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Frontline managers matter: Wellness for Effective Leadership

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This chapter describes the implementation of an intervention targeting over 400 frontline managers in the public health sector from 2009 to 2014. Evidence is provided of the personal and interpersonal contexts and the organisational cultures that tend to constrain frontline managers and limit effective leadership, despite commitment to their work. Buried emotional trauma and its negative impact on relationships with families and colleagues are also brought to the surface. Much of this trauma relates to growing up and working under apartheid.

The chapter describes the Wellness for Effective Leadership (WEL) Programme, which helps groups of frontline managers to identify these and other issues and which, through a series of workshops, facilitates a journey whereby positive shifts are enabled, spanning the personal and interpersonal and extending into leadership practice and service delivery.

The results and implications for health services transformation and for any leadership development programme and health systems development are discussed. The authors conclude that the contribution of the WEL Programme to the further leadership development and health system strengthening in South Africa is its demonstration of the need for leadership development initiatives to have an intentional focus on dealing with buried personal trauma, ensuring adequate self-care, paying attention to work-life balance, strengthening effective stress management, enhancing the emotional carrying capacity of individuals and teams, and building resilience and emotional intelligence.

Reports of WEL participants indicate that these are changes that can be implemented in a relatively short period, which can begin to have effect outwards, and may well contribute to a bottom-up approach to changing overall organisational culture.

The WEL Programme guides public sector health managers towards positive shifts in personal and interpersonal contexts, leadership practice and service delivery.

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Introduction

Failures in health service delivery in South Africa are attributed to a complex disease burden and to a dysfunctional health system.[1,2] In recognition of the need to strengthen the South African health system, special emphasis has been placed on improving health management.[3] Until recently, little attention has been given to leadership,[4,5] even though it is a key thematic area in the Human Resources for Health Strategy for the Health Sector: 2012/13–2016/17.[6] In many current leadership development initiatives, the focus is on technical competencies, regulations and information management. While these aspects are important, the organisational culture and the human interactions that occur at the micro-levels of the system[5] are critical to effective leadership, and are neglected components in the public sector in South Africa, including in the health sector.

The importance of leadership and management for effective transformation in the South African health sector has been discussed,[5] including a call for people-centered,[7] value-based leadership,[8] which engenders trust.[9] Internationally it has been recognised that "emotional intelligence … and social intelligence … are as important to leadership as cognitive intelligence"[10] in complex contexts. This chapter builds on this existing evidence.

Many national, provincial and donor-supported programmes and several major initiatives have been implemented to transform and increase the effectiveness of the health system, realign it with the primary health care approach, and strengthen human resources for health, but the overall impact on the health system has been disappointing. Since 1995, all editions of the *South African Health Review* have presented a focus on improving primary health care (PHC) services, and most have included chapters on the human resources needed. The 2011 *Review* has three such chapters.[5,11,12] However, the wellness of frontline managers in terms of their agency, resilience and energy has largely been neglected.

This chapter provides evidence of the personal and interpersonal contexts and the organisational cultures that tend to constrain frontline managers and limit effective leadership. The chapter further suggests that a relatively simple intervention to build emotional intelligence and develop personal and interpersonal competencies can make a significant contribution to implementing key national policy initiatives, such as PHC re-engineering, the NHI pilot districts, and Operation Phakisa 2 (Ideal Clinic Realisation and Maintenance) and ensuring that all have maximum impact.

More than 400 managers in the health sector, mostly working at facility, sub-district and district level, have completed a Wellness for Effective Leadership (WEL) Programme over the past six years. The WEL Programme uses a people-centered, context-responsive approach to identify and respond to the leadership development needs of frontline managers. The needs assessments have provided evidence of common strengths and challenges, and of the organisational contexts and cultures within which frontline managers work. The Programme promotes the 'wellness' of participants and cultivates their personal and interpersonal competencies towards developing leadership, strengthening health system performance and delivering quality health services, within new policy initiatives. The WEL Programme recognises that most managers work hard in a context that is complex and stressful,[8] have strengths and insights to share with others, want to do a good job, and have diverse needs.

The chapter begins by providing an overview of the WEL Programme. Data arising from the implementation of the WEL Programme are then presented, drawn from participant accounts of personal and organisational contexts at the beginning of a Programme and of shifts attributed to their participation in the WEL Programme at its completion. The discussion deals with the key contextual issues that emerge and the reported positive shifts, and the implications for leadership development and health systems strengthening in the South African context. Concluding recommendations address programmatic, research and health system strengthening aspects.

Overview of the WEL Programme

The WEL Programme began as an intervention to address a crisis in health service delivery. In 2008, in one district in the Eastern Cape, 140 babies died of diarrhoea and dehydration in three months, with 52 of these deaths occurring in one hospital. A ministerial task team concluded: "This increase in childhood mortality is most likely a reflection of poor health care to a vulnerable community".[a] Further investigation suggested that most local managers cared deeply about their work, wanted to provide good services, felt they had done their best, and could not think of anything they themselves could do to prevent similar deaths in the future. They felt powerless and lacked agency.[b] After consultation with a senior psychologist at the Centre for the Study of Violence and Reconciliation (CSVR), the first WEL Programme was launched in January 2009.

The WEL Programme draws on eclectic and complementary theoretical underpinnings, encompassing psychology, adult learning, creative art therapy, organisational learning, critical theory and complexity leadership theory.

The theory of change underpinning the WEL Programme is based on facilitating 'wellness', change and transformation from the intrapersonal level outwards (Figure 1). In summary, this theory of change posits that at the core of transformation of any service are the individuals who run the services, and that the changes brought about through greater self-awareness and self-care, perceptions of well-being and reduced stress, lead to an increased ability to manage stressful situations and conflicts. This interpersonal change and transformation translates into greater productivity at work, improved teamwork, outputs and performance against service delivery target indicators, and improved client satisfaction. The model acknowledges the multiple interactions between the inner and the outer circles of influence and vice versa.

a Department of Health: Report on Childhood Deaths, Ukhahlamba District, Eastern Cape, 30 April 2008

b Department of Health: Report by Dr Tim Wilson on 18 Priority Districts, December 2008.

Figure 1: Model underpinning the WEL Programme Theory of Change

Fundamental to the WEL Programme approach is that each person matters, learns most from reflecting on their own experiences, and can build their emotional intelligence and agency.

A standard WEL Programme comprises three two-day workshops, followed by a final one-day workshop. Six to eight weeks are allocated for reflection and experimentation between each workshop (see Figure 2). This amounts to a total of seven days contact time over a five- to six-month period.

The first and final workshops (Workshops 1 and 4) follow a fairly standard format, while the design and content of Workshops 2 and 3 vary greatly, depending on the needs of the particular group. In Workshop 1, informed consent is obtained from participants. Workshop 1 is primarily a needs assessment workshop. The needs emerge from participants reflecting on their life's journey and their contexts at home and at work. The standardised ProQOL™[c] supports the needs assessment by screening participants for compassion satisfaction, risk of burnout and secondary traumatic stress. Initial interventions in Workshop 1 include ensuring that participants experience a safe space, respect, and being listened to. Confidentiality, trust-building and deep reflection are promoted.

After the first workshop, facilitators reflect on and analyse the needs that emerge from that group, and the results of the ProQOL™. Based on their findings, facilitators plan a programme appropriate for and relevant to a specific group, to be implemented in Workshops 2 and 3. Common topics include: stress, burnout and personal trauma; self-reflection, self-awareness and emotional intelligence; impact of self on others, and understanding others; effective communication and feedback; and power relations, teamwork and conflict management. The context and participant needs define the depth and breadth of the content covered.

Between workshops, participants reflect on and implement their learning, and report back to the group at subsequent workshops.

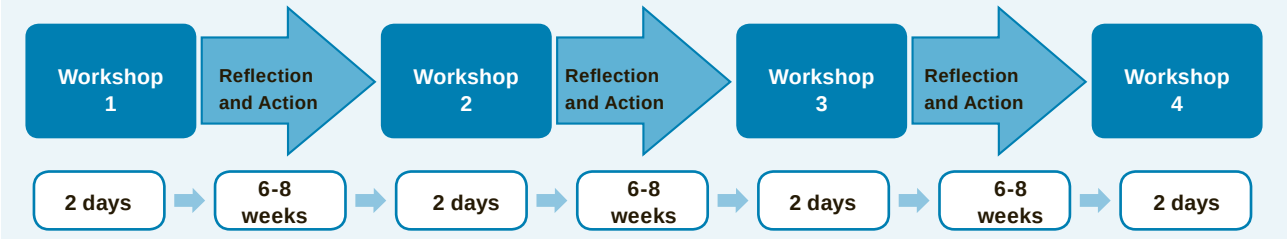
The final workshop follows a standard format, allowing time for participants to reflect on and consolidate their learning through 'learning by teaching' as they prepare and implement a report-back to colleagues, family members and visitors. The latter often affirm participant experiences by confirming the shifts reported. Furthermore, at Workshop 4, an external facilitator conducts a final participant evaluation.

Box 1: Overview of methodology used in the WEL programme

The methodologies and tools used during WEL workshops are described in detail in a facilitator manual, currently being updated. Special use is made of the following:

- Regular 'check-ins' to encourage participants to reflect on the 'baggage' that each person brings to work each day, the actions taken between workshops, and experiences within the workshop.
- A range of experiential exercises that encourage full and equal participation, reflection and discussion.
- The River of Life (ROL) exercise in which participants reflect deeply on their life journey, draw their own River of Life showing good and bad experiences and significant milestones, and share this with the group.
- Victor Frankl's Stimulus-Response-Outcome Theory emphasising that we can choose how to respond in any situation, either instinctively or deliberately.
- Steven Covey's Circle of Influence and Circle of Concern and the value of focusing attention and action on matters within one's Circle of Influence.
- A standardised psychometric test (ProQOL™) which measures Compassion Satisfaction (CS), Risk of Burnout (BO) and Risk of Secondary Traumatic Stress (STS). The test is administered in the first and final workshops.

Figure 2: Structure of a WEL Programme



c ProQOL™: Professional Quality of Life Scale – measures the satisfaction one derives from being able to do one's work well, feelings of hopelessness and difficulties in dealing with work or in doing one's job effectively, and work-related, secondary exposure to extremely stressful events. See: ProQOL™ © B. Hudnall Stamm, 2009. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). /www.isu.edu/~bhstamm

Continual monitoring and evaluation of processes and outcomes is a vital part of every WEL Programme and occurs at multiple levels. Participants provide written feedback on the content and process at the end of each workshop, the facilitators give structured, written feedback to each other and write a report on each workshop, the Programme Co-ordinator reviews all feedback, and suggestions are considered for subsequent workshops.

Those who initiate and attend a WEL Programme vary from one group to another. In all except two groups, someone who participated previously in a group has initiated a WEL Programme. The most senior manager in a setting is asked to attend and to invite both clinical and administrative staff of different ranks.

Two professional, experienced facilitators who have undergone specific intensive training in the WEL approach facilitate each WEL Programme. Given the deep emotional pain that may emerge as a result of the tools used, it is vital that facilitators are self-aware, reflective and able to ensure that no psychological harm comes to any member of the group. For each new group, the WEL Programme Co-ordinator selects a pair of facilitators after considering race, gender, age, experience and availability. She ensures that at least one of the pair is fluent in the mother-tongue of most of the participants, one is experienced in counselling, and one has management experience.

The Co-ordinator is consciously and thoughtfully supportive to facilitators, contributing to a 'WEL culture' that is different from other work settings in which facilitators operate. Modelling how colleagues can work together is an important part of the WEL Programme and participants often comment on how well their facilitators have supported each other.

Methodology

The purpose of this analysis was to document the participants' views of their contexts and the shifts they reported as a result of their participation in the WEL programme. Facilitators are keenly aware of their ethical responsibilities to do no harm and participants give informed consent to participate in the programme and in the psychometric test. However, this analysis is not a research study; it is an evaluation of interventions to address identified problems.

There were three sources of data: firstly, confidential reports by facilitators on the participants' life stories and the associated emotional trauma; secondly, the Workshop 4 reports, which are in the public domain; and thirdly, the ProQOL™ results. Ethical principles of confidentiality are maintained in the compilation of these reports. The Workshop 4 reports have a standard format, consisting of:

- the external evaluator's overview and summary of Workshops 1 to 3 (evaluator's summary);
- observations and a record of participant presentations (unstructured);
- a record of questions posed by guests and answers (validation);
- a summary of issues raised during the final evaluative focus group discussion (semi-structured); and
- a summary of individually written before-and-after stories (semi-structured).

Facilitators sign off reports as a true reflection of the process.

Workshop 4 reports for 30 of the 35 groups who completed a WEL Programme between 2009 and 2014 were available for analysis. Five reports were missing. A limitation of this qualitative data is that it involves high-level aggregation, measures mostly the perceptions of participants, and lends itself to positive reporting.

Participants completed a ProQOL™ questionnaire at Workshop 1 and then again at Workshop 4. During the course of a WEL Programme, group feedback is given (maintaining the confidentiality of the identity of individuals' scores), and on request, to individual participants on their specific scores. For the purpose of this analysis, to compare the before-and-after scores, a template for data entry and analysis was designed with support from a statistician at the University of the Witwatersrand.

For the ProQOL™ analysis, data were available for 26 groups. Of the 340 participants in these 26 groups, only 216 (64%) attended their final workshop and so completed a second ProQOL™ questionnaire. Analysing the scores of all participants who completed a questionnaire at Workshop 1, and looking for differences between participants for whom a follow-up score at Workshop 4 was available and those for whom a follow-up score was not available, no statistically significant difference was detected. Therefore, paired before–after analyses were possible for 216 participants, for each of the three domains measured by the ProQOL™.

Table 1 shows the number of groups, by province, for which data were available.

Table 1: Number of WEL Groups, by province, with available data, 2009 – 2014

	EC	FS	KZN	LP	NC	NW	HST	Total
Workshop 4 Reports	7	5	6	3	2	1	6	30
Paired ProQOL™ questionnaires	6	5	5	3	1	1	5	26

With regard to data analysis, a mixed-methods approach was used to identify the initial contexts and the shifts that participants reported and attributed to their participation in the WEL Programme. A qualitative, directed content analysis was implemented to analyse the Workshop 4 reports. The directed content analysis approach was conducted through QSR NVivo.[d,10] Both a deductive and an inductive approach were used to identify nodes. Initially, nodes were created based on the WEL Theory of Change. Further inductive analysis revealed additional nodes. Data were coded and the definitions for each code as well as the number of references to each code were listed (Table 2). The initial coding was done by one person and reviewed by the co-authors.

In the paired quantitative comparison of ProQOL™ scores, each domain assessed (compassion satisfaction, risk of burnout and secondary traumatic stress) was subjected to before–after comparison.

d QSR NVivo[10] QSR International. URL: www.qsrinternational.com

Findings

First, an account is provided of the nodes identified, the definition of the nodes, and the number of times reference was made to each node. Subsequently, the findings document the initial contexts reported by participants, followed by the shifts identified. Evidence of shifts is provided by the outcome of the quantitative paired comparisons of the ProQOL™, whereafter the qualitative findings are presented, reporting on shifts that participants attributed to their participation in the WEL Programme. Relevant quotes have been selected to illustrate the major findings under each theme. To maintain confidentiality, quotes are identified by province and year, but not by group.

Table 2 lists the nodes, the definition of each node, and the number of times reference was made to the node.

Initial context

Participants reported challenging personal, home and work contexts. However, they also identified positive influences within their contexts.

At the personal level, deep reflection on the River of Life exercise often brought considerable unresolved emotional trauma to the surface. Trauma was apparent in the experiences of both black and white participants. The trauma was mostly buried and hidden, or if ever revealed, certainly not to work colleagues. Reported sources of past trauma included extreme poverty and frequent hunger, difficulties in getting to school, the humiliation of not having shoes or books, repeated forced removals as a child, and witnessing friends being shot dead. Multiple bereavements, having to take responsibility for siblings and other relatives at a young age, and domestic abuse as children or adults, were also sources of trauma.

In the home context, identified stressors stemmed from extended families, unemployment, financial difficulties, living with HIV and violence. Conversely, consistently identified motivators were "passion", strong personal faith, and commitment to helping to improve the lives of those in the communities they serve, reflective of dedicated and caring individuals.

In the work context, a strong and recurring theme voiced by participants was the perception of working within an authoritarian, unsupportive culture of blame within the public service. Senior managers were perceived as unsupportive, punitive in their management styles, and sometimes abusive. Participants reported that when problems occurred, every effort was made to blame someone, usually a junior official.

> *In our district we come out of our meetings destroyed. We blame ourselves for not achieving. But then you realise that you can't all have the bad IQ you are told you have. I am happy that the participants have been able to pull my head up again. EC 2013*

> *I was tired every day and irritable when someone phoned me because I felt belittled, not appreciated and at some point even decided to leave this job. EC 2013*

Participants recognised that they sometimes treat their subordinates in the same way.

> *We crush them into nothingness – we wound them. The person coming into our office may be already wounded, as I might be myself, and then I wound them further. So we need to be aware that they are carrying their own things. As managers we need to make sure that we do not add more pain unnecessarily. FS 2013*

Other quotations give a sense of how managers describe their work situation at the start of their WEL Programme.

> *The OM [Operational Manager] is subjected to a lot of stress. You feel useless, down and out. You don't know what to do. No-one helps you with the challenges you face. The office of the OM is inundated with responsibilities. You can't deal with what you have … you have new things to deal with every day, every hour, every minute. I could not distinguish between things that fell on my desk. EC 2013*

> *We were not doing well. We were not meeting outcomes. I worried at night. I worked late at night. I worked like a headless chicken with no outcomes. I was forgetful. I was always tired. I was not healthy. My body was in pain. I didn't achieve. I selectively listened. I was not confident. I doubted my decisions. EC 2014*

> *My resignation was ready. I just had to sign it. I was fed up. My manager could pick this up. My manager sent me to the WEL programme. Now I realise that the Department is not so bad. There are challenges. Now I can meet and adapt to these challenges. FS 2013*

Table 2: Nodes, node definitions and node counts

Node	Node definition	Node count
Personal effectiveness	Text containing references to self-awareness, self-care, emotional intelligence, personality style, personal power and agency. Includes comments and observations made by guests.	435
Stress, burnout, trauma	Text containing references to stress, burnout and psychological woundedness and how these have shifted.	209
Communication	Text containing references to listening, conflict, descriptions on changes within communication styles, and the effect of improved communication.	205
Family	Text containing examples of how the WEL lessons are applied or used within the family setting. Includes comments made by guests who attend.	116
Team	Text making reference to team and teamwork.	212
Leadership and management	Text references and examples of changes in Leadership and Management. Includes sustainability.	339
Change and service delivery	Text references to service delivery and changes that indicate improved outputs, outcomes and impact.	415

Participants realised the interwoven connectedness between buried personal trauma, circumstances at home, and the context at work. Recognition was expressed of each one being a whole person, partly at home, partly at work, and partly in the community.

Shifts

Reporting on the identified shifts begins with a description of the shifts captured through before–after comparisons of the ProQOL™ questionnaire, followed by a description of the qualitative findings.

Before–after ProQOL™ scores

Analysis of the 216 paired questionnaires showed statistically significant changes. The mean score for Compassion Satisfaction, which was in the moderate range to start with, increased by 1.5 points ($p<0.0025$). The mean score for Risk of Burnout decreased by 6.2 points ($p<0.001$), and the mean score for Risk of Secondary Traumatic Stress dropped by 4.1 points ($p<0.001$). The highly significant improvements in mean scores for the risks of burnout and secondary traumatic stress were despite the fact that the scores of 28% of participants 'went the wrong way' and actually reflected increased risks at Workshop 4. Yet all of these individuals said that they were feeling less stressed. A possible explanation for this is that these individuals were correct in saying that they were less at risk than they had been, and that their initial risk was greatly underestimated because they were in denial.

For illustrative purposes, a pair of before–after graphs from one group of 13 WEL participants in the Free State is shown in Figures 3 and 4. Compassion Satisfaction (CS) (blue bars) is similar to Job Satisfaction; Risk of Burnout (BO) (dark grey bars) and Secondary Traumatic Stress (STS) (pale grey bars) are reflective of stress.

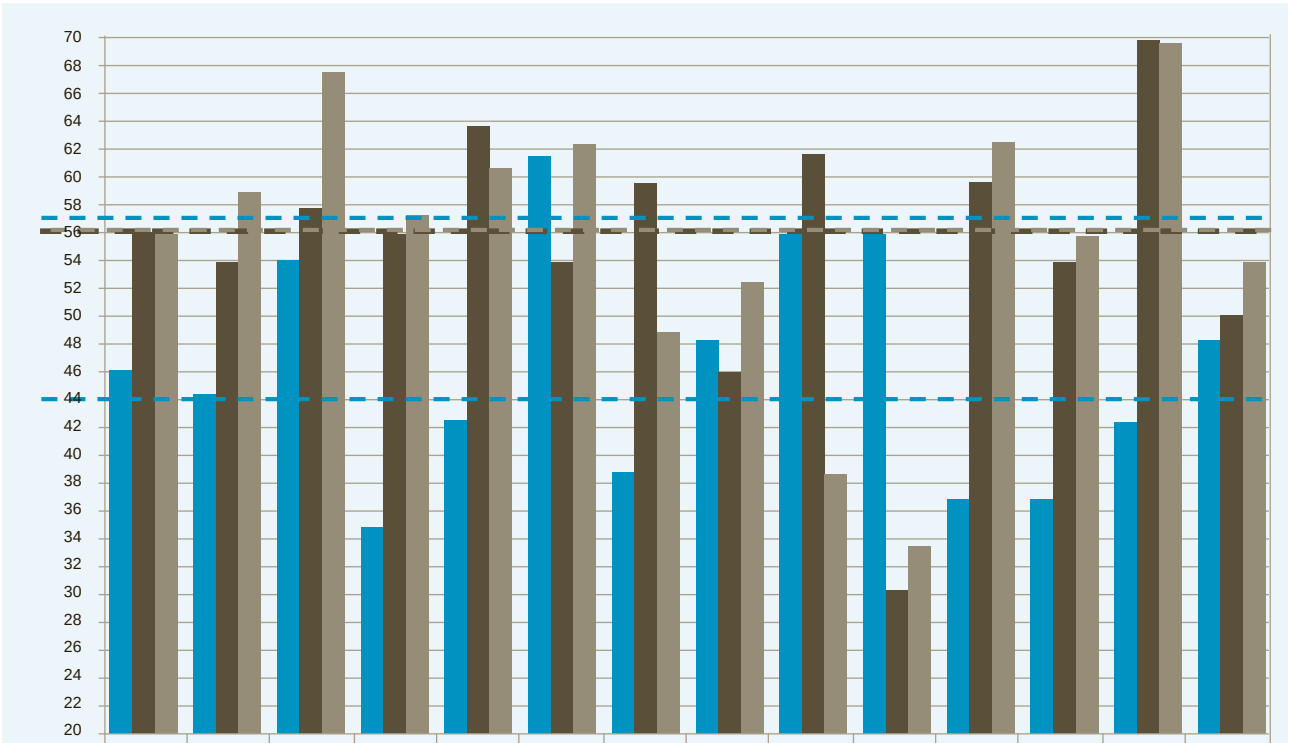
In Figure 3, each individual participant P1 – P13 has a set of three bars. The lower dotted line is the border between moderate and low compassion satisfaction. The set of upper dotted lines are the borders between moderate and high scores for the three indicators. In this group, compassion satisfaction was low and the risks of STS and burnout were relatively high. All except one participant was at moderate or high risk of burnout. Facilitators confirmed the vulnerability of the group, reporting that its members were in great distress. This group's graph is not the worst identified in the findings, and there are many groups in which a significant proportion of participants were at high risk.

Figure 4 shows the ProQOL™ scores of the same cohort six months later. Scores for Compassion Satisfaction are higher, and those for STS and Burnout are much lower than had been noted six months earlier. The changes in the scores of P12 are particularly striking. P1 did not attend the final workshop. The implication for this group is that they were now more likely to successfully take on new challenges and support each other.

Qualitative shifts

The findings of the qualitative data analysis are presented as shifts in personal competencies; interpersonal competencies; leadership and management; and service delivery. Although the shifts are presented as discrete entities, it is recognised that they are often inter-related.

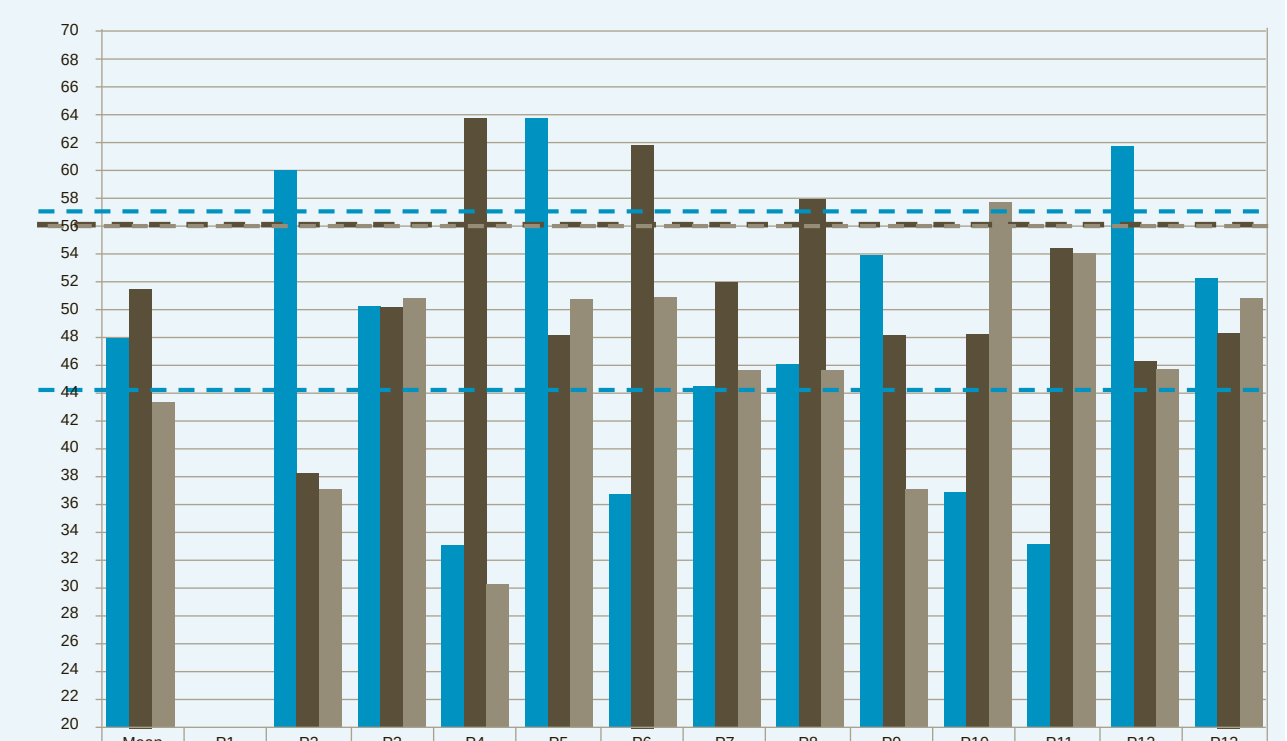
Figure 3: ProQOL™ scores from Workshop 1, Free State WEL Group



	Mean	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13
CSt-1	46	45	54	35	43	62	39	48	56	56	37	37	43	48
BOt-1	56	54	58	56	64	54	60	46	62	31	60	54	81	50
STSt-1	56	59	68	58	61	63	49	52	39	34	63	56	75	54

Key: CSt: Compassion Satisfaction t-score BOt: Risk of Burnout t-score STSt: Risk of Secondary Traumatic Stress t-score

Figure 4: ProQOL™ scores from Workshop 4, Free State WEL Group



	Mean	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13
CSt-2	48	-26	60	50	33	64	37	45	47	54	37	33	62	52
BOt-2	51	0	38	50	64	48	62	52	58	48	48	54	46	48
STSt-2	43	8	37	51	30	51	51	46	46	37	58	54	46	51

Key: CSt: Compassion Satisfaction t-score BOt: Risk of Burnout t-score STSt: Risk of Secondary Traumatic Stress t-score

Shifts in personal competencies

The reported shifts in personal competencies are grouped as personal effectiveness and recorded as shifts from reported stress, burnout and trauma to greater energy, agency, self-confidence and self-care, improved ability to manage stress, reduced levels of stress or burnout, and feelings of release from past trauma.

The River of Life stories shared in the group touch everyone deeply. At subsequent workshops, people often reported on how extraordinary it was to be listened to, the huge relief they have felt since sharing their story, and their new sense of peace.

> *I feel as if this burden has slipped from my shoulders. FS 2014*

> *It has been a healing session to all of us. LP 2013*

> *WEL provided a place for healing for us. We are not a dysfunctional team but we had issues and WEL opened up the space to speak about these. FS 2014*

In discussion, people reflected on the fact that they were unaware of how past wounds were affecting their relationships with others, and their ability to work.

The stories of adversity, accompanied by stories of survival and perseverance in order to achieve tertiary education and good jobs, enabled participants to become aware of their own resilience. As participants reflect on the past obstacles they have overcome in life, they recognise the strength within themselves to overcome current obstacles at home and at work. Listening to colleagues sharing their stories of overcoming obstacles helps the whole group to build resilience.

One of the most striking changes in almost every group observable from the commencement of a WEL programme to its completion five or six months later is the increase in energy and agency in the group. This was evident in the first two groups who had no agency and did not believe that there was anything they could do to prevent another epidemic of infant deaths. At a workshop held six months later, one of the participants looked directly at senior provincial and national officials and said:

> *Before, when there was a problem, we would say, 'Bhisho must do this or that, and national should do something', but now we say, 'what can we do ourselves?'. EC 2009*

This trend has been seen in all WEL groups:

> *I am so happy senior management is here to understand what we have experienced. I want them to know that my 'NO' is not being cheeky, rude or impossible but it's because I can't anymore. EC 2013*

> *WEL has the power to shift perceptions from pessimism about self and work to optimism and enthusiasm. The Rivers of Life help you move forward and delve into who you are and where you have been and what life has done to reduce you to nothingness – and then you reach inside and find your own potential. KZN 2014*

Before WEL I was stressed and had lots of tension and was thinking of leaving the Department. Nursing had become boring and I could see no future for myself in it. Now I can see the way. I have regained my passion. I plan my work and am purpose-driven. My eyes are open and I have a vision, a future. KZN 2014

I am a new person. I go to work every day with new enthusiasm, with new commitment. FS 2014

In several groups, participants reported that they would never previously have been able to speak in front of very senior officials and other "important guests", but that the WEL Programme had given them the self-confidence to express their own views in meetings at work and in a workshop with strangers.

WEL workshops encourage frontline managers to take better care of themselves. Participants found that caring for themselves enhanced their resilience. Some of their experiences are documented as follows:

You are an engine. You have needs. To be well, you have to take care of your needs so that you have energy to lead others, inspire others, meet goals and expected outcomes. The self is the engine of leadership. If you service the car right it will take you where you need to be. EC 2014

This WEL programme has had some serious impacts on us. There are now things that we are doing and some things that we are not doing. In self-care for example we never did things to help ourselves and make ourselves feel good. My life revolved around the office. I worked on weekends and then did my studying. FS 2014

I know that I used to neglect myself. Now I can talk about my needs. I was so focused on what other peoples' needs were. Now I ask: what do I need? I am also a person. FS 2014

The most common self-care strategies deployed by participants were very simple. These included going for a walk or a run two or three times a week, leaving work by 19h00, occasionally taking a whole weekend off, not working on their laptops for hours every evening and most importantly, giving themselves 'permission' to spend part of their salaries on something for themselves.

A senior politician who attended a Workshop 4 observed:

The health environment is probably one of the toughest environments to work in today. We have huge challenges and still we work with patients who need us to help them. … I am blown away by the discussions that took place here today that explored the possibilities of what you can do to stay in the system and not allow the system to crush you. FS 2014

Other quotations reflect reported shifts and reductions in personal stress that validate the participants' experience.

My children said: 'What has happened?' They could see the change. This programme has transformed me. I really don't know what would have happened if this programme did not take place. I see myself as an achiever now. I am prepared to be a change agent to my colleagues. I now send messages of appreciation of the people around me. EC 2014

I spend time with the family now, in the morning I spend time with my daughter and she appreciates it as it is her time. During weekends the laptop is not in the bedroom, my husband he appreciates it. I have more time more energy and [am] healthier and can support others. LP 2013

Shifts in interpersonal competencies

As personal competencies improve and participants learn to understand and manage themselves more actively, their interpersonal competencies improve. Significant shifts are noted in the areas of communication, family relations and teamwork.

Participants reported becoming more aware of their communication styles and ways in which to improve and modify their behaviour, resulting in more positive outcomes, both professionally and personally.

This active listening business works, you know. It really works. I've tried it with my husband and it really works." EC 2009

My communication with my family has improved. I never talked to my son. Now my son and I talk to each other regularly. FS 2014

Sometimes employees come to you with solutions and you don't even hear them because you are busy with other things… She thinks I am not listening to her and feels she is not important. But when you listen attentively, you can support, guide and coach her. So I must listen, hear her keywords and work with her to come up with solutions. KZN 2014

You cannot be a successful leader without communicating effectively with your colleagues; and appropriate communication is not about shouting at them. I learned important things about getting your message across: that we all often have preconceived ideas and notions, and that how the message is sent is also critical – how the message is put across. KZN 2014

[I learnt] that the tone of my voice was a 'fighting' tone. Coming on [WEL] has helped me to realise that this is how I talk, but if it is having a negative impact (e.g. intimidating others), then I must do something about it! FS 2014

A crucial skill for frontline managers is the ability to give and receive feedback, and participants practised this. They all appreciated positive feedback, commented on how rare it is to be praised for their work, and undertook to give more positive feedback to each other and to their colleagues, both senior and junior. They also learnt how to give and receive critical feedback, particularly around poor performance. At subsequent workshops, participants reported:

It was a joyful experience to do a performance review – we could have a real conversation where in the past there would be fragility and barriers. NC 2014

Key to managing performance was the ability to give constructive feedback. FS 2014

Participants also reported how their own improved communication skills had improved their team's performance and reduced conflicts in the workplace.

Check-in is very important. With checking-in, you learn about what is happening with your staff. FS 2014

Before, I would just focus on my agenda – for my meetings. Now I check with them (my colleagues) how they are feeling at the beginning of the meetings. I have learned so much about them. This brings me much closer to them – and to know how to deal with the different individuals. Now there are fewer conflicts between myself and my peers and my subordinates. FS 2013

Now we see each other. EC 2010 and LP 2013

In most groups, participants also learnt about their own personality traits and styles, and those of others. This helped them at work and at home.

Understanding staff through the personality traits and taking a step back to reflect and change how to approach staff helped reverse a resignation and created renewed commitment and productivity. EC 2013

I have grown tremendously as a mother. I'm not a dictator with my children anymore. NC 2013

My tone is better when I'm talking to my children. NC 2013

WEL is about building. It is even good for our family. Previously I just reacted to situations without listening to a thing. I don't just act in situations now. It even gave us the skill to deal with teenagers. EC 2014

This was affirmed by guests who attended only Workshop 4.

I realise this about the people who attend WEL: I can see how that they are relating to problems and people in a different way. I can see the difference in them. FS 2014

I have seen changes in my mom. My mom is a lot happier. She is more positive about the people she works with and the working environment. NC 2014

Shifts in leadership and management

Leadership is complex, and effective leadership originates from personal and interpersonal effectiveness. Shifts in the areas of managing oneself slowly expand as participants begin to see and try new ways to lead their families, peers and subordinates.

You cannot be different at home, at work, in the broader community, etc. If you don't listen at home, this is what is going to come out at work and wherever you are moving. KZN 2014

Throughout all three workshops, the facilitators help participants to pause, think and reflect, and encourage them to sustain this approach between workshops so that it becomes habitual. In applying Viktor Frankl's Stimulus-Response-Outcome Theory, they begin to understand themselves and their own instinctive reactions, and start to experiment with different responses to common stimuli. From Steven Covey's Circle of Influence model, they learn to analyse particular problems that they face, and discriminate between what lies within their "circle of influence" and what is merely in their "circle of concern". The participants surveyed for this chapter practised these techniques at home and at work, and reported that they could respond differently and get different results, and that by focusing on their circle of influence, they could increase their influence, achieve their targets and improve their job satisfaction.

Once I understood the subconscious messages that I heard when growing up, sits between stimulus and response, I could start to control my responses and be more assertive when I need to be. FS 2014

This model did wonders for me especially at home and in my personal life. I am handling things differently, focusing on what I can do [and] what I can control... And at work I am seeing we are different, and I am seeing we are working together better. FS 2014

Now I can at least count [from] one to 10 before responding to an individual, whether face-to-face or via email... it is really worth it and has improved my patience skills! NW 2013

I had depression. I felt this is a senseless situation. The circle of concern and the circle of influence changed my mindset. I now prioritise what I can affect directly. For example, I can influence the personnel to do quality work. It spinned [sic] my mindset to see life positively. EC 2013

When we talk about the circle of influence, it is our responsibility to stand together. We must make an appointment with the District Manager, set the agenda, and together we must come with something [to solve these problems]... we must build cohesion across the sub-district and the district. FS 2014

Leadership is not a 'one size fits all'. You need to know who you are dealing with, their maturity levels, temperaments, how to best motivate them, and help them to develop further. FS 2014

With this course, I have improved the team spirit at work. I've also had changes at home... creating a more stable home environment. KZN 2014

The WEL Programme has sharpened my leadership skills. I can do things in my circle of influence to reach the goal. FS 2014

As a manager I can praise, acknowledge and give feedback to subordinates that I am leading. FS 2014

It has brought me internal awareness, and increased awareness of other people. I have become more sensitive to other people's styles of leadership and have a better understanding what motivates my own and other people's behaviour. It has also helped me understand how I might need to change to get the desired response of results in my team. I have also learnt to be flexible: if something doesn't work, to try from a different angle. FS 2014

Shifts in service delivery

Participants and their supervisors assert that participation in a WEL Programme contributes to a notable difference in service delivery. A year after the first two WEL groups had been run in the district where 140 babies had died, a Chief Director in Bhisho commented:

You know, that district always used to be a problem. But now it is no longer a problem. EC 2010

She attributed the change to the WEL programme, and pointed out that there had not been another epidemic of infant deaths.

At a Workshop 4 in Limpopo, a guest asked for evidence that the WEL programme worked. A participant who was responsible for the HIV Counselling and Testing (HCT) programme replied with vehemence:

> *Before the WEL programme, the HCT programme in my area was underperforming at 44% delivery. By the third session the HCT delivery was at 72% and currently it is on 97%. Does it (WEL) work? Here's the evidence! LP 2013*

Participants consistently reported that since completing the WEL programme, their teams have been functioning much more effectively, they themselves have been performing to a higher standard, and their service delivery has been improved.

> *When you go back to your work, after being part of the WEL programme, you try to work better with your team. You can see that some of the indicators are going up, because we are working better together as a team. KZN 2014*

> *A [WEL] buddy can help you improve your work. After discussion with my buddy, I implemented an idea so that the PHC supervision rate moved from 47% to 100%. I am now working on a plan for recognising good performance. KZN 2013*

> *A report showed that our district had 47.8% out-of-stock items. Today [at Workshop 4] we are 23.8% out of stock on tracer items in our facilities. NC 2013*

A supervisor observed:

> *I've noticed a change in people who did the course. There's sometimes a shortage in the clinic, or the mobile doesn't show up. Then I get a message that's about what that person is going to do about it, rather than about the problem itself. KZN 2013*

Discussion

The following section deals with the key issues that emerge from the implementation of the WEL Programme, and concludes with a profile of the relevance of the key issues to leadership and health system development in the South African context. Concluding recommendations address programmatic, research and health system strengthening aspects.

Data generated through participant needs assessment at the beginning of each WEL Programme have revealed the health system, organisational and personal contexts of frontline managers. At the health system level, renewed evidence has emerged of the complexities of operating in frontline settings in South Africa. These complexities have been documented elsewhere and have been traced to historical, political, social and economic antecedents, and to more recent failures in leadership and management.[1,8.9.13,14,15,16] Most other studies on the context in which people work have involved only a few managers, often in one district. The evidence presented here from 403 managers across six provinces confirms earlier findings and shows that the contexts and complexities remain notably similar over time, across provinces, districts and groups. The prevailing accounts of the health system context may be due partly to a systemic resistance to change, despite several high-level policy initiatives over time to improve health system performance, and partly to managers being inadequately equipped to negotiate the complex challenges that characterise in frontline settings. However, the evidence presented here suggests that one of the root causes may be a systemic failure to see and treat managers as people. All public servants are regularly urged to treat clients according to the Batho Pele principles, but there has been no similar pressure to treat managers and colleagues in the same way. The WEL programme is likely to be as relevant in education and other sectors as it is in health.

At the organisational level, participants' descriptions of an authoritarian, unsupportive, punitive and blaming organisational culture highlight the stressful, undermining and dehumanising effects on themselves and, in turn, on co-workers and subordinates. Previous reports have documented abusive attitudes of health workers towards their patients[1,5] and of an overall culture of deference to authority.[8] However, participants in WEL Programmes have provided narratives of a pervasive 'top dog' syndrome,[17] and of stifling, overbearing control exercised by higher-level leaders that has been identified as suppressing and limiting trust, adaptive capacity and innovation in organisations.[9,18] Despite this context, frontline managers remain driven by their desire to serve, as confirmed by the Compassion Satisfaction scores.

At the personal level, inadequate leadership capacity has been identified as an urgent and widespread problem affecting the delivery and utilisation of healthcare services in frontline settings.[6,15,19] Strategies to develop leadership capacity have focused on the knowledge, practices, motivation and leader-identity of frontline managers.[6,15,19–21] Conceptual frameworks place performance within a complex web of interactions between personal, interpersonal and organisational factors, embedded within broader organisational and societal cultural contexts.[20,22,23] Missing from the strategies and frameworks proposed to date is the buried experience of personal, community and societal trauma, experienced by a diversity of South Africans, and uncovered by the WEL Programme. This trauma has been wrought by the structurally violent and repressive context of apartheid South Africa, and through criminal violence and obdurate social injustice and inequities post-1994.[1] Paying attention to frontline manager needs for healing of personal trauma is an imperative and a facet of developing leadership capacity.

Memory and truth projects such as the South African Truth and Reconciliation Commission, the Healing of Memories initiative and the Mandela Dialogues[24–27] have shown the powerful post-conflict need for stories of woundedness and pain to be told, heard and acknowledged in order for healing and new creative energy to be released at personal and collective levels. A unique contribution of the WEL Programme has been to enable frontline managers to tell previously untold stories of personal trauma. The personal testimonies of WEL participants underscore the importance of creating safe spaces, structures and processes for trauma narratives to unfold and be brought to light. Facilitating storytelling in intentionally mutually respectful and safe environments contributes to minimising the symptomatic 'othering' that justifies the ongoing perpetration of aggression and violence,[24] reported by participants as being present

in relationships between higher-level and frontline managers, and between health workers and patients, and contributes to building a humanising framework for health care.[28]

The positive shifts reported by participants as having been enabled by the WEL Programme span the personal and the interpersonal, and extend into leadership practice and service delivery. At the personal level, an emergent recognition of resilience and growth through adversity has underpinned cognitive transformation.[29] This includes positive self-perceptions, a growing appreciation for the need for self-care, enhanced ability to manage stress, increasing self-confidence and assertiveness, and heightened energy and personal agency. Bandura has pointed out that

> among the mechanisms of personal agency, none is more central or pervasive than … self-efficacy beliefs. People must have a robust sense of personal efficacy to sustain the perseverant effort needed to succeed. Self-doubts can set in quickly after some failures … difficulties and setbacks; it is resiliency of self-belief that counts.[30]

The WEL programme strengthens resilience of self-belief within challenging organisational and health system contexts, and enables statistically significant positive shifts among frontline managers, away from high risk of burnout and secondary traumatic stress.

Increased emotional intelligence, high-quality connections and 'emotional carrying capacity' have been identified as contributing to subjective wellbeing, life satisfaction, and individual and team resilience.[31,32] The positive shifts reported by WEL participants at the interpersonal level have contributed to high-quality, trusting connections both at work and at home, enhancing integrity between the work and home personae. The shifts include an appreciation for 'checking-in' with colleagues and family, improved styles of communication, active listening, constructive feedback, and authentic conversations. The identified shifts are synergistic, with the literature identifying the need for people-centred, values-based and humanising health systems.[7,8,28]

Frontline managers report leadership and management practices as being influenced by these positive personal and interpersonal shifts. Furthermore, reflective techniques and practices developed during the WEL Programme have been shown to enable more effective teamwork and a more considered approach to the challenges encountered at work and at home. Reported improvements in service delivery are consistent with the literature linking personal and team effectiveness to team performance, quality of care and patient outcomes.[33–36]

There has been no systematic evaluation of whether the reported changes have been sustained, but those who attended two subsequent provincial workshops said that they were still benefiting from the WEL training one to five years after completing their programmes.

Implications of the WEL Programme for leadership development and health systems strengthening

The need for a shift in the overall health contexts and organisational cultures within which frontline managers operate has become of crucial importance and can no longer be ignored. WEL participants describe the contextual shifts experienced in their workplaces that have contributed to improved teamwork and service delivery. The reported shifts have been enabled by a seven-day intervention over five to six months. Of concern is the unchanging narrative of frontline managers depicting the overall health system context, documented over a 15-year period by previously cited authors. Outdated models of top-down, command-and-control, hierarchical leadership with strong deference to positional authority are no longer effective and stifle adaptive innovation and learning,[18,37] limiting the attainment of desired targets and outcomes. The narratives and ProQOL™ scores generated at the beginning of WEL programmes have provided evidence of the damage caused by outdated models of leadership to frontline health managers. They are at high risk of burnout, secondary traumatic stress, with concomitant limited capacity to deliver effectively on the health system's mandate and social compact. More enabling, relational forms of leadership are required to mediate the bureaucratic context.[18,37]

Leadership perspectives have evolved over time from focusing on the study and development of the leader, to addressing the relationship between leaders and followers, to understanding leadership as a distributed process and an emergent, interactive, generative dynamic between agents, influenced by complex contexts.[18,38–40] The perspective of the WEL Programme as regards leadership development and health system strengthening, with its focus outwards from the personal to the interpersonal and from the team to the health system, is consistent with multilevel nested models. Multilevel nested models see leadership effectiveness as emerging from multidirectional influences and interactions between individuals, teams, organisational contexts and broader contexts.[33] In these models, individual and team effectiveness is attributed to mediating emergent states, for example agency, potency, psychological safety and collective affect, which contribute to outcomes.[33]

Recent calls for leadership training programmes which comprise action learning and reflective practice[5] and people-centered heath systems which prioritise relational capacities of trust-building, dialogue and responsiveness[7] affirm the WEL approach. Learner-centeredness,[41] and experiential and action learning are core principles of the WEL approach.[42]

Conclusion

Transformation of the health services in South Africa is essential and frontline managers at district, sub-district and facility levels are the key to such transformation. The WEL Programme was launched in response to a crisis, initially reaching 12 participants and growing to capacitate 403 participants. In its responsive and adaptive implementation over time, the Programme has evolved into a leadership development initiative that is synergistic with evolving leadership perspectives and conceptualisations of health system strengthening, and complements other leadership development initiatives in the country.

The unique contribution of the WEL Programme to advancing leadership development and health system strengthening in South Africa is its demonstration of the need for leadership development initiatives to have an intentional focus on being explicit that each individual manager matters as a person. Such initiatives must help her to build her emotional intelligence, deal with any buried personal trauma, ensure adequate self-care, pay attention to work-

life balance, and strengthen effective stress management, and must enhance the emotional carrying capacity of individuals and teams. WEL participant reports indicate that these are changes that can be implemented in a relatively short period, can begin to have effect outwards, and contribute to a bottom-up approach to changing the overall organisational culture.

Recommendations

Concluding recommendations address programmatic, research and health system strengthening aspects.

1 A tool that is appropriate for the South African public service should be developed to measure relevant personal and interpersonal competencies.

2 Meanwhile, a formal independent evaluation of the WEL Programme and a cost and qualitative benefit analysis would be very useful. It should include investigation of the group whose ProQOL™ scores deteriorated, and could also explore potential areas of co-operation with other leadership development programmes.

3 All leadership development initiatives should consider teaching and encouraging the practice of a regular brief check-in to positively influence the emotional carrying capacity of teams and build team resilience and agency.

4 The public service should consider embarking on a major initiative to encourage all civil servants, and their principals, to recognise that they all matter, and to apply the Batho Pele principles to their interactions with each other.

5 A programme such as WEL should be tried in another sector such as education where frontline workers are likely to be as traumatised as health workers.

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