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Situational Leadership and Performance of Public Health Facility Boards in Kenya: The Role of Organizational Culture

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Abstract

Leadership within public health facility governance bodies remains an under-researched area in Africa, despite its importance in shaping service delivery outcomes. This paper critically reviews the applicability of situational leadership to the performance of public health facility boards and committees in Kenya's devolved health system. Using a narrative-critical review methodology, the paper synthesizes conceptual, theoretical, and empirical literature on situational leadership, health facility governance, organizational culture, and board performance. The review identifies three key gaps: limited conceptual clarity on board-level leadership styles, inadequate Kenya-specific empirical evidence, and an overreliance on quantitative studies that offer limited explanation of leadership processes. In response, the paper proposes an integrated conceptual model linking situational leadership styles to board and committee performance through team capability, with organizational culture serving as a moderating factor. The review concludes that situational leadership is highly relevant to public health facility governance because it allows board leaders to adapt their style to the capability, motivation, and task demands of governance teams. The paper contributes to leadership and health governance scholarship by offering a context-sensitive framework for future empirical research, leadership development, and policy improvement in Kenya's public health sector.

Keywords: *situational leadership, public health facility governance bodies, organizational performance, organizational culture, devolution, Kenya, governance, team capability*

1.1 Statement of the Problem

Public health facility boards and committees are expected to strengthen governance by supporting planning, resource oversight, accountability, and community responsiveness within Kenya's devolved health system. However, evidence shows that many of these governance bodies continue to operate with unclear mandates, limited decision-making authority, weak accountability instruments, and inadequate capacity to perform core governance functions (Goodman et al., 2011; Waweru et al., 2013). These weaknesses reduce the ability of boards and committees to guide facility performance effectively, especially in settings where facilities face resource constraints, staff shortages, changing community expectations, and county-level administrative pressures (Nyikuri et al., 2015).

A key problem is that leadership within public health facility boards has not been sufficiently examined as a direct governance factor. Existing studies in Kenya have documented challenges in health facility committee functionality, financial management readiness, devolution-related pressures, and clinical leadership patterns, but they have paid limited attention to how board leaders adapt their leadership styles to the competence, motivation, and task demands of board and committee members (Goodman et al., 2011; Waweru et al., 2013; Nzinga et al., 2018). As a result, public health facility boards may continue to rely on rigid, bureaucratic, or top-down leadership practices that do not adequately support participation, role clarity, teamwork, and effective decision-making (Nzinga et al., 2018; Lodenstein et al., 2017).

This gap is urgent because devolution has placed greater responsibility on county-level and facility-level governance structures to deliver responsive and accountable health services. Where situational leadership is weak or absent, board chairs and facility leaders may fail to provide appropriate direction to inexperienced members, adequate support to members facing complex governance tasks, or sufficient delegation to capable members. Such leadership weaknesses can undermine board meetings, financial oversight, staff engagement, accountability, and service delivery improvement (Waweru et al., 2013; Nyikuri et al., 2015).

Conceptually, the leadership styles of public health facility boards and committees remain under-theorized, particularly through the lens of situational leadership. Contextually, there is limited Kenya-specific evidence explaining how adaptive leadership may strengthen board and committee performance within devolved health governance. Methodologically, existing studies tend to describe governance structures and leadership patterns without sufficiently explaining how leadership behaviours interact with team capability and organizational culture to influence performance outcomes (Goodman et al., 2011; Fagerdal et al., 2022; Martinussen & Davidsen, 2021). Therefore, this paper addresses the problem by critically reviewing situational leadership as a governance framework and proposing a conceptual model linking situational leadership, team capability, organizational culture, and the performance of public health facility boards and committees in Kenya.

1.2 Objectives of the Study

The study is guided by the following objectives:

i. To review the conceptual literature on situational leadership and its relevance to public health facility governance.
ii. To examine the theoretical frameworks that underpin situational leadership in organizational settings.
iii. To identify conceptual, contextual, and methodological gaps in the existing literature.
iv. To propose a conceptual model linking situational leadership, team capability, organizational culture, and board performance.

1.3 Significance of the Study

This review contributes to three domains. For scholars, it provides a synthesized conceptual and theoretical foundation for future empirical studies on health facility governance and leadership. For practitioners; county health officials, board members, and facility managers, the proposed model offers a diagnostic and prescriptive framework for leadership development. For policymakers, the review presents evidence-based grounds for incorporating leadership theory into

Kenya's health sector strategic plans, which have historically treated governance as peripheral to clinical outcomes.

2. Research Methodology

A narrative-critical review approach was used in this paper to explore the applicability of situational leadership in the function of public health facility boards and committees in Kenya. A narrative-critical review was deemed suitable as the study is not empirical based and does not aim to statistically synthesize findings, but rather conceptual and theoretical based. A narrative-critical review provides more context and interpretation of ideas, theories, debates, and gaps in the literature of an under-theorized research area than a systematic review, which is highly structured and has specific rules for comparing and quantifying the evidence within similar empirical studies (Ridley, 2012; Creswell, 2014). This method was therefore appropriate for exploring the use of situational leadership to public health facility governance as the available literature is conceptually varied and less standardized for a systematic synthesis.

Hence, this methodology was also supported because the purpose of this paper was not to test a measurable hypothesis, but to construct a conceptual argument. The review aimed to define situational leadership, review the theoretical basis of situational leadership, explore its application to health governance and suggest a conceptual model for future empirical testing. In these situations, a critical review will be helpful for the researcher as it would allow him to compare theories, look for areas of conceptual weakness, explore methodological shortcomings in existing literature, and formulate new theories from the reviewed literature (Imenda, 2014). The approach therefore gave flexibility to linking theory of leadership, theory of organizational culture, theory of team capability and theory of board performance in the devolved health governance structure in Kenya.

Google Scholar, PubMed, JSTOR, ResearchGate and African Journals Online were used to search the literature. These databases have been chosen as they offer wide coverage of leadership and governance, health systems, public administration, and African-context scholarship. The search terms that were used the most were: "situational leadership" (9), "Situational Leadership II" (7), "contingency leadership" (6), "health facility governance" (5), "board performance" (5), "public health management committees" (5), "devolution and health Kenya" (4), "organizational culture" (4), and "organizational performance in the health sector" (4). To narrow down the search, Boolean operators were added such as the following: "situational leadership AND health facility," "board governance AND performance," "health facility committees AND Kenya," and "organizational culture AND leadership performance."

Based on the initial search, there were 60 sources identified that were potentially relevant to the review. The sources were initially selected by title and abstract to check if they covered leadership, governance, organisation performance, public health management or committees of health facilities. Such sources as purely clinical, non-leadership/non-governance, non-academic opinion pieces, and non-English language sources without a translation were not included. The remaining sources were then examined in detail for their conceptual relevance, their contribution to theory, their methodological quality and their usefulness for the study in context.

To include items in the study, they had to be published during the last 25 years (2000-2024) with the exception of key theoretical works that were required to establish the foundations of the leadership concepts. The sources eligible for inclusion were peer-reviewed journal articles,

scholarly books, book chapters, theses and authoritative institutional documents that discussed leadership, governance, organizational culture, health systems or public sector performance. Only those studies that gave the theory a foundation were kept, including situational leadership, contingency theory, social cognitive theory, and self-determination theory. Full-text evaluation resulted in 40 sources being retained and cited that offered the most significant conceptual, theoretical, and/or empirical support and/or contextual information for the paper.

There were four criteria used to evaluate the selected sources. The conceptual relevance was first judged based on the contribution of the source to understanding situational leadership, team capability, organizational culture, or board performance. Second, theoretical relevance was measured in terms of its ability to explain the leadership-performance relationship. Third, contextual relevance was taken into account by prioritising studies on health facility governance, African health systems and on the devolved health sector in Kenya. Fourth, methodological credibility was evaluated based on the clarity of the study design, the quality of the evidence, and contribution to gaps identified.

Literature synthesis was done by thematic approach. The selected sources were grouped under five broad themes: conceptual bases of situational leadership, theoretical views that support situational leadership, empirical evidence from health and public sector contexts, evidence from Kenya and other African contexts of health governance and gaps in current scholarship. Then the themes were compared and interpreted with each other and the three types of convergence, contradiction and lack in the literature were found. This process helped the paper to develop a conceptual model that was integrated, which linked situational leadership styles, team capability, organizational culture and the performance of board and committees.

To enhance methodological transparency, the review separated out information sources that were used for theoretical justification, empirical evidence, and contextual justification. The key concepts were defined and explained using the sources of fundamental leadership and the practical implications of situational leadership in the organizational setting were evaluated based on empirical health-sector studies. The argument was supported by Kenya-specific and Africa-wide studies. The layered synthesis helped to ensure that the model proposed was theoretically sound, as well as contextually relevant to public health facility boards and committees in Kenya.

The narrative-critical review method was broad and interpretive analysis but it had its limitations. The review was not statistically based or yielded formal systematic-reviews like PRISMA screening. Thus, the findings should be interpreted as theoretical and conceptual and not as empirical evidence. This is, however, quite suitable to the purpose of the paper which is to clarify concepts, identify gaps and lay out a framework for future empirical testing.

3. Conceptual Review of Situational Leadership

This section reviews the concept of situational leadership by tracing its historical development, core definitions, leadership styles, and key operational dimensions. It provides the conceptual basis for understanding how leadership flexibility, task clarity, leader-member relationships, and contextual responsiveness apply to public health facility governance.

3.1 Historical Evolution and Conceptual Foundations of Situational Leadership

Situational leadership has its roots in the 1969 publication of “Life Cycle Theory of Leadership” by Paul Hersey and Kenneth Blanchard, which was based on Reddin's 3-D management style

theory, which defined task orientation, relationship orientation and effectiveness as the three dimensions of leadership (Northouse, 2016; Graeff, 1983). Reddin's idea that a leader is effective when he or she uses a style that is appropriate for the situation provided the conceptual foundation for the development of situational leadership theory.

Much work in refining the theory was done between the 1970s and 1990s. Hersey and Blanchard were amicably parted ways as the founding authors of SL, and Hersey then created the Situational Leadership Model, while Blanchard evolved the Situational Leadership II (SLII) model. The SLII; the review which mainly engages, incorporated feedback from practitioners and academic researchers in the field, including Malcolm Knowles' adult learning theory, Bruce Tuckman's five stages of team development, and Susan Wheelan's 10 year empirical study on the effectiveness of groups (Ken Blanchard Companies, n.d.; Stein, n.d.). These integrations allowed SLII to be used not just in a leader/follower relationship, but in team development as well.

Situational leadership is essentially about fitting the leader into the situation and/or the task and putting him into a mode that is fitting for that situation or task (Northouse, 2025). Most important, this definition suggests two skills: (i) diagnosis of follower developmental level and (ii) adaptation of one of four suggested styles of leadership. The theory is clearly prescriptive and provided a framework for making decisions, instead of just a descriptive typology.

3.2 The Four Leadership Styles and Follower Development Levels

Situational leadership is all about the combination between the leader's style of leadership and the follower's level of development. In SLII, follower development is categorized on two important factors: competence (knowledge and skills required for the task) and commitment (motivation and confidence). The model suggests four styles of leadership based on these dimensions. The directing style is characterized by its high level of directive and low level of supportive behavior and is appropriate for enthusiastic novices with high commitment and low competence. The leader gives clear directions and tight supervision in this instance. Coaching style is high directive and high supportive, suitable for the learners who have achieved certain competence but are losing their motivation. The leader here clarifies decisions, guides and encourages. The supporting style is characterized by low directive and high supportive behavior and is appropriate for able, but wary performers with good capability and variable commitment. This method allows the leader to facilitate, consult and support in the decision making process. This delegating style involves low directive and low supportive behaviors, and is used with self-reliant achievers who display high competence and high commitment and the leader imparts responsibility to the follower. This typology has been extensively used in organizational training and leadership development courses due to its ability to promote leadership development through differentiated strategies for various team members and the fact that a single person can employ different leadership styles for different tasks (Northouse, 2016; Blanchard *et al*., 1993).

3.3 Key Conceptual Perspectives

Three overarching perspectives structure the operationalization of situational leadership:

3.3.1 Task Clarity

Task clarity refers to the degree to which the parameters, expectations, and procedures of a task are defined and understood by the person assigned to it. When team members lack role clarity, performance suffers regardless of their general motivation levels (Daft *et al*., 2020; Northouse, 2016). In the context of health facility boards, task clarity is particularly critical: studies from

Kenya (Nyikuri *et al*., 2015), Zambia (Topp *et al*., 2015), and Australia (Brown, 2019) consistently find that vague board mandates, generic performance indicators, and unclear accountability structures undermine governance effectiveness. Task clarity is therefore not merely an administrative concern but a leadership responsibility — one that situational leaders address through appropriate directing or coaching behaviors.

3.3.2 Leader-Member Relationships

The situational leadership approach conceptualizes leadership as fundamentally relational. Effective leaders build trust with their followers by offering the type of support — directive or relational, that matches the follower's situational needs (Northouse, 2016). Studies from Norwegian hospital settings confirm that leaders who maintained inclusive, consultative relationships with their teams were more effective in navigating dynamic and resource-constrained environments (Fagerdal *et al*., 2022). In Kenyan public health facilities, by contrast, Nzinga *et al*. (2018) found that bureaucratic and top-down leadership patterns dominated clinical hierarchies, with expert power suppressing relational leadership behaviors and limiting staff agency.

3.3.3 Leadership Context

Leadership does not occur in a vacuum. Zigarmi and Arnold (n.d.) identify five leadership contexts through which situational leadership operates: self, one-to-one, team, organizational, and external. For public health facility boards, all five are relevant: board members must exercise self-leadership, engage effectively in one-to-one relationships with facility managers, contribute to team-level deliberations, appreciate the organizational performance context of the facility, and respond to external health system demands. Kenya's devolution has intensified the significance of the organizational and external contexts, as county governments must now navigate distinct political, financial, and infrastructural environments (Goodman *et al*., 2011).

3.4 Capacity Building as a Situational Leadership Function

Situational leadership is not just a diagnostic and matching leadership and follower typology, it also has a dimension of capacity building. Leaders should not only match the current development level, but actively raise followers from lower to higher level through purposeful training, mentoring and intentional stretch assignments (Northouse, 2016). In public health facility governance, this means that the governance chairs and public health facility managers actively invest in the capacity of the committee members to enhance their financial oversight, strategic planning and accountability mechanisms, which many committee members are not formally trained in (Waweru *et al*., 2013).

This capacity building dimension is related to the Skills Model of leadership, which suggests that technical, human and conceptual skills are learned and can be developed at all levels of an organization (Northouse, 2016). At the board and committee level; where concept and human skills are most critical, intentional leadership development is not an option, it is a governance imperative

4. Theoretical Review

Situational leadership does not stand alone theoretically. As this review establishes, it belongs to the broader family of contingency leadership models and is complemented by several motivational and developmental theories. This section reviews the key theoretical anchors of the proposed model.

4.1 Contingency Theory

Fiedler's Contingency Theory (1964), first formalized in organizational research in the 1960s, establishes the foundational premise that no single leadership style is universally effective (Daft *et al*., 2020). Instead, leadership effectiveness is a function of the match between a leader's style and the situational favorableness, determined by leader-member relations, task structure, and the leader's position power. This tripartite situational model provides the structural rationale for situational leadership's prescriptive approach.

For public health facility governance, contingency theory is directly applicable. The environments in which Kenyan public health facilities operate vary enormously: urban Level 5 hospitals operate in contexts of relative infrastructure, staffing, and financing strength, while peri-urban and rural facilities; particularly in arid and semi-arid counties, face acute resource constraints and community healthcare challenges that demand entirely different governance responses (Goodman *et al*., 2011). Contingency theory legitimizes context-differentiated leadership as a rational governance strategy rather than an improvised response.

4.2 Path-Goal Theory

Situational leadership theory complements Robert House's Path-Goal Theory (1971) in that it clarifies the process of how the leader's behavior influences the followers' motivation and effectiveness. The theory suggests that successful leaders are interested in discovering and eliminating obstacles that stand in the way of followers from achieving their desired results, and are proactive in explaining the routes to desired results (Northouse, 2016). There are four types of leader behavior suggested that are suitable for different followers and tasks; directive, supportive, participative and achievement-oriented.

There is a situational leadership component in both: both models acknowledge that leadership behavior needs to be adjusted to respond to follower and task differences. Path-goal theory is valuable because it explicitly includes the contributions of follower motivation and perceived equity as outcomes of leadership. Path-goal theory also helps explain why facilitating, recognizing and supporting the contributions of board members is a more effective governance lever than directive behaviors from the board chair alone (Martinussen & Davidsen, 2021) in health facility boards where board members tend to be volunteers that have less formal authority.

4.3 Self-Leadership Theory

Self-leadership theory, advanced by Manz (1986) and later synthesized by D'Intino *et al*. (2007), posits that effective leadership begins with an individual's capacity to direct and motivate themselves. Drucker (2008, p.1) famously observed that great contributors across history "have always managed themselves," developing self-awareness about their strengths, values, and optimal contribution environments.

In the situational leadership context, self-leadership is foundational: leaders who cannot self-regulate their own directive and relational behaviors; who default to habitual styles regardless of situational cues, cannot be genuinely situational. For health facility board chairs and committee leaders, self-leadership competencies include the ability to diagnose team dynamics objectively, resist the temptation to over-direct skilled members, and maintain motivational support for members navigating unfamiliar governance tasks.

4.4 Social Cognitive Theory

Bandura's (1997) Social Cognitive Theory contributes to the situational leadership framework by explaining how followers acquire behavioral patterns through observational learning and social interaction. In organizational settings, followers who interact with effective situational leaders learn to interpret leadership cues, internalize performance expectations, and develop self-efficacy for assigned tasks. This theoretical insight has direct implications for health facility boards: board members who observe capable, contextually adaptive leadership from board chairs are more likely to develop governance competencies over time, creating a virtuous cycle of capacity development.

4.5 Self-Determination Theory

Self-Determination Theory (SDT), developed by Deci and Ryan (1985) and described as one of the dominant 21st-century motivation theories, explains follower motivation in terms of three basic psychological needs: autonomy, competence, and relatedness (Bandura, 1997). SDT provides a motivational rationale for the matching logic of situational leadership: when a leader accurately identifies and supports a follower's current developmental needs, they satisfy these three psychological needs, generating intrinsic motivation and sustained performance.

The theory is particularly salient for understanding the delegation style (S4): when highly competent board members are given autonomy and delegated responsibility, SDT predicts enhanced engagement and performance. Conversely, when directive leadership (S1) is applied to competent, motivated members, it is predicted to undermine autonomy and relatedness, reducing intrinsic motivation, a dynamic consistent with findings from Brazilian nursing contexts (Andrigue *et al*., 2016) and Norwegian hospital leadership studies (Fagerdal *et al*., 2022).

5. Empirical Review: Situational Leadership In Health Settings

This section presents an empirical examination of situational leadership concepts. The core concepts comprise its application, gaps and underlying limitations. This review complements the existing literature on leadership in various contexts.

5.1 Application of Situational Leadership in Health Facilities

Empirical studies on situational leadership in health care are limited in comparison to other organizations, such as business and education, and offer some evidence about the frequency and impact of various leadership styles. In a seminal study by Andrigue *et al*. (2016) in Brazil, the most common directing and coaching styles were found, with none of the leaders studied delegating. The authors identified high power distance institutional culture, staff uncertainty, and low organizational commitment as the reasons for lack of delegation, much like what was found in Kenyan public health facilities.

In studying the situational leadership styles of American healthcare organizations, Bull (2010) reported that coaching was the most commonly used leadership style among facility managers, which reflects a tendency on the part of health professionals to be at the disillusioned learner development stage more often than others, and a pattern consistent with the high turnover, skill gaps, and challenges to motivation prevalent in public health systems in resource-poor settings. Bull suggested that deliberate delegation and support styles be used with high-skill staff because they might be over-directing their staff and lead to turnover intention.

In an Indonesian military hospital, Harsono *et al*. (2020) investigated the relationship between situational leadership and individual performance of physicians and discovered that situational leadership was statistically significantly associated with individual performance with the

mediating variable of motivation and organizational culture. This results are consistent with the conceptual model presented within this paper and the hypothesis that organizational culture acts as a mediating variable between leadership and performance.

5.2 Leadership Context and Health Facility Governance

Good governance of health facilities requires a multi-level approach to leadership and not a supervisory role alone. Public health facility board chairs and committee leaders not only need to lead the deliberations within the public health facility, but also need to understand the broader public health facility institutional priorities, support members with varying capabilities, and connect public health facility-level decisions with county health system expectations. This is particularly important if the health system is devolved or has variable accountability, financial and administrative arrangements. One way to look at it is that effective leadership involves being able to shift from one focus to another – from organizational awareness, to team coordination, to individual support – based on the situation. This is in line with Fagerdal et al. (2022) in their qualitative research on the Norwegian hospital team leader, who identified three aspects of effective leadership: the umbrella perspective, the one-to-one support and the active structuring of team processes.

This evidence is applicable to the governance context of Kenya's public health facilities boards since board chairs and committee leaders are also involved in complex governance settings. They have to ensure the coordination of the internal board processes as well as the involvement of the county-level board finance, staff, supplies and administrative support. Leaders with more contextual awareness and organizational networks are more successful in getting around resource limitations and being effective coaches. According to Fagerdal et al. (2022), leaders who had more organizational connections had better responses to operational challenges and could better support teams in real-time. This reinforces the thesis that situational leadership is appropriate for public health facility governance as it calls for the leader's behavior to vary based on the demands of the task, the capability of the members, and the broader organizational context.

The need for relational and supportive leadership is also highlighted in healthcare contexts, where leadership over professionals, teamwork, and motivation impact performance. In governance situations, it is more likely that board members and committee members will be able to participate meaningfully if leadership encourages them to do so, clarifies roles, and inspires them to trust, rather than relying on directive or compliance-based approaches. Martinussen and Davidsen (2021) concluded that a professional-supportive leadership style (professional climate and relational support) was related to a more positive social climate, innovation climate and staff engagement than an economic-operational management style. This discovery strengthens the main tenet of situational leadership, which is that leadership effectiveness is contingent on the congruency of direction and support provided to followers and the demands of the task.

This means that Kenyan public health facility boards need an approach to performance improvement that goes beyond the formal board setting. While boards can be well structured and convene meetings, the effectiveness of the board is driven by the quality of leadership interaction that influences participation, trust, decision making, and accountability. A board chair may be required to give guidance to inexperienced boards, coach inexperienced boards when they need encouragement, support them when they are competent but not confident and delegate to them

when they are ready and willing to take ownership. So, the findings of these health leadership studies provide evidence to support the idea of how situational leadership can help to enhance board performance by fostering adaptive, relational and context sensitive governance processes.

5.3 Evidence from Kenyan and African Health Facility Governance

Studies from Kenya and the broader African region provide the most proximate empirical context for this review. Goodman *et al*. (2011) found that health facility committees in Kenya's Coast Province were engaged in management functions but lacked clearly defined mandates, decision-making powers, and accountability instruments. The study established a pattern of ambiguous roles and inconsistent engagement that has been replicated in subsequent research.

Waweru *et al*. (2013), in a nationally representative study of health facility management committees, found that most were not ready to implement financial management responsibilities, citing limited member capacity, unclear roles, and inadequate support from county-level health management teams. This evidence directly substantiates the need for a situational leadership approach: the findings describe a governance population that is, at best, at the "disillusioned learner" stage; requiring coaching-style leadership characterized by high direction and high support.

Nzinga *et al*. (2018) provided arguably the most nuanced account of leadership dynamics in Kenyan public health facilities, demonstrating through ethnographic observation that clinical departmental heads operated primarily through bureaucratic, top-down authority, while expert clinicians exerted informal but pervasive influence over institutional decisions. The study concluded that this power dynamic "is so deeply embedded and taken for granted in healthcare that the associated problems it propagates are accepted"; a governance culture that is antithetical to the flexible, follower-responsive orientation of situational leadership.

Lodenstein *et al*. (2017), reviewing health facility committees across West and Central Africa, similarly recommended explicit clarification of committee mandates, powers, and accountability instruments as a precondition for effective governance. These recommendations align closely with the task clarity dimension of situational leadership and underscore the practical urgency of the framework proposed in this paper.

5.4 Identified Gaps from the Empirical Review

The empirical literature reviewed reveals three categories of gaps:

5.4.1 Conceptual Gaps

No study to date has explicitly theorized or operationalized the leadership styles of public health facility boards and committees using the situational leadership framework. Research has defaulted to generic leadership constructs (e.g., transformational, transactional) without considering the specific task-related and developmental characteristics of board governance contexts.

5.4.2 Contextual Gaps

The majority of empirical evidence on situational leadership in health settings comes from high-income countries (Norway, USA, Brazil, Australia) or private sector facilities. Kenya-specific evidence is limited to governance functionality studies (Goodman *et al*., 2011; Waweru *et al*., 2013) and ethnographic leadership observations (Nzinga *et al*., 2018), none of which explicitly measure situational leadership constructs.

5.4.3 Methodological Gaps

Most studies use quantitative survey approaches that capture leadership style prevalence but cannot explain the mechanisms through which specific styles produce performance outcomes in specific contexts. Mixed-methods designs; combining structured measurement with qualitative depth, are needed to generate actionable evidence for policy and practice.

6. Results and Discussion: Proposed Conceptual Model

6.1 Model Overview

Drawing on the conceptual and theoretical review, and grounded in the empirical evidence from health settings, this paper proposes an integrated conceptual model linking four variable clusters: situational leadership styles (independent variable), team capability (intermediate variable), organizational culture (moderating variable), and board and committee performance (dependent variable).

Table 1: Conceptual Model: Variables and Operational Indicators

Variable Role	Variable Name	Operational Indicators
Independent	Situational Leadership Style	Leader assessment capacity; diagnostic practices; task behaviors; relationship behaviors
Intermediate	Team Capability	Employee competency level; commitment; engagement; task clarity; motivation
Moderating	Organizational Culture	Leader-member relationships; leadership context; teamwork dynamics; task structure
Dependent	Board & Committee Performance	Board constitution; regularity of meetings; funds availability; employee performance; employee satisfaction

Source: Author's conceptualization based on reviewed literature (2024)

The model posits that a leader's deployment of appropriate situational behaviors; directing, coaching, supporting, or delegating, produces intermediate outcomes in team capability, which then interact with the prevailing organizational culture to influence board and committee performance. This is consistent with the findings of Harsono *et al*. (2020) and Fagerdal *et al*. (2022), which identified organizational culture as a critical mediating or moderating variable in the leadership-performance relationship.

6.2 Theoretical Propositions

Four propositions are advanced from the model to guide future empirical research:
Proposition 1: The deployment of appropriate situational leadership behaviors by health facility board leadership has a positive and significant influence on board and committee performance.
This proposition is supported by the general finding that leadership style significantly affects organizational performance (Northouse, 2016; Harsono *et al*., 2020; Akparep *et al*., 2019), and by the expectation that a prescriptive, context-sensitive approach is particularly well-suited to the heterogeneous governance challenges of public health facilities.

Proposition 2: Situational leadership initiatives are positively correlated with improved team capability, measured through enhanced employee competency, commitment, and engagement.
Supported by self-determination theory (Deci & Ryan, 1985) and social cognitive theory (Bandura, 1997), this proposition predicts that leaders who match their style to follower developmental levels will produce measurable gains in follower competency and motivation over time.
Proposition 3: Organizational culture moderates the relationship between situational leadership styles and performance outcomes, such that a collaborative, trust-based culture amplifies the positive effects of situational leadership.
This proposition draws on Harsono *et al*. (2020) and Martinussen and Davidsen (2021), both of which identified organizational culture as a critical determinant of whether leadership behaviors translate into performance gains. In contexts where bureaucratic or expert-power cultures dominate; as Nzinga *et al*. (2018) document for Kenyan public health facilities — the moderating effect of culture may suppress the positive impact of situational leadership, demanding deliberate culture-change strategies.
Proposition 4: The leadership context moderates the pathway from situational leadership behaviors through team capability to board and committee performance, such that organizational and external contexts have the strongest moderating effects in devolved governance settings.
Kenya's devolution has created 47 distinct governance environments, each with unique financing, infrastructure, and community contexts. This proposition, informed by Zigarmi and Arnold (n.d.) and Fagerdal *et al*. (2022), predicts that the effectiveness of any given leadership style will be significantly shaped by these contextual variables, requiring leadership assessments and interventions to be county-specific rather than nationally uniform.

6.3 Discussion

The conceptual model we propose is that situational leadership can enhance the performance of public health facility boards and committees by matching leadership behavior to the capability, the motivation, and the task demands of the governance team. This fits into situational leadership theory because it suggests that a leader's effectiveness is dependent on the level of readiness of the followers, and this view holds that the amount of direction and support should vary depending on the level of readiness (Northouse, 2016; Blanchard et al., 1993). As a public health facility board, this means that it is important to chair a board and lead a facility using a leadership style that isn't a one-size-fits-all approach. Rather, they are supposed to offer guidance when the members don't know how to govern, coaching where members need guidance and encouragement, support where members have competence and a lack of confidence, and delegation where members are competent and ready and willing to lead.

This model is particularly relevant for Kenya, where the devolved health governance structure is embedded in complex and unequal institutional contexts, as the boards and committees of the health facilities exist in these environments. The governance of health facilities in Kenya has been studied and committees are reported to have ambiguous mandates, little authority, poor accountability mechanisms and lack of readiness when it comes to financial management roles and responsibilities (Goodman et al., 2011; Waweru et al., 2013). The shortcomings indicate that there are structural problems but also leadership problems. In situations where members are not clear and/or not confident, a situational leader may be able to apply directive and coaching behaviours to help clarify roles, enhance participation, and develop governance competence. In situations

where members are more capable, supportive and delegating behaviours can foster ownership, accountability and improve the quality of decision making.

Situational leadership in public health facility boards cannot be assumed to be an automatic success, however. The environments of public health facilities can be highly bureaucratic and involve a hierarchical order of authority, a formal process of decision making, and less than optimal resource control, staffing, and policy implementation by the leaders. Nzinga et al. (2018) found that leadership within Kenyan public hospitals is influenced by the bureaucratic authority and professional hierarchy which can constrain inclusive decision-making and adaptive problem-solving. Situational leadership may also be limited by county-level controls, inflexible reporting systems, professional power relations and institutional autonomy, even when board chairs are aware of situational leadership.

The second is situational leadership assumes that leaders have the ability to accurately judge followers' ability and commitment. This in practice might be challenging within public health facility boards as members could have different professional backgrounds, different level of governance literacy, and community representation and understanding of health financing, procurement, accountability and governance. Many health facility management committees in Kenya were found to be poorly prepared for financial management in their health facilities (Waweru et al., 2013), suggesting that board capacity cannot be taken for granted. If leaders underestimate or overestimate their members' capabilities, they might be able to direct their better members to do more, but as a result, their members become less motivated; or they might delegate too early to members whose capabilities are not yet fully developed, and thereby reduce oversight and accountability.

The model is thus highly reliant on the organizational culture. Organizational culture helps moderate the relationship between situational leadership and board performance in 3 ways: first, it influences whether the leadership behaviours are accepted, resisted, or implemented; second, it influences the nature and extent of the connection between situational leadership and board performance; and third, it influences who is impacted by situational leadership within the organization. Directive leadership might be seen as being helpful, coaching might facilitate learning, supportive leadership might build confidence, and delegation might foster ownership in a collaborative and trustful culture. Whereas, in a bureaucratic/fear-driven culture, the same leadership practices might produce less impact due to the fact that members might not communicate openly or defer too much to leadership or only attend meetings to complete the formalities. This aligns with the findings of Martinussen and Davidsen (2021), who determined that leadership practices that focused more on professional than economic aspects were related to more positive social climate and innovation climate and staff engagement.

Another intermediate pathway in the proposed model is between organizational culture and team capability, which is also found to be shaped by organizational culture. A culture of support helps build your team's capability by making it safe to ask questions, share information, learn from mistakes, and be part of board decisions. Initiatives supported by strong leadership in the hospital were found to contribute to adaptive capacity through organizational awareness, one-to-one support and structured team processes as shown by Fagerdal et al. (2022). This means that team capability is built not just on individual skills but on interaction with the team. A culture which

allows open communication, clear roles, teamwork and learning is likely to improve how situational leadership positively impacts public health facility performance for boards.

On the other hand, if the organizational culture is low, it can thwart the situational leadership benefits. In such cases as poor communication, lack of trust, unclear roles, political interference, or too much reliance on senior officials, the adaptive leadership behaviours may not be met with enthusiasm by board members. Lodenstein et al. (2017) highlighted that health facility committees need to be mandated, held accountable and have institutional arrangements that work in their favor. Therefore, weak governance systems cannot be fully mitigated with situational leadership. Instead, it is best complemented by a culture that has a high value on participation, transparency, responsibility, and continuous learning.

The discussion further implies that the level of board functioning needs to be discussed beyond compliance metrics. The classic governance questions are if boards are formed, if meetings are conducted, if there are funds to cover expenses, and if reports are shared. These indicators are relevant, but don't necessarily capture the quality of leadership, deliberation, participation and accountability in the board process. Thus, the proposed model emphasizes behavioural governance instead of just focussing on the presence of governing bodies. It suggests that good board performance is enhanced by effective membership development, by meaningful involvement of board members, and by making board decisions in keeping with the facility and community needs.

It also has policy implications for the devolved health system in Kenya. County governance and health sector policymakers should not see 'leadership' as an informal quality of an individual, but rather as a governance capability that can be built, evaluated and followed. There is a need for public health facility board (PHFBs) leadership development activities incorporating training on role clarity, adaptive leadership, communication, conflict management, financial oversight, and accountability. This supports the findings of Goodman et al (2011) and Waweru et al (2013) who indicated that the health facility committees need increased clarity, authority and capacity support in order to function well. Situational leadership training would be most helpful when it is applied to specific board tasks and not as broad leadership principles.

In summary, the proposed model is a new contribution to health governance scholarship by introducing situational leadership as a tool for strengthening the capability and performance of boards. But its impact relies on the broader organization culture and institutional context of boards. Situational leadership will likely be more successful in environments where there is trust, learning, involvement and accountability. It will likely have less impact in settings where the need for bureaucracy is paramount, directives are ambiguous, there is little autonomy, and decision making is hierarchical. Thus, empirical research in future should be done to test the role situational leadership plays in board effectiveness as well as the effect of organizational culture, team ability and institutional constraints on the said relationship amongst the devolved public health governance system in Kenya.

7. Conclusion

This paper is a critical conceptual and theoretical analysis of situational leadership that seeks to establish its relevance to governance and performance of public health facility management boards and committees with emphasis on the devolved health system of Kenya. The findings of the review

indicate that the concept of situational leadership with a prescriptive, follower responsive and context dependent approach is theoretically relevant and applicable to the Kenyan context of governance issues facing health facility boards. The theoretical backbone is sound: all the theories together (contingency theory, path-goal theory, self-leadership, social cognitive theory and self-determination theory) offer multiple level scaffolding of the situational leadership-performance link.

The key findings of the empirical evidence, all point to the potential relevance of the situational leadership construct, with all four studies from Norway, Brazil, the United States, and Indonesia, as well as the one study from Kenya, indicating that relational, context-adaptive leadership is a key factor in influencing staff performance and organizational governance quality.

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