity as the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. This means that Smith et al. (2006) recognise commitment as an element of capacity. If this is accepted, then if the capacity was high in the MoPH then the directors' commitment would be high. This again links commitment to the qualifications of directors, as the WHO considers qualifications as a measurement for the managers' competence. Competence is synonymous to capacity. If so, then again it would emphasise that the Government and MoPH need to place a high level of importance on the qualifications of directors.

The competence elements that were introduced by Cumberland et al. (2016) were considered in this study. Here, competence includes characteristics, knowledge/skills and behaviour. It does not include commitment as one of its elements. If we do not count commitment, one of the competence elements in this study, then it will be counted as a rival explanation - a possible 'other influence'. This means that some directors may have competence, but their commitment is affected for other reasons. For instance, by their political commitment or tribal patronage, which undermines the national goals. According to Yin (2013)'s definitions for the rival types (Section

4.17), this explanation comes under the ‘super rival’ where a larger force accounts for the result. As the findings in this PhD study demonstrate a complicated situation exists in the MoPH, which includes political and socio-cultural influences as well as being donor driven and dependent.

In summary, investment in high quality human resource capacity is essential for sustaining the leadership and management of national Public Health programmes (Shaw 2002). The findings reveal that the MoPH leaders’ competence could be described as low and the underpinning factors for the apparent low-level competence are summarised below with some suggestions for the solution.

The directors’ selection criteria need to be based on needs

As discussed above, the bachelor's degree as a minimum criterion for the position of directors may not be enough. Especially in the current complicated situation of the Afghan health system that requires very competent people to manage it. The subject of candidate qualifications is another issue to be considered in selecting people who will have important responsibilities in the MoPH. Qualifications in management/leadership, Public Health or relevant subjects needs to be a critical criterion for the directors' position in the MoPH. If the government determines a degree of higher than a bachelor’s and specifies the relevant subjects in the selection criteria for the director’s position then this will be clear to all (WHO 2009). This will also prevent political interference and increase transparency and accountability in the MoPH. The politicians will not be able to introduce a person with only a clinical background or a person trained in/ or experienced in a totally different field like the economy. Attention also needs to be paid to other selection criteria of directors quoted in Section 8.3.1 as this is a critical position in organisations. These criteria need to be measurable and can be assessed appropriately to make sure appropriate people are selected.

Improvement of commitment

Directors’ commitment was influenced by their political and socio-cultural commitment. If commitment is an element of capacity, then in order to improve the directors’ commitment their capcity require to be built. Meanwhile the political and

socio-cultural influences need to be reduced or ideally eliminated in the MoPH. The MoPH also needs to revise the requirements for the position of director making sure the directors that are introduced to the system are highly committed and competent to run the directorates.

Accreditation system for the quality of graduates and in-service training

The MoPH needs to pay attention to the quality of graduate programmes (Section 5.4.2). It can be a catastrophe when people in the MoPH get degrees while the quality of the qualification they receive is not as high as expected. There is an urgent need for an accreditation system in the MoPH to assess the quality of institutions that run graduate programmes. This needs to be in place, otherwise many people will have the required certificates, however, they will be useless in terms of quality.

This is the same with in-service training. Although the MoPH and partners have developed a strategic plan and policy for training they do not seem to have been implemented. The MoPH needs to implement the policy and strategy on training and the quality of training. Training programmes require to be accredited. The supervision, monitoring and evaluation of training programmes as well need to be improved.

While this Section strongly supports proposition three that managers who get the management training can manage well. The findings also illustrate that the quality of the qualification or training they get is important as well as the relevancy of that training/qualification to the management roles.

8.4. Political and socio-cultural dynamics

This Section includes proposition four; 'political and socio-cultural aspects negatively affect leadership'. The findings of this study support this proposition as it was evident from this study that favouritism, nepotism, cronyism and political party support is widespread (Sections 5.3 and 5.4.3). The directors selected such issues as one of the most significant obstacles towards achieving their goals as they were seen to negatively affect the system and procedures and were perceived to cause discrimination, inconsistency and unfairness in the MoPH. The negative effects of

political and cultural issues are shown in the health ministries of a number of LMICs. Asante et al. (2012) found in the Solomon Islands that political power meant success and the hiring system was found to be affected by political interference. Kolehmainen-Aitken (2004), found that national civil services were not applied consistently where there was political pressure and influence in the hiring system. The interaction between culture, politics and kinship has already been found in previous studies in Afghanistan creating organisation dynamics that can have a detrimental impact on organisational morale and performance (Schmeidl 2016; Arnold et al. 2018).

Whilst socio-cultural issues and political interference are significant problems in the MoPH causing bias, unfairness and lack of transparency, unsurprisingly they are not mentioned or addressed in the MoPH policies and related documents. The current Government policy is that the ministries and key positions in the ministries are divided between the President and the Chief Executive. These key positions are filled by their favourite people who belong to these two political groups rather than by competent people whose knowledge and skills are considered (Section 5.4.3).

Nepotism and conflicts of interest were issues addressed in the MoPH '*anti-corruption statement'* (MoPH 2015c), which suggests the MoPH identified nepotism and conflict of interest as causes of corruption. However, interestingly the socio-cultural issues are not recognised in the '*National Policy'* (MoPH 2015a) or the '*National Strategy*' (MoPH 2016a), which are the two most important documents and are central to the management and direction of the MoPH. All other policies and strategies are expected to be aligned to these two documents and given implementation periods are from 2015 - 2016 to 2020, it would indicate the socio-cultural issues are not being sufficiently recognised or addressed.

If the MoPH is to achieve its organisational goals and improve the health of the country's population it must first tackle the existing problems. This study would suggest that political and socio-cultural issues are one of the main obstacles to progress, however political influence is not unique to Afghanistan. Literature suggests that such influences can affect the development of effectiveness (Ulikpan et al. 2014). In a study in Tajikistan by Mirzoev et al. (2015) found that 'powerful' people in authority in the MOH did not have their work appraised. Asante et al. (2012) also found that there were people whose power determined their success.

People were successful where they were supported by their patron. Similarly, Arnold et al. argued that the health system in Afghanistan is "*shaped by culture, history and politics*'' (2018, p.17). Arnold and colleagues while studying the culture in a maternity hospital in Afghanistan found the negative impact of culture and politics not only on the healthcare institution, but also on the people who worked there in addition to health standards. Employees were frustrated by the inconsistency and unfairness which existed due to connections (Arnold et al. 2018). This echoes the findings of this study with people being introduced into the key positions in the MoPH without consideration of their merit and ability.

Socio-cultural and political influence and their negative effects were typically found in the literature reflecting countries who had passed through war and internal conflict, which had ruined significant aspects of their lives (Asante et al. 2012; Mirzoev et al. 2015; Arnold et al. 2018) and exerted negative effects on their economy, education, health, infrastructure and socio-cultural aspects (Lopes Cardozo et al. 2004). War brought poverty and unemployment in Afghanistan (CSO 2018). Needs and obligations might cause people to do some unwanted things for the survival of themselves and their family and relatives. This might cause and promote kinship, nepotism and other kinds of socio-cultural obligations and slowly it can change behaviour (Eggerman and Panter-Brick 2010). In Afghanistan, decades of war might be the root causes of such socio-cultural issues. This might also be due to tribal friction, which has increased in the last decades (Barfield 2012; Lee 2018). This suggests a relationship between war and the influence of political and cultural issues. The literature reviewed in this study demonstrates that political and socio-cultural issues had a particularly negative effect in the countries that had experienced war. While in Tanzania, which had not experienced war, there was a positive effect of culture from leaders who created an encouraging environment where evidence-based practice was promoted and every employee was able to practise and promote their new knowledge and skills (Mkoka et al. 2015).

The long conflict has resulted in weakened government institutions and severe social and ethnic rifts (Islamic Republic of Afghanistan 2017). This in turn has caused political parties to work for their own benefits, while the Government has remained weak and powerless (CSO 2018).

Issues of gender

Gender discrimination is another cultural issue that was found to exist in the MoPH. The discrimination is based on the number of directors and the female staff salary. Three out of 24 directors were female, the reason was not known whether there are women with skills and qualifications, or they are not given the chance for promotion. However, this is an indication of the restriction for women in management roles. This is similar to a study carried out by WHO (2009) in three African countries: Ghana, Tanzania and Ethiopia. In Ghana 16.3% of managers and in Tanzania only 7.6% of managers were female but the data for Ethiopia was not provided. In Ghana, only four out of 28 directors and deputy directors were female in the national headquarters of the MOH, which becomes 14 %. This is similar to figures in the MoPH in Afghanistan. This figure, it was mentioned, to be due to family obligations or child rearing. However, it was not sought whether the work environment was enabling them to improve their career and to have the chance for promotion. The data in this study shows that females were paid less than their male counterparts and got less overtime pay for their extra work than males, which can cause disappointment and demotivation. This concurs the study of Martineau et al. (2017) in conflict affected settings where gender was not considered in the implementation of remuneration and incentive policies. Females account for almost half of Afghanistan's population (CSO 2018). If women are not given the chance of promotion it limits half of the population. The impact of not empowering woman to make valuable contributions to society and the economy would likely affect the progress of the country. The Government of Afghanistan is committed to advancing women in the government and business in the next 15 years (Islamic Republic of Afghanistan 2017), so, the MoPH needs to work on this issue to fulfil this promise.

To understand the impact of cultural issues on the MoPH, it is helpful to consider Schein's work on organisational culture. Schein (2010) describes very well the importance of leaders understanding organisational culture:

> "*Culture is an abstraction, yet the forces that are created in social and organizational situations deriving from culture are powerful. If we don't understand the operation of these forces, we become victim to them. Cultural forces are powerful because they operate outside of our awareness. We need to understand them not only because of their power but also because they help to explain many of our puzzling and frustrating experiences in social and organizational life.* (Schein 2010, p.77)

Sections 5.3 and 5.4.3 suggest that cultural issues have distracted the MoPH from its core purpose, which is the provision of healthcare for all Afghan citizens. Indeed, the MoPH is the 'victim' of culture, because the kinship, favouritism, cronyism and nepotism are practised daily and from examination of internal documents, attention is rarely if ever focussed on how much harm these issues can do. People in the MoPH are happy for the immediate benefits of nepotism and favouritism for example, but do not consider how broad the harm is and how long it will continue to harm the work environment, organisation and consequently undermine the whole health system. Schein (2010) understands leadership and culture as two sides of the same coin in which leaders can influence the process of culture creation. The management of culture in an organisation is the essence of leadership and if a part of the culture is dysfunctional then it may be a reflection of the quality of leadership. As Schein points out culture can be deliberately changed;

> "*to surmount their own culture and speed up the normal evolution processes with forced managed culture change programs*" (Schein 2010, p.33).

However, the findings from this research indicate that the leadership in the MoPH is not able to manage the culture. Although socio-cultural issues were part of daily life and both employees and directors knew they were significant obstacles to organisational achievement, no work was being considered to eradicate these practices. Meanwhile, evidence suggests that directors were influenced by the socio-cultural issues for instance, the directors had to give the employees good scores in their appraisals because of the social relations not based-on the evidence. Schein (2010) also points out that cultural evolution and change by leaders will allow the group to survive in a changing environment. If, however, leaders are ignorant of their culture, then they will all be managed by culture. This is exactly the current situation in the MoPH. The leadership are unaware of their own culture and that is why the culture is managing them. The understanding of culture is necessary to all but is essential to leaders (Schein 2010). The findings show that directors were aware of the negative effects of socio-cultural issues and this poses a question of why the leaders in the MoPH were not aiming to manage the culture that is negatively influencing the system they work in. Alternatively, they might not be able to manage

it, and this might be because of the low levels of competence or some of them may not want to change because they will lose out. It may also be possible that they are not aware that this is their responsibility to manage the culture in their organisation. If this is true, then again it shows their lack of awareness of their job and responsibilities. If they were highly competent, then they would be able to recognise this gap and work on it. From the findings, it seems that political and socio-cultural interference is like a serious, transmissible and malignant disease that no one in the MoPH remains unaffected by.

This was also evident in this research that political interference was not a new problem. In fact, it has worsened under the current government (Section 5.4.3). Interestingly, the political and socio-cultural influence is much less in the MoPH than in the other ministries (Section 5.4.3). These comments were mostly provided by senior employees who have important responsibilities in the MoPH and were from a different tribe rather than the tribe who has the responsibility of the MoPH. This demonstrates that the current Minister is trying to work on this obstacle, which is a positive point, however, the result does not seem obvious. This may need the commitment of others.

The findings demonstrate that similar to other ministries, the MoPH was under the pressure of powerful people and politicians to hire their favourite people. Politicians were blamed for interfering in staff hiring for even lower positions, no matter if they were suitable in those positions or not. The following bullet points explain the underpinning factors responsible for making the MoPH suitable for the penetration of interference by powerful people;

1. ***Ineffective management*:** The findings suggest that the key positions in the MoPH were filled based on the political connections, not merit-based. This might be an explanation for why those who have not come based-on merit cannot work effectively. There can also be other reasons for ineffectiveness by such people. They may benefit from their position by fulfilling their political commitments to their patron who placed them there by helping them to place more people aligned to their political party. Such directors also fear being dismissed because it was perceived that their subordinates' capacities were higher than them. In this case,

they would try to hire from their own parties, friends or tribes regardless of suitability because other people will realise their low capacity and will raise their voice on their ineffectiveness. Section 5.4.1.2 shows that employees at the same position had different capacity levels and the directors had an important role in their hiring. This is a problem and a distinct disadvantage to committed employees. Such directors may also be the reason for promoting the interference of parliamentarians and other powerful people because to retain their positions they must fulfil unfair requests of powerful people in the MoPH so that when they need help the powerful people will in turn help them.

2. ***Lack of strict system*:** The findings show that there was a significant problem in the system, procedures and structures of the MoPH. Both, the systems were weak, and the implementation and follow up of procedures were weak. The hiring system was one of the systems found having a critical problem because the process was not transparent. The lack of strict system regulations may allow misuse to occur. It was found (Section 5.4.3) that "*special job description is developed for a particular person. There are special candidates to be hired"*(interviewee 9). This may be happening in other organisations or countries too but the difference here is the decisions may be taken for the good of the organisation rather than for a personal benefit. However, the aim of the study participant here is the political and socio-cultural influence. This researcher remembers when she went to the MoPH for the first time to submit the research documents. She was referred to a directorate working for research. Then she was referred to another directorate responsible for research. She was never referred back to the directorate where she had visited first. That directorate was not included in the organogram approved by the Minister (Appendix 1). This created a question to the researcher that why the MoPH had two directorates responsible for the research. This was also found from questionnaires and interviews that parallel directorates with the same objectives had created problems in the MoPH. This shows a problem in the structure and systems. It means that if the official systems and procedures are not implemented and followed by the employees themselves even if it is approved by the Minister then how are external people expected to respect and follow the MoPH systems. These might be the issues that allow external people to easily interfere with the MoPH work. This is even easier

for them when the MoPH has weak management with low capacity. If the directors and other key authorities were strong enough then they would be able to work on the system, making sure all the system and procedures are working effectively and prevent misuse by internal and external people.

3. ***Leaders' commitment:*** It was found that high-level authorities in the MoPH including the directors were responsible for promoting the political and socio-cultural issues (Section 5.4.1.2). This may be an indication of a weak commitment to their organisational aims. As the findings in this research show, people who were introduced by political parties, placed their tribal priorities above those in the public interest (Section 5.4.1.2). If so, then it represents a big gap and opens the door to external interference. This can also be the reason that the law was not implemented and was not similar to all in the MoPH. That is why the employees suggested a good commitment to the MoPH aims.

Analysing the findings, one point attracted attention that the political parties in Afghanistan harm the country and limit the benefits for the public. Political parties buy influence when they are able to secure political party members good jobs, good positions and more power just because it is them. This, in turn, would obligate them to work for their party's agenda no matter how fair or unfair. Unfortunately, there are countries such as South Africa that have similar situations to Afghanistan where people are linked to a political party in power, are supported and get opportunities while people who are not linked to those powerful parties do not get support (Gumede 2019). The situation in Afghanistan seems very complicated. Here, the education or the quality of it, in general, may matter. Capacity may be weak in general. Politicians would not be able to critically think and analyse the situation to make a decision, which can benefit the entire country; including their own party. In the Afghanistan context, the understanding of the political parties is that they have always thought of their own personal benefits rather than the benefits of the entire country. Findings in this research also indicate that employees were affected by the environment, family and ethnic culture. These were mentioned as reasons by which the directors were influenced, and this caused them trying to hire their favourite people. Low quality of education, in general, may affect all the population. If the

education quality was good, then there was a difference in their decision-making skill sets compared to uneducated people.

As seen socio-cultural and political negative influence was found by the research studies in health systems in LMICs but rarely was a solution suggested on demolishing these issues. Surprisingly, the researcher did not encounter any documents showing the negative effects of socio-cultural issues or political influence, which is recognised by the WHO in LICs; including Afghanistan. This issue was good to be considered in the 'Leadership and Management Strengthening Framework' of WHO (2007) because this framework is developed specifically for the strengthening of leadership in the health system of LICs. As leadership and culture are the two sides of a coin in an organisation (Schein 2010), it is argued that leadership will not be strengthened until there are no socio-cultural and politically negative influences. This means an important issue has been missed by the WHO and it is a gap in the literature. These need to be reconsidered by the international community, specifically the WHO in the health policy, strategy and frameworks.

Given that the cultural and political issues are perhaps the most pressing problems affecting the MoPH, it is surprising this is not more clearly recognised and articulated as a problem with some attempts at a solution. There may well be a process of self-preservation at play with those in charge being reluctant to make changes that might lead to a diminution of their power and influence. It might therefore be very difficult for the political issues to be tackled, which may be interpreted as working against the Unitary Government's policy. However, those in senior positions could work together to prevent some of the negative consequences of the policy within the individual directorates. Due to this national unity policy, whilst there is always the risk that the most senior leadership positions are appointed by political officials, the MoPH can ensure the remaining key positions are filled by people with the appropriate skills, knowledge and aptitude.

Political and socio-cultural issues were not yet recognised as problems in the MoPH with only kinship and conflict of interest mentioned in a sentence in one document. This will, therefore, make the solution difficult. These issues need to be first identified as problems and then work needs to be done to eliminate them. It has become common behaviour not only in the MoPH but in the whole country. A study of the culture of a hospital in Afghanistan found that "The hospital culture closely

mirrored the culture and core values of Afghan society" (Arnold et al. 2015, p. 1). Behaviour change is one of the most difficult things to achieve. The MoPH needs to seek different ways to solve this massive problem including setting a penalty system. One of the solutions can be the existence of a strict system, procedures and structure. Particularly, work is needed to make the hiring system and procedures transparent. Strict system and procedures will prevent misuse by the internal and external people.

One of the most critical solutions for the political and socio-cultural issues will be the strong commitment of the MoPH authorities including directors. Their political/tribal commitments should not affect their country negatively. They need to give the first priority to their country's benefit rather than to the benefit of a group. The directors can use their power and authority in a positive way. They can use them in their directorates to bring positive changes. They can change their culture, which has a negative impact on their environment to a positive one that can have a positive and productive impact on the entire county.

It could be argued that investment in training, designed specifically to explore and address socio-cultural issues, is needed to help managers gain insight into their own behaviour. To support such an approach, Cumberland et al. (2016) introduced a leadership competence development framework that develops self-awareness, where participants are given the opportunity to identify and reflect on their own values, attitudes and behaviour. This may help to overcome what (Earley and Ang 2003) describe as a 'cultural roadblock'. Such training could also be supported by appropriate mentoring and coaching to raise participants' self-awareness of their cultural biases.

8.5. Lack of transparency, accountability and corruption

Transparency in this thesis means openness, while accountability is an assurance that a directorate is evaluated on the performance for which they are responsible. Where organisations are subject to issues concerning lack of transparency, accountability and corruption, there is likely to be a profound impact on the service provided. This theme includes the fifth proposition; 'the lack of transparency and accountability and corruption of the management system affect staff and organisational performance.' The findings of this study support this proposition as the evidence suggests that there

was a lack of transparency in all procedures and systems. Opportunities were provided to staff inconsistently and unfairly, such as their career development and promotion. Employees perceived having to work without having clear plans, objectives or job descriptions. There were directorates that did not record achievement and progress properly, which shows a lack of accountability. It was also deemed that significant corruption existed in the MoPH.

Encouragingly, the lack of transparency and accountability and the presence of corruption is well recognised by the MoPH and the Government (Islamic Republic of Afghanistan 2017; MoPH 2017b) and consequently, the MoPH is committed to eradicate corruption from the MoPH and the health system of Afghanistan. That is why the MoPH from 2015 started to work on the eradication of corruption by issuing an anti-corruption statement (MoPH 2015c). 'A good governance statement' and 'the MoPH briefing note on accountability' were two other steps taken in the same year (MoPH 2015d, 2015f), which emphasised the need for greater transparency and accountability. Accountability was not only identified as a high priority in the briefing note but was also seen as part of a new vision and mission for the MoPH. Additionally, corruption has been recognized at the level of national policy and strategy (MoPH 2015a, 2016a) with the mission of "zero tolerance to corruption" (MoPH 2015a, p.11) and the determination to enhance the transparency and accountability in all procedures and regulations. The MoPH has identified and prioritised six key corruption risk areas to work on:

> “1) health regulatory management, 2) delivery of health services, 3) product distribution and storage, 4) marketing of health products, 5) procurement, and 6) financial and workforce management” (MoPH 2017b, p. 14).

However, what was absent from the reviewed documents was clear identification of the factors that lead to a lack of transparency and accountability and causes of corruption and what has been or is being done to address these problems. The findings suggest little or no improvement in transparency and accountability or the eradication of corruption has been made, despite more than two years having passed since these statements and policies were implemented. Issuing of statements and policies may be one aspect, but its implementation that makes the difference in

practice is another aspect. To reinforce this point, Jhpiego (2013) found that Afghanistan is rich in policies, but poor in the implementation of those policies. A review of 'vulnerability to corruption in the Afghan MoPH' was carried out by an independent committee in 2016 (Monitoring Evaluation Committee (MEC) 2016). The review found that participants perceived "difficulties with corruption, often in great detail". They acknowledged a wide range of problems, missteps, and missed opportunities in managing corruption in the health sector, as well as frustration and disappointment" (MEC 2016, p.36).

Research has shown that organisational effectiveness relies on accountability and transparency, but where they do not exist, then progress can be slow (Ulikpan et al. 2014). The problem is that a lack of transparency and accountability affects the morale, motivation and performance of employees (Bradley et al. 2013). In a health project in Tanzania (Mkoka et al. 2015), employees reported a lack of transparency in processing payments of their allowance entitlements, which caused them to have feelings of unfairness, perceiving that payments were made to senior employees but not juniors and often without explanation. The study by Martineau et al. (2017) study in Sierra Leone, Zimbabwe, northern Uganda and Cambodia found that there was a fragmentation of the system where the incentive and remunerations were poorly funded and implemented. These countries similar to Afghanistan were identified as post-conflict countries.

The gaining of funding for health services (WHO 2008) has been subject to corruption in Afghanistan. Whilst Dalil et al. (2014) claimed that the MoPH was fully accountable for the funding it gets from the external donors, the evidence from this PhD study seems to suggest a lack of accountability and corruption in the awarding of Public Health and private sector contracts (Section 5.4.3). These were perceived to be largely won by policymakers, parliamentarians, powerful people and decision-makers. An independent source also found that the contracting processes for BPHS and EPHS has been perceived "...as suspect, compromised, corrupted, and inconsistent" (MEC 2016, p.15), which has caused frustration, suspicion, and weakened trust in the MoPH. Weak governance and corruption were also indicated by WHO (2010b) as a critical challenge in the health system of Afghanistan.

Less accountability and transparency in the governance and financial management is shown in LICs to prevent funding commitments because donors have concerns about

corruption in those countries, thus hindering development as a result (Ulikpan et al. 2014). That is why the WHO (2008) emphasises the improvement of accountability in those countries; highlighting that they need to be able to demonstrate how aid is allocated and what impact it has. However strangely, the WHO has not raised any specific concerns about transparency and accountability of the MoPH in the country cooperation strategy for Afghanistan (2018).

From the documentary review in Afghanistan there seems to be a trend in that many problems remain unidentified or where identified, the factors that cause those problems are not fully articulated. Although the lack of transparency, accountability and corruption are identified by the MoPH, by the Government and by the WHO. No documents from these sources were helpful in understanding the root causes of these problems in the MoPH. Consequently, the underpinning factors are never fully addressed, which leads to inadequate actions that maintain the current situation. It was found that the implementers in Public Health are the decision makers and the powerful people (Section 5.4.3).

> *"People who are powerful own the contracts; people who are powerful are the implementers, people who are powerful are the decision makers, so when weaknesses and gaps are reported, they are considered superficially"* (Interviewee 3).

From this quote, it seems that the contracts are won by the decision makers and the decision makers are the authorities in the MoPH. If this perception is right, then there is a conflict of interest, which may suggest corruption by the MoPH policy/decision makers. This might be one of the main underpinning factors for the lack of transparency and accountability. If there was transparency this would be a disadvantage for people who currently win the contracts. Evidence suggests that the lack of transparency and accountability in the directorates relates mainly to the political and socio-cultural issues. It was found that the directors introduced to the MoPH by the politicians or powerful people were more likely to attempt to hire people from their political party or tribes. This consequently promoted the lack of transparency in that directorate as the directors preferred to provide opportunities unfairly to their favourite people and treat the employees differently.

The lack of transparency and accountability might possibly be due to the lack of awareness about the policies and procedures and low capacity. Alternatively, there could be a sense of awareness, but the policies and procedures are neglected and not followed. This study found that neither employees nor their line managers knew how the appraisal system and procedures were carried out (Section 5.4.1.1). Annual leave rules represent another policy that the employees were unaware of. This might be the same in other procedures and systems. This suggests that there is no orientation system to new procedures or systems. There were complaints about the complicated and time-consuming procedures, which were causing delays in work (Sections 5.3 and 5.4.2). This may be one of the reasons for the employees choosing not to follow procedures and systems, which in turn affects transparency and accountability. An auditing system in an organisation is critical for ensuring transparency in that organisation. Unfortunately, the auditing system in the MoPH was dated and inadequate. Instead the system meant to help improve transparency and accountability, created more problems in the ministries, than it solved, causing unnecessary stress.

In a study by Zurcher (2012), it was found that international aid can fuel corruption in fragile countries' like Afghanistan. Zurcher argues that international aid providers mostly lack basic information about the host country and there is a lack of capacity amongst both donors and recipients to track the flow of resources and monitor the implementation process. As a result, it causes corruption. Schmeidl (2016) goes even further to explain that international actors are complicit in encouraging negative behaviour in Afghanistan, which undermines the building process and seriously damages confidence in Afghans' credibility and reliability. Afghanistan has got the score of 16 out of 100 internationally where '0' is 'highly corrupt' and '100' is 'very clear' (Transparency International 2020). Schmeidl (2016) argues that international actors support the political elites who are unwilling to change and wish to remain in power. Schmeidl's study shows a very complicated and worrying situation in Afghanistan. However, it was not the purpose of this study to examine the effectiveness of international aid per se, nevertheless, further research would be helpful to understand whether international actors have any role in promoting corruption in the MoPH. Few years ago, "Nigeria used to be synonymous with corruption" (United Nations Office on Drugs and Crime (UNODC) 2020), where

billions of dollars were embezzled by leaders, which could have gone towards children's vaccination programmes, building roads, schools and hospitals. Currently, a politician by the name of Nuhu Ribadu is fighting with corruption leading the Economic and Financial Crimes Commission, which is a bold step in removing the corrupt staff from organisations. This was proved to be showing significant results, which can be an example for the rest of the world (UNODC 2020). Klitgaard (2010) also argues that corrupt actors should be named and punished. Another strategy that Klitgaard (2010) suggests for the eradication of corruption is academic leadership education and training for senior managers. This is because the managers will be able to influence and support new visions in the country for the elimination of corruption.

To summarise this theme, the findings of this study fully support the relevant proposition as the lack of transparency and accountability and corruption affected the motivation and performance of employees in the MoPH and increased the feelings of unfairness, inconsistency and frustration. At the same time, it may affect the donors' commitment to funding the health system of Afghanistan. Although the MoPH has been committed to improving transparency and accountability and eradicating corruption, the fulfilment of this commitment was only seen in the documents of the MoPH but not in practice. Considering the findings and the above discussion, it is suggested that the Government needs to work on the NGOs' contracts and establish transparent procedures to ensure that the contracts are not granted to the policy and decision makers and the powerful people in the MoPH. Until conflict of interest is eliminated the transparency and accountability issues will remain.

Policy, systems and procedures' awareness would be another solution for appropriate transparency and accountability. Every new policy or procedure needs to be explained to employees. The relevant department is required to provide a presentation to employees to describe for instance; what is the aim of the new procedure, what are its advantages to the employees and the requirement from the employees. This needs to be strictly followed up, supervised, monitored and feedback provided to ensure proper implementation. Directorates who were perceived to be with low capacity to support the system and procedures may need more support. They can have question and answer sessions to sure they can implement the new policy, systems and procedures appropriately. The existence of good systems, procedures, strict rules and punishment for breaking them, regulations

and follow up will help to minimise the lack of transparency and increase accountability.

Directorates are needed to work together to simplify the systems and procedures so that to make the employees' work easier and increase the effectiveness of their work. The directors are required to know that it is their responsibility to do this. The auditing system needs to be undated to ensure better transparency and accountability. Transparency has been critical in making major progress (WHO 2008). Currently, the health system of Afghanistan relies for 75% on external financial aid (MoPH 2012), so, this is vital for the MoPH to promote transparency and control corruption because accountability and transparency is important for the external donors. Corruption was one of the main reasons for the donors' reluctance in providing funding to Uzbekistan and Turkmenistan (Ulikpan et al. 2014). The MoPH and the Government need to work on the improvement of transparency and accountability in the MoPH and the health system in Afghanistan and restore the trust of the public as well as the international community. This will be possible if the root causes are identified and the relevant policies are implemented.

8.6. Insufficient support

8.6.1. Low management support

Effective organisational performance and productivity are dependent on having enabled, transparent and fair systems that ensure human, financial, capital resources and IT are appropriately targeted and deployed. These according to the Black Box Model (Moynihan and Ingraham 2004) are the components of effective organisational management capacity and are the resources needed for the achievement of organisational goals. In this theme, all common support systems, including financial, human, space, structure, systems, procedures, authority and the MoPH leadership support are examined. In particular, the adequacy of resources, given that resource shortfalls were often cited by participants as reasons for organisational failure. This Section will also discuss whether the findings of this study support proposition two 'The management support system affects the work of managers'.

All directors were not getting support consistently. It was found that the MoPH leadership provided support differently to different directorates. This had affected their management roles in the relevant directorates because they were not able to provide the support that the employees needed for better work productivity. Although some directors were happy with the support they were getting, others were not happy. The literature indicates that inconsistency affects performance and can be a constraint towards reaching goals (Mkoka et al. 2015). Proposition two demonstrates the relationship between the management support and the performance of managers. However, manager competence was not considered in gaining the required support or how to use that support. Whereas, the findings in this study support the proposition that the management support system affects the work of managers. This argument suggests that obtaining the MoPH leadership support also depends on the directors' hard work, commitment and competence. As an interviewee claimed that if an incompetent director was given six advisors instead of one, they still won't be able to achieve their goals because they were with low competence and were not able to use the provided support appropriately. It means that the directors’ competence has a critical role in gaining the required management support and using the support efficiently. That is why the manager competence role was added to this proposition in gaining the support and the use of the support in Chapter 6. Meetings with the MoPH leadership such as the Minister or Deputy Ministers were needed by directors for the improvement of coordination. This indicates that the MoPH leadership does not conduct meetings with the directors as per their requirements. The literature investigation in this research suggests that the organisational leadership meetings with managers provides them with more confidence, creativity, empowerment and consequently improves productivity (Nankumbi et al. 2011; Mayfield and Mayfield 2017).

It was evident that participants’ work was affected by over-complicated procedures, systems and structures (Section 5.4.2). There were directorates working with overlapping objectives, which created problems, whilst others were either overloaded by work or did not have sufficient work to do. Two key problems, which were the source of considerable delays in the directorates' work, were bureaucracy and the auditing systems. It seems that the MoPH is well aware of these challenges, as they make reference to them in the national policy (MoPH 2015a) and acknowledge that

bureaucracy hampers the ability of the Ministry to perform efficiently. Whilst efforts have been made to decrease bureaucracy, it was not specifically included in the national strategy (MoPH 2016a). Excessive bureaucracy is found to affect collaboration of LICs with international partners and results in them gaining fewer external funds (Ulikpan et al. 2014). Bureaucracy and auditing systems were also found by an independent source that reducing efficiency and causing delays in the MoPH, Afghanistan (MEC 2016).

One of the important supports that an organisation may require to provide to the employees would be a system to ensure their job security/sustainability. This will assure the employees of their job security helping them work without being stressed about their jobs. This in turn motivates them and affects their performance positively. People who were working as a consultant (in developmental projects) were worried about the ending of the projects. These kinds of projects in LICs were found to increase the concerns about what would happen if the project ended (Nankumbi et al. 2011). However, this problem is not unique to Afghanistan and other LICs, for example, van Teijlingen and Huby (1998) found similar problems in UK charities. There was no system in the MoPH for employees, including the directors, to ensure the sustainability of their jobs. Staff in the MoPH were worried about the insecurity of their jobs, whereas job security is valued by employees and can affect staff morale and performance (Kolehmainen-Aitken 2004). There was a similar case found in this literature review in the MOH of Tajikistan where these similar issues affected their performance and productivity (Mirzoev et al. 2015).

Besides this, there was generally a fear of being dismissed among both the directors and the staff (Section 5.4.1.1); again, whatever the reason is, this highlights the instability and inappropriateness of the current management system. If a robust system existed, then the employees would not experience unnecessary fear. Strategic planning includes the monitoring of external and internal threats (Kolehmainen-Aitken 2004). So, this is a threat that distracts the employees including the directors from their organisational goals and being distressed about their position and jobs. However, it does not seem the MoPH has any such system to protect the employees and the health system from external and internal threats. While it is the government's responsibility to provide a mechanism for the job protection of employees and the system. It seems that procedures, systems and structure challenges are known, as it

is addressed in strategy (MoPH 2016a) indicating the MoPH will work on the improvement of structure and systems. However, the findings do not suggest any improvements are evident.

Another important support that an organisation requires to provide to the employees would be a system to ensure employee equity. People who were working as a consultant were paid several times higher salaries than the ordinary staff, which had created differentiation and dissatisfaction among staff. This may be an indication of inequity in the MoPH. These kinds of projects in LICs were found creating job dissatisfaction. It is the responsibility of the government to consider equity. Leadership needs to provide appropriate mechanisms to monitor inequity in the quality and quantity of staffing and all other aspects (Kolehmainen-Aitken 2004).

Authority is an important support that is needed for the fulfilment of the directors' jobs. This study shows different findings about the directors' authority. Although 91.7% of directors responded that they were given the authority that they require in doing their jobs, some directors were not happy with their limited authority in their directorates. The hiring and firing of subordinates were not in the directors' mandate (Section 5.3 and 5.4.1.2). However, the research also found that the directors hired political party members and favourite people in their directorates. This shows an unclear system where some directors can misuse their power and positions, and others are not given the required authority to manage their subordinates. Research shows that even the performance of highly skilled managers was affected if they were not provided with a conducive work environment (WHO 2009) and the WHO introduced authority for decision-making as one of those factors that influences managerial work. Directors' limited authority affected their ability to support employees and organisational performance. The literature reviewed in this research indicates that authority played an important role in the managerial success of health organisations (Kolehmainen-Aitken 2004; WHO 2009; Latifov and Sahay 2013). Managerial support was limited in the employee performance and productivity where the managers had limited financial and HR management authority (Kolehmainen-Aitken 2004). In fact, authority was a good motivation and incentive for managers in enabling their success (Latifov and Sahay 2013).

Shortage of resources

Shortage of resources, specifically financial and human was the chief obstacle that the managers were facing in reaching directorate goals. There were routine shortages of equipment; supplies, infrastructure, electricity and IT (Section 5.3). There were complaints about the shortage of physical space too. The shortage of resources has been shown in the literature to be a substantial challenge in LICs (Mshelia et al. 2013; Turner and Short 2013; Bradley et al. 2013). The lack/shortage of electricity and physical space were also compounding factors in achieving organisational goals in poor resource countries (Nankumbi et al. 2011; Latifov and Sahay 2013; Mkoka et al. 2015).

The MoPH is mainly financed by external funds (Feroz 2018) and there is a shortfall in the national budget. The shortage of resources is also indicated in the MoPH strategy (2016a) affecting the implementation of programmes across the country. This reveals that the MoPH is struggling with the shortage of funds and remains dependent on external support. Unsurprisingly, the evidence shows that the availability of resources has a vital role in organisational success. As pointed out:

> “Effective provision of resources is key to the empowerment of staff and essential for work effectiveness” (Nankumbi et al. 2011, p.7).

The shortage of resources affects the empowerment of employees and employee performance and productivity (Mshelia et al. 2013; Bradley et al. 2013). It further hinders the HR contribution to achievement of organisational goals (Wyss 2004; Bradley et al. 2013).

Both, directors, as well as employees, expressed that shortage of resources was one of the main challenges. Shortage of resources can also contribute to lack of transparency as the resource cannot be distributed consistently to all employees, which gives the impression of lack of transparency and unfairness. Literature found fragmentation of remuneration and incentive packages in poorly resourced settings and conflict affected states where employees perceived unfairness and lack of transparency in their entitled allowances (Mkoka et al. 2015; Martineau et al. 2017). This in turn impacted the employees' morale and motivation. The findings also showed that employees were not provided with facilities such as heating system to

comfortably perform in the winter. Employees were not getting their overtime pay and it was not clearly explained to them why this was. This consequently affected their motivation.

This was the same with directors, they were feeling they are not supported consistently by the MoPH leadership (Sections 5.3 and 5.4.1). Some linked the leadership support to the tribal relationship, some others linked it to the lingual or political relationship claiming that the leadership support is provided to those who were from their tribe or political party. However, the shortage of resources may be one of the possible reasons for the inconsistent support. It may cause the MoPH leadership to support the one who asks for it. A lack of resources may also prevent the MoPH from providing internet to the directorates that are located outside the MoPH headquarters, which has consequently affected their performance and communication capabilities.

One of the managers' responsibilities is to ensure that employees have the necessary resources and tools for a productive work environment (Nankumbi et al. 2011). However, if there is a shortage of resources in general, then what can a manager do? These are issues that are out of the managers' control in the MoPH, but ones that affect their ability to achieve and implement organisational objectives and policies; including the interests and concerns of their employees. This may even be out of the MoPH control because the finance of the MoPH mostly relies on external funding. The unavailability of resources can affect the performance of even highly qualified managers because they cannot provide a conducive working environment in which employees can perform (Mkoka et al. 2015). Performance and productivity are influenced by staff motivation, which is a considerable challenge for managers in low resource settings (Kolehmainen-Aitken 2004; Bradley et al. 2013).

War and conflict converted Afghanistan into one of the poorest countries in the world (Islamic Republic of Afghanistan 2017). In 2001 and 2002, after the Taliban Government was removed, the international community announced their interest and investment in all sectors in Afghanistan including the MoPH. However, the donors' interest and investment have decreased in the last few years (Belay 2010). This has resulted in the creation of national resource problems. It is not clear why the donors' interest decreased but this may be due to the lack of transparency. This was evident in the literature that in LICs, (Section 3.2.5) donors were reluctant to provide funding

and the reasons were the lack of transparency and unclear financial procedures. The lack of transparency may also be due to a lack of capacity in the management of finance within the MoPH. As the findings of this research show, many of the directors were not trained in budgeting and accounting. The literature also suggests that lack of financial knowledge and skills prevented managers from managing their financial targets, which in turn affected all their activities due to delays in funding (Asante et al. 2012).

The MoPH is also aware of this. Consequently, one of the ways in which the strategy will be revised, will be to strengthen the capacity for effective planning, effectively linking it with the budget and with the available resources (MoPH 2016a). The low capacity may also affect the MoPH's ability to raise funds or advocate for funding with the government and the international community. The Literature (Ulikpan et al. 2014) shows that in LICs where there is bureaucracy in the system, they were not able to attract the attention of donors. Bureaucracy was one of the problems identified in the MoPH. All the health services in the public sector were free of charge therefore, the MoPH did not have any income that can help provide enough resources to its employees. Although it has started earning from the hospitals in the last year, the earned revenue is spent by the hospitals themselves.

The shortage of resources in the MoPH affects the management capacity and leadership as an external factor. It means that the current situation depends not only on MoPH internal factors but also on external factors. Being dependent on donor funding, limits the power of the MoPH to ensure the necessary resources. If the rival types of Yin are applied to this study, the 'super rival' would be applicable, which is: "*a force larger than but including the intervention accounts for the results*" (Yin 2013, p.141). This means that the internal factors are not the only reasons for the low performance and productivity in the MoPH, but rather there are a wide range of challenges and obstacles such as shortage of funds and resources that affect the organisational performance as the external factors that are included in the larger force of this super rival.

To summarise this theme, based on the discussion above on the management support to the directorates and managers, it is suggested that the MoPH leadership needs to identify every single responsibility it has for the support of directors. The work of even qualified directors and their directorates is affected if they are not provided with

the support they need (WHO 2009). The MoPH in its ‘Good governance statement’ refers to a culture supportive of staff at all levels (MoPH 2015e). This statement, correctly implemented, would strengthen the Ministry’s capacity for effective and efficient management (MoPH 2015b). So, these policies need to be fulfilled practically. The findings of this study support proposition two that there is a strong relationship between the managers performance and the management support system. However, the managers competence also has an important role in gaining the support and the use of it.

Once the standard system, procedures and structure are in place, then the foundation is laid, and improvements are possible. However, if the foundation is not in place and the procedures are not transparent, then even large investments may not be helpful. Currently the basic system and procedures are still not standardised and not working as required (Section 5.4.1.2). These are the aspects that can directly be referred to directors and other key positions such as the Minister, Deputy Ministers and General Directors. They are appointed into those key positions to make things happen towards the goals of the organisation. The directors need to improve the system, structure and procedures. However, they need the support of the MoPH leadership and enough authority to fulfil those responsibilities. The given authority should not be misused by directors. Again, a clear system is needed to control all these issues. The director also needs the required competence in the fulfilment of those tasks.

The reason why the directorates are not supported consistently by the MoPH is unclear. Interviewees as well as surveys participants claimed the inconsistent support of the MoPH but claimed different reasons. Managers with creativity who provided justification for their activities were supported well, but this does not seem an appropriate reason. More support may be needed for those who are not able to present justification and show creativity.

The solution for the problem of the shortage of resources does not seem to be completely in the hand of the MoPH, which can only advocate with the government as well as with the donors. To do so, the MoPH requires competent people who can deal with donors and government. The MoPH may also need to work on a more transparent system and procedures to gain the trust of the international community.

The MoPH may need more efforts to reduce bureaucracy. To prevent the misuse of resources, the MoPH needs to establish a stricter control system.

8.6.2. Relationships between managers' support and employee performance

The interpersonal relationships between managers and their employees are critical to organisational performance and productivity. Previous research indicates that managerial support can be achieved through a number of different processes including the supervision and monitoring of employee performance, the communication between managers and employees, the working conditions and environment, systems for acknowledging employees concerns, work-life balance, treatment of employees, managing changes of practice, maintaining employees' motivation and promoting best practices (Doris et al. 2004; Wyss 2004; Spence Laschinger et al. 2009; Nankumbi et al. 2011; Asante et al. 2012; Turner and Short 2013; Mkoka et al. 2015).

In this study, while the findings strongly support the first proposition that there is a relationship between managerial support and employee performance, the evidence also shows the important role of managers' competence in supporting their employees (Sections 3.2.1 and 3.2.2). Where leadership is seen as supportive, teams typically operate more effectively. Indeed, supportive leadership is seen as a good enabler for organisational development. However, the absence of supportive leadership impacts on the ability of the organisation to change (Turner and Short 2013), which supports the findings of this study. This theme includes findings on performance appraisals, annual leave, work-life balance, communication and managers' treatment with employees and the employees' concerns, which are all relevant to HRM and to the line manager's support.

Performance appraisal

The performance appraisal is the evaluation of the actual performance of employees against the expected performance objectives. The study demonstrates that the employees were not happy with the performance appraisal system for many reasons. In contrast many directors viewed the appraisal system more positively indicating they thought it benefited the employees. However, there were directors with similar

comments to the employees. The employees and directors' negative perceptions were because the appraisal was not based on planned performance and evidence.

Unfortunately, effective performance management in public services has rarely been found in LICs (Martinez and André 2007; Bradley et al. 2013; World Bank 2014b). The findings support previous evidence that employee performance was reportedly not being monitored appropriately; however, the competence of managers was found to have a vital role in the managers' ability to support their employee performance.

The appraisal system is often poorly understood by those responsible for implementing it and good performance is not incentivized in LICs (World Bank 2014b). Appraisal systems do not always have a clear process and promotions are often unrelated to appraisal outcomes (WHO 2009). The wider literature further suggests that the lack of a good appraisal system causes demotivation and can negatively affect employee performance (Bradley et al. 2013). Employees in this study were demotivated and disappointed because their skills and their performance were not recognised by their managers (Section 5.4.1.1).

The appraisal system is clearly described in the HR policy of the CSC (2005) provided to the MoPH. The CSC is an independent administrative governmental source that has the responsibility to make sure all HR related aspects are managed well across all the ministries in Afghanistan. They need to ensure that the procedure and policy concerning the appraisal system are fully implemented by the ministries and benefit the employees.

Participants perceived that as appraisals are a new concept it was not carried-out correctly and professionally. This shows an idea that any new system or procedure that is introduced is expected not to be followed correctly, because it is new. This idea can hinder the appropriate implementation of a new system or procedure. This can also be the indication of the new systems or procedures not being introduced properly as required by the relevant department. That is why people would have difficulty in the filling-out of its forms because they are not confident enough about them.

Section 5.4.1.1 suggests that people in the MoPH remember the appraisal forms when the year comes to the end. This may display a shortcoming about the appraisal system from the HR department, from the managers and from other staff and

suggests that the importance of appraisals is not addressed in the MoPH. If the importance was identified by the managers and employees, then itself will better inform the employees to eagerly follow the process. If the appraisal process is not fulfilled from the starting of the year, where the line manager and the employees set objectives for the employee activities to be fulfilled during the annual period, then it is not possible to do the rest of the process and to keep evidence of their achievement. That is why it was said that it is not evidence-based. The employees need to develop their annual plan based on the set objectives at the beginning of the year and record every achievement to present as evidence of their performance to their line managers at the end of the year. The line-managers also have the responsibility to ensure the employees are fulfilling their tasks throughout the year. However, it was also found that in the directorates where the employees perceived that the directors were not appointed on merit, were seen as poor appraisers. They were deemed to be lacking in competence and the skills to recognise the different dimensions of their employees' abilities and use them in appropriate ways. Consequently, there was a high perception of mismanagement, which demotivated employees.

Low wages were another reason for line managers to give good scores on employee appraisal forms to ensure they received an increment to their salary. As the findings showed that employee salaries were not enough to run their lives properly (Section 5.4.1.1). This means that the employee performance was undermined, and the appraisals were only used to increase their salaries. This shows the line-managers sympathy for the poor employees. However, it is argued that this sympathy cannot help them significantly but can even harm the employees, the organisation and the entire country. Because, first, the performance appraisal is there to help good performance of employees to be recognised. If the appraisal is carried-out negligently then it is an injustice to the employees who perform well.

Secondly, the system and procedures are there to bring transparency and improve accountability. The managers' sympathy will create a lack of transparency and accountability among employees, directorate and organisation. A manager's sympathy for an employee may cause the manager to avoid the policy and procedure. Sometimes managers are required to be flexible, but not as flexible as to harm a procedure and the organisation in the aim of helping an employee. The appraisal

system is for monitoring the employee performance, if it is not carried out properly then good performance is not recognised, neither promoted. This situation will not benefit other employees because their good performance is not recognised. Similarly, if the appraisal is not done appropriately then it will affect the transparency of the procedures, which is a disadvantage for the organisation.

Thirdly, such unfairness could have many other negative consequences; for instance, employees who demonstrate good performance will become demotivated and their performance will be affected. The findings show that employees were demotivated by the perception that those who were not doing well were treated the same as the employees who were working well (Section 5.4.1.1). This means good performers are not identified and rewarded. That is why employees were arguing for a performance management system. It is suggested that managers can help poor employees through acceptable ways. For instance, they can make sure the employees know the appraisal system very well. If they understand the appraisal system properly then they will know that by their good achievement they can themselves get an award or increased salary without the managers' sympathy. In this case, both the employees as well as the organisation will benefit. Another problem that was raised by many participants was about the structure and design of the appraisal form. It was mentioned that the skills that are in the appraisal form are not measurable (Section 5.4.1.1).

Socio-cultural issues and favouritism were other issues that were found to affect the appraisal. As it was found that people who had good performance got a bad score and it was mentioned that friendships made a difference. Some directors had to give the employee a good score to keep the personal relationship (Section 5.3). Again, this finding shows that the aim and the scope of the appraisal form are not yet known by the directors as well as by their employees. This also indicates the negative effects of the socio-cultural issues on the MoPH performance overall.

It seems clear that what was needed is for the HR department, with the help of directors, to introduce the appraisal system appropriately in order to guide and support employees. However, findings suggest that neither the HR personnel, nor the directors, have the capacity to provide this guidance or ensure appropriate use of the forms. The employees need to have a good understanding of the appraisal procedure, its aims and advantages to themselves, to the management and to the organisation.

The employees and directors need to appreciate that the appraisal form is not a form that can affect their personal relationships. Rather it should help both to discuss the activities and achievements and the areas where improvement may be needed. If it is carried out appropriately and consistently, it can help employees in their career development and address their career weaknesses.

Annual leave is another aspect that is included in this theme as the managers are needed to make sure the employees were getting this support that they are entitled to. Employees did not take their leave but, only a few directors realised that was due to the lower salary. While employees either did not take their leave or if they did take their leave faced challenges (Section 5.4.1.1). The findings suggest that there was not a proper system for annual leave. Many directorates did not have any leave planning and the employees did not know about the annual leave policy. This may indicate a lack of proper system as well as a lack of employees' awareness of their own leave policy. The work-life balance of employees, as well as directors themselves, did not seem to be considered important (Section 5.4.1.1). Staff sometimes worked beyond their official time as well as at weekends and performed official work at home in order to complete their work.

An investigation of the current literature in this study shows findings about the work-life balance of employees but not exactly about the annual leave, which may be a gap in HR in the LMICs. Managers in LICs often pay insufficient attention to employee related issues such as working hours, working conditions, career structure and remuneration (Kolehmainen-Aitken 2004; Martineau et al. 2017). Section 5.4.1.2. suggests that employees worked a lot, but their work was not effective as the achievements were not obvious. Arnold et al. (2019) indicate that employees were overworked, they reported feeling exhausted, undervalued and often dissatisfied. Similarly, overloading with work responsibilities affects job satisfaction (Spence Laschinger et al. 2009) and contributes to low morale, productivity and motivation (Doris et al. 2004). A balanced work-life leads to a motivated workforce and high employees morale while work-life conflict was a major source of stress that impairs the employees' overall wellbeing, productivity, commitment and consequently affected their performance (Mwangi et al. 2017). The study's aim was to examine the effects of work-life balance on employee performance in Kabarak University. Work-life conflicts were linked to dissatisfaction and high turnover. Mwangi et al. (2017)

recommend organisations create a balance between employees' work and life/family priorities. Unfortunately, from the findings it does not seem that the balance between work and personal life is taken into account.

Unfortunately, the findings of this study raised similar concerns, with the negative effects of work overloading on employees and their performance not being recognised. There was little or no concern amongst directors or the MoPH in this regard. Communication and treatment by line managers affected the employee performance (Sections 5.4.1.1 and 5.3). Interviewees thought that managers who were introduced directly by political interference without consideration of merit were found not to be opened minded. They were causing unnecessary conflict and contradiction in the office. Many participants were not happy with the unprofessional treatment that existed in some directorates. These disputes caused employees to either carefully share or not share their ideas because they thought it will create conflict in the office. This is definitely not a good working condition. The literature shows the lack of an effective communication system between managers and employees can cause strikes and employee dissatisfaction (Bradley et al. 2013; Mkoka et al. 2015) and poor working conditions are obstacles towards reaching the organisation's goals.

Again, the role of managers' capacity was found to have a critical impact on the eradication of such inappropriate treatment. Section 5.4.1.1 highlightes that the culture of unprofessional treatment of staff was minimised in directorates that are run by managers perceived as competent. This culture is more common in the directorates where the directors were perceived to have a low capacity. Research suggests that in a positive working environment, there is open communication and employees' good work is recognised and rewarded (Wyss 2004). The current findings suggest that managers who were perceived to be competent, conducted meetings with staff regularly but the managers who were perceived to be incompetent, due to low capacity, did not conduct meetings because they were deemed not confident in their roles. These were the key examples of the manager's competence role in employee support that caused the competence role to be added in the first proposition. Regular meetings and communication can have a positive impact on employees making them feel valued (Bradley et al. 2013). The staff appreciate being

consulted and included in decision-making (Bradley et al. 2013; Mayfield and Mayfield 2017).

In any organisation, the provision of time for employees to share their concerns is very important. In the MoPH it was often found that employee concerns were not heard. Some directors even responded that employees didn't have any concerns while 71% of staff raised concerns. Some of the directors believed that employees had already accepted the situation when they applied for the job (Section 5.3). This can display a lack of knowledge about the HRM. It also suggests that the employees' working conditions and satisfaction are not taken into account. Managers are required to make sure their employees' working conditions are good and supportive. However, literature shows that employees were found to be demotivated because their concerns were not heard and not properly addressed (Arnold et al.2019).

The importance of the managers' role in the success of a programme in a health facility was found by a study from Jacucci and coleagues (2006). They found a manager who had utilized her knowledge, had a good understanding of the organisation's vision and her skills and behaviour by which she created an atmosphere of good teamwork and good working conditions. Employees were kept motivated and this enabled them to happily undertake new tasks. Teamwork was found to help the team members to share their knowledge and creativity (Jacucci et al. 2006). The surprising aspect that Jacucci et al. (2006) found was that no external intervention or any pressure was involved in their work. This might be because when management capacity is evident to other stakeholders, then they trust and feel confident that nothing will go wrong. The management capacity may also have prevented external interference. Jacucci et al. (2006) argued that this manager used her authority to lead rather than as a means of controlling activities. Whereas in this study (Section 5.3) some directors used communication capabilities only as the means to control staff.

Employees are generally concerned about issues such as employment stability, salaries, working conditions, and professional development opportunities (Kolehmainen-Aitken 2004). These were also important among employees in this research study. An improved working environment decreases work stress (Spence Laschinger et al. 2009) and increases job satisfaction (Doris et al. 2004). It is also very important for employees' motivation, which in turn improves their performance

and productivity (Jacucci et al. 2006; Bradley et al. 2013). However, workforce crises in LICs are the predominant challenge affecting the health systems' functioning (Martineau et al. (2017). The study of Arnold et al. (2019) is a strong example of a workforce crisis in Afghanistan, where the workload, work pressure, punitive and stressful working environment had affected the ability and motivation of staff.

It was evident that the HRM system was not taken seriously in the MoPH, which may be the main reason for many of their problems. The WHO (2006) emphasizes that good HR management motivates and develops employees to achieve the goals of the organisation, while poor HR management negatively affects the employees' morale and causes poor performance (Bradley et al. 2013). Even in a very small organisation, an important foundation is an effective HR system, which is run according to acceptable standards and regulations. Apart from training, a good HR system may not require much investment. However, the system needs clear policies and regulations, which can be monitored by the relevant people, including the head of each directorate. This will provide good support for employees, which will enhance their performance.

Unfortunately, HR management in LICs was found to be one of the main challenges with an inadequate focus on HR development (Van Lerberghe et al. 2002; Jacucci et al. 2006; Bradley et al. 2013). This might be because HR planning responsibilities are given to managers who lack the relevant knowledge and skills (Kolehmainen-Aitken 2004), and lack adequate training for these roles. According to the MoPH organogram (Appendix 1), there is one general directorate for HR with five directorates but no head of directorate in the MoPH was found in the archival records in Section 5.2 to have a qualification relevant to HR. Such a qualification may help them fill the relevant gaps in HR and solve some of the problems raised by staff. The participants thought that if the managers were competent, particularly in HR issues, then many of the existing problems could be solved (Section 5.4).

To improve the performance and to achieve the goals of the organisation, the MoPH needs to take into account the employees working conditions. The MoPH needs to seek ways to keep the staff satisfied, boost morale and motivation. These supports can be provided better by the managers who were competent that is why competence was added in the managers support in proposition one that has strong relations with

the employee performance. The findings in many LICs reveals similarities in working conditions creating significant obstacles towards achieving international health-related goals, which in turn, should be a concern for the international community. In order to resolve this situation, the first step is for employees' concerns to be heard by directors. The directors need to have open communication and regular meetings. The managers need to make sure that the working environment is supportive of the employees' productivity. The employees need to be treated respectfully as an important partner in a shared endeavor. They should be valued and understand that they are valued by the organisation. The literature suggests that the HRM is weak in LICs (Kolehmainen-Aitken 2004; Bradley et al. 2013), which is consistent with the findings of this study. In this case, another solution can be if the WHO could be on-hand as a technical partner. It needs to work on a unified HRM framework that all the LICs can use. If such frameworks already exist then they need to be introduced, implemented and promoted in these countries including Afghanistan. It may include the appraisal system, work-life balance and working hours, the regularity of meetings and regulations on annual leave.

8.7. Change is hoped for

Both the directors and the employees are asking for a change in the current situation (Sections 5.3 and 5.4.5). It seems that inconsistency exists throughout the MoPH. The directors asked for consistency from the MoPH leadership while employees asked for consistency from the directors as well as from the MoPH leadership. Consistent implementation of the law was another issue brought-up by the directors as well as the employees, which may be the indication of a weakness in the implementation of law in the MoPH.

Eradication of political interference and socio-cultural influence and promotion of meritocracy were the main recommendations that participants were asking for (Section 5.3 and 5.4.5). Although some of the directors may have been employed through the politicians, many directors were asking for the cessation of political interference, which shows that everyone in the MoPH is frustrated by the current political interference. This may be because they themselves have recognised the negative consequences of such political interference in their work.

The country has overcome a variety of difficulties and challenges during the last decades, which have affected all aspects of life including the MoPH. The hope of the directors and their employees should be important for the MoPH, government and the international partners. These have the responsibility to respond to employee demands.

To bring improvements in Public Health, it is the desire of the MoPH employees to make a difference to the health of the nation. They have the important role in bringing changes in the system by their unity, competence and commitment.

8.8. Summary of discussion

To perform well there is a need for capacity. This means that when the organisation does not have the capacity then good outputs or performances cannot be expected. The findings suggest poor capacity in the MoPH (Sections 5.3, 5.4.1 and 5.5.1). The international community and the MoPH have recognised these challenges and the donors have taken the coordination responsibility of capacity building in the MoPH. Unfortunately, capacity building in the MoPH was not achieved as was expected by the MoPH and donors. Based on the main findings discussed above, there are factors that are important in explaining the current management capacity and leadership in the MoPH and how they contribute to the performance of the employees and organisation. If all the problems and obstacles that were found affecting the performance of the MoPH are categorised, they are divided into two main categories: internal and external. Table 8.1 illustrates the factors that affect the MoPH performance.

Internal factors	**External factors**
Low capacity	Political and socio-cultural influence
Low commitment	Shortage of resources
	Donors’ persistent negligence in regard to capacity building

Table 8-1 Factors affecting the MoPH performance

The low capacity in the MoPH may be a big gap and a critical foundation for all other problems found in this study as it affects all other components of the management capacity such as finance, HR, capital, IT and leadership. If the key authorities were competent enough then they would be able to put a strong foundation in the system with the adequate structure, systems and procedures. They were also able to easily recognise any gap in the system and work on them. They were able to identify the problems created by the political and socio-cultural interferences and all their consequences including lack of transparency and accountability, unfairness, inconsistency and corruption. Their competence would not allow any kind of influence to affect their commitment to their organisational goals.

The findings also suggest that the directors could have the required competence, but their commitment was undermined by their commitment to their political and tribal patronage. This made them support the employees unfairly and inconsistently. Employees were neither getting the required support that they needed in their performance. All these situations affected the motivation and the performance of employees. Besides the management capacity there are many other contributory factors involved influencing managerial work. Each of those gaps makes the leadership work more complicated.

The external factors include the factors that are not under the MoPH's control. The MoPH is mainly relying on the external funding. The shortage of finance causes a shortage of staff, space, instruments and other equipment that are needed for employees to do a better job. Shortage of resources was the top obstacle that prevented the directors in reaching the organisational goals. Political and socio-cultural influence is one of the main factors that has an external origin and influences the performance of the MoPH but is supported from the inside by the MoPH. This causes other problems such as lack of transparency and accountability, corruption and other cultural issues such as nepotism, kinship and favoritism, which in turn is causing inconsistency, unfairness and bias treatment amongst employees. Unfortunately, it seems that they are not officially recognised as a problem by the MoPH. If issues are still not seen as critical challenges, then it will be even more difficult to be solved and the solutions will take a long time.

Performance has a direct positive link to the capacity and capacity needs to be built among the MoPH employees. Since 2002 the international community is working on the capacity building of the MoPH, but the findings show no improvements. The coordination of capacity building was the responsibility of the donor. Although the donor had accepted their fault in regard to their responsibility in 2007, the situation was found to be the same during this PhD study. This shows persistent negligence, but the reasons for this negligence was not specified. The current situation in the MoPH shows a complicated situation, which is a cyclical phenomenon through which every single problem causes another problem and together these problems not only prevent improvement in the MoPH, but also causes the same problems to persist. All these problems together prevent the MoPH from strengthening its management capacity and as a result the management capacity remains low throughout the whole system, which affects the performance in the MoPH.

8.9. Combined and revised management capacity Strengthening framework

To explore management capacity, this PhD followed the Black Box Model (Moynihan and Ingraham 2004) and the Leadership and Management Strengthening Framework (WHO 2007a), (Sections 2.5.1. and 2.5.2). First, the elements of the model and framework were summarised as the guidance in Section 2.6. Then the application of those elements to this case study were discussed in Section 4.18. This section discusses this case study by linking to those elements and then discussing it in the context of LMICs.

The case study, as the model and framework suggest, shows that leaders are at the centre of the management system in an organisation. It is up to the leaders how to manage the work environment and promote a culture among their team that helps productivity. For good performance an organisation requires a balance of management and leadership. The important role of leaders/managers is to integrate other dimensions of management system of capital, finance, HR and IT and ensure that they all contribute to meeting organisational goals. These five components are introduced by the Black Box Model and they have been included in this revised management strengthening framework.

This study found that these dimensions also require leaders/managers who are competent enough to fulfil these critical responsibilities, which is why the element of

'competence' was added to the Black Box Model. 'Competence' is nominated as one of the four components of the WHO framework. In the WHO framework, qualifications are assessed to understand the leaders' competence. This case study also found that assessing qualifications is an easier and clearer way to evaluate leaders' competence as well as revealing other issues around it. This research, for example, found that the criteria for the directors' qualifications were very low. Directors also gained the position through political connections rather than through merit, and the irrelevance of some qualifications was another problem. These affected directors' competence in the MoPH (Sections 5.2, 5.3 and 5.4).

If a leader/manager is competent enough but does not get enough support to achieve organisational goals, then this affects the performance of the leader/manager and her/his team. This case study found different issues in the support to directors in the MoPH that affected their performance (Sections 5.3 and 5.4). One of the examples was that almost 86% of directors had a shortage of resources in their directorate and nearly 62% directors reported inadequate management support. This indicates that besides competence to achieve organisational goals, leaders need a supportive system. Therefore, 'Support System' was added to the framework.

For good performance an organisation requires capacity. Management capacity and leadership affect employee performance. It suggests that the higher the management capacity the more efficient and effective the organisational performance will be. This case study illustrates that the employees' motivation and performance were affected in different ways by the issues of the management system and leadership (Section 5.4). Therefore, 'Employee Performance' was added to this revised framework to show the output of management capacity in an organisation.

The framework was revised based on the findings of this case study which was carried out in Afghanistan as a low-income conflict-affected country. This framework would most likely be applicable to other LMICs, and particularly applicable to those which are fragile and conflict-affected, as the additional components (discussed above) are more challenging in LMICs (Section 3.2). The Black Box Model is a general model that can be applied to all organisations in any country, whereas the WHO framework was developed specifically for strengthening leadership and management in LICs. This is because leadership and management capacity are generally low in LICs and are considered paramount organisational

components in these countries and strengthening them improves the effectiveness of their health systems (WHO 2007a). This means that leadership and management capacity have an important role in the wider context of health system strengthening which can achieve more equitable and sustained improvements in the health system as a whole. The literature review in this study identified the lack of capacity in health planning and management specifically in HR development, financing and the analysis of health situations, most of which depend on the managers' duty to carry out their responsibilities. This is even more obvious in LIC, conflict-affected countries where capacity is poorer (World Bank 2012). Similarly, a support system is another component that is necessary for organisations in LMICs as again the literature review of this study (Section 3.2.1) shows that leaders/managers received inadequate support and the support system was ineffective. The challenges in these aspects extensively affected employees' performance. To link these results to the bigger picture discussed in Section 1.5, these support the discussion that for a better outcome of health services in conflict affected LMIC settings, it is essential that attention is paid to management capacity and leadership.

To summarise, based on the study findings, 'Competence', 'Support System' were integrated as elements of the Black Box Model and WHO framework. 'Employees Performance' was also added to the framework. However, as this is a small study carried out in one setting, additional research is required in other settings that can explore the integration and the addition of these elements in this revised framework. The components and their importance as suggested by this study are highlighted in green in Figure 8.

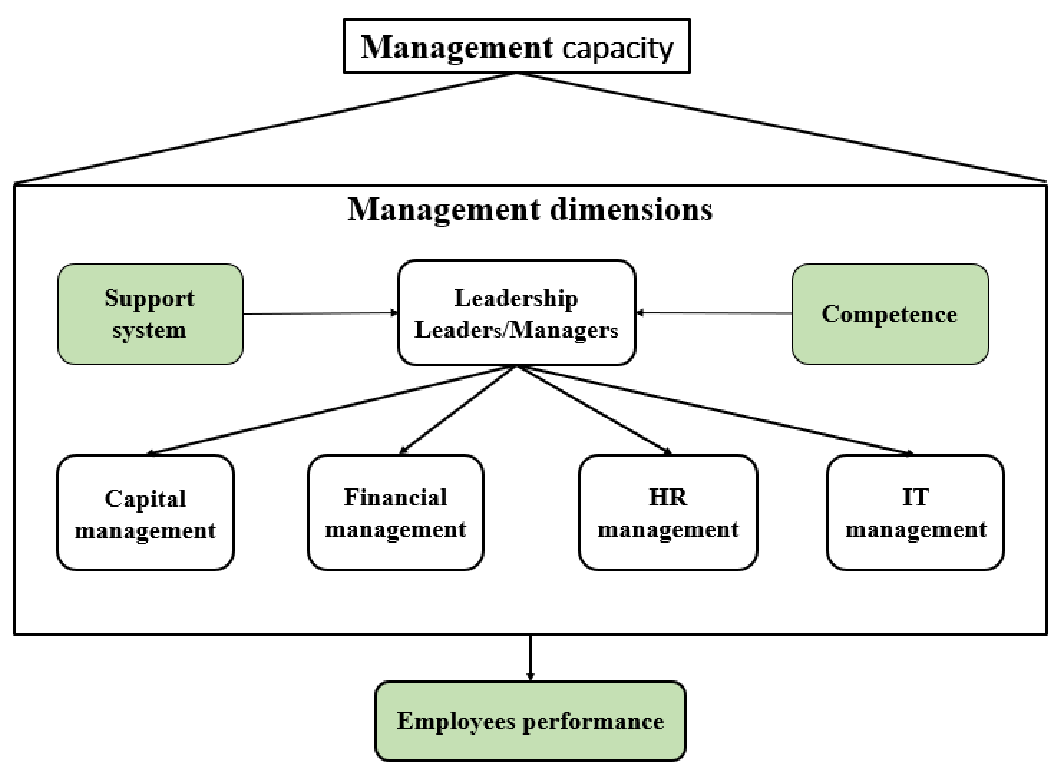

Figure 8. 1.Revised management capacity framework (incorporating Black Box Model and WHO Leadership and Management Strengthening Framework)

8.10. Strengths and limitations of the study

8.10.1. Strength of the Study

The main strengths of this PhD study is the comprehensive literature review to help the selection of the case study design. The literature review also helped in the understanding of management capacity and the unique importance of the leadership components from the Black Box Model (Moynihan and Ingraham 2004) and WHO framework (2007). Through the literature review the gaps in the management capacity and its effect on performance was identified.

This is the first study that has been carried-out about the management capacity and leadership in the MoPH in Afghanistan. Data were collected directly from the directors themselves and their employees who were working directly under their supervision. Previously, studies were undertaken about the health services or health

system but not on the MoPH itself. During data collection participants commented that they had participated in interviews or surveys before, but they never found out what happened to the data they had provided therefore the draft findings were shared with participants. Although the research was not without its challenges, everything was achieved according to the study plan and methodology. No obligations affected the study that could increase bias. Being an Afghan and working for more than ten years in the health system of Afghanistan in the partnership of the MoPH and other stakeholders helped the researcher to get enough insight about the MoPH and the health system. This insight consequently helped in the development of a proper plan for PhD study and chosing the appropriate approach.

8.10.2. Limitations of the study

The interview transcripts were in local language. Only one transcript was translated into the English language. This may limit the supervisory team's ability to cross check the data properly. However, the coding process and the development of themes were all in English, which were cross checked by the supervisory team. The directors and the senior employees were included in this research to explore ideas about management capacity and leadership in the MoPH. It would be more helpful to include the health service implementing NGOs and the international partners in the study to assess their perception about the MoPH management capacity and leadership and how it influences their performance. Perhaps this requires a separate study to be carried out with those partners.

Another limitation can be the selection of the theoretical propositions in the study. Although they helped as guidance and the study materials were developed based on those propositions, this might have restricted other factors to be explored. The questionnaires and interviews, however, included open-ended questions that explored other factors beside the ones in those propositions.

8.11. Reflexivity

Carrying-out this research had a significant impact on my thinking around the health system of Afghanistan and the MoPH. Although I had previously worked in the Afghanistan health system and in partnership with the MoPH, but I had never noticed many of the challenges and problems in the health system. My PhD study challenged my thinking around the MoPH and health system. It has made me think and seek

solutions to the many questions, which have arisen in my mind even though the solutions are beyond my ability and level.

PhD study is not possible without challenges. Working on those challenges and overcoming them gave strengths. The significant challenge I faced during my PhD programme was the difference of culture in which I was born and grew-up in and the culture of the UK where I did my PhD programme. One of those cultural challenges that I faced was, in my country we were trained not to disrespect the elders or senior people such as our school, college and university teachers. We should accept what they say without giving any reason. This was the same in the work environment, employees needed to accept what the line managers say. At the start of my PhD, when I was receiving comments from my supervisory team on my work, without providing my reason or justification I used to bring changes based on the comments despite not being happy with it, especially when I knew more about the context of my study and had work experience about it. This was difficult for me, but I was thinking this was a requirement of the system. Slowly, I started thinking about how I can carry my study in a manner that I want to do it. I felt there was an obstacle in front of me and I slowly discovered that obstacle was the culture in which I had lived. At the same time, I was learning a new culture around me in the academic environment that was totally different from my own culture. I realised that the academic argument or reasoning are appreciated but if you do not give your reasons or justification, it may be thought that you do not have anything to say. This was more annoying to me because I had many things to say and discuss but did not do that. Many times, though I had very good reasons and justifications but quietly give up what I wanted.

One thing that helped me a lot to become curious about this was the literature of the LICs where the findings were similar to the aspects I had experienced and witnessed myself in my country and they were discussed in the literature as problems and challenges for improvement and progress. While in my country, I used to consider it normal and not a challenge. This means when you travel to another place with a different culture then you slowly try to seek more about your own culture where you lived before. Or like an outsider person observes and analyses one’s own culture and tries to find out the advantages or disadvantages of that culture. After discovering my obstacle towards the aim of my PhD programme it took me long time to eliminate it.

Behaviour change is not easy, and it takes time. I slowly started providing my reasons to my work and the choices I was making about my PhD work. I found that my justifications and the provision of reasons were welcomed and appreciated, which helped as a good motivator to change my behaviour.

Chapter 9. Conclusion

9.1. Introduction

This chapter concludes the thesis by summarising the broad factors that were found in this PhD to affect the management capacity and leadership in the MoPH along with the rival explanations. This is followed by the study recommendations/implications and finally the plans for dissemination of this PhD research are presented.

The purpose of this current study was to explore the factors that affect the management capacity, leadership and employee performance in the MoPH. Low management capacity had been raised in the policy and other documents of the MoPH. The MoPH low capacity was also introduced as a big obstacle towards development and progress by WHO (2010b). However, no research was found that is carried out on the management and leadership capacity in the MoPH to find if it is low and if so what effects and consequences it has. This was a big gap. This study is the first study conducted specifically on leadership and management capacity in the MoPH. It offers details of why the management capacity and leadership is low, what effects and consequences it has on employee performance, on the system and procedures and on the goals of the organisation.

This study found six broad factors (Section 8.1) that play an important role in the management capacity of the MoPH and consequently on employee performance and the goals of the organisation. First, there were factors related to political and socio-cultural aspects that were interfering with the hiring system in the MoPH, which in turn prevented competent, technical and experienced people from managing the directorates. Directors who were given the responsibility because of politics seemed to be more committed to their political and tribal patrons than the organisational aims. These factors affected the work setting and caused many other problems. Although people were frustrated by the situation these issues had never been identified in the MoPH documents and an agenda had never been made for improvement. This is the first time these issues and their consequences have been reported by research. Socio-cultural and political issues were found in the previous literature in other LMICs. However, their consequences were rarely discussed, and

any solution has rarely been suggested. This study, in addition to their consequences, suggests some solutions.

Secondly, this study corroborated findings from the previous literature about how management qualifications and training can help managers manage better. The qualifications subject of many of the directors was not relevant to their jobs and many of the directors only had a bachelor's degree. These reasons were affecting their ability to do their work. This study also identified that the quality of the universities that employees graduate from is important. If experience is added to qualifications that is more beneficial. The relevancy of the training is also found to be important. Bureaucracy affecting an organisation can affect the managers' work even if they are sufficiently qualified.

Thirdly, the support that was provided from the MoPH leadership to the heads of directorates and similarly, the support that was provided by the heads of directorates to their teams were found to be insufficient. The new knowledge added by this study was the role of managerial competence in gaining the desired support from the higher levels and in the use of that support. Similarly, the findings demonstrated that the managerial competence helped the head of directorates to provide the employees with the required support and to create an enabling work environment. However, the findings also suggested that the MoPH is struggling with shortages of resources including financial, HR, and other facilities. Problems in the MoPH structure, system and procedures are other problems. All of these are important components of the management capacity and affected the organisation's performance.

Fourthly, the findings in this study support the findings from previous literature that the lack of transparency and accountability and corruption affect the performance of staff and the organisation. It was noted that the lack of transparency and accountability had affected all procedures and systems in the MoPH, which besides other negative consequences, had demotivated the employees. Although, this issue was identified by the MoPH and the government and the MoPH had taken some planned steps to eradicate the unwanted behaviour, those steps were only on paper and did not turn into action. Therefore, the follow up of the issues and the evaluation of such important tasks needs to be a continuous and ongoing process.

Fifthly, this study supports the previous literature findings that the MoPH management capacity and leadership was low and the existence of the factors that were described above are the main factors for low capacity in the MoPH. The capacity building that was coordinated by the donors was weak and not systematic. TA that was implemented in more than 16 years was not much successful and not much helpful to the employees' capacity building in the MoPH.

Sixthly, this study also highlighted the demands of the employees about their work environment, which was not included in the previous literature in LMICs. It was noted that both the directors and the employees were exhausted by the current situation. Although some of them may have benefited from this situation through being hired or promoted, it seems that they knew that this was unfair and would affect everyone. The political and socio-cultural issues were the main issues that were indicated by the study participants to be eradicated so that meritocracy can be promoted, and the organisation can be run by competent people.

The case study was framed by the Black Box Model (Moynihan and Ingraham 2004) and the Leadership and Management Strengthening Framework (WHO 2007a). The findings of the case study suggested development of this model and framework by integrating their elements into one single framework. The ‘Competence’ and ‘Support System’ elements were transferred from the WHO framework to the Black Box Model and ‘Employee performance’ was also added. The revised framework would be another achievement of this PhD which might help in strengthening management and leadership capacity in LMICs, but it should be tested in other similar settings and then can be used as a useful tool in exploring similar topics in LMICs.

This study also sought to find out if there are other possible factors that can be responsible for the current situation beside the other factors that were identified. This study was designed in a way that may encompass all the possible rivals as the study question tended to explore all the factors that affect management capacity and leadership and consequently employee performance. However, the shortage of resources and lack of willingness and commitment are considered as the two rival explanations in this study and discussed in Sections 8.3.1 and 8.6.1. Though the shortage of resources came under ‘management support’ in this study, it is also

categorised in the possible rival proposition. The reason for this was that the shortage of resources might be beyond the support of the MoPH leadership in Afghanistan, particularly since public expenditure on health largely relies on donor funding. The shortage of resources was the issue that was frequently identified in the literature that affects managers' potential success and achievement in LICs. The second was the managers' willingness and commitment in the achievement of organisational goals, which was affected by their political aims.

9.2. Study recommendations/implications

9.2.1. The implications

The current situation in the MoPH is complex where the MoPH and the international community, along with powerful donors such as the World Bank and USAID have been unable to bring about meaningful changes in MoPH capacity despite huge efforts. However, change in the MoPH may need stricter roles and commitment than spending vast amounts of money. The findings of this study are important because they add to the literature about LMICs. The findings can also be considered by policy makers and in practice by organisations in those countries. As there is a shortage of literature on this topic in LMICs, this will also help the international community who work for health improvements in such countries.

To understand the issues of capacity in the MoPH, further research would help to generate more insight into what directors think about the situation themselves. Exploring the role of technical support by the international community in the progress of the health system of Afghanistan, specifically, the MoPH in the last 16 years would also inform improvements, as would exploring the issues of technical assistance, talking to technical advisors and organisations involved in capacity building and the inclusion of a review of their documents and reports on capacity building.

Sections 9.2.2 and 9.2.3 provide the recommendations of this study to the MoPH and the international community.

9.2.2. Recommendations to the MoPH

As the political and socio-cultural aspects are the main factors for low capacity in the MoPH and its performance (Sections 5.3 and 5.4.3), the government should first address this problem, which will help in making the solutions to other problems

easier. The presidential elections were held in September 2019 and the result may cause the Unitary Government to come to an end. However, historical studies indicate that there has always been political influence on every aspect of the governmental system. It would be better for the government to minimise the political influence on the systems. Socio-cultural and political aspects have caused the most harm to performance in the MoPH. However, this problem is not recognised officially by the MoPH, as it is not identified in MoPH documents. The socio-cultural issues would be better identified in the policy and strategy of the MoPH and be placed at the top of the agenda to be solved with strict follow up. If necessary, a disciplinary procedure for the people who commit behaviour such as favouritism or nepotism would be helpful. If these issues are resolved, people will be prepared to focus and work towards national goals in the MoPH. It will help many other problems that were found in this study including consistency and fairness among staff members. This will also help competent people from diverse groups with different views to compete to enter the system, which will boost improvement.

Transparency and accountability (Section 5.4.4) will also be promoted when staff are treated consistently and fairly. Diversity will help creativity in an organisation. Competent managers are the substantial solution in an organisation. They will be able to overcome complex situations. They will be able to manage HR appropriately and develop or influence the system and procedures to become simple and useful.

Capacity and capacity building are another agenda that needs urgent attention and work. Capacity building design despite much financial effort has not been successful for the last 16 years in the MoPH (Sections 5.4.2 and 5.5.1) and donors and the MoPH should not await further outcomes from it but need to seek another solution. This might involve a transition from donor-driven to MoPH-driven objectives and instead of TA, other methods such as coaching/mentoring should be considered. It is also important to consider the culture and background in the design of capacity building programmes, which should not be copied and pasted from other developed countries with different cultures and backgrounds. There are many other managerial competence development programmes that can be used in Afghanistan. Other essential training would be into the understanding of culture and its effect on the organisational environment. It is essential that the universities from which the

managers and other employees gain their qualifications are assessed for quality by an accreditation system.

One of the solutions for capacity building might be for the MoPH to take on this responsibility and establish a centre in the MoPH where programmes for capacity building can be carried out. Training programmes can be designed and coaching, and mentoring can be planned there. The professionals who work there should demonstrate high capacity so as to be able to bring about significant changes. Afghan and non-Afghan professionals can be included, and they should have enough knowledge and understanding of the context and the people accessing their services. They also need to be experts in organisational capacity building and their knowledge and skills updated. The top and senior management in the MoPH needs to have a strong commitment to their responsibilities and willingness for progress. If there is not strong commitment, then all the efforts and investment is useless and a waste. Even if they are assigned by their political parties, inside the MoPH, they need to establish a unified protective circle, which can prevent external interference, including political parties, parliamentarians, and powerful people.

Although the MoPH has tried to find solutions for the eradication of corruption, it still exists (Sections 5.3., 5.4.3 and 5.4.4). Therefore, MoPH senior managers need to find ways to address this. The anti-corruption documents of the MoPH have mostly focused on working on corruption in local health systems, but it would be helpful to co-ordinate this centrally from the MoPH headquarters. For instance, there is more likely to be corruption in NGOs' contracts. This may include developing a strategy by learning lessons from other LICs who have succeeded in eliminating corruption from their systems. Additionally, the HR system needs strict rules and regulations, to follow up and monitor people.

9.2.3. Recommendation to the international community

The literature review and the research in this current study suggest that there were many similarities in the problems in health systems and their causal factors among LMICs (Section 3.2 and Chapter 5). The international community needs to be aware of these similarities as this can help in designing and implementing many of the programmes in those countries in regard to time and accurate allocation of resources and a programme which is successful in one of those countries is more likely to be

successful in others. This would be the same for the failed programmes, as discussed in the Discussion chapter (Section 8.2) about capacity building. The failure should not be repeated in other similar countries. This may be helpful.

Political and socio-cultural factors were the first and foremost reason for the failure of the MoPH in Afghanistan (Sections 5.3 and 5.4.3), but the international community does not seem to recognise these big challenges. Although some of them have indicated that low capacity in the MoPH is a big obstacle towards progress and development, unfortunately, the root causes were not sought (Section 8.5). The international community's aim is to help countries technically and financially. This requires them to investigate and understand the root causes and underpinning factors for the problems. However, unless they are identified, how is the work expected to succeed?

Low management capacity in the MoPH is an extra challenge for technical and financial partners. Similarly, lack of transparency and accountability are another extra challenge. As discussed (Section 8.2), the employees of some of the international organisations assigned in Afghanistan as well as the expatriates that worked for capacity building in the MoPH had low capacity themselves. Therefore, another recommendation for international actors is to assign competent and experienced expatriates in Afghanistan. If the capacity of technical partners is not higher than the MoPH employees, then they will not be able to support the MoPH as needed.

One of the substantial foundations for development and progress would be research, which can be an important element of capacity and capacity building. Unfortunately, research is not promoted in LMICs. This echoes the findings of this study (Section 8.2) that there was limited evidence to provide knowledge and information about capacity building in the health system in Afghanistan. The researcher faced the challenge of the lack of records or study on MoPH capacity building (Sections 5.2 and 8.2). As the international community is the main technical and financial partner of the MoPH, it has an important role in its success or failure. Firstly, if the international community commenced and promoted research to find out about capacity and capacity building in the MoPH and other ministries, Afghanistan would improve its capacity and would be able to run their organisations well. For now,

there is a lack of capacity, but no study exists to show the shortfalls or progress and no proper planning will take place.

9.3. Dissemination of research findings

The researcher plans to publish the study so that it can be used by the relevant stakeholders who serve the health system in Afghanistan. The literature review findings of this study have already been disseminated at an international conference in Afghanistan. It is planned to publish the findings of each theme separately. Currently, the first article is drafted on political and socio-cultural influence, targeting the *International Journal of Health Policy and Management* (IJHPM). The researcher will try to reach the international community involved in the health care system in Afghanistan. The researcher also plans to develop a policy brief containing major findings of the study to present/submit to the policy makers of the MoPH and its national and international partners. This study will not only benefit the MoPH but will also be a resource for LMICs. Therefore, it will be published in a way that can easily be accessible focusing on Open Access journals to the stakeholders in LMICs.

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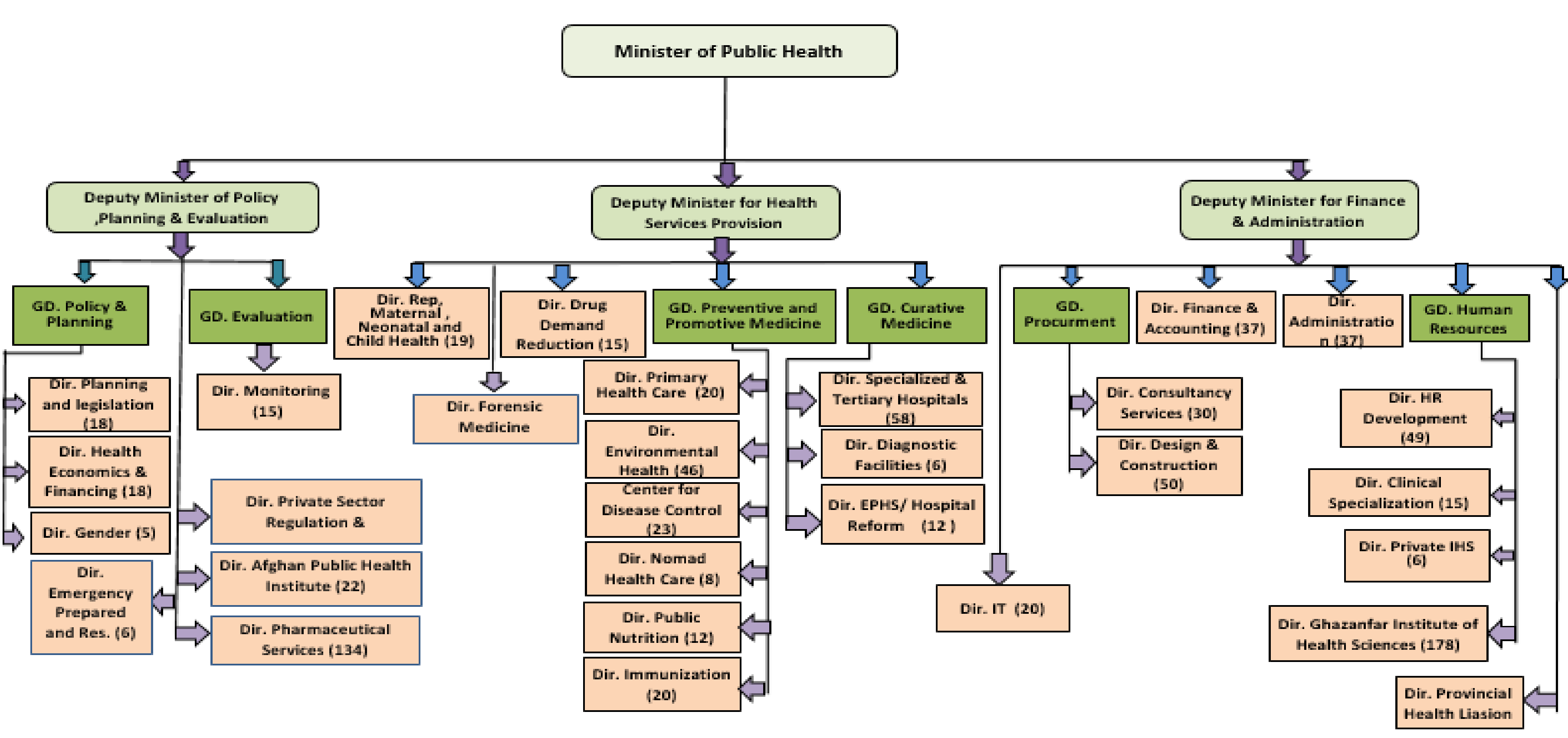
Appendices

Appendix 1: MoPH structure diagram



Appendix 2: the quality assessment of the reviewed papers

1. Critical Appraisal Skills Programme (CASP)

Three answer can be used; Yes, Can’t tell, No

Qualitative research	**Turner and Short 2011**	**Mkoka et al. 2015**	**Mirzoev et al. 2015**	**Ulikpan et al. 2014**	**Chanturidze et al. 2015**	**Asante et al. 2012**	**WHO 2009**	**Jacucci et al. 2006**
Questions								
1. Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell
5. Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6. Has the relationship between researcher and participants been adequately considered?	Yes	Can’t tell	Yes	Yes	Yes	Can’t tell	Yes	Yes
7. Have ethical issues been taken into consideration?	Yes	Yes	Yes	Yes	Yes	No	Can’t tell	No
8. Was the data analysis sufficiently rigorous?	Yes	Yes	Yes	Yes	Yes	Can’t tell	Yes	No
9. Is there a clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10. How valuable is the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

2. Methods Appraisal Tool (MMAT) – Version 2011

Systematic review	
Questions	**Kolehmainen-Aitken 2004**
1. Did the review address a clearly focused question?	Yes
2. Did the authors look for the right type of papers?	Yes
3. Do you think all the important, relevant studies were included?	Can't tell
4.Did the review's authors do enough to assess quality of the included studies?	No
5. If the results of the review have been combined, was it reasonable to do so?	Can't tell
6.What are the overall results of the review?	Yes
7. How precise are the results?	Yes
8.Can the results be applied to the local population?	Yes
9. Were all-important outcomes considered?	Yes
10. Are the benefits worth the harms and costs?	Yes

Nankumbi et al. 2011, mixed method:

- Integration of qualitative and quantitative methods in this mixed method research is a relevant and proper design for getting the answer.
- Regarding the quantitative sampling, although it is mentioned that in each included clinic 24 to 40 (mean of 30) staff including support staff were exist but only 20 staff filled the questionnaires. It neither mentioned that to how many staff the questionnaires were distributed, so the sample size is small (this was also mentioned by the authors) and response rate is not mentioned.

Latifov and Sahay 2013, mixed method (case study type):

- Mixed method (case study type) is a relevant design to find the proper answer for the study question.
- The sample size of the study for qualitative or quantitative was not mentioned. Although it was a case study which seems to be a relevant approach for this study and various health program managers was mentioned to be interviewed. Study of national reports, participation in various formal and informal meetings and analysis of the legacy database were done but the authors did not mention about the sample size of the study.

Appendix 3: Study protocol

Project summary

Abstract:

Leadership competency has received considerable attention in the literature, with management capacity being recognised as key to organisational success. Research has shown that countries with high capacity are comparably more successful than their counterparts who laeddleck capacity. The World Health Organization (WHO) emphasises the importance of the capacity of governments in achieving their goals. However, in many developing countries, leadership competence is very low, with little being done about it.

Afghanistan is a developing country where little published research has been conducted to explore leadership of the health system. This research aims to address this gap by determining which enablers and barriers leaders face in order to achieve their organisational goals.

An embedded single-case study strategy will be employed to explore the leadership enablers and barriers in 30 directorates of the Ministry of Public Health (MoPH), Afghanistan. A leadership competence framework framed from the Black Box Model (Moynihan and Ingraham 2004) and WHO framework (World Health Organization (WHO) 2006), will be used to study the phenomena of leadership competence and the enablers and barriers to effectiveness. To explore the different dimensions of the phenomena a variety of data collection methods will be utilised, including; archival records, questionnaires, in-depth interviews and documentary reviews. There will be two groups of participants in the study, the heads of directorates who will complete the questionnaires and the second group will be the senior staff members who will be interviewed. Data collection is planned to be started on 1st August 2017 and will be finished on 30th October 2017.

Data analysis will be undertaken using theoretical propositions. The themes and concepts generated will then be discussed with reference to the study aims.

It is hoped that the findings will increase understanding of enabling work environments and that this will support the continued development of the MoPH.

General information

Protocol title:	MoPH, Afghanistan
Principle Investigator:	Shaqaieq Ashrafi Dost, MD, MPH and PhD researcher
Supervisor:	Dr. Carol Bond, Principal academic
Institutions involved:	Bournemouth University (BU), England, UK

Rationale & background information

The health system of Afghanistan was re-established at the commencement of the new government in 2002. Years of war had destroyed all its systems and infrastructure. Everything had to be re-established (Newbrander et al. 2014). At the same time the country was lacking the human resources (HR) that was a crucial component for system development. Most of the skilled/well qualified professionals had had to leave the country due to insecurity (Currie et al. 2007). In addition, women were not allowed by the Taliban government to complete their education and serve the population in their roles. Therefore, in order to start to deliver a well-co-ordinated package of health services at the national level, the MoPH obtained the financial as well as technical commitment of the international community (MoPH 2015b).

Studies show that since its re-establishment, the health system is developing successfully (Waldman and Newbrander 2014; Dalil et al. 2014). Whilst there are many dedicated people with life-long experience who can contribute to continued success, sadly this is not enough. For a young health system to flourish, there is a need for many other skilled and qualified people to work toward sustainability in the system. In 2010, 60 % of the health sector was financed by external donors (WHO 2010b). Capacity building has been recognised as a challenge and considered in the strategy from 2002/3 by the MoPH (2005). Additionally, capacity building was identified as one of the most important actions to be taken in the Governmental National Development Strategy from 2008 to 2013 (Islamic Republic of Afghanistan 2008). The international community, such as WHO, USAID, EC and the World Bank, has had significant input since then with many people awarded scholarships to study abroad or undertake distance learning. However, capacity building is still mentioned in the most recent MoPH strategies and policies as requiring improvement

amongst management staff at national as well as provincial level (MoPH 2015a; MoPH 2012). WHO claims that Afghanistan health indicators remain worryingly high in regional and global comparison (WHO 2015a), which urgently need more attention – the maternal mortality ratio is 460 per 100 000 live births, and the under-five mortality rate is 99 in 1000 live births. Afghanistan also remains one of the three polio endemic countries globally. Communicable and non-communicable diseases are also other burdens that cause high mortality in the country. WHO (2018a), recognised the limited capacity at the managerial level in the MoPH as a challenge and an obstacle towards the success and improvement of health in the country. For this reason, WHO prioritised the health professionals' capacity building in its strategy (WHO 2018a).

Unfortunately, donor resources from the international community, is likely to decrease in the years ahead, requiring the MoPH to focus on sustaining the health sector (Newbrander et al. 2014). One of the main components to assure sustainability, is capacity building within the MoPH.
In this study, the MoPH was targeted because it has the stewardship role in the country and all other international and national NGOs are working under the MoPH (Islamic Republic of Afghanistan 2008; MoPH 2012). The MoPH is required to have the necessary capacity to manage all health stakeholders and guide the health system by developing policies, strategic planning and high-quality guidelines by which the population can improve the quality of their health. However, having some of the highest health indicators in the world, the MoPH of Afghanistan needs to intensify its action to address the related health problems. This major initiative requires the most qualified and competent people. According to the MoPH organogram (MoPH 2016), all the MoPH services are carried out by 30 directorates under six general directorates, which are in turn working under three deputy ministers- a Deputy Minister for Health Services Provision, a Deputy Minister of Policy and Planning and a Deputy Minister for Financing and Administration. The aim of this study is to explore capacity across the 30 directorates of the MoPH.

Study goals and objectives

The aim of this study is to explore the enablers and barriers faced by leaders in MoPH which affect the performance of staff members in achieving their goals. The findings will help the Health Ministry to consider those factors in their strategic plan

and work on them toward improvement. This will also help the donors and development partners in their support of the MoPH. It is hoped that the findings of this study will provide significant information for policy makers to improve the capacity of the MoPH and the success of the health system in Afghanistan.

The research question is ' What are the enablers and barriers faced by leaders in the MoPH in Afghanistan toward the achievement of their organisational goals?' This question is in turn divided into the following sub-questions.

1. What are the leaders' perceptions of the enablers and barriers they face to achieve their organisational goals?
2. What are staff perceptions of the enablers and barriers faced by leaders that affect staff's performance to reach the organisational goals?

The specific objectives to achieve the overarching aim are to:

1. Obtain aggregate data about workforce investment such as qualification, training and capacity building in relation to leadership and management. These data will be collected from the HR departments of the MoPH.
2. Collect data from 30 heads of directorates by self-assessment questionnaires to find out what enablers and barriers they face in order to achieve organisational goals.
3. Interview 30 senior staff from the included directorates regarding the enablers and barriers faced by leaders.
4. Review the key policies and strategies from the included directorates, to determine whether capacity building is considered and fulfilled.

Study Design

A case-study design has been selected to carry this study which is a mix of qualitative and quantitative methods. Writers on case study suggest it provides a more detailed picture of a situation. Its special strength is being able to use a variety of evidence which is not usual in other methods (Yin 2013). This is more important and useful when a researcher aims to do an in-depth search of a complex situation. A case study involves the detail and intensive analysis of a single case (Bryman 2015). According to Stake (2005), it is concerned with the complexity and particular nature of a case. Gerring suggests that a case study is ''best defined as an intensive study of

a single unit with an aim to generalise across a larger set of units'' (Gerring 2004, p. 341). Piekkari et al. (2009, p. 569) define case study as:

> ''a research strategy that examines, through the use of a variety of data sources, a phenomenon in its naturalistic context, with the purpose of "confronting" theory with the empirical world''.

However, the challenge to be considered when conducting a case study is that it is one of the hardest research methods to conduct (Yin 2013) due to the lack of a well-documented procedure. Another point to be noted is that, many case study researchers have a predetermined position about a case, which can lead them into collecting supportive evidence and avoiding contrary evidence (Yin 2013). A further problem is a tendency that researchers develop too broad question to investigate or the study has too many objectives to be analysed, which prevents the case being sufficiently explored (Yin 2009; Stake 1995). Each of these challenges can be addressed through careful design of the procedures.

Yin argues that conduct of a case study with a formal design makes the study stronger and more straightforward in terms of process (2013). He refers to four designs for case study:

1. Holistic single-case design

2. Embedded single-case design

3. Holistic multiple-case design

4. Embedded multiple-case design

(Yin 2013).

The difference between multiple (or collective) case study and a single-case study with embedded units is in the number of cases. In a multiple case study, the researcher can analyse several cases to find out the similarities or differences, but in a case study with embedded units a researcher only analyses and understands one single extreme/critical case (Baxter and Jack 2008).

For the purposes of this study the embedded single-case study design, will be employed. The MoPH is counted as one single case with embedded units of analysis.

The directorates will be the subunits of the case that enables the researcher to explore a single question (Baxter and Jack 2008).

In this current study, it was initially proposed to focus only on the Maternal, Neonatal and Child health directorate, but by selecting only one directorate it would be more difficult to keep the identity of the leadership anonymous. In addition, focussing on a single (holistic) case study design has a very high risk if the participants reject assessment. Therefore, it was decided to include 30 directorates of the MoPH (same organisation) in the study to make sure potential identification is less of an issue as well as to increase flexibility if any directorates decline to take part.

Methodology

Data collection source and questions:

The heads of directorates and staff of related directorates will be the sources of data collection. Staff records of these directorates and other key documents such as policies and strategies will also be the data collection sources.

The study questions are developed based on a theoretical proposition. Theoretical propositions help to focus the data collection, determine the direction and scope of the study. Like hypotheses in quantitative studies, they can make an educated guess to the possible outcomes of the research studies. The following propositions are developed from literature review carried out by researcher in this study and will be used to examine and explain what enablers and barriers leaders face in the MoPH to achieve their organisational goals:

- There is a strong relationship between managerial support and personnel performance
- The management support system affects the work of managers
- Managers who have managerial training can manage well
- Political and socio-cultural influence affect leadership
- The transparency and accountability of the management system affect staff and organisational performance.

Questionnaires will be completed by the heads of directorates. Questionnaire is included in this submission.

Interview will also be carried out with the senior staff. Interview in turn is based on theoretical proposition developed from literature review.

a. Data collection methods:

A characteristic of case study is the use of multiple sources which is a good strategy to enhance study credibility (Yin 2003; Patton 1990). Baxter and Jack (2008) have claimed each data source as a single piece of a puzzle which can contribute to the understanding of the case. Yin (2013) has introduced six common types of evidence that are mostly used in case studies:

1. Interview
2. Document analysis
3. Survey
4. Archival records
5. Observation
6. Participant observation

Triangulation from multiple resources is needed to understand the reality (Axinn and Pearce 2006). To increase the triangulation of the study, archival records, questionnaires, in-depth interviews and document analysis will be used. These methods will be complementary making sure the case is studied from several angles. The rationale for these choices is detailed below.

Archival records

Archival records are mostly used for specific purposes and specific audiences and include examples such as census data to inform planning. This method will be used in the current study to collect historic data about workforce investment such as qualifications, training and capacity building in relation to leadership and management of the included directorates. These data will be collected from the HR departments in the MoPH, after permission has been sought and will be appropriately anonymised.

Questionnaires

Questionnaires in case studies are also called survey interviews, which are structured and used to produce quantitative data (Yin 2013). In this study, structured

questionnaires will be used which will include both open and closed ended questions. Questionnaires will be completed by the heads of directorates. This will be carried out before the in-depth interviews to inform the interviews. Questionnaires will be provided in both English and local languages and will be informed by the findings from the literature review about developing countries.

In-depth interviews

In-depth interviews will be conducted with the senior staff from those 30 directorates. One staff member from each of the 30 directorates will be selected and interviews will be conducted till the data are saturated. Interviews are one of the most important sources of case study research. The interviews in case studies are fluid rather than rigid which is also called 'intensive interviewing', in-depth interviewing or unstructured interviewing (Yin 2013). The interview will take up to one hour and will be carried out after the heads of directorate have completed questionnaires. It will be audio recorded after provision of study information and informed consent. Written field notes will be taken where required.

Document review

Documents have an explicit role in data collection in case study research (Yin 2013). They are very useful though they are not always accurate and lacking in bias. In the current study, the policies and strategies will be reviewed whether or not capacity and competencies are considered. Consequently, they will help to follow and examine, whether the planned activities for capacity building are fulfilled. Document review can be carried out alongside the other methods. Documents such as policies and strategies are easily accessible through the MoPH website.

Method used	When (in 2017)	Who/what (data source)	Sample size	Rationale
Archival records	August-October	Aggregate data on capacity building	The related records will be reviewed	To assess the investment in capacity building, qualification, awards, training etc.
Questionnaires	August	Heads of directorates	30	Helps to learn the perception of leaders

				about the enablers and barriers they face.
In-depth interview	October	Senior staff members	30	Helps to learn the perception of senior staff about the enablers and barriers their leaders face.
Document review	August-October	Policies, strategies of related directorates	Related documents will be reviewed	To find out about capacity building and fulfilments

Table 1: Summary of the methods and when they will be carried out in the current study

Sample size of the study

It is important to determine the sample size of the study prior to commencement. For quantitative studies, as the name indicates, the quantity of participants is important as it aims to increase the generalisability of the study (Aceijas 2011). For qualitative studies, the sample size is small but the detail and in-depth analysis are important (Hewitt – Taylor 2011). In case studies, generalisation is about theoretical proposition, not about populations (Hartley 1994). The goal is not statistical generalisation, but analytical generalisation, which allows the researcher to move beyond the boundaries of the case and its setting and be applicable to other situations (Yin 2013). In analytical generalisation, a previously developed theory is used as a template with which to compare the empirical results of the case study (Yin 1989). In this study, propositions have already been developed from the literature review. The propositions are compared with the study findings and the analysis involves asking what it is similar to, what it contradicts, and why. A case cannot be a sample but it is an opportunity to study an issue within a bounded system (Baxter and Jack 2008). These boundaries indicate the breadth and depth of the study (Yin 2013; Baxter and Jack 2008).

In the current study, 30 questionnaires are to be distributed to the heads of included directorates. In-depth interviews will be carried out with the most senior staff member (one) in each of those 30 directorates. The interviews will be carried out until the data are saturated.

b. Study participants

This study has two groups of participants:

1. Heads of directorates who are directly involved in the daily activities and processes of directorates. They are also in supervisory and responsible positions.

2. Senior staff who work under the direct supervision of the heads and their work can be directly affected by them in each directorate. Senior staff are selected because they are more experienced in these directorates and will have greater insights into the issues.

e. Data collection procedures:

Since the data collection situation is in the context of real life, it means the researcher will need to be flexible and adaptable. Thus, as far as possible it is important to plan well and ensure that contingencies are in place.

Contact persons doing fieldwork - Lead researcher: Shaqaieq Ashrafi Dost.
Supervisory team: Dr Carol Bond

Access will be gained to the participants via their mobile number and email address which will be gained from the HR departments. This will be easy after getting the approval from the Research directorate, MoPH Afghanistan.

In order to complete the case study successfully the following resources will be required: computer access and location for writing, digital recorders to be sourced through BU. To avoid any data loss two recorders will be used for all data collection in case there is a fault with one. Regular supervisory input will be sought on a monthly basis to assist and guide the lead project researcher.

c. Data collection schedule - see Gantt chart

Timetable	2016				2017				2018				2019
Tasks/quarter	1	2	3	4	1	2	3	4	1	2	3	4	1
Getting the ethics on line training													
Submission of initial review													
Submission of annual monitoring report													
Conduction of Literature review													
Attendance to workshops, trainings/BU events													
Submission of transfer/progression report													
BU ethical application submission													
MoPH Afghanistan ethical application submission													
Risk Assessment Approval													
Starting data collection													
Data analysis													
Writing up the thesis													
Proof reading and final change													
Intention to submit													
Submission of thesis													

Safety Considerations

Regarding health and safety considerations, the study will be carried out in the Health Ministry headquarters in Afghanistan. Security is a concern there, especially as the MoPH is located beside the United States of America embassy and close to the airport, both of which are often targeted by the Taliban.

The safety issues to be considered and managed to minimise the risk are as follows:

- The researcher has a family home in Kabul, which is a safe base.
- The researcher will seek the advice of the Ministry's security advisors before conducting any field work and will, if needed, complete any risk assessment tool to comply with local rules and regulations.
- Official guidance will also be sought and news updates regularly listened to.
- The researcher will wherever necessary use the phone or Skype to avoid travelling.
- The researcher will use emails to make contact with participants when needed to avoid travelling.

- The researcher has attended the risk assessment workshop provided by BU and is aware of all related aspects.
- A BU risk assessment checklist has been completed and approved.

Follow-Up

As mentioned above the duration of this research (data collection) is three months (August to October 2017). Participants will be contacted during these three months. This study does not include any follow up study.

Data Management and Statistical Analysis

Yin (2013) suggests four general strategies for data analysis; 1. Relying on theoretical propositions, 2. Working your data from the ground up, 3. Developing a case description and 4. Examination of plausible rival explanations. In this study, the first strategy will be followed. The collected data will be linked to the theoretical propositions. Using propositions is intended for the three following reasons: firstly, this will lead to a focused analysis; secondly, exploring rival propositions is an attempt to provide an alternate explanation of a phenomenon; thirdly, confidence in the findings is increased as the rival propositions are addressed and accepted or rejected. The data will be converged in an attempt to understand the whole case, as if each data source were treated independently and reported separately (Baxter and Jack 2008). At this point, some parts of the findings will be understood rather than the overall case.

Quality Assurance

Yin (2009) suggests the internal validity, external validity, reliability or replicability are the key quality criteria of case studies, while other scholars such as Stake (1995) seem rarely to discuss these criteria. There are arguments about the singularity of case studies. The singularity of case studies can cause bias and lack of validity, reliability and generalisability (May 2011). Others, such as Simons (2009) argue that case study is a valuable and valid tool because its aim is ‘particularisation’. Particularisation is the process of presenting a rich picture or description of a single setting, contributing to the knowledge of a specific topic. Stake (2005), as a strong defender of case studies, argues that singularity is a strength that enables the researcher to focus on the particularity and complexity of a single case, which helps in understanding its activities within important circumstances. Additionally, Stake describes the importance of the researchers’ role in case studies being reflected in

their research. Bias will occur if the researcher does not remain sensitive to the social context they study (May 2011; Simons 2009).

The role of the researcher in this study and the potential for bias and influence will be carefully considered as the researcher has already worked more than 10 years within an international health organisation working in partnership with the MoPH. The researcher has considerable understanding of the study context, which is both important in case studies but also a source of risk (May 2011). Yin (2013), suggests the critical role of generalisability of case study is through sharing lesson learned. However, Bryman (2015) argues that the case study evaluation depends on how researchers feel about their study's quality. Yin (2013) has introduced the following criteria for the quality of case study research design:

Criteria for the quality of case study research design	
Tests	**Case study tactic**
Construct validity	• Use multiple sources of evidence • Establish chain of evidence • Have key informants review draft case study report
Internal validity	• Do pattern matching • Do explanation building • Address rival explanations • Use logic models
External validity	• Use theory in single-case studies • Use replication logic in multiple-case studies
Reliability	• Use case study protocol • Develop case study database

Table 2: Criteria for the quality of case study adapted from Yin (2013)

Expected Outcomes of the Study

The outcome of the study depends to the MoPH, Afghanistan. The result of this research will be shared with the MoPH and it is hoped that the findings will increase understanding of enabling work environments and that this will support the continued development of the MoPH.

This study will also be considered for publication and hope it could be able to contribute to literature on the improvement of leadership in LICs including Afghanistan and finally seek to improve health sector performance.

Dissemination of Results and Publication Policy

The result of the study will be shared with the MoPH including the participants of this study. This will also help the donors and development partners in their support of the MoPH. It is hoped that the findings of this study will provide significant information for policy makers to improve the capacity of the MoPH and the success of the health system in Afghanistan.

Related journals will be targeted to the result to be published so that other LICs as well could be benefitted from it. The principal investigator will take the lead in publication and the supervisors will come as co-investigators. The support and help of the MoPH will be acknowledged.

Duration of the Project

Data collection is planned to be started on 1st August 2017 after obtaining ethical approval and informed consent from participants and will be finished on 30th October 2017. The archival records and document review will be conducted concurrently with other methods (1st August to 30th October 2017) while the questionnaires and in-depth interview will be conducted in a sequential manner. Firstly, questionnaires will be distributed in August, then in-depth interview will be conducted after compiling the results of the questionnaires, which is estimated to be done in October.

Problems Anticipated

We do not think of a problem that we may face. We hope that the MoPH would be supportive to this study. The only concern we have is about the confidentiality and anonymity of participants. This is because research is not common in Afghanistan. Participants may have concern about their anonymity even when they give their consent for this study. The solution we think about this issue would be the researcher will meet the participants before their consent and ensure them about this. The anonymity and confidentiality are one of the main standard criteria of studies and is strictly followed up by Universities.

Project Management

This research study including data collection, analysis and reporting will be carried out by a PhD student - Shaqaieq Ashrafi Dost from BU. She will be supervised by her supervisory team at BU.

Ethics

All researchers at BU are required to obtain the Bournemouth University Research Evaluation Committee's (BUREC) approval before starting their study. The ethical committee approval demonstrates that all ethical issues have been considered by the committee (Hewitt – Taylor 2011). Ethical, health and safety issues must be considered when carrying out any research with human participants **(Alderson and Morrow** 2011). Ethical approval to conduct this study will be obtained from the above-mentioned committee. When carrying out case study research, special care must be taken. This involves gaining informed consent, protecting participants from harm including the avoidance of any deception, and ensuring anonymity and confidentiality (Yin 2013). Targeted participants will be provided an information about the study and will be given time to have their question and discussion. This will help them to have their informed decision. For better understanding, all the information will be provided in English and local languages. The Participant Information Sheet and Participant Agreement Form are included in both languages in this submission.

Informed Consent Forms

As mentioned above, both Information Sheet and Participant Agreement Form are provided in both English and local languages. The study will have two group participants; one group for completing questionnaires, and another for interview, therefor, the informed consent forms are developed specifically for each group. This will help each group to make an informed decision.

Budget

The PhD student- Shaqaieq Ashrafi Dost is funding this research.

Other support for the Project

None

Collaboration with other scientists or research institutions

None

Links to other projects

None

Curriculum Vitae of investigators

The CV of the Principal Investigator is included in this submission.

Other research activities of the investigators

This is the first primary research of the Principal Investigator as a PhD student.

Financing and Insurance

N/A

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Appendix 4: BU ethical approval

Research Ethics Checklist

Reference Id	16327
Status	Approved
Date Approved	10/07/2017

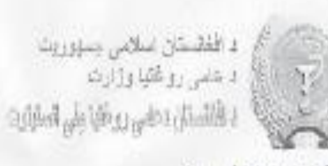
Researcher Details

Name	Shaqaieq Ashrafi Dost
Faculty	Faculty of Health & Social Sciences
Status	Postgraduate Research (MRes, MPhil, PhD, DProf, DEng)
Course	Postgraduate Research - HSC
Have you received external funding to support this research project?	No
Please list any persons or institutions that you will be conducting joint research with, both internal to BU as well as external collaborators.	N/A

Project Details

Title	What are the enablers and barriers faced by leaders in the MOPH in Afghanistan toward the achievement of their organisational goals?
Proposed Start Date of Data Collection	01/07/2017
Proposed End Date of Project	30/09/2017
Original Supervisor	Carol Bond
Approver	Research Ethics Panel

Appendix 5: IRB, MoPH study approval



Islamic Republic of Afghanistan
Ministry of Public Health
Afghanistan National Public Health Institute
Institutional Review Board

Date: August. 02. 2017

No. 49868

To: Dr. Shaqaieq Ashrafi Dost
PhD researcher
Health and Social Science (HSS), Bournemouth University, UK

Subject: Approval for proposal entitled, "**Factors influencing the leaders and their personnel in reaching their organisational goal**".

Dear Dr. Ashrafi Dost,

Institutional Review Board, Ministry of Public Health has examined and reviewed your proposal entitled, "**Factors influencing the leaders and their personnel in reaching their organisational goal**".

We are pleased to declare that your study is approved. However, we reserve to the rights to monitor and audit your study and any violation of ethical norms during the course of study shall lead to withdrawal of given approval.

The duration of approval for a study to begin the research project is valid for six months and the implementation plan and monitoring plan should be shared to IRB secretary (irb.afg@gmail.com).

You are bound to share the result of your study with MoPH prior any dissemination plan.

Sincerely,

Bashir Noormal MD MPH
Director General
Afghanistan National Public Health Institute (ANPHI) &
Chairman, Institutional Review Board (IRB)
Ministry of Public Health

Appendix 6: Participant information sheet (for in-depth interview)

Participant Information Sheet (for in-depth interview- senior staff)

Project Title: What are the enablers and barriers faced by leaders in the Ministry of Public Health (MoPH) looking to reach their organisational goals?

Invitation to participate in the study:
You are invited to participate in a research study carried out by a researcher - Shaqaieq Ashrafi Dost from Bournemouth University (BU). Before you decide, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything you do not understand, or if you have any questions, please feel free to contact Shaqaieq Ashrafi Dost. You will find contact details at the end of this information sheet. Thank you for reading this.

Title of this study:
What are the enablers and barriers faced by leaders in the MoPH looking to reach their organisational goals?

What is the purpose of this study?
The purpose of this study is to explore the enablers and barriers faced by leaders in MoPH which affect the performance of leaders and staff members in achieving their goals. The findings will help the Health Ministry to consider those factors in their strategic plan to improve the enabling environment for staff productivity. This will also help the donors and the development partners in their support of the MoPH. It is hoped that the findings of this study will provide significant information for policy makers to improve capacity of the MoPH in the success of the health system in Afghanistan. The aim of this research is to find out the perception of managers and their personnel in the MoPH in response to the study question. The duration of the study will be three months and is anticipated to take place from July to September 2017.

Why have I been chosen?
All the directorates (total 30) that are working under the three deputy ministers of the MoPH are included in this study. The participants for this study are all the related directors and the most experienced personnel of the related directorates. You have been chosen to take part in this study because you are one of the senior staff members that work in those chosen directorates.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep (and be asked to sign a **participant agreement form**). You can withdraw at any time, up to the point of when transcripts are anonymised, so your identity cannot be determined. You do not have to give a reason. Your decision not to participate or to withdraw will not affect any aspect of your work.

What would taking part involve?
The researcher, Shaqaieq will conduct an interview with you which will not be longer than one hour in duration. The interview will be carried out in a meeting room in the MoPH, where you will be comfortable. To start with, you will be asked to introduce yourself by saying your name so that your voice can be identified on the audio recording. You will be asked several open-ended questions about your experience of your working environment. All the information gained is confidential and only the research team at BU will have access to it.

This information is important because it will help explore which management factors influence the employee performance. Understanding this will help to know how to create an enabling working environment.

Will my voice be recorded, and how will the recorded voice be used?
The audio recordings of your voice during your interview will be used only for analysis and the transcription of the recording(s) for anonymised illustration in my PhD thesis and other outputs. No other use will be made of them without your written permission, and no one in Afghanistan and outside other than the Research Team will have access to the original recordings.

What are the benefits of taking part?

Whilst there are no immediate benefits for those participating in this study, it is hoped that the findings will increase understanding of enabling work environments and that this will support the continued development of the MoPH.

Are there any disadvantages to taking part?
Taking part in the study will take up your valuable time (up to one hour). Other than this there are no disadvantages.

Will the information I provide be kept confidential?
All the information that we collect about you during the course of the research will be kept in according withthe Data Protection Act 1998. Nobody in Afghanistan and outside other than the Research Team will have access to the personal data. You will not be able to be identified in any reports or publications. All data relating to this study will be kept for 5 years on a BU password protected secure network.

What will happen to the results of the research study?
The study findings will be written up as part of a PhD thesis as well as for publication in journals. It will also be presented in conferences in Afghanistan or

in other countries. The summary of the findings can also be shared with the participants by email based on request.

Who is funding the research?
This research is funded by the PhD researcher (Shaqaieq Ashrafi Dost).

Contact for further information or complaints:
If you have any further questions, concerns please contact the principal investigator, Shaqaieq Ashrafi Dost by email at sashrafidost@bournemouth.ac.uk,

If you have any complaints please contact Prof. Vanora Hundley, Deputy Dean for research and Professional Practice: researchgovernance@bournemouth.ac.uk

Thank you for reading this information sheet.

Appendix 7: Participant information sheet (Dari) (for in-depth interview)

فورم معلومات اشتراک کننده (برای مصاحبه با کارمندان ارشد)

دعوت بخاطر اشتراک در مطالعه تحقیقی:

از شما دعوت به عمل می آید تا در مطالعه تحقیقی که توسط داکتر شقایق اشرفی دوست محصل پوهنتون بورنموث کشور انگلستان صورت میگیرد اشتراک نمایید. قبل از اشتراک، این مهم است که شما در مورد اینکه چرا این تحقیق اجرا میشود و چه موضوعات را در بر میگیرد بدانید. لطفا معلومات ذیل را به دقت مطالعه نمایید و اگر خواستید میتوانید با دیگران نیز مشوره نمایید. اگر موضوعی برای شما مبهم بود و یا اینکه شما سوالی داشتید، میتوانید با داکتر شقایق اشرفی دوست در تماس شوید. جزییات تماس در آخر این فورم ذکر گردیده است. از شما تشکر ازینکه این فورم معلوماتی را مطالعه نمودید.

عنوان این مطالعه تحقیقی:

کدام توانمند ساز ها و موانع را روسای وزارت صحت عامه در رسیدن به اهداف وزارت مواجه میشوند.

هدف این مطالعه چه است؟

هدف این تحقیق، مطالعه چالش ها و توانمندساز های است که رهبران و کارمندان شان دررسیدن به اهداف شان به آنها مواجه میشوند.

دریافت های این مطالعه، وزارت صحت عامه را کمک خواهد نمود تا این فکتورها (چالش ها و توانمند ساز ها) را در پلان استراتیژیک برای بهبود محیط کاری و موثریت کارکرد کارمندان مد نظر بگیرد.

این مطالعه ،مراجع تمویل کننده و همکاران بین المللی را نیز بخاطر حمایت بهتر وزارت صحت عامه کمک خواهد کرد.

امیدواری این است که دریافت های این مطالعه، معلومات مفید و قناعت بخش را به سازنده های پالیسی بخاطر ظرفیت سازی وزارت صحت عامه وموفقیت سیستم صحی افغانستان فراهم نماید. مقصد ازین مطالعه دریافت دید گاه مدیران و کارمندان شان در پاسخگویی به سوال این تحقیق میباشد. این مطالعه مدت سه ماه را در بر میگیرد یعنی از ماه جولای الی ماه سپتمبر سال 2017 دوام خواهد کرد.

چرا من انتخاب شده ام؟

تمام ریاست ها (مجموعاً 30 ریاست) که در تحت چتر سه معینیت در وزارت صحت عامه کار میکنند، درین مطالعه دخیل شده اند. اشتراک کننده گان این ریسرچ تمام روسا و مجربترین کارمند آن ریاست ها میباشند. شما به خاطر آنکه از جمله آن کارمندان مجرب هستید درین مطالعه دعوت شده اید.

آیا من مکلف به اشتراک درین مطالعه استم؟

تصمیم مربوط به شما است ،که آیا دراین مطالعه سهم میگیرید یا خیر. اگر تصمیم گرفتید که درین مطالعه سهم داشته باشید، در آنصورت این فورم معلوماتی جهت معلومات به شما داده میشود و از شما خواسته میشود تا فورم موافقه اشتراک کننده را امضا نمایید.

شما در صورت اشتراک در هر مقطع میتوانید که از پروسه انصراف نمایید تا زمانی که گفته های شما در بین دیگر گفته ها مدغم شده و نام شما ناشناخته گردد. شما مجبور به ارایه دلیل نیستید. منصرف شدن شما از اشتراک در پروسه، کار های رسمی شما را متآثر نمیسازد.

اشتراک شما در مطالعه شامل چه چیز های خواهد بود؟

تحقیق کننده با شما مصاحبه خواهد داشت که زیادتر از یکساعت نخواهد بود. مصاحبه در یک اتاق جلسه در وزارت صحت عامه که برای شما مناسب باشد دایر خواهد شد. مصاحبه با معرفی نام شما آغاز میشود تا صدای شما در ریکارد قابل شناخت باشد. از شما سوالات در مورد تجارب تان از محیط کاری تان پرسیده خواهد شد.

تمام معلومات بدست آمده به شکل محرم حفظ میگردد و تنها تیم تحقیقی پوهنتون بورنموث کشور انگلستان به آن دسترسی خواهد داشت.

آیا صدای من ثبت میگردد، و از صدای ثبت شده من به چه شکل استفاده صورت میگیرد؟

صدای ثبت شده شما در جریان مصاحبه صرف بمنظور تحلیل و رونویسی در رساله دوکتورای من و نشرات مربوطه آن استفاده میشود. از این معلومات به دیگر مقاصد بدون اجازه کتبی شما استفاده صورت نمی گیرد و هیچ فرد یا مرجعی در داخل افغانستان و یا خارج از افغانستان به این معلومات (ثبت اصلی صدا) دسترسی نخواهد داشت به استثنای تیم تحقیقی پوهنتون بورنموث.

اشتراک در این مطالعه چه فایده خواهد داشت؟

شما منفعت مستقیم بخاطر اشتراک درین مطالعه دریافت نخواهید کرد. اما امیدواری این است که دریافت های این تحقیق بخاطر ایجاد محیط مناسب کاری برای رهبران/ روسا و کارمندان کمک خواهد کرد. .

آیا اشتراک در پروسه کدام ضرر خواهد داشت؟

اشتراک در پروسه صرف تا یکساعت وقت با ارزش تان را خواهد گرفت، در غیر آن کدام ضرر ندارد.

آیا معلومات که من ارایه نموده ام محرم نگهداری خواهد شد؟

تمام معلومات که در جریان پروسه تحقیق از شما بدست آورده ایم مطابق به قانون حفاظت ارقام و معلومات جهانی سال 1998 به شکل محرم نگهداری خواهد شد. هیچ فردی در داخل افغانستان و یا خارج از افغانستان به این معلومات دسترسی نخواهد داشت به استثنای تیم تحقیقی پوهنتون بورنموث. هویت شما در هیچ یک از راپور تحقیق یا انتشارات مربوط به این تحقیق قابل شناخت نخواهد بود. معلومات مربوط به این تحقیق برای مدت 5 سال در سیستم پوهنتون بورنموث با داشتن رمز محافظتی امن نگهداری خواهد شد.

نحوه استفاده از نتایج این مطالعه تحقیقی چطور خواهد بود؟

دریافت های این مطالعه ، دربخش از رساله دوکتورا نوشته خواهد شد، در ضمن در ژورنال مربوطه نشر خواهد گردید. همچنان نتایج این مطالعه تحقیقی در کنفرانس هال ملی در داخل افغانستان و کنفرانس های بین المللی در خارج از کشور ارایه خواهد شد. خلاصه دریافت های این مطالعه تحقیقی با اشتراک کننده گان پروسه نیزدر صورتیکه خواسته باشند از طریق ایمیل شریک ساخته خواهد شد.

تمویل کننده مالی این تحقیق کی میباشد؟

این مطالعه تحقیقی توسط داکتر شقایق اشرفی دوست محصل برنامه تحقیقی دوکتورا تمویل میگردد.

جزییات تماس در صورت نیاز به معلومات بیشتر یا داشتن شکایت:

اگر شما سوالات و یا ملاحظات بیشتر دارید ،لطفاً با تحقیق کننده ،داکتر شقایق اشرفی دوست از طریق ایمیل آدرس sashrafi.dost@bournemouth.ac.uk در تماس شوید.

در صورت داشتن شکایت لطفاً با پروفیسور ونورا هندلی معاون دیپارتمنت تحقیق پوهنتون بورنموث از طریق ایمیل آدرس researchgovernance@bournemouth.ac.uk درتماس شوید.

تشکر ازینکه این فورم معلوماتی را مطالعه نمودید.

Appendix 8: Participant information sheet (for questionnaire)

Indicative Participant Information Sheet (for questionnaire completion by directors)

Invitation to participate in the study:
You are invited to participate in a research study carried out by a researcher - Shaqaieq Ashrafi Dost from Bournemouth University (BU). Before you decide, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything you do not understand, or if you have any questions, please feel free to contact Shaqaieq Ashrafi Dost. You will find contact details at the end of this information sheet. Thank you for reading this.

Title of this study:
What are the enablers and barriers faced by leaders to reach to their organisational goals?

What is the purpose of this study?
The purpose of this study is to explore the enablers and barriers faced by leaders in MoPH which affect the performance of leaders and staff members in achieving their goals. The findings will help the Health Ministry to consider those factors in their strategic plan to improve the enabling environment for staff productivity. This will also help the donors and the development partners in their support of the MoPH. It is hoped that the findings of this study will provide significant information for policy makers to improve capacity of the MoPH in the success of the health system in Afghanistan. The aim of this research is to find out the perception of managers and their personnel in the MoPH in response to the study question. The duration of the study will be three months and is anticipated to take place from July to September 2017.

Why have I been chosen?
All the directorates (total 30) that are working under the three deputy ministers of the MoPH are included in this study. The participants for this study are all the related directors and the most experienced personnel of the related directorates. You have been chosen to take part in this study because you are one of the directors that work in those chosen directorates.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part, please keep this information sheet. You will be asked to sign a consent form before you start the research. If you decide to take part, you are free to withdraw at any time up to the point of anonymization without giving a reason. Your

decision not to participate or to withdraw will not affect any aspect of your work. If you do decide to withdraw, you may request that any or all the information already collected be destroyed or withheld.

What would taking part involve?
The researcher will ask you to fill in a questionnaire which should take no longer than 30 minutes to complete. The questionnaire will ask various questions including demographics, qualifications, work experience, support required to manage, the support you provide, the enablers that can help you to achieve more, the obstacles you face in managing your personnel and fulfilling the organisational objectives.

All the information gained is confidential and only the research team at BU will have access to it.

What are the benefits of taking part?
You will not receive any direct benefits from taking part in this study. However, it is hoped that the findings of this research will help understanding how MoPH leaders and employees can work in an enabling environment.

Are there any disadvantages to taking part?
Taking part in the study will take up your valuable time (approximately 30 minutes). Other than this there are no disadvantages.

Will the information I provide be kept confidential?
All the information that we collect about you during the course of the research will be kept strictly confidential according to the Data Protection Act 1998. Nobody in Afghanistan and outside will have access to it. You will not be able to be identified in any reports or publications. All data relating to this study will be kept for 5 years on a BU password protected secure network.

What will happen to the results of the research study?
The study findings will be written up as part of a PhD thesis as well as for publication in journals. It will also be presented in conferences in Afghanistan or in other countries. The summary of the findings can also be shared with the participants by email based on request.

Who is funding the research?
This research is funded by the PhD researcher (Shaqaieq Ashrafi Dost).

Who is supervising the researcher?
This PhD research is supervised by:

Supervisors	Designation	Faculty
Dr. Carol Bond, PhD	Principal academic	Health and Social Science

Prof. Steve Tee, DClinP, MA, PGCEA, BA, DPSN, RMN, PFHEA	Executive Dean	Health and Social Science

Contact for further information or complaints:
If you have any further questions, concerns please contact the principal investigator, Shaqaieq Ashrafi Dost by email at sashrafidost@bournemouth.ac.uk,

If you have any complaints please contact Prof. Vanora Hundley, Deputy Dean for Research and Professional Practice: researchgovernance@bournemouth.ac.uk

Thank you for reading this information sheet.

Appendix 9: Participant information sheet (Dari) (for questionnaire)

فورم معلومات اشتراک کننده (برای تکمیل نمودن پرسشنامه توسط روسا)

دعوت بخاطر اشتراک در مطالعه تحقیقی:

از شما دعوت به عمل می آید تا در مطالعه تحقیقی که توسط داکتر شقایق اشرفی دوست محصل پوهنتون بورنموث کشور انگلستان صورت میگیرد اشتراک نمایید. قبل از اشتراک، این مهم است که شما در مورد اینکه چرا این تحقیق اجرا میشود و چه موضوعات را در بر میگیرد بدانید. لطفا معلومات ذیل را به دقت مطالعه نمایید و اگر خواستید میتوانید با دیکران نیز مشوره نمایید. اگر موضوعی برای شما مبهم بود و یا اینکه شما سوالی داشتید، میتوانید با داکتر شقایق اشرفی دوست در تماس شوید. جزییات تماس درقسمت اخیر این فورم ذکر گردیده است. از شما تشکر ازینکه این فورم معلوماتی را مطالعه نمودید.

عنوان این مطالعه تحقیقی:

کدام توانمند ساز ها و موانع را روسای وزارت صحت عامه در رسیدن به اهداف وزارت مواجه میشوند.

هدف این مطالعه چه است؟

هدف این تحقیق، مطالعه چالش ها و توانمندساز های است که رهبران و کارمندان شان دررسیدن به اهداف شان به آنها مواجه میشوند.

دریافت های این مطالعه، وزارت صحت عامه را کمک خواهد نمود تا این فکتورها (چالش ها و توانمند سازها) را در پلان استراتیژیک برای بهبود محیط کاری و موثریت کارکرد کارمندان مد نظر بگیرد.

این مطالعه ،مراجع تمویل کننده و همکاران بین المللی را نیز برای حمایت بهتر وزارت صحت عامه کمک خواهد کرد.

امیدواری این است که دریافت های این مطالعه، معلومات مفید و قناعت بخش را به سازنده های پالیسی بخاطر ظرفیت سازی وزارت صحت عامه وموفقیت سیستم صحی افغانستان فراهم نماید. مقصد ازین مطالعه دریافت دید گاه مدیران و کارمندان شان در پاسخگویی به سوال این تحقیق میباشد. این مطالعه مدت سه ماه را در بر میگیرد یعنی از ماه جولای الی ماه سپتمبر سال 2017 دوام خواهد کرد.

چرا من انتخاب شده ام؟

تمام ریاست ها (مجموعاً 30 ریاست) که در تحت چتر سه معینیت در وزارت صحت عامه کار میکنند، درین مطالعه دخیل شده اند. اشتراک کننده گان این ریسرچ تمام روسا و مجربترین کارمند آن ریاست ها میباشند. شما به خاطر آنکه از جمله آن روسا هستید درین مطالعه دعوت شده اید.

آیا من مکلف به اشتراک درین مطالعه استم؟

تصمیم مربوط به شما است که آیا دراین مطالعه سهم میگیرید یا خیر. اگر تصمیم گرفتید که درین مطالعه سهم داشته باشید، در آنصورت این فورم معلوماتی جهت معلومات به شما داده میشود و از شما خواسته میشود تا فورم موافقه اشتراک کننده را امضا نمایید.

شما در صورت اشتراک در هر مقطع میتوانید که از پروسه انصراف نموده و فورم پرسشنامه را به تحقیق کننده بازگشت ندهید.

به هرصورت ، زمانیکه شما پرسشنامه تکمیل شده را به تحقیق کننده تسلیم کردید، در آنصورت تحقیق کننده نمیتواند که پاسخ های شما را از مطالعه خارج سازد. شما مجبور به ارایه دلیل نیستید. منصرف شدن شما از اشتراک در تحقیق، کار های رسمی شما را متآثر نمیسازد.

اشتراک شما در مطالعه شامل چه چیز های خواهد بود؟

تحقیق کننده از شما میخواهد تا یک پرسشنامه که اضافه از 30 دقیقه وقت شما را نخواهد گرفت ،خانه پری نمایید. پرسشنامه شامل سوالات مختلف از قبیل معلومات دیموگرافیک، درجه تحصیلی ، تجارب کاری ، حمایت مقتضی بخاطر مدیریت بهتر، حمایت های که شما ارایه مینمایید، اهداف کاری کارمندان و اهداف ریاست مربوطه شما و غیره میباشد.

تمام معلومات بدست آمده به شکل محرم حفظ میگردد و تنها تیم تحقیقی پوهنتون بورنموث کشور انگلستان به آن دسترسی خواهد داشت.

اشتراک در این مطالعه چه فایده خواهد داشت؟

شما منفعت مستقیم بخاطر اشتراک درین مطالعه دریافت نخواهید کرد. اما امیدواری این است که دریافت های این تحقیق بخاطر ایجاد محیط مناسب کاری برای رهبران/ روسا و کارمندان کمک خواهد کرد.

آیا اشتراک در پروسه کدام ضرر خواهد داشت؟

اشتراک در پروسه صرف تقریباً 30 دقیقه وقت با ارزش تان را خواهد گرفت، در غیر آن کدام ضرردیگر ندارد.

آیا معلومات که من ارایه نموده ام محرم نگهداری خواهد شد؟

تمام معلومات که در جریان پروسه تحقیق از شما بدست آورده ایم مطابق به قانون حفاظت ارقام و معلومات جهانی سال 1998 به شکل محرم نگهداری خواهد شد. هیچ فردی در داخل افغانستان و یا خارج از افغانستان به این معلومات دسترسی نخواهد داشت به استثنای تیم تحقیقی پوهنتون بورنموث. هویت شما در هیچ یک از راپور تحقیق یا انتشارات مربوط به این تحقیق قابل شناخت نخواهد بود. معلومات مربوط به این تحقیق برای مدت 5 سال در سیستم پوهنتون بورنموث با داشتن رمز محافظتی امن نگهداری خواهد شد.

نحوه استفاده از نتایج این مطالعه تحقیقی چطور خواهد بود؟

دریافت های این مطالعه ، دربخش از رساله دوکتورا نوشته خواهد شد، در ضمن در ژورنال مربوطه نشر خواهد گردید. همچنان نتایج این مطالعه تحقیقی در کنفرانس های ملی در داخل افغانستان و کنفرانس های بین المللی در خارج از کشور ارایه خواهد شد. خلاصه دریافت های این مطالعه تحقیقی با اشتراک کننده گان پروسه نیزدر صورتیکه خواسته باشند از طریق ایمیل شریک ساخته خواهد شد.

تمویل کننده مالی این تحقیق کی میباشد؟

این مطالعه تحقیقی توسط داکتر شقایق اشرفی دوست محصل برنامه تحقیقی دوکتورا تمویل میگردد.

جزییات تماس در صورت نیاز به معلومات بیشتر یا داشتن شکایت:

اگر شما سوالات و یا ملاحظات بیشتر دارید ،لطفاً با تحقیق کننده ،داکتر شقایق اشرفی دوست از طریق ایمیل آدرس sashrafidost@bournemouth.ac.uk در تماس شوید.

در صورت داشتن شکایت لطفاً با پروفیسور ونورا هندلی معاون دیپارتمنت تحقیق پوهنتون بورنموث از طریق ایمیل آدرس researchgovernance@bournemouth.ac.uk درتماس شوید.

تشکر ازینکه این فورم معلوماتی را مطالعه نمودید.

Appendix 10: Participant Agreement Form

Indicative Participant Agreement Form

Full title of project: What are the enablers and barriers faced by leaders to reach to their organisational goals?
Name, position and contact details of researcher: Shaqaieq Ashrafi Dost, PhD student, Bournemouth University. Email: sashrafidost@bournemouth.ac.uk
Name, position and contact details of supervisor: Dr Carol Bond, Principal Academic,
Bournemouth University, Tel: (+ 44) 1202 961748, Email: cbond@bournemouth.ac.uk

Please initial/tick here

I confirm that I have read and understood the participant information sheet for the above research project.	
I confirm that I have had the opportunity to ask questions.	
I understand that my participation is voluntary and that I am free to withdraw at any time up to the point of anonymization, without giving reason and without there being any negative consequences. In addition, should I not wish to answer any particular question(s), I am free to decline.	
I give permission for members of the research team to have access to my anonymous responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	
I agree to take part in the above research project.	

------------------------------------ ------------------------ --------------------------------

Name of participant Date Signature

------------------------------------ ------------------------ --------------------------------

Name of researcher Date Signature

This form should be signed and dated by all parties after the participant receives a copy of the participant information sheet and any other written information provided to the participants. A copy of the signed and dated participant agreement form should be kept with the project's main documents which must be kept in a secure location.

Appendix 11: Participant Agreement Form (Dari)

فورم موافقتنامه اشتراک کننده

عنوان مکمل پروژه: رهبران وزارت صحت عامه برای رسیدن به اهداف موسسه/نهاد خود به کدام توانمند سازها و موانع مواجه میشوند؟

جزییات تماس تحقیق کننده (ریسرچر): شقایق اشرفی دوست محصل دوکتورا پوهنتون بورنموث ، نمبر تماس ۰۷۹۵۴۶۰۸۴۸ . ایمیل آدرس: sashrafidost@bournemouth.ac.uk

نام ،وظیفه و جزِییات تماس سوپروایزر: داکتر کرل باند مدیرعلمی پوهنتون بورنموث، نمبر تماس (+44) 1202961748، ایمیل آدرس: cbond@bournemouth.ac.uk

لطفآ اینجا را نشانی نمایید

من تصدیق میکنم که فورم معلومات اشتراک کننده برای پروژه تحقیق که نامش در بالا ذکر است را خوانده و فهمیده ام.	
من تصدیق میکنم که فرصت سوال کردن را داشتم.	
من دانسته ام که اشتراک من به شکل اختیاری بوده و میتوانم در هر مقطع تا زمانی که معلومات من با دیگر معلومات مدغم گردد بدون ارایه دلایل و بدون اینکه تاثیرات منفی بالای کارکردم داشته باشد منصرف شوم. علاوتآ من میدانم که مجبور به ارایه جواب به سوالی که نمیخواهم نمیباشم.	
من به اعضای تیم تحقیق اجازه میدهم تا به پاسخ هایم بدون اینکه نامم شناسایی شود دسترسی داشته باشند. من میدانم که نام من با مواد تحقیق ارتباط نخواهد داشت و هم میدانم که نام من در راپور تحقیق شناسایی یا قابل شناس نخواهد بود.	
من موافق استم که در پروژه تحقیق که در فوق ذکر است سهم بگیرم.	

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اسم اشتراک کننده	تاریخ	امضا
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اسم تحقیق کننده	تاریخ	امضا

Appendix 12: Risk assessment approval

Sun 19/03/2017 16:48

Shaqaieq Ashrafi Dost

FW: Risk Assessment Approved

To 'HealthandSafetyTeam@bournemouth.ac.uk'

This message is part of a tracked conversation. Click here to find all related messages or to open the original flagged message.

Dear Shaqaieq Ashrafi Dost,

Your risk assessment has been **approved**.

Date of assessment: 13/03/2017
Date of activity: 01/05/2017
Description: I will distribute questionnaires to the participants who are working as the directors in the Ministry of Public Health (MoPH) in Afghanistan. I will also conduct interview with the senior staff members of the same directorates in the MoPH in Afghanistan.
Location: MoPH, Kabul Afghanistan

To view the risk assessment please visit the Risk Assessment website risk.bournemouth.ac.uk

Thanks,

Web team

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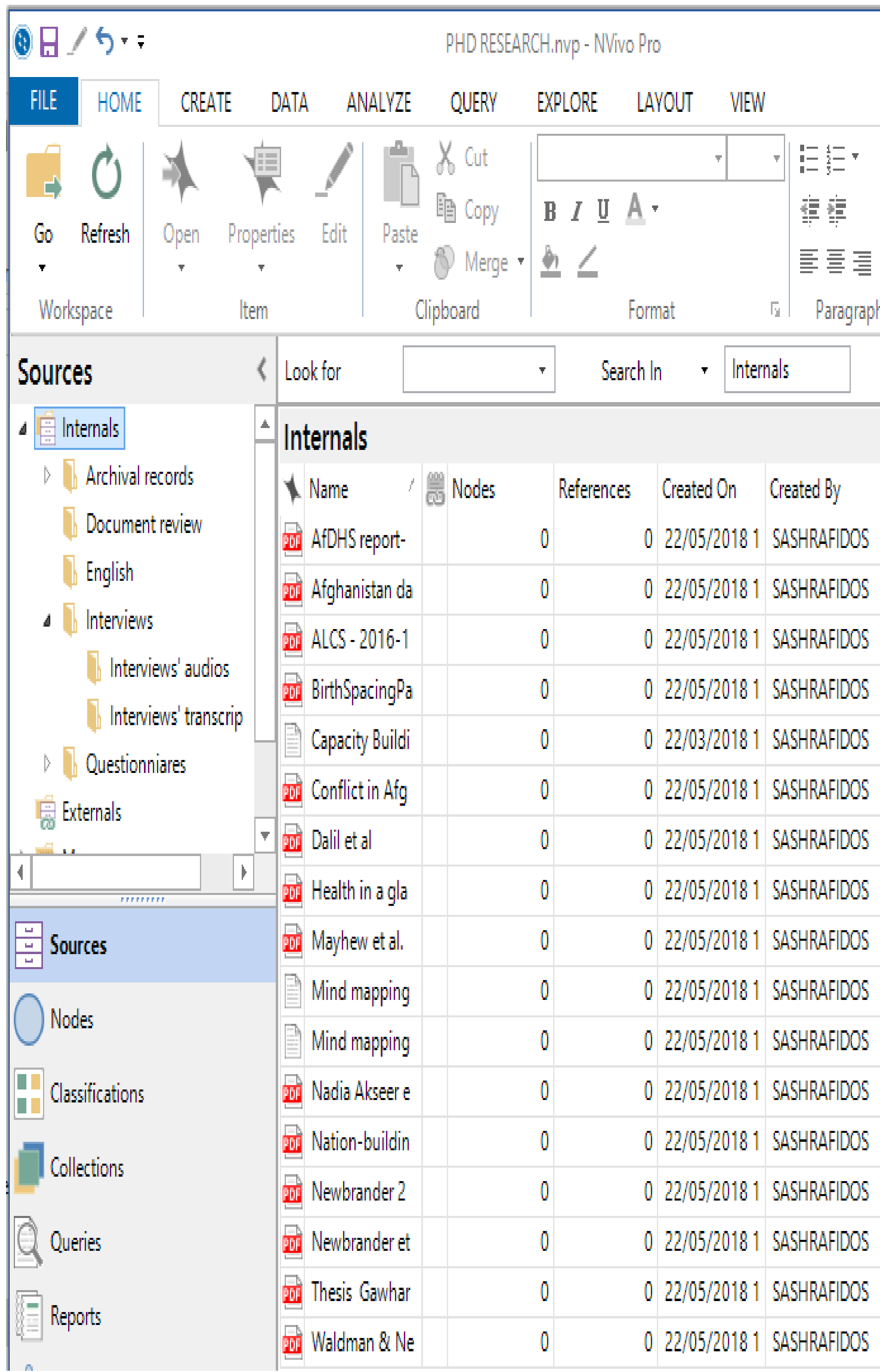
Appendix 13: NVivo, The master database



Appendix 14: Questionnaire

Respondents: MoPH directors

Before filling this questionnaire, please answer the following questions about yourself.

Gender:

male ☐ female ☐

Last qualification degree:

a. Medical Doctor (MD) ☐
b. Master ☐
c. Doctor of Philosophy (PhD) ☐
d. other, please specify: ……………… ☐

Age range:

a. 20-30 ☐
b. 31-40 ☐
c. 41-50 ☐
d. above 50 ☐

Total years of work experience in the health field: ……………………

Years at current position: ……….…………….

Are you…………………………? *(fill-in-the-blank)*

Married ☐
single ☐
widowed ☐
other, please specify: ………………. ☐

Number of total employees (technical and non-technical) working in this directorate:

1 – 5 ☐
6 – 10 ☐
11 – 15 ☐
16 – 20 ☐
20+ ☐

Date of the questionnaire completion: …………………….

A. Managers' support and personnel's performance

1. When personnel show initiative (a new plan or process to achieve something or solve a problem)**, they are** *(You can check more than one box)*

a. encouraged verbally ☐
b. appreciated in a staff meeting ☐
c. promoted (Grade or Step) ☐
d. rewarded financially ☐
e. given appreciation letter ☐
f. not praised ☐
g. other: please specify………… ☐

Internal communication refers to exchange of information and messages between persons and departments of an organization. Internal communication may be divided into two, oral and written communication. These are divided into their own types. The next 4 questions are about internal communication.

2. How do you communicate with personnel in this directorate? *(You can check more than one box)*

a. by telephone/mobile ☐
b. through meetings ☐
c. by email ☐
d. face to face in their work place ☐
e. through reports ☐
f. other, please specify……………☐

3. On average, how often do you communicate with personnel (e.g. one person) in this directorate? *(You can check one box)*

a. monthly ☐
b. biweekly ☐
c. weekly ☐
d. daily ☐
e. sometimes ☐
f. rarely ☐
g. never ☐
h. other, please specify ………… ☐

4. What three main benefits do you derive from your communication with personnel?

1. …………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
2. …………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
3. …………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………

5. How often do you give time for staff to talk to you about their concerns or problems? *(You can check one box)*

a. Never ☐
b. Rarely ☐
c. Sometimes ☐
d. if I have time ☐
e. regularly ☐
f. other, please specify………… ☐

Please assess yourself by writing one number from 1 to 4 in the related column in front of each question, (1 is 'not known', 4 is 'well known').

	Question	1	2	3	4
6	**I know the educational background of the people I supervise.**				
7	**I know the professional background of the people I supervise.**				
8	**I know the job descriptions of staff members.**				
9	**I know the work plans of staff members.**				
10	**I advocate for my staff if appropriate (e.g., appropriate salaries, resources, training opportunities)**				
11	**I treat people fairly and consistently (similarly)**				
12	**I respect staff and their contributions**				

13. How do you monitor the performance of personnel in this directorate? *(You can check more than one box)*

a. by daily asking ☐
b. by checking the monthly activity report (*if applicable*) ☐
c. by filling their appraisal form versus their annual planning ☐
d. through meetings ☐
e. through monthly work plan ☐
f. other, please specify………………………………………… ☐

14. How often is the personnel performance appraised? (*You can check one box*)

a. annual basis ☐
b. bi annually ☐
c. less than 6 months ☐
d. never ☐
e. other, please specify…………………………………… ☐

15. Does appraising staff bring benefit? (*Please select Yes or No*)

Yes ☐ No ☐

16. If you selected 'No', why do you think it doesn't bring any benefit. If you selected 'Yes' what do you think is/are the benefit/s of appraising personnel?

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…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

17. Do the staff in this directorate raise concerns about their work environment? (*Please select Yes or No*)

Yes ☐ No ☐

18. If you selected 'No' why do you think they do not raise concerns. If you selected 'Yes', a. what happen to those concerns? b. what are those concerns specifically about?

…………………………………………………………………………………………
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19. Do staff take their annual leave? (*Please select Yes or No or other*)

Yes ☐ No ☐ other, please specify: …………………. ☐

20. If you selected 'No' or 'other', please explain, why?

……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………

21. What support/motivation do the staff get from you to do their best in achieving the goal? *(You can write up to five kinds of support/motivation that you provide to staff. You can use more space if you need for your answer)*

1. ……………………………………………………………………………………
2. ……………………………………………………………………………………
3. ……………………………………………………………………………………
4. ……………………………………………………………………………………
5. ……………………………………………………………………………………

B. Management support system *Please select 'Yes' or 'No'*

22. Are you given the authority you think is required for this (your) position?

Yes ☐ No ☐

23. Does this directorate have sufficient staff to achieve its goals? Yes ☐ No ☐

24. Do you think capacity building (*a process that supports the initial stages of building or creating capacities*) **is required in this directorate?**

Yes ☐ No ☐

25. Does this directorate have a capacity building plan for staff?

Yes ☐ No ☐

26. Beside this job, do you have any other job Yes ☐ No ☐

27. If 'No', skip this question, if 'Yes', please select the answer *(You can check more than one box)*

1. private clinic ☐
2. work with an NGO ☐
3. work in the partnership with an NGO ☐
4. self-employee ☐
5. NGO owner ☐
6. other, please specify……………………… ☐

28. Please list below any further support you need to achieve your directorate's goal? *(you can write up to five supports which you think you have but are insufficient or do not currently have).*

1……………………………………………………………………………………
…………………………………………………………………………………….......................
2……………………………………………………………………………………………………
……………………………………………………………………………………………………
3…………………...………………………………………………………………………
…………………………………………………………………………………………………
4……………………………………………………………………………………………………
……………………………………………………………………………………………………
5……………………………………………………………………………………………………
...………………………………………………………………………………………………

C. Management training

Please select 'Yes' or 'No':

	Yes	No
29. Have you received any training about Human Resources Management (HRM) at the directorate level?		
30. Are there any particular aspects of management training *(e. g. financial or HRM)* that would enable you to do your job better?"		

31. If you selected 'Yes' for question 30, what is this training?

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……………………………………………………………………………………………

Please add if you think there is something important about management training that you would like to mention here. (optional)

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………………………………………………………………………………………

D. Leadership/management capacity

32. How were you hired to this position? *(You can check more than one box)*

a. by competition ☐
b. promotion ☐
c. after getting Master's degree ☐
d. recommended by a higher position at the Ministry of Public Health ☐
e. recommended by politics ☐
f. other, please specify………………………………………………. ☐

33. In your opinion, a good manager is someone who; *(You can write up to 5 characteristics)*

1. ……………………………………………………………………….
2. ……………………………………………………………………….
3. ………………………………………………………………………
4. ……………………………………………………………………….
5. ……………………………………………………………………….

Please assess yourself by writing one number from 1 to 4 in the related column in front of the next two first questions, (1 is 'never', 4 is 'always')

	Questions	1	2	3	4
34	**I take ownership of key planning and budgeting processes within own responsibility**				
35	**I succeed in achieving maximum results with limited resources**				

Please select 'Yes' or 'No'.

	Yes	No
36. Have you had any financial management training?		
37. Have you ever faced any problems in preparing budgets?		
38. Do you think you need some financial management training?		

Please add if you think there is something important and is necessary to mention about financial management here. (optional)

……………………………………………………………………………………………

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……………………………………………………………………………………………

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E. Socio-cultural/political effects on leadership

39. Please rate in order the following obstacles/problems that you face in reaching your directorate's goal? (***1*** *is the first main obstacle,* ***2*** *is the second main obstacle and so on. You can ignore if you do not face any of the obstacles).*

politics/political issues	
cultural aspects	
low support of management	
shortage of resources	
corruption	
low transparency	
low knowledge of management	
family issues or other personal issues	
intimidation/pressure from powerful people	
other, please specify……………………………………	

40. What would be your suggestion for solving or preventing the top three problems mentioned above (please give as much detail as you like).

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…………………………………………………………………………………
…………………...
....
…………………...……………………………………………………………
…………………………………………………………………………………

Please add if you think there is something important about Socio-cultural/politics and is necessary to mention here. (optional):

…………………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………
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F. Management system transparency and accountability

41. Do you think there are any cultural issues or aspects in the MoPH in general that affect the leadership work? (*Please select Yes or No*)

Yes ☐ No ☐

42. If yes, please *check* **the** *box* **that best corresponds to your answer/s**. *(You can check more than one box)*

1. punitive management ☐
2. the act of using power or influence to get good jobs for members of own family (Nepotism) ☐
3. unfair support shown to one person or group, specially by someone in authority (Favouritism) ☐
4. the relationship between members of the same family (Kinship) ☐
5. the situation in which someone important gives jobs to friends rather than to independent people who have the necessary skills and experience (Cronyism) ☐
6. juniors have to accept what the senior colleagues say even it is not correct. ☐
7. unprofessional treatment with staff ☐
8. other, please specify……………………………………………… ☐

43. Do you think there are political issues or discrimination that affect your work negatively? Such as grouping, political inference in hiring/firing of staff, nationality, religion, language, race, gender.

(Please select Yes or No. If yes, please explain below).

Yes ☐ No ☐

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44. How are staff promoted in your directorate? *(You can check more than one box)*

a. by competition ☐
b. internal promotion ☐
c. after getting Master's degree ☐
d. recommended by politics ☐
e. recommended by higher authorities ☐
f. based on performance appraisal ☐
g. other, please specify………………………………… ☐

Please add if you think there is something important not been asked above and is necessary to mention here. (optional)
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Thank you very much for your time and efforts

Appendix 15: Questionnaire (Dari)

پرسشنامه

پاسخ دهنده: روًسای محترم وزرات صحت عامه

قبل از پرکردن این پرسشنامه لطفآ سوالات ذیل را در باره خودتان جواب بدهید.

جنسیت:

ازطبقه اناث ☐ ازطبقه ذکور ☐

آخرین درجه تحصیل:

الف: داکتر طب ☐
ب: ماستر ☐
ج: دوکتورا ☐
د: دیگر، لطفآ مشخص نمایید............ ☐

محدوده سنی شما :

الف: 20-30 ☐
ب: 31-40 ☐
ج: 41-50 ☐
د: بالاتر از 50 ☐

سالهای تجربهٔ کاری تان در بخش صحت...................

سالهای کاری تان در موقف فعلی تان:.........................

آیا شما ....هستید؟ (خانه خالی را پر نمایید)

متآهل ☐
مجرد ☐
بیوه ☐
دیگر؛ لطفآ مشخص نمایید:.............☐

تعداد پرسونل (تخنیکی و غیر تخنیکی) که در این ریاست کار می کنند.

1-5 ☐
6-10 ☐
11-15 ☐
16-20 ☐
+20 ☐

تاریخ تکمیل نمودن پرسشنامه:...........................

الف: حمایهٔ مدیران و اجراات کارمندان

1. **کارمندانی که از خود شایستگی و ابتکار**(یک پلان یا پروسه جدید برای بدست آوردن چیزی یا حل کدام مشکلی) **نشان میدهند آیا آنها** *(شما بیشتر از یک جواب را انتخاب کرده میتوانید)*

الف. تشویق شفاهی میشوند. ☐
ب. در جلسه رسمی کارمندان تشویق میشوند. ☐
ج. ارتقا می کنند (Grade و Step). ☐
د. پاداش مالی بدست میآورند. ☐
ذ. تقدیر نامه اهدا میشوند. ☐
ر. ستایش نمی شوند. ☐
ز. دیگر ، لطفآ مشخس سازید...................................... ☐

مکالمه داخلی شامل تبادله معلومات و پیام ها بین اشخاص و دیپارتمنت های یک موسسه میباشد. مکالمه داخلی به دوشکل میباشد: مکالمه شفاهی و مکالمه کتبی. که هرکدام این ها به انواع مختلف تقسیم شده اند. چهار سوال بعدی در ارتباط به مکالمه داخلی میباشد.

2. **شما چطور با کارمندان تان در این ریاست مکالمه میکنید؟** *(شما بیشتر از یک جواب را انتخاب کرده میتوانید)*

الف. ازطریق تیلفون/ مبایل ☐
ب. از طریق تدویر جلسات ☐
ج. از طریق ایمیل ☐
د. رو در رو در ساحه کاری شان ☐
ذ. ازطریق راپور ☐
ر. دیگر، لطفآ مشخص سازید................................ ☐

3. **بطور اوسط تکرر تماس یا مکالمه شما با یک کارمند دراین ریاست چقدر است؟** (لطفآ*یک جواب را انتخاب نمایید)*

الف. ماهوار ☐
ب. هر دوهفته ☐
ج. هفته وار ☐
د. روزان ☐
ذ. بعضی اوقات ☐
ر. ندرتآ ☐
ز. هیچگاه ☐
س. دیگر، لطفآ مشخص سازید.............................. ☐

4. **سه مزایای عمدهٔ ارتباط و مکالمهٔ شما با کارمندان تان چه ها استند؟**

.1 ....
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2. ....
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3. ....
....

5 . آیا کارمندان تان میتوانند مشکل یا ملاحظات شانرا با شما در میان بگذارند؟ *(لطفآ یک جواب را انتخاب نمایید)*

الف. هیچگاه ☐
ب. ندرتاً ☐
ج. بعضی اوقات ☐
د. اگر وقت داشته باشم ☐
ذ. منظمآ ☐
ر. دیگر، لطفآ واضح سازید................................. ☐

لطفآ خود را با نوشته نمودن یک نمبر از ۱ تا ۴ در ستون در مقابل هر سوال ارزیابی نمایید. (عدد ۱ ' نمیدانم' و عدد ۴ ' بسیار خوب میدانم' میباشد)

	سوال	1	2	3	4
6	**سابقه تحصیلی کارمندانی را که تحت نظارت من است میدانم**				
7	**سابقه مسلکی کارمندانی را که تحت نظارت من است میدانم**				
8	**لایحه وظایف کارمندان را میدانم**				
9	**پلان کاری کارمندان را میدانم**				
10	**حمایت از حقوق کارمندان جاییکه مناسب باشد (مثلآ معاش خوب ، منابع ، فرصتهای آموزشی)**				
11	**برخورد منصفانه و یکسان با پرسونل**				
12	**احترام به کارمندان و سهم گیری شان**				

13. چطور اجراات پرسونل تانرا درین ریاست نظارت میکنید؟ *(شما بیشتر از یک جواب را انتخاب کرده میتوانید)*

الف. با پرسیدنهای روزمره ☐
ب. از طریق چک کردن راپور فعالیت ماهوار (اگر موجود باشد) ☐
ج. از طریق خانه پری فورم ارزیابی (Appraisal) در مقایسه با پلان سالانه شان ☐
د. از طریق مجال ☐
ذ. از طریق بلان ماهوار ☐
ر. دیگر، لطفآ مشخص سازید.. ☐

14. در چه مدت زمان کارکرد پرسونل ارزیابی میگردد؟ *(لطفاً یک جواب را انتخاب نمایید)*

الف. سالانه ☐
ب. سالانه دو مرتبه ☐
ج. کمتر از شش ماه ☐
د. هرگز ارزیابی نمیشود ☐
ذ. دیگر، لطفاً مشخص سازید.. ☐

15. آیا ارزیابی کار کرد پرسونل مفید واقع میشود؟ *(لطفاً بلی یا نخیر را انتخاب نمایید)* بلی ☐ نخیر ☐

16. اگر جواب نخیر باشد به نظر شما دلیل چه خواهد بود. و اگر جواب تان بلی باشد به نظر شما مزایای ارزیابی پرسونل چه ها خواهد بود؟

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17. آیا کارمندان در مورد محیط کاری در ریاست شما شکایت می کنند ؟ بلی ☐ نخیر ☐

18. اگر جواب نخیر باشد به نظر شما چرا آنها شکایت نمیکنند. اگر جواب تان بلی باشد. الف: چگونه برخورد با آن شکا یا ت صورت گرفته است. ب: آن شکایات در چه موارد خاص بوده اند؟

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19. آیا کارمندان از رخصتی سالانه شان استفاده میکنند؟ *(لطفاً بلی یا نخیر ویا دیگر را انتخاب نمایید)*

بلی ☐ نخیر ☐ دیگر ،لطفاً مشخص سازید...

20. اگر شما نخیر یا دیگر را برای سوال ۱۹ انتخاب کرده اید لطفاً تشریح نمایید چرا؟

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21. کدام نوع حمایت و انگیزه را کارمندان تان بخاطر رسیدن به اهداف ریاست از شما دریافت میکنند؟
(لطفاً تا پنج نوع حمایت را که به پرسونل خود تآمین می کنید درج نمایید. در صورت ضرورت بیشتر جای را میتوانید استفاده نمایید.)

1. ....
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2. ....
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3. ....
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4. ....
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ب. سیستم حمایوی مدیریتی:

لطفآ بلی یا نخیر را انتخاب کنید

22. آیا صلاحیت وظیفوی که متقاضی موقف شما است به شما داده شده است؟ بلی ☐ نخیر ☐

23. آیا ریاست شما به طور بسنده کارمند دارد تا اهداف این ریاست را به دست آورید؟ بلی ☐ نخیر ☐

24. به نظر شما آیا این ریاست ضرورت به ظرفیت سازی (پروسه که قدمهای اساسی ساختن یا خلق کردن ظرفیت را حمایت میکند) دارد؟ بلی ☐ نخیر ☐

25. آیا پلان ظرفیت سازی کارمندان دراین ریاست موجود است؟ بلی ☐ نخیر ☐

26. در پهلوی موقف فعلی تان، آیا کدام وظیفهٔ دیگر هم دارید؟ بلی ☐ نخیر ☐

27. اگر جواب نخیر باشد از این سوال بگذرید. اگر جواب بلی باشد لطفآ جواب را حلقه نمایید *(شما بیشتر از یک جواب را انتخاب کرده میتوانید)*

1. کلینیک شخصی ☐
2. کار با یک موسسه غیر دولتی ☐
3. کار در شراکت با یک موسسه غیر دولتی ☐
4. خود کارمند (Self-employee) ☐
5. مالک موسسه غیر دولتی (NGO) ☐
6. دیگر لطفآ مشخص نمایید..................................... ☐

28. لطفآ بمنظور رسیدن به اهداف ریاست تان حمایت های بیشتری را که نیازدارید در زیرلست نمایید.
(لطفآ تا پنج نوع حمایت را که فکر میکنید ندارید ویا کمتر دارید نوشته کنید)

1. ....
....
2. ....
....
3. ....
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4. ....

ج. ترینگ مدیریتی:

لطفاً بلی یا نخیر را انتخاب کنید

بلی نخیر

29. آیا شما ترینگ مدیریت منابع بشری را گرفته اید؟

30. آیا کدام بخش خاص ترینگ مدیریت (مانند مدیریت مالی یا مدیریت منابع بشری) استند که اشتراک در آنها شما را درانجام بهتر وظایف تان کمک نماید؟

31. اگر جواب شما برای سوال 30 بلی باشد، پس این ترینگ ها کدام ها اند؟

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اگر به نظر شما بعضی مسایل مهم در مورد ترینگ مدیریتی وجود دارد لطفاً در ذیل ذکرنمایید (اختیاری)

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د. ظرفیت اداری/ رهبری:

32. چطور درین موقف استخدام شده اید؟ *(شما بیشتر از یک جواب را انتخاب کرده میتوانید)*

الف. از طریق رقابت آزاد ☐

ب. ارتقا ☐

ج. بعد از کسب درجه ماستری ☐

د. معرفی توسط مقامات عالیرتبه وزارت صحت عامه ☐

ذ. معرفی توسط سیاسیون ☐

ر. دیگر، لطفاً مشخص سازید.............................. ☐

33. به نظر شما یک مدیر خوب کسی است که : *(لطفاً تا پنج خصوصیات نوشته نمایید)*

1. ....

2. ....

3. ....

4. ....

5. ....

لطفاً خود را با نوشته نمودن یک نمبر از ۱ تا ۴ در ستون در مقابل دو سوال بعدی ارزیابی نمایید. (عدد1 به معنی 'هیچگاه' وعدد 4 به معنی 'همیشه' میباشد)

سوال	1	2	3	4

34 من اختیار پروسه های کلیدی پلان گذاری و بودجه سازی را در محدوده مسولیتم بعهده دارم.

35 من موفق به کسب نتایج اعظمی با منابع محدود میگردم.

لطفآ بلی یا نخیر را انتخاب نمایید.

	بلی	نخیر
۳۶. آیا شما کدام تریننگ یا ورکشاپ مدیریت مالی را گرفته اید؟		
۳۷. آیا گاهی در جریان بودجه سازی به مشکل مواجه شده اید؟		
۳۸. آیا فکر میکنید که شما نیاز به تریننگ مدیریت مالی دارید؟		

معلومات که به نظر شما در مورد مدیریت مالی مهم و ضروری است درین بخش لطفآ اضافه نمایید (اختیاری)

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ذ. اثرات وضعیت اجتماعی-فرهنگی/ سیاسی بالای رهبریت:

39. لطف نموده موانع ومشکلات که به نظر شما بخاطر رسیدن به اهداف ریاست تان مواجه میشوید ارزیابی نمایید. (*عدد **1** اولین مانعه عمده، عدد **2** دومین مانعه عمده و به همین شکل میباشد. شما میتوانید که مانعه ایی را که مواجه نشده اید نادیده بگیرید)*

سیاست/موضوعات سیاسی

موضوعات کلتوری

حمایت کم از طرف اداره

کمبود منابع

فساد اداری

شفافیت پایین

دانش پایین مدیریتی

موضوعات فامیلی یا دیگر موضوعات شخصی

فشار از طرف اشخاص با قدرت

دیگر لطفاً مشخص سازید....................................

40. پیشنهاد شما برای وقایه یا حل موانع و مشکلات که در بالا ذکر شدند چه ها است؟ *(لطفاً جزییات مطابق میل تان بدهید)*

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....

معلومات که به نظر شما در مورد وضعیت اجتماعی-فرهنگی/ سیاسی مهم است درین بخش لطفاً اضافه نمایید (اختیاری):

....
....
....
....
....

ر. شفافیت و حسابدهی در سیستم مدیریتی:

41. آیا به نظر شما بصورت عموم موضوعات کلتوری در وزارت صحت عامه ،کار کرد رهبریت را متاثر میسازد؟ *(لطفاً بلی یا نخیر را انتخاب نمایید)*

بلی ☐ نخیر ☐

42. اگر جواب بلی باشد ، لطفاً جواب/جوابهای تان را انتخاب نمایید. *(شما بیشتر از یک جواب را انتخاب کرده میتوانید)*

1. مدیریت مجازاتی ☐
2. استفاده از قدرت برای استخدام اعضای فامیل در وظیفه های خوب (خویش و قوم پرستی) ☐
3. حمایت غیر عادلانه ازیک شخص یا گروپ اشخاص توسط شخص با صلاحیت (طرفداری) ☐
4. ارتباط بین اعضای عین خانواده (خویشاوندی) ☐
5. محول کردن کارهای مهم به دوست یا رفیق در حالیکه کارمند دیگر اهلیت و مهارت کار را دارد (رفیق بازی) ☐
6. پایین رتبه ها مجبور به قبول کردن حرف های اشخاص بلند رتبه اند حتی اگر درست هم نباشد ☐
7. رفتار نامطلوب با پرسونل ☐
8. دیگر، لطفاً مشخص سازید.. ☐

43. آیا فکر میکنید که موضوعات سیاسی و تبعیضات در وزارت صحت عامه وجود داشته و تاثیرات منفی بالای کارکرد شما دارد؟ طور مثال گروپ بازی ها، مداخله اشخاص سیاسی در استخدام/انفکاک کارمندان، ملیت ، مذهب، لسان، نژاد، جنسیت. *(لطفاً بلی یا نخیر را انتخاب نمایید)*

بلی ☐ نخیر ☐

اگر جواب بلی باشد لطفاً در ذیل توضیح دهید.

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44. کارمندان در این ریاست چگونه ارتقا می یابند؟ *(شما بیشتر از یک جواب را انتخاب کرده میتوانید)*

الف. از طریق رقابت آزاد ☐
ب. ارتقا داخلی ☐
ج. بعد از کسب درجه ماستری ☐
د. معرفی توسط سیاسیون ☐
ذ. معرفی توسط مقامات عالیرتبه وزارت صحت عامه ☐
ر. به اساس ارزیابی کاری ☐
ز. دیگر، لطفاً مشخص سازید................................ ☐

اگر موضوعات که به نظر شما مهم است ودر بالا پرسیده نشده ، لطفا در ذیل اضافه نمایید (اختیاری)

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از دادن وقت و همکاری شما جهان سپاس

Appendix 16: Interview questions' route

The study question: What are the enablers and barriers faced by leaders in the Ministry of Public Health (MoPH) looking to reach their organisational goals?

<table>
<tr><td colspan="2">Please tell me a little about yourself and your role within the MoPH.</td></tr>
<tr><td>Propositions</td><td>Major questions</td></tr>
<tr><td>The management support system affects the work of personnel.</td><td>1. Does the personnel's appraisal have beneficial? If yes, what would be the benefits.
2. Do you have any concern/complain regarding your work environment? Have you shared with your line managers this, what happened? (if the participant names some problems)
3. What motivate you in doing your best in your work?
4. What make you demotivated in your work?
5. Does your directorate receive enough management support needed from higher level?</td></tr>
<tr><td>Managers who have managerial training can manage well</td><td>6. Do you think there is a relation between the director's qualification/trainings and their support with staff performance?</td></tr>
<tr><td colspan="2">Are you comfortable, would you like to continue?</td></tr>
<tr><td>Political and socio-cultural aspects negatively affect leadership</td><td>7. Is there any socio-cultural aspect that you think affect the leadership work?
8. Are there any political issues in this directorate that you think affect the work negatively?</td></tr>
<tr><td>The transparency and accountability of the management system affect staff and organisational performance.</td><td>9. Do you think all staff are treated equally/fairly in regard to salary, promotion, opportunities such as trainings, capacity building, etc.
10. Do you think there are discriminations that affect the work negatively in the MoPH? Such as grouping, political inference in hiring/firing of staff, nationality, religion, language, race, gender and etc.</td></tr>
<tr><td colspan="2">Additional questions (these questions are used when necessary)</td></tr>
<tr><td colspan="2">• How your director treat/behave with you and other staff members?</td></tr>
</table>

• If your line manager asks you to suggest him/her one thing for improvement of his/her work, what will you suggest? (It will consequently affect positively your work.)
• Is there a proper way for staff to communicate with their line managers?
• Do the staff take their annual leave easily? Doesn’t their manager refuse their leave?
• What would be your suggestion for solving or preventing the mentioned problems. (*if the participant names some problems)*
• Is there anything that you think is remained and is necessary for you to add?

Appendix 17: The list of included documents for the review

No.	Name of the documents	Characteristics
1	Community Based Health Care Strategy 2015-2020	• There is the signature of the Minister • The consistency and organisation indicate it is the final version • It is in PDF
2	Communication Strategy for Public Relations 2016–2020	• It has the signature of the Minister • It is organised and consistent although some errors can be seen. (situation analysis) • It is in PDF
3	National Health Strategy 2016–2020	• The name of the Minister was there with his signature. • The document was organised and complete. • It is in PDF version
4	National Health Policy 2015-2020	• The name of the Minister was there with his signature. • The document was organised and complete. • It is in PDF version
5	National Health Promotion Strategy 2014-2020	• The name of the Deputy Minister was there with his signature. • The document was organised and complete. • It is in PDF version
6	National Pharmaceutical Quality Assurance Policy 2015	• The name of the Minister was there with his signature. • The document was organised and complete. • It is in PDF version
7	National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy 2017-2021	• The name of the Minister was there with his signature. • The document was organised and complete. • It is in PDF version
8	National Strategy for Prevention and Control of Non-Communicable Diseases (NCDs) 2015-2020	• The name of the Minister was there with his signature. • The document was organised and complete. • It is in PDF version
9	Prison Health Services Strategy 2.0, 2015/1394	• The name of the Deputy Minister was there with her signature. • The document was organised and complete. • It is in PDF version

Appendix 18: A sample of thematic analysis using Braun and Clarke (2006) process

Phase 2: Generating initial codes	Phase 3: Searching for themes	Phase 4: Reviewing themes	Phase 5: Defining and naming themes
• Gov. policy increased problems • Heads, as source of conflict • Hiring is based on political support not merit • Motivation, serving to public and country • De motivation, politicians influence • Technical people are not supported • Friendship matters • Favouritism, • Nepotism • Appraisal no evidence-based, no benefit • Good work can be badly appraised • Directors brought by politicians • Technical knowledge skills not used • Incompetent leaders affect the performance • No proper capacity building • Not need based trainings • Unprofessional treatment • Institute is important • No difference after graduation • Misuse of power • Corruption of public properties • MoPH deals for political benefit not public • Low capacity managers are not open minded • Low capacity of heads de motivates • Communication not easy • Procedures problem • Asking accountability Asking transparency • Health should be running by professional not by politicians • Fear from dismiss • System delay work • Low capacity cause failure • Unfairness in training	• Political influence • Corruption • Low capacity of directors • Socio-cultural issues • Meritocracy is not considered • Hiring system not transparent • Problem in procedure • Lack of accountability • Support needs connection • Performance not monitored properly • Qualification quality • Not supportive environment • Problem in capacity building • Suggestion for improvement	• Lack of accountability, transparency and corruption • Problem in management support • Political influence • Problem in capacity and capacity building • Socio-cultural influence • Suggestion for improvement	• Enough resources, but evaporate • Change is demanded • Is the required support provided? • Socio-cultural and Political influence, the significant abstractions • Why capacity and capacity building affected in the MoPH?

Appendix 19: Record of PhD supervision meetings

Date	Discussion main points	Supervisors presented
01/02/2016	Discussion on initial thoughts about the topic, general information on PhD programme, researcPAD, training and workshops, ethical modules, HSS forum and etc.	Shaqaieq Ashrafi Dost (SAD), Carol Bond (CB), Zoe Sheppard (ZS)
03/03/2016	Discussion on training I attended, and I need to attend including online. Discussion around the study topic and networking	SAD and ZS
22/03/2016	Discussion on my summary about the study aim, objectives, question and methods	SAD, CB and ZS
27/04/2016	Discussion on sample size, the departments to be included, and the topic to be more specific.	SAD, CB, ZS and Steve Tee (ST)
22/06/2016	Discussion on the points raised for the initial review and on coming milestone (transfer)	SAD, CB and ZS
13/07/2016	Discussion on literature review around the topic and how to be systematically	SAD, CB, ZS and ST
20/09/2016	Discussion on the draft on capacity and the MoPH organogram and which departments to be included	SAD, CB, ZS and ST
24/10/2016	Discussion on the study question, methods and sample size of study	SAD, ZS and ST
24/11/2016	Discussion on literature review and development of framework/structure for literature review	SAD, CB, ZS and ST
07/12/2016	Discussion on literature review, transfer report, and study plan, all rationales	SAD, CB, ZS and ST
26/01/2017	Discussion on shortening lit for transfer report, research philosophy and ethics approval from the MoPH, Afghanistan	SAD, ZS and ST
21/02/2017	Discussion on number of cases, sample size, reflective diary, PIS, PAF development and transfer report.	SAD, CB, ZS and ST
21/03/2017	Discussion on proofreading of transfer report draft, submission of TR, Examination, limitation and strengths of lit and the key documents to be included.	SAD, CB, ZS and ST
25/05/2017	Discussion on preparation to viva exam, BU ethics committee comments and annual monitoring report	SAD, CB and ST
08/06/2017	CK joined our team Discussion on the examiners feedback on TR, Ethics committee comments and PIS and PAR.	SAD, CB, ST and Clare Killingback (CK)
19/10/2017	Discussion on completed questionnaires, practice on interviewing, and document and archival records review.	SAD, CB and ST
13/11/2017	Discussion on the interview questions and the importance of practicing the interview technique	SAD, ST and CK
20/12/2017	Discussion on Interview and other methods of data collection in Afghanistan.	SAD, CB, ST and CK

	Discussion on analysis of the interview.	
08/02/2018	Discussion on the analysis of qualitative and qualitative data.	SAD, CB, ST and CK
05/03/2018	The analysis of qualitative answers of the questionnaire, the interview transcription in Dari language and stating of methodology chapter	SAD, ST, CB and CK
23/05/2018	Discussion on finding and discussion chapters structure, use of SPSS and checking of Nvivo database by Clare	SAD, CB and CK
25/06/2018	Cross checking of my coding by Clare before meeting and discussion on the finding chapter	SAD, ST and CK
02/08/2018	Discussion on the comments on the finding chapter	SAD, ST, CB and CK
20/09/2018	Discussion on the discussion chapter and usage of a theory	SAD, ST and CK
31/10/2018	Discussion on the external/internal examiners, intention to submit, sharing of interview finding with the participants and a summary of the thesis in 3 minutes.	SAD, ST, CB and CK
22/11/2018	Discussion on discussion chapter, rival explanation and contrary evidence	SAD, ST and CK
18/03/2019	Discussion on critical thinking (Blooms taxonomy) in discussion chapter	SAD, ST and CK
1,2/04/19	Viva questions, themes, propositions	SAD, CB
10/09/2019	Introduction with new group of supervisory team and they will supervise. I explained my thesis	Prof. Edwin van Teijlingen (EvT), Rachel Arnold (RA), SAD
02/10/2019	Discussion on Chapter 1 and 2 and general comments	EvT, RA, SAD
16/10/2019	Discussion on Chapter 3 and frameworks	EvT, RA, SAD
11/11/2019	Discussion on the use of theoretical propositions	EvT, RA, SAD