Strengthening Nursing & Midwifery Leadership in Malawi

Learning Brief

Lead partners:

Florence Nightingale Foundation
Nurses and Midwives Council Malawi
Nursing Council Kenya

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HIGHLIGHTS in photos






Introduction

Project context and purpose

Malawi's health system delivers services across a wide range of settings, including district hospitals, faith-based facilities, and referral services. The system operates in a context of high demand for care and ongoing constraints in resources and workforce capacity. These conditions place significant responsibility on health workers and managers to maintain safe, effective services while responding to competing operational priorities.

Nurses and midwives are the largest professional group within Malawi's health workforce and play a central role in service delivery, including clinical care, coordination, supervision, and community-facing health interventions. Strengthening leadership and management capacity within nursing and midwifery is, therefore, an important component of improving service quality, workforce support, and health system performance.

Mid-level nursing and midwifery managers are a key group within this system. They lead teams and services at ward, department, facility and district level, and are responsible for implementing policies and standards, managing workforce challenges, and supporting day-to-day service delivery. Stakeholders identified that structured leadership development and mentorship support for this cadre is not consistently available at scale, despite their influence on service delivery.

The purpose of the project was to address this gap through delivery of a leadership development programme for mid-level nurses and midwives in Malawi, supported by mentorship and quality improvement planning. The overall aim was to strengthen leadership capability in a cadre positioned to influence service delivery, workforce experience, and improvement activity within routine practice.

This project was developed in alignment with Malawi's national health priorities, including the Health Sector Strategic Plan III (2023–2030), which identifies leadership and governance and human resources for health as critical enablers of service delivery and quality improvement. It also reflects priorities set out in Malawi's nursing and midwifery policy direction and the strategic priorities of national nursing and midwifery stakeholders.

PROGRAMME OBJECTIVES

1. Co-design and deliver a leadership development programme for Malawi.
Develop a contextualised leadership programme, including curriculum, delivery plan and participant materials, suitable for use within Malawi's health system and aligned to national strategic priorities.

2. Strengthen leadership capability among mid-level nurses and midwives.
Deliver leadership training to 50 mid-level nursing and midwifery managers to support development of practical leadership knowledge, skills and confidence.

3. Establish mentorship support through senior nurse and midwife mentors.
Train 10 senior nurse and midwife mentors and support structured mentorship engagement with programme participants.

4. Support applied quality improvement planning.
Enable participants to develop quality improvement project proposals relevant to their own service areas, supported by training and coaching.

5. Strengthen local delivery capacity through faculty development.
Support Malawian faculty to co-develop and co-facilitate programme delivery, increasing capacity for future delivery and mentorship support.

6. Strengthen partnership working and shared learning.
Support collaboration between partners through joint design, delivery, governance and learning processes, to inform sustainability and potential future scale-up.

Approach

The project used a blended leadership development approach, combining intensive face-to-face learning with sustained post-training support. It was designed to strengthen leadership capacity among mid-level nurses and midwives in Malawi by linking leadership development to workplace improvement, supported through mentorship and structured quality improvement (QI) project development.

The delivery model was structured around four core activities:

1. Residential leadership training for 50 participants.
2. Residential mentor development training for 10 senior nurse and midwife mentors.
3. Ongoing mentorship and support for QI project development.
4. A close-out event to consolidate learning, showcase achievements, and support sustainability.

Programme design and contextualisation

The programme was co-designed through a multi-stakeholder working group, drawing on learning from our previous leadership programme delivered in Kenya and adapting the content, structure, and materials for the Malawian context. This ensured the curriculum was relevant to the realities of nursing and midwifery leadership in Malawi, while maintaining consistency with evidence-based leadership and improvement principles.

A key adaptation made during the design phase was simplifying and refining content to avoid overload and allow more space for reflection, application and discussion. The partnership also recognised early that QI project development would require more support than initially anticipated, and this was reflected in the strucure of both the face-to-face training and the follow-on support.

Participant and mentor recruitment (national reach and inclusion)

Participants and mentors were recruited through a structured process led by national partners in Malawi. Selection was designed to ensure representation across settings and geography, and to support gender inclusion in line with workforce composition. Recruitment was undertaken through nominations involving District Health Management Teams, central hospitals, the Christian Health Association of Malawi (CHAM), and national institutions.

This approach aimed to strengthen legitimacy, relevance, and ownership, while supporting participation from across the country rather than concentrating opportunities in a small number of urban sites.

Residential leadership training (core capacity-building component)

The residential programme provided intensive training for participants and mentors, using a mix of teaching formats including presentations, interactive workshops, and group practice sessions. Core topics included leadership and management styles, communication and influencing, workforce planning, and quality improvement methods.

Separate breakout sessions were used to differentiate learning for mentors and mentees, including:

- Mentor preparation for supportive supervision and coaching roles.
- Participant preparation for QI project identification, planning, and proposal development.

This design ensured that learning was not purely conceptual, but linked to the leadership tasks participants were expected to carry out after training.

Mentorship model and post-training QI support

Following the residential training, participants received structured mentorship support from the senior nurse and midwife mentors. Mentorship was positioned as a practical mechanism for reinforcing learning, supporting application in the workplace, and providing accountability during QI project development. QI was embedded as an applied component of the leadership programme. Participants were supported to develop QI project proposals relevant to their own service areas, with structured guidance and review.

Innovation and scalability

A core innovation within the programme design was the deliberate use of a train-the-trainer approach to strengthen local delivery capacity and support future scalability. Rather than relying on external facilitation alone, the programme was structured to develop Malawian faculty capability alongside delivery, with local faculty involved in curriculum contextualisation, preparation, and co-facilitation of the residential training.

Methodology and Data Collection Strategy

The evaluation used a mixed-methods approach, combining routine programme monitoring data with structured feedback tools to assess delivery, participant experience, and early outcomes (see Table 1). Data were collected at multiple points across the programme to capture baseline measures, immediate post-training change, and progress during the mentorship and quality improvement (QI) support period.

Table 1: Data Collection Strategy Summary

Data collection tool	Timing	Target respondents	Outcomes or activity measured
Pre-programme questionnaire	At start	Programme participants (n=50)	Baseline measures of participants' leadership confidence and development needs, professional engagement / identity, and perceptions of advocacy and influence within the profession
Generalised self-efficacy scale – adapted	At start	Programme participants (n=50)	Baseline self-efficacy (confidence in ability to manage challenges, solve problems, and achieve goals)
Residential training evaluation survey	Following completion of residential training	Programme participants (n=50) Mentors (n=10)	Immediate post-training feedback on perceived learning and skills development and satisfaction
Mentorship session logs	Monthly following residential training	Mentors (n=10)	Level of mentorship activity delivered (number and frequency of sessions)
QI project proposal scoring matrix	End of programme	Faculty from all partner organisations	Quality and feasibility of QI projects against minimum quality criteria
Mentor experience survey	End of programme	Mentors (n=10)	Mentor confidence and preparedness to continue mentorship beyond the programme, perceived effectiveness of mentorship model
Post programme survey	End of programme	Programme participants (n=50)	End of programme measurement of participant self-efficacy and leadership capability to enable comparison with baseline

Ethical considerations and confidentiality

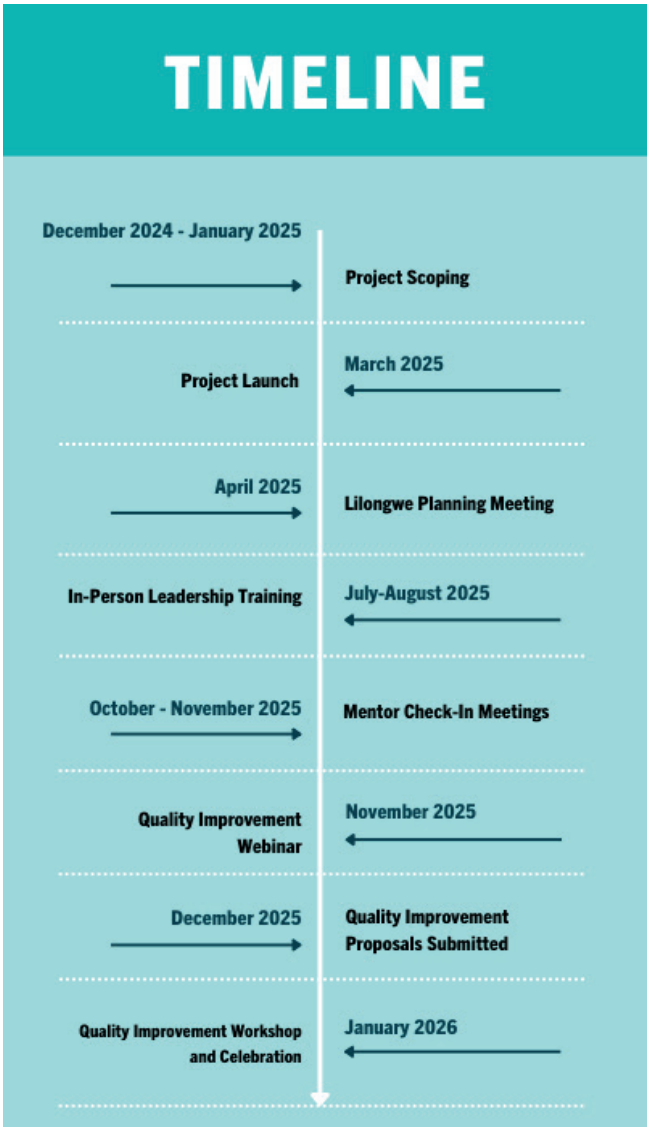
Written informed consent was obtained from all participants during the face-to-face leadership training in Malawi and again during the QI workshop and Celebration Day. Verbal consent for audio recording was secured before any interview. The project stored all participant data in line with FNF's data and information security policy, ensuring secure data storage and handling.

Implementation Process

The project followed a structured 10-month implementation process from April 2025 to January 2026, with preliminary work beginning in late 2024 for partnership formation and grant acquisition. The core implementation phase launched in July 2025 with the intensive leadership training programme, followed by ongoing webinars and mentorship activities that extended through January 2026.

Data Analysis

We employed a mixed-methods approach to evaluate this programme. Quantitative analysis included tracking attendance for webinars and mentorship sessions, alongside pre and post-programme impact surveys. Qualitative data from participant and partner interviews and focus groups was analysed through detailed summary notes to identify key themes and patterns.



Limitations

The programme evaluation faced notable limitations, including a relatively short 10-month implementation period that constrained the assessment of long-term impacts on leadership development, workforce retention, and service improvement. Much of the outcome evidence relies on self-reported survey data, which may not fully reflect changes in leadership behaviour in practice. Finally, variation in mentorship engagement and early challenges in tracking and documentation may have affected the completeness and consistency of monitoring data.

Programme Delivery Effectiveness and Feedback

Key Findings and Achievements

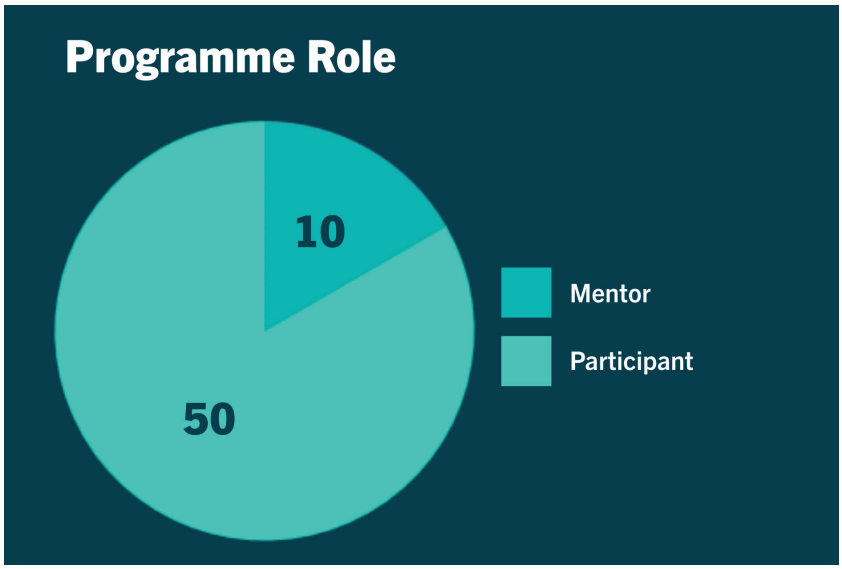
- 50 nurse leaders were recruited through a geographically and gender-responsive selection process. 10 nurse mentors were identified through the NMCM, CHAM and the MoH.
- 49 nurse leaders and 10 nurse mentors completed a one-week residential leadership training programme.
- Participant satisfaction was high, with 100% reporting improved skills and 71% rating the programme as excellent, particularly valuing its relevance and practical leadership focus.
- The hybrid leadership model - combining transformational leadership, stakeholder management, systems thinking, and applied QI - strengthened participants' confidence and ability to navigate complex organisational environments.
- The mentorship component of the programme was strengthened by mentors attending the training and spending time in-person working with the participants on the leadership projects.
- The QI component functioned as an applied leadership laboratory, enabling participants to translate theory into practice through structured mentorship and stakeholder engagement.
- 10 QI projects selected for MoH endorsement, demonstrating alignment with national policies and enhanced sustainability beyond the grant period.

Participant Demographics

60 participants [mentees (n=50); mentors (n=10)] were purposively recruited, successfully filling all places on the programme.

NMCM led the selection of a structured nomination process involving District Health Management Teams, central hospitals, CHAM, and national institutions, with eligibility based on current leadership roles and academic qualifications. Mentors were purposively chosen from MoH, NMCM, and CHAM based on prior leadership training and experience in supportive supervision and mentorship, using a selection process and criteria agreed by the partnership steering group.

Figure 1: Programme Role (n=60)



A key challenge in achieving gender equality was addressing the gender imbalance in middle management positions within the nursing and midwifery sector in Malawi.

Figure 2: Gender of Participants (n=60)

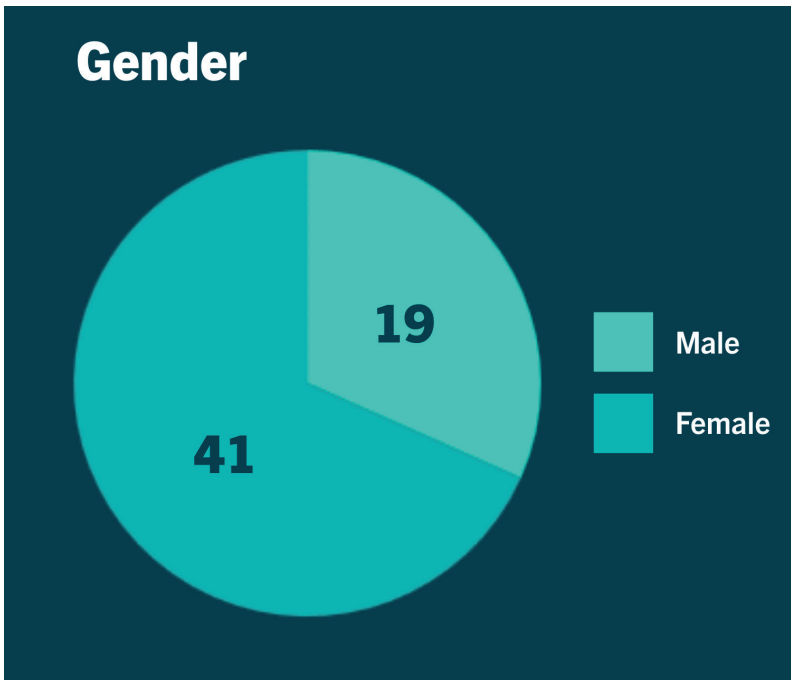


Figure 3: Service Area Geography (n=60)

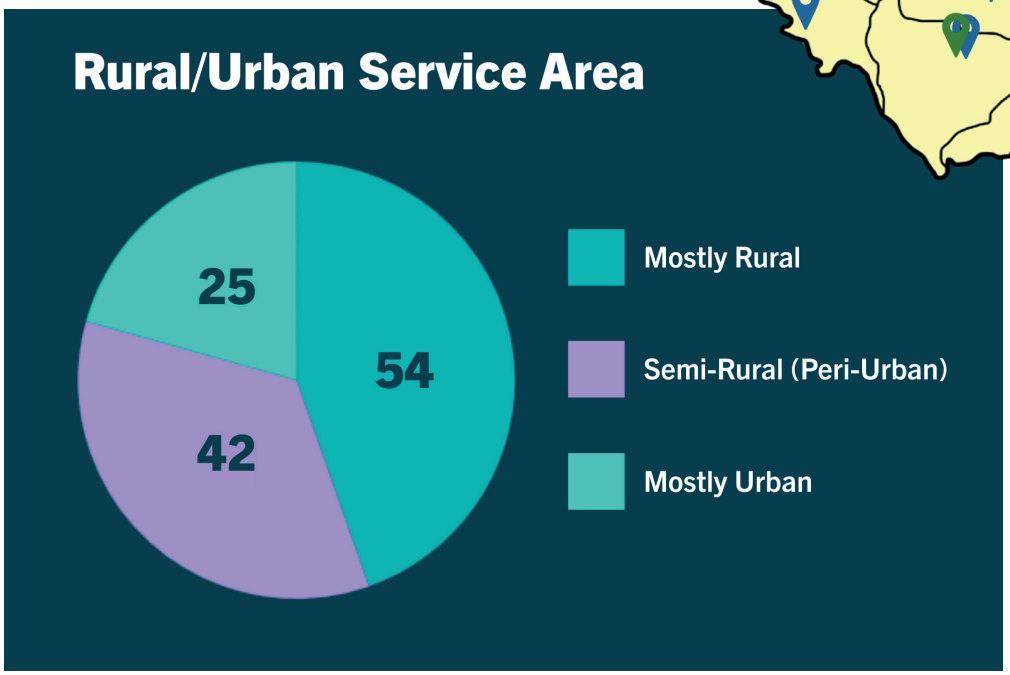
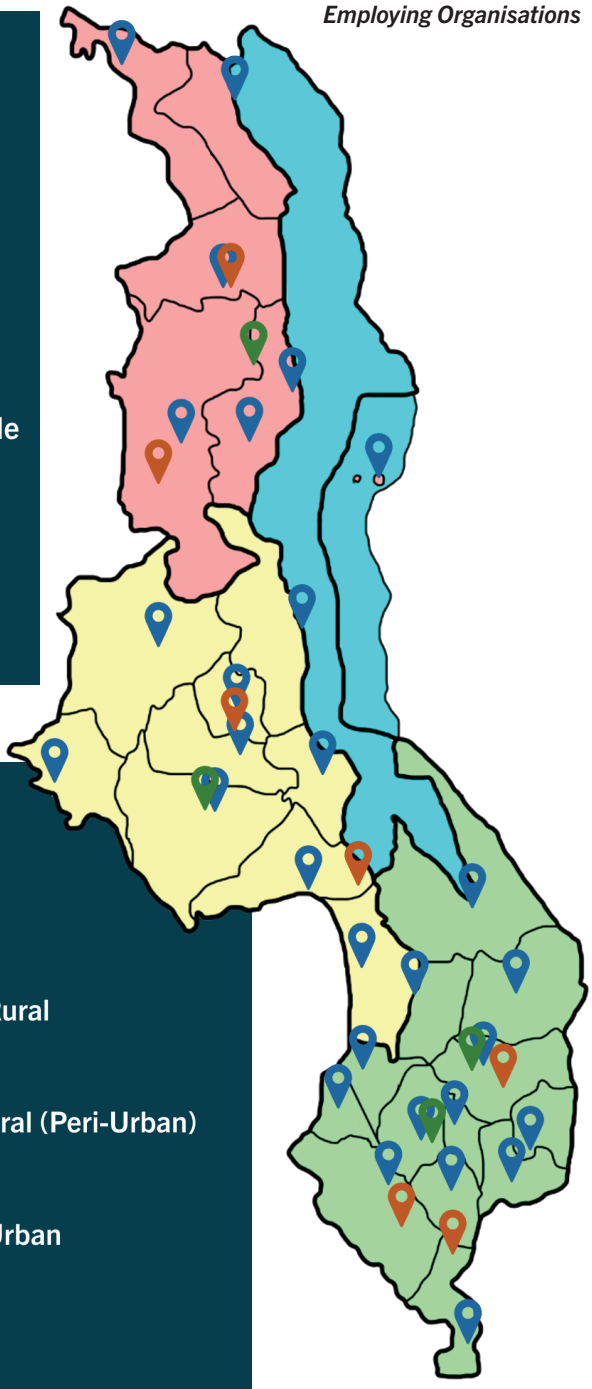


Figure 4: Map of Participant's Employing Organisations



Despite the broader nursing and midwifery workforce being predominantly female, men are overrepresented in our target roles. Managing this required deliberate intervention to ensure equitable participation in the leadership development programme. Conscious efforts were made to achieve balanced gender representation among both mentors and participants, resulting in 70% female programme participants and 60% female mentors.

Efforts were made to ensure geographical inclusion and that all districts of Malawi were represented by programme participants. Participants were selected from hospitals serving both rural and urban communities.

Evaluation of the Leadership Training

The leadership development programme in Malawi was designed to build on the success of the Kenya project while responding to the specific context of Malawi's health system. The initial training was delivered as an intensive week-long programme, aimed at strengthening the capacity of middle-level (mentees) and more senior (mentors) nurse and midwife leaders to lead change in complex, resource-constrained environments.

Diverging from the structure of the Kenya project, due to the programme's 10-month timeframe and the identification of different workforce needs, participants were not required to implement full projects, but rather to focus on stakeholder engagement, consultation, and the design of sustainable, evidence-informed interventions. This approach allowed participants to develop a practical understanding of how to identify system gaps, prioritise effective and cost-efficient interventions, and make compelling cases for change at both institutional and policy levels.

While the programme was largely grounded in transformational leadership, emphasising self-awareness, inspiring and motivating teams, influencing others, and fostering shared purpose, it evolved into a hybrid, practice-focused model. The curriculum integrated elements of adaptive leadership, applied quality improvement, and systems thinking, reflecting the technical, political, and procedural demands of the health system leadership needs in Malawi.

The residential training programme combined sessions on reflective thinking, case-based problem solving, and structured quality improvement project planning to help participants develop core leadership skills and then translate them into actionable strategies. Separate break-out training sessions were held to provide specific training on mentorship and quality improvement design.

Following completion of the training, faculty identified skills such as navigating organisational hierarchies, prioritising scarce resources, building evidence-based arguments, and linking interventions to outcomes and potential confounders using a theory of change approach, as key areas for further leadership development.

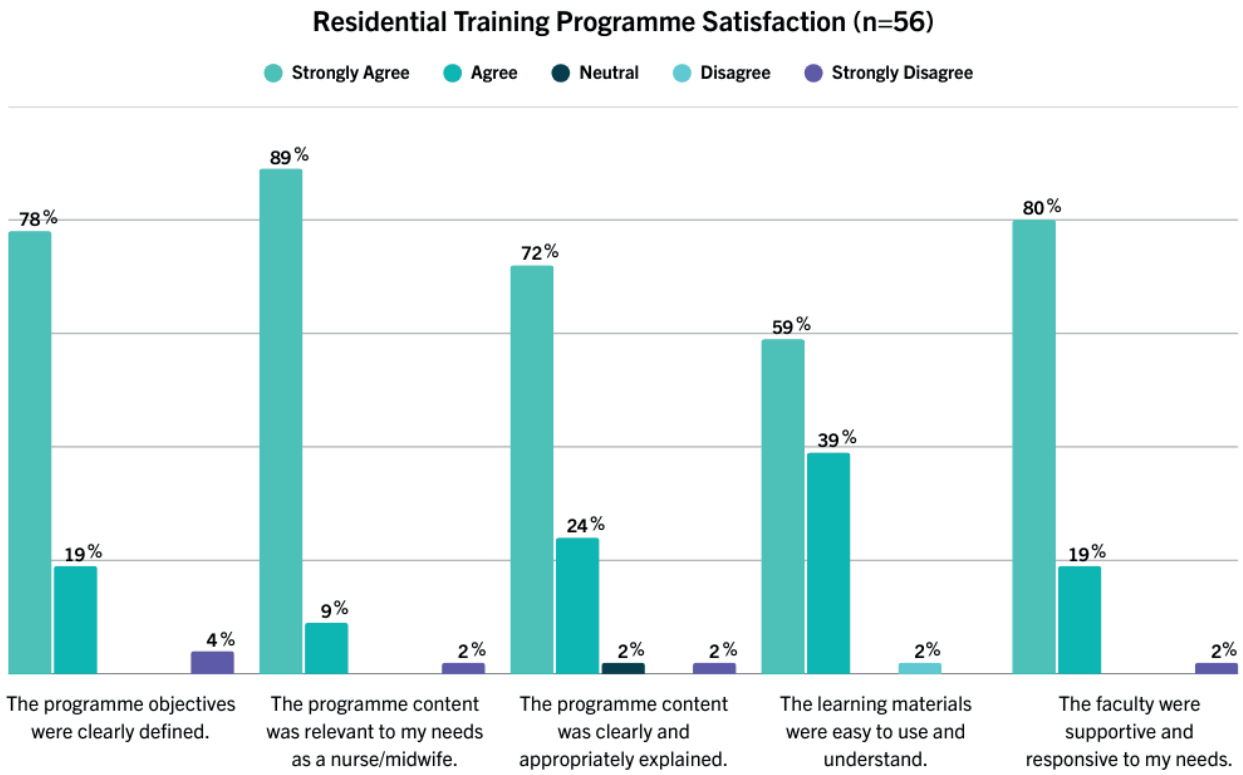
Training Evaluation Findings

Participant Satisfaction

Satisfaction rates for the residential training programme were positive across all our programme delivery indicators. Overall, participants (mentees and mentors) rated the programme very positively: 71% of respondents rated the programme as "excellent" and 29% rated it as "good". Respondents reported specifically high satisfaction with the relevance of the programme content to their needs as a nurse/midwife, and noted how supportive and responsive the faculty were to their needs.

"The training is relevant and has come in good time as an eye opener. I enjoyed each and every presentation. An interactive training, so superb and relevant."

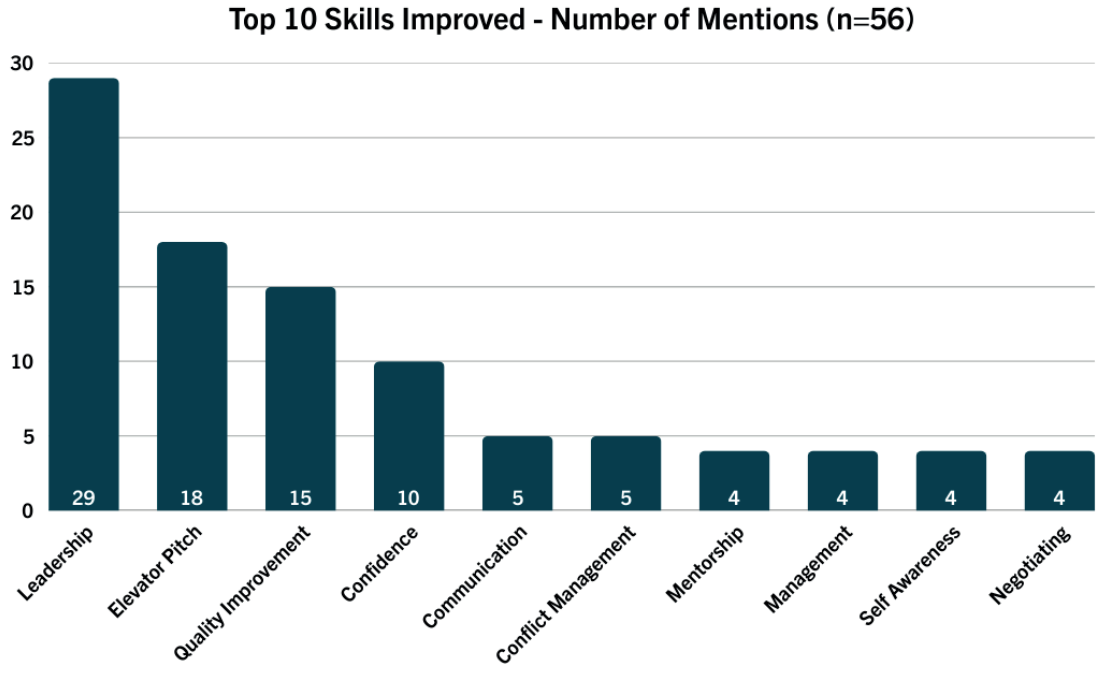
Figure 5: Residential Training Programme Satisfaction (n=56)



Participant Learning

100% of respondents reported having developed or improved specific skills or competencies by participating in this programme. Overwhelmingly, respondents recognised their developing leadership skills as a result of the residential training. **Presenting** and **'elevator pitch skills'**, **quality improvement and change management**, and general f**eelings of confidence** were also frequently mentioned.

Figure 6: Top Skills Improved During Residential Training by Number of Mentions (n=56)



Most Helpful Aspects

Participants valued the **Change and Improvement Frameworks,** particularly the structured QI and change management tools that could be directly applied in their workplaces. **Leadership Development** was also highly regarded, with many highlighting the opportunity to reflect on their own leadership journey and better understand different leadership styles. The programme's **Interactive Learning** approach – through breakout sessions, group discussions, and peer exchange – was frequently mentioned as a strength, alongside the practical focus on **Skill Application**, including use of workbooks and preparation of elevator pitches. Sessions addressing **Team Dynamics**, power, and conflict were seen as especially relevant to real-world leadership challenges.

Areas for Improvement

In terms of improvement, participants noted that **Time Allocation** felt insufficient for key topics, particularly quality improvement and leadership reflection. Some also suggested improvements to **Scheduling and Communication** and felt the overall **Programme Intensity** could be better balanced by extending the length of the training.

Faculty Learning and Reflections

Faculty reflections suggested that the programme's impact relied not only on leadership principles but on developing participants' practical judgment and confidence in addressing complex challenges in real life situations. By the end of the week, participants had strengthened their ability to engage stakeholders effectively, advocate for change, and plan interventions with strategic and contextual awareness.

Faculty further highlighted how quality improvement projects were framed a **"way to develop participants leadership skills"**. In this way, the programme fed directly into the wider project aims by producing leaders equipped to drive sustainable improvements within Malawi's health system, blending motivational and conceptual frameworks with applied, context-sensitive skills.

Figure 7: Top Skills Improved During Residential Training Programme (n=56)

Ongoing Skill Development and Application: Mentoring and Quality Improvement Projects

Developing as Leaders through Quality Improvement

Upon completing the residential programme, participants continued to work closely with their assigned mentors as they developed their quality improvement (QI) projects. This post-training mentorship was deliberately structured to reinforce the leadership concepts introduced during the week-long course, providing a practical space for applying new skills, testing ideas, and receiving accountability and support.

The training focused on learning the **process** of quality improvement rather than completing a project end-to-end. This allowed mentees to concentrate on diagnosing problems, engaging stakeholders, using data, and planning sustainable change, and in doing so, to understand the leadership capabilities required for real-world improvement work.

As part of the programme's commitment to south–south learning, a Kenya leadership programme graduate delivered a webinar to share her experience of developing and leading a QI project. This session allowed Malawi participants to learn directly from a peer working in a comparable health-system context, gaining practical insights into the QI process and the leadership behaviours required to drive improvement.

With the support of their mentor, participants developed project proposals spanning 7 key areas of their practice – from maternal health to infection prevention control – with a number of them successfully beginning implementation of their projects over the programme period.

QI proposals were evaluated through a two step assessment process. First, mentors and mentees met in person to review each proposal using a QI Project Plan Assessment Tool aligned with MoH Quality Management Policy, the National QI Framework, and HSSP III priorities, resulting in the top 20 projects being shortlisted. These were then independently reviewed by three members of the global partnership faculty and assessed using a GESI framework, with the top 10 progressing to a quality improvement refinement workshop with multi-agency stakeholders, including the Ministry of Health.

The Quality Improvement Workshops

To support sustainability beyond the grant period, the Ministry of Health committed to backing the implementation of the 10 most promising QI projects emerging from the programme. A dedicated one-day QI Project Workshop, held alongside the project close-out and celebration event, provided an opportunity for these projects to be refined and prepared for implementation with Ministry and local stakeholder support.

Facilitated by FNF, NCK, and local faculty, the workshop brought together the 10 selected participants and their mentors to strengthen project design, clarify implementation plans, and align proposals with district and national priorities. The selected projects reflect a wide range of system-level priorities, including maternal and neonatal outcomes, infection prevention, clinical audit, supervision, CPD fulfilment, records management, triage protocols, and workplace safety.

Projects were drawn from all three regions (South 4, North 3, Central 3), with equal gender representation (5 female, 5 male participants).

Table 2: Participant Quality Improvement Project Themes

Key Area	**Description of Initiatives** (non-exhaustive)	**Outcomes (high level)**	**Impact**
Maternal health	• Partograph improvement • Labour monitoring • Assisted delivery skills • Maternity audits	• Reduced maternal complications • Improved labour monitoring • Improved decision-making	• Reduced maternity morbidity / mortality • Safer childbirth
Neonatal care	• Skin-to-skin • Warming/ resuscitation prep • Transport practices	• Reduced neonatal hypothermia	• Improved newborn survival and quality of care
Child health	• WHO triage training and mentorship • Routine monitoring	• Faster emergency recognition and response	• Reduced preventable child harms and deaths
Infection and prevention control	• Hand hygiene improvement • Theatre environmental cleaning	• Improved IPC compliance • Reduced infection risk	• Safer care environments • Fewer avoidable infections
Workforce training and strengthening	• Supportive supervision tools • Structured ward supervision • Roster adherence • Student indexing	• Improved staffing reliability • Enhanced supervision	• More consistent care quality and accountability • More robust workforce pipeline
Clinical documentation and information quality	• SOAPIER documentation • Vital signs chart • Treatment chart documentation	• Improved completeness and accuracy of documentation	• Reduced preventable harm • Stronger safety culture
Professional standards and patient experience	• Name tags, uniform compliance	• Improved staff identification and professionalism	• Improved patient confidence and experience

Project Case Study:
Beatrice Kanyimbo

Strengthening Maternal Care Through Near-Miss Audits at Zomba Central Hospital

Beatrice Kanyimbo identified a critical gap in maternal care: while maternal deaths were routinely audited, **obstetric near-miss cases were not reviewed at all**, resulting in a zero percent audit rate despite national MPDSR policy requirements. Near-miss cases - women who survive life-threatening complications during pregnancy or within 42 days of termination - offer vital learning opportunities. Without auditing these cases, preventable gaps in care remained hidden.

Using a **quality improvement stepwise assessment approach**, Beatrice conducted a root cause (fishbone) analysis. Key challenges included limited staff knowledge, absence of standard operating procedures (SOPs), lack of a structured review system, and competing clinical priorities. In response, she led the development of a structured maternal near-miss audit system aimed at increasing the audit rate from 0% to 25% within six months in Zomba Central Hospital.

The changes she led included establishing a functional multidisciplinary MPDSR committee, introducing a maternal near-miss register, developing SOPs for identification and documentation, building staff capacity, and initiating routine audit meetings with feedback and follow-up on action plans. Physical registers were introduced in wards to improve case identification and documentation, with plans to expand access across additional units.

Implementation was not without challenges. Meeting attendance and documentation compliance were initially inconsistent due to workload pressures. However, Beatrice identified these hurdles and responded by strengthening staff orientation, reinforcing the purpose of near-miss audits amongst colleagues, and improving communication across the OBGYN department.

Through this project, Beatrice strengthened her leadership skills in **negotiation, communication,** and **change management**. She reported increased confidence in facilitating multidisciplinary discussions, tracking action plans, and using evidence to advocate for improved maternal care.

This initiative demonstrates how structured quality improvement can transform policy into practice.

By embedding near-miss audits within routine systems, Beatrice's project is creating a sustainable mechanism for learning, accountability, and improved maternal outcomes.

Programme Outcomes and Impact

KEY FINDINGS

- The programme strengthened professional identity, with alumni seeing themselves as leaders who can influence practice and uphold professional standards.
- Confidence in advocacy improved significantly, with almost a 20% increase in alumni feeling equipped to influence decisions and represent the profession in leadership forums.
- Advocacy efforts over the course of the programme focused on safe staffing, access to essential resources, and protecting nursing autonomy within multidisciplinary settings.
- Self-efficacy increased for 86% of participants, with gains in problem-solving, goal attainment, and confidence navigating complex challenges.

What does it mean to be a 'Nursing and/or Midwifery Leader'?

A nursing or midwifery leader means:

- ***"Being insightful and ready to guide others in the right direction. Being accountable and responsible."***
- ***"The ability to inspire, influence, and motivate healthcare professionals as they work together to achieve their goals."***
- ***"To be exemplary. To be able to influence change. To be a team builder. To mentor others. To be passionate. To be able to make a difference in the people one leads."***

Upon completing the programme, we asked our graduates what it meant to be a nurse or midwife leader. According to them, nursing or midwifery leadership is ***influence grounded in role-modelling, advocacy, and action.***

Firstly, they consistently framed leadership as ***role-modelling, guiding others***, and ***upholding professional standards***. Mentees emphasised the leader as someone who **"inspires, influences and motivates teams to achieve"**, while mentors recognised in themselves the need to be ***"insightful and ready to guide others to the right direction… accountable and responsible".***

Secondly, they recognised ***a nursing or midwifery leader is an advocate***, both for patients and the nursing and midwifery profession. One mentee noted that a leader is ***"an advocate for my nurses… promoting professional growth"***, and mentors emphasised a leader's ability to ***"influence policy and improve the quality of nursing and midwifery practice at all levels of the health system."***

Finally, respondents highlighted that ***nursing and midwifery leaders must be able to engender practical change***, navigating real world constraints, purposefully and creatively, to achieve better outcomes for patients and foster environments where colleagues can succeed. As our participants put it, a nurse or midwifery leader ***"empowers staff to deliver high-quality, patient centred care, regardless of holding a formal title", "driving change in resource-constrained environments"***, and achieving ***"high quality patient care to achieve good patient outcomes and achieve healthcare goals".***

As detailed in this section, our outcome measures showed how the Global Health Partnerships Malawi Leadership Programme successfully supported the development of these leadership capacities amongst nurses and midwives.

Outcome Measures

Nursing and Midwifery Professional Identity

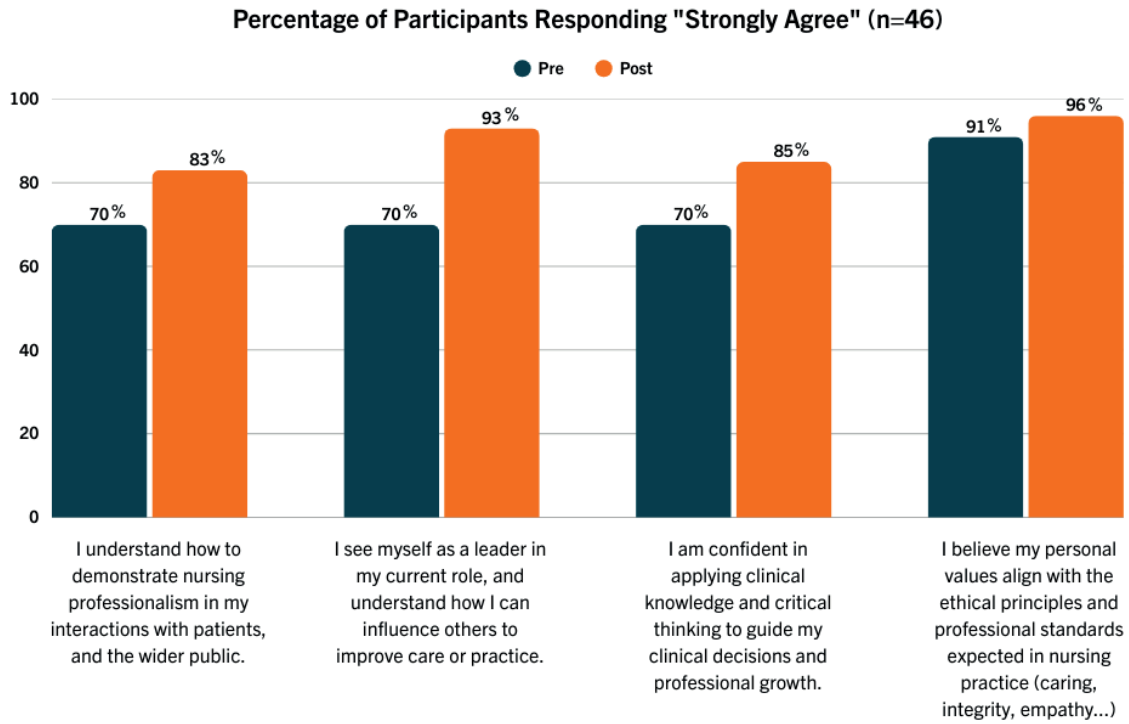
Drawing on the International Society for Professional Identity in Nursing (ISPIN)'s definition of professional identity in nursing (PIN), we explored how far our programme strengthened our participants self-identification as nurses. The ISPIN's definition encompasses four domains: values and ethics, knowledge, nurse as leader, and professional comportment (Marold et al. 2025).

We found that our participants demonstrated a very high level of professional identity pre-programme. Participants had responded particularly positively to the statement ***"I believe my personal values align with the ethical principles and professional standards expected in nursing practice (Caring, Integrity, Empathy, Inclusivity)."***, with 91% strongly agreeing with the statement and 9% agreeing.

However, participants nevertheless reported improvement, with average scores increasing across all four domains[1].

We saw a significant increase in the number of our participants reporting that they strongly agree with the statement ***"I see myself as a leader in my current role and understand how I can influence others to improve care or practice."***

Figure 8: Percentage of Participants Responding "Strongly Agree" to Professional Identity in Nursing Confidence Statements (n=46)



Given the focus of the training programme, an increase in identification with leadership and influencing was expected. However, it was positive to see substantive improvement in other areas core to the development of nurse and midwife leadership capacity. The increases in confidence applying clinical knowledge and critical thinking skills links directly to the QI development approach outlined in the previous chapter, and the specific training on professional comportment in the Malawian context helped to equip nursing and midwifery professionals with the skills needed to demonstrate professionalism in interactions with health system stakeholders at all levels.

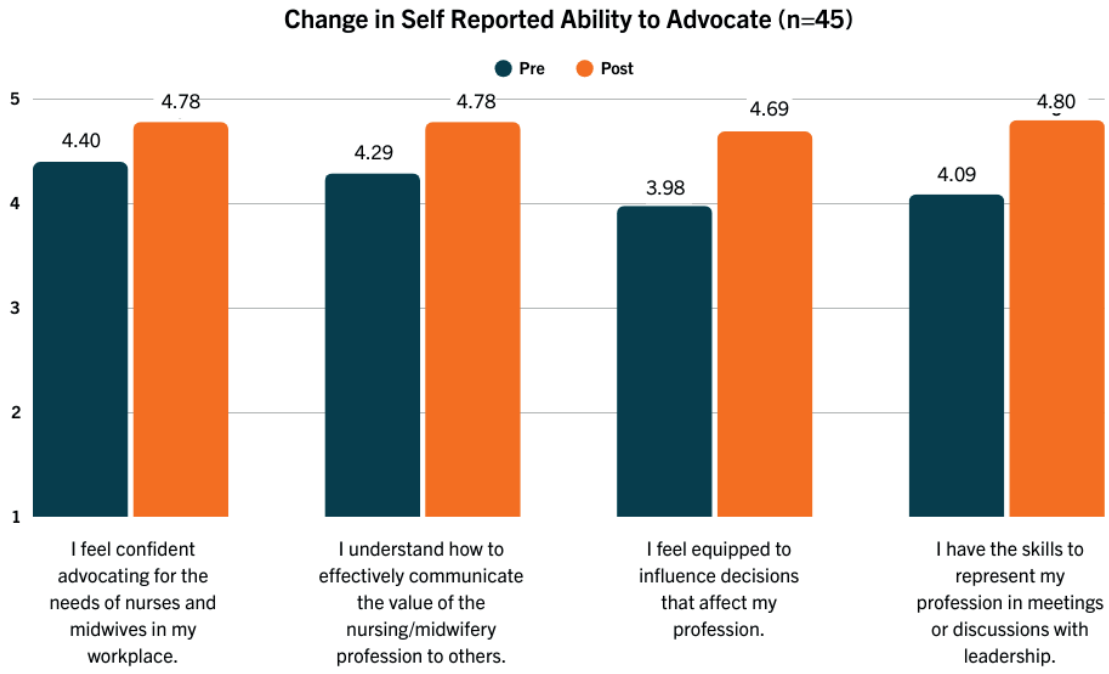
1 5-point scale mapped from Strongly Disagree=1 … Strongly Agree=5

Advocacy

Prior to the programme, participants reported feeling reasonably confident in their ability to advocate for the profession, however only a minority reported "strongly agreeing" with each statement. Positive change was seen in both average scores and in the strength of agreement with each statement[2]. Post-programme follow up found an almost 20% increase in average scores for the statements:

- ***I feel equipped to influence decisions that affect my profession.***
- ***I have the skills to represent my profession in meetings or discussions with leadership.***

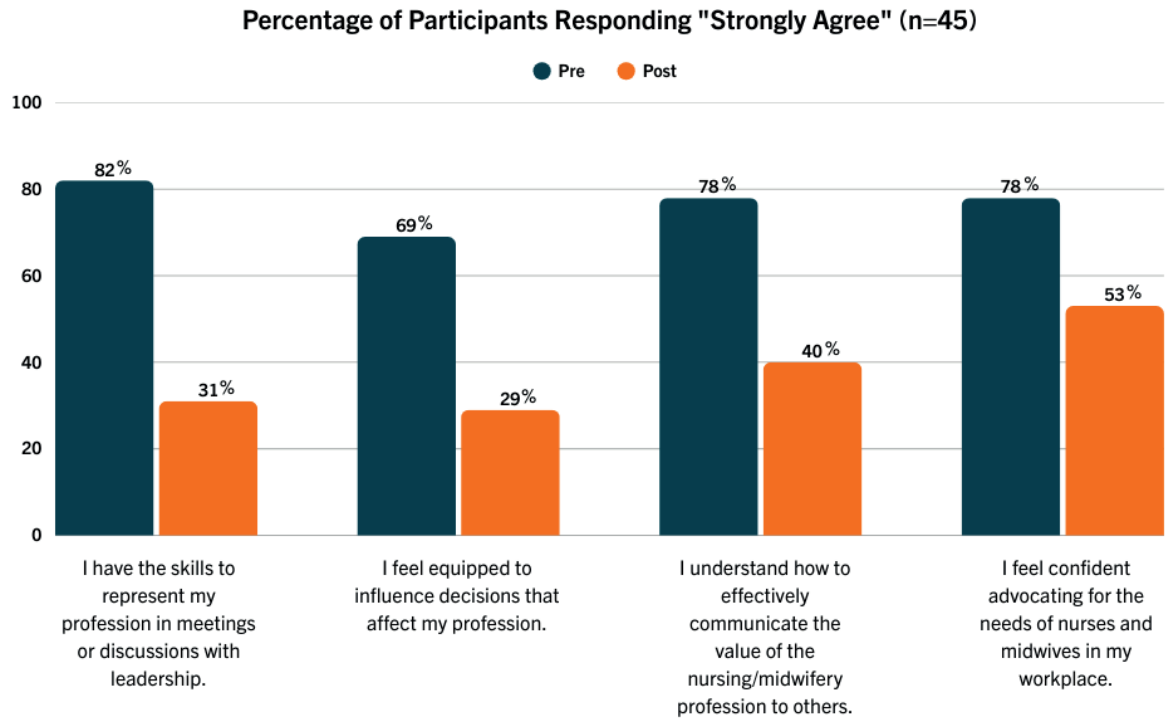
Figure 9: Average Scores of Participant Cohort for each Ability to Advocate Confidence Statement (n=45)



This overall change was driven by a strong increase in confidence across the measures, with the number of respondents strongly agreeing to each statement increasing to a large majority in every instance.

2 5-point scale mapped from Strongly Disagree=1 … Strongly Agree=5

Figure 10: Percentage of Participants Responding "Strongly Agree" to Ability to Advocate Confidence Statements (n=45)



At the end of the project, respondents were asked to reflect on their role as advocates for the profession. Responses demonstrated the breadth of the need for advocacy by the nursing and midwifery profession, ranging from addressing frontline staffing issues, to involvement in national level policy influence.

The strongest areas of advocacy across the cohort centred on **staffing**, **resources and working conditions**, and **professional respect and autonomy**. Participants frequently described advocating for secure safe staffing levels, recognising and highlighting the direct link between workforce capacity and quality of care: ***"I advocated for number of nurses to be increased in a critical care ward"*** and ***"vacancies… were filled and reduced to around 40%."***

Alongside staffing, many advocated for essential resources and better working conditions, challenging situations where nurses lacked PPE, meals, uniforms, or basic clinical supplies; as one respondent put it, ***"There was no PPE… so had to advocate for sourcing of PPE,"*** while another secured lunch provision because midwives ***"cannot go out looking for food during lunch hour."***

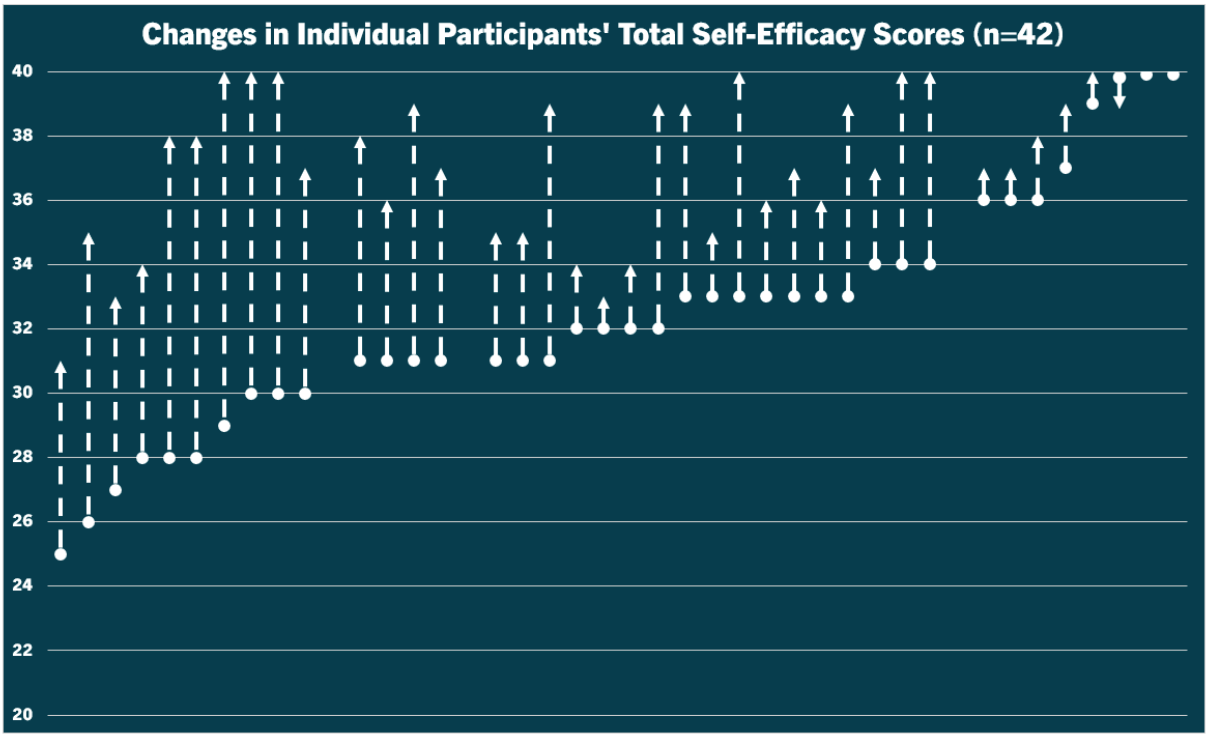
A third major theme was defending professional boundaries and ensuring nursing voices were heard in decision-making, such as ***"clinicians wanted to take full control of nursing issues… I had to meet the leader,"*** or standing firm when ***"nurses felt like being sidelined."***

Self-Efficacy

The programme led to a measurable improvement in self-efficacy – the belief in one's ability to successfully execute tasks or achieve goals in a particular situation. Scores were taken before programme commencement and after the programme celebration event . **86% (n=42) reported an overall increase in self-efficacy, with an average Generalised Self-Efficacy (GSE) score improvement of 4.54.**

3 The total self-efficacy score is calculated by finding the sum of all 10 items. For the GSE scale, the total score ranges between 10 and 40, with a higher score indicating more self-efficacy (Not at all true = 1; Hardly true = 2; Moderately true = 3; Exactly true = 4). ***Based on 42 complete leadership programme impact surveys as of 09/02/2025.***

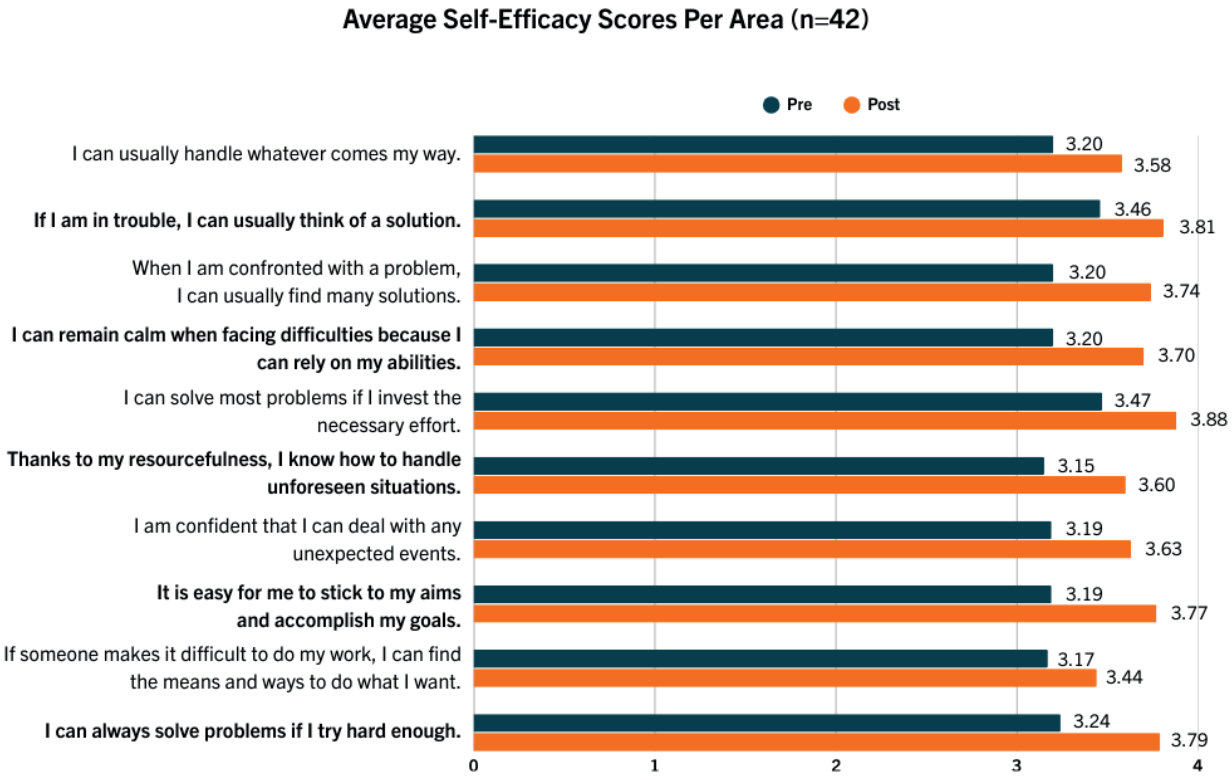
Figure 11: Changes in Individual Participants' Generalised Self-Efficacy Scores (n=42)



57% reported an increase in at least 5 areas of the self-efficacy scale. This strong pattern of improvement across measures for the majority of respondents suggests that the programme was effective in building participants' confidence and capabilities across multiple dimensions of leadership and professional practice. The most substantial improvements for the cohort were seen in responses to the statements:

- ***I can always solve problems if I try hard enough.***
- ***It is easy for me to stick to my aims and accomplish my goals.***
- ***When I am confronted with a problem, I can usually find many solutions.***

Figure 12: Average Scores of the Cohort for Each Generalised Self-Efficacy Item (n=42)



Gender Outcomes

An important finding from the post-programme outcome analysis was the comparatively higher improvement rates observed among female participants across all three outcome domains. While both male and female participants demonstrated measurable growth, female participants showed proportionally larger gains, especially in their belief in their ability to advocate for their profession:

Average Change in Score			
	Self-Efficacy	Professional Identity	Ability to Advocate
Male	4.154	0.643	1.615
Female	4.724	0.709	2.581
Gender Differential	14%	10%	60%

Mentor Impact

Mentors reported consistently positive experiences of the programme, with 100% (n=8) stating they strongly agreed that they felt confident in the knowledge, skills, and abilities needed to mentor in the future, and 100% reported they were overall satisfied with the mentorship experience.

Their reflections highlight that mentorship was not only effective for supporting mentees, but also a powerful professional development opportunity for mentors themselves. They described gaining and strengthening key leadership skills – including active listening, constructive feedback, motivation, negotiation, time management, emotional intelligence, and patience – and several noted that mentorship became a "two-way" learning relationship that boosted their own confidence and broadened their perspectives.

At the same time, mentors acknowledged challenges such as limited in-person contact, digital access constraints, and the need to provide additional orientation on QI fundamentals, but overall emphasised that the experience was transformative, rewarding, and directly applicable to their ongoing leadership roles.

Project Case Study:
John Nepiyala

Reflections from Local Faculty

"Malawian nurses and midwives have been identified as healthcare providers that have played a role in making the country achieve our health goals.

We learned how to come up with a training package that will make our mid-level nursing managers impactful in terms of management. So that helped us in terms of coming up with a syllabus of what topics that can make sense to equip our nurses and midwives.

This training also addressed some of the challenges that we've been able to identify as Nurses and Midwives Council through our supportive supervision of health facilities. We discussed with the international faculty how we can make this package, this leadership training, address those issues. We identified the gaps and how can we now intervene.

As this project was just for one year, I don't think in M&E terms we talk about impact, because impact happens after. But maybe we are talking about outputs. This language helps us. This is how we can track programme implementation. As we were able to see that these were our objectives, we were able to come up with these new activities.

That knowledge is very important because you are clear in terms of this is coming in because of this. It wasn't there, but the now the introduction of this has brought about change. Trying to understand the field of change. Those are things that we have also benefited from this project.

And again, as a leader, there is an element of advocacy. Smart advocacy. As a global south country, a developing country, priorities are just so many. You have to learn how to put priorities within the priorities.

Through this programme, we have a lot of things that we need to attend to in our health facilities. But what is it that we should do first? With the little resources, how can we maximize the impact? We learned there are things that may feel like 20% of the problem, but when you intervene on them, they will bring about 80% of change that we want to see. So, as a leader knowing that, and especially a leader that is working in an environment that is resource constrained, that's very important."

Lessons Learnt

The implementation of this programme has yielded valuable insights for future initiatives aimed at strengthening healthcare partnerships and leadership development, and speaks to broader issues of health workforce capacity and performance, health system strengthening, partnership models, and gender equity.

1. Quality Improvement as an Integrating Mechanism, Not an End in Itself

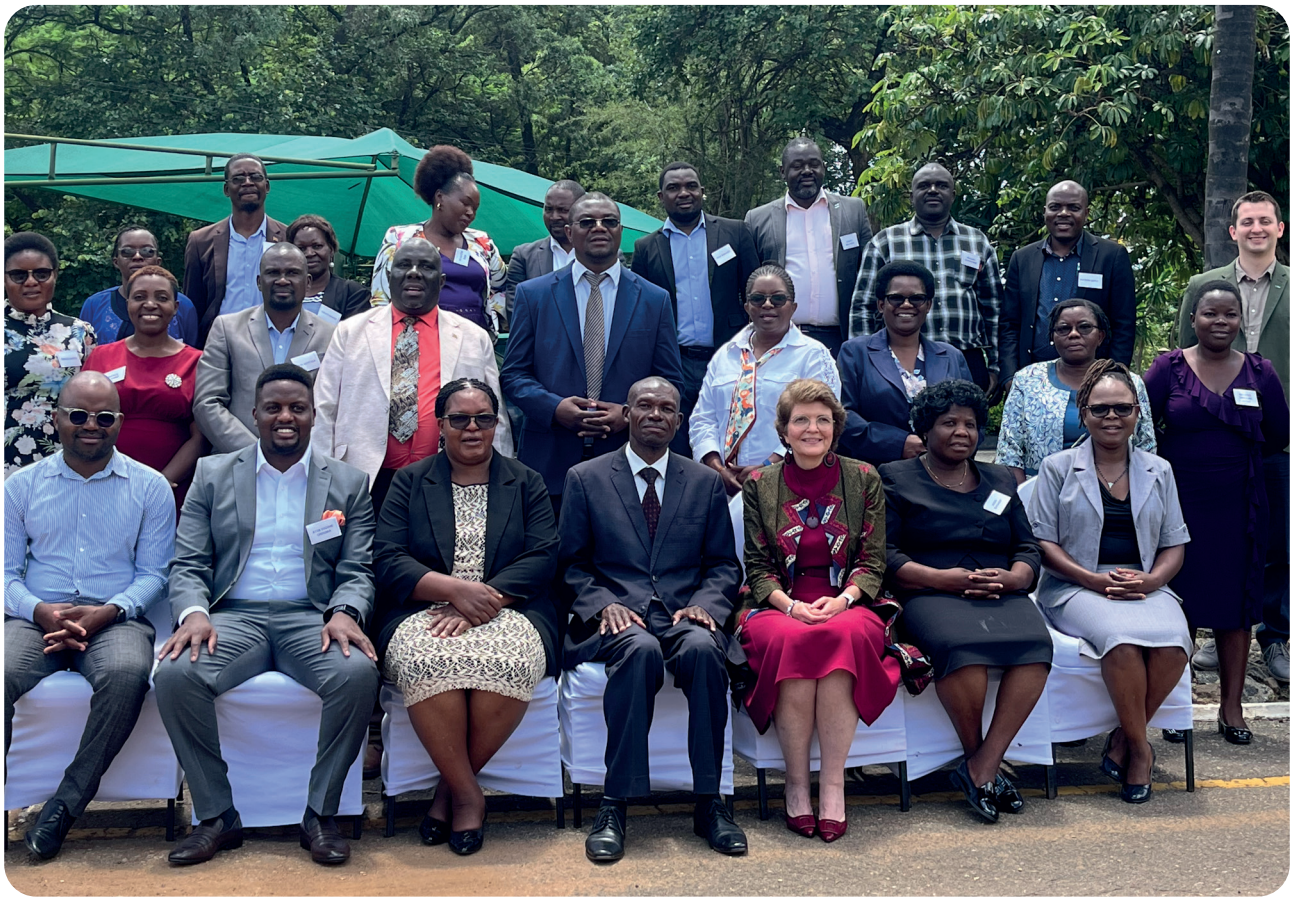
A consistent theme across findings was that QI was most valuable when understood as a practical leadership tool rather than a technical endpoint. Faculty emphasised that resource constraints did not always prevent effective quality improvement; rather, they exposed the need for key leadership competencies such as better planning, prioritisation, and team engagement.

In this way, QI functioned as a unifying thread, connecting leadership development, service performance, and systems thinking. It provided a structured way to translate theory into action.

2. Contextual Responsiveness Drives Relevance and Uptake

The residential training programme's success was closely linked to its responsiveness to local context. Participants valued practical examples drawn from their own facilities, opportunities to work on real-time challenges, and faculty who understood the operational realities of Malawi's health system.

While the programme drew on the successes of the Kenya model, implementation in Malawi demonstrated the importance of contextual adaptation. Insights from faculty highlighted how elements of the original design were refined to better suit the Malawian context, and noted the importance of responsiveness and flexibility in programme design and delivery.



Alignment with the Malawi Government's health sector priorities further enhanced legitimacy. By situating training objectives within national plans – in particular around strengthening pathways for professional growth within the health system.

3. Building Health Workforce Capacity Through Confidence and Practical Skills

Participants most valued the development of practical leadership skills, structured problem-solving approaches, and increased confidence in leading teams and managing stakeholders.

Many reported that the training shifted their mindset – from viewing constraints as immovable barriers to seeing them as challenges that could be addressed through better organisation, teamwork, and effective use of data.

This reflects a deeper lesson about health workforce capacity and performance: strengthening capacity is not only about technical knowledge, but also about self-efficacy, accountability, and the ability to mobilise others. The combination of leadership theory, applied QI, and peer learning created a space where participants could practise these competencies in a supportive environment.

4. Value to Faculty: Mutual Learning and Institutional Strengthening

Faculty described significant value in their own professional development. Delivering the programme enhanced their mentoring skills, deepened their understanding of implementation challenges, strengthened collaboration between institutions, and improved their understanding of how to communicate programme impact.

5. Mentoring as a Critical Enabler of Change

Ongoing mentoring emerged as a central component of the programme's effectiveness. Participants valued follow-up support that helped them translate workshop learning into sustained action within their professional practice. Faculty noted that mentoring helped maintain momentum, troubleshoot implementation challenges, and reinforce accountability.

The lesson is that short-course training alone is insufficient to shift performance. Structured mentoring bridges the gap between knowledge and practice and is essential for embedding leadership behaviours and QI approaches within routine systems.

6. Gender Outcomes

An important insight from post-programme outcome analysis was the comparatively higher improvement rates observed among female participants across measures of self-efficacy, advocacy confidence, and professional identity. While both male and female participants demonstrated measurable growth, female participants showed proportionally larger gains in their belief in their ability to influence decisions, represent their profession, and see themselves as leaders within their current roles.

This pattern suggests that the programme may have had an empowering dimension, particularly in strengthening internal confidence and leadership self-concept among women working within middle-management roles. Given the documented gender imbalance in leadership positions within Malawi's nursing and midwifery sector – where men are overrepresented in senior roles despite a predominantly female workforce – these findings are significant.

The structured combination of leadership reflection, mentorship support, applied QI ownership, and peer exchange may have created a psychologically safe environment that enabled women to consolidate their professional identity as leaders and advocates. The emphasis on voice, influence, and structured problem-solving appears to have reinforced both capability and confidence.

This lesson highlights the importance of intentionally designed leadership programmes as mechanisms not only for system strengthening, but also for advancing gender equity within health workforce leadership structures.

7. Health Partnership Model: The Strength of Tridirectionality

This project illustrates the added value of the Global Health Partnerships (GHP) Workforce model, particularly the strength of its tridirectional structure. Rather than operating as a traditional North–South technical assistance model, the programme brought together three institutional partners from Malawi, Kenya, and the UK in a collaborative and reciprocal arrangement.

A key lesson is that tridirectionality strengthened both relevance and sustainability. The Nursing Council of Kenya contributed practical experience from implementing a similar leadership programme in a comparable health system context. This South-South learning was highly credible to Malawian stakeholders, as it reflected similar workforce constraints, governance structures, and service delivery realities. The Kenya experience provided tested tools and approaches, while also demonstrating what adaptation looks like in practice.

At the same time, UK partners contributed technical expertise in leadership development, curriculum design, evaluation methods, and quality improvement frameworks. Importantly, this input was not positioned as prescriptive, but as supportive and responsive to locally identified priorities.

The Nurses and Midwives Council of Malawi and Ministry stakeholders played a central role in contextualisation, participant selection, and alignment to national strategy. This ensured that ownership and decision-making remained grounded in-country.

RECOMMENDATIONS

The following recommendations draw on the programme's lessons learnt and are intended to support sustainability, scale, and continued alignment with Malawi's national health priorities, particularly the Health Sector Strategic Plan III (HSSP III 2023–2030), the National Quality Management Policy, and Human Resources for Health (HRH) strengthening objectives.

1. Continue investing in leadership training for mid-level nurses and midwives in Malawi to develop their confidence and leadership abilities, thus enabling them to bring about change, to strengthen the health service in which they work, and impact on health outcomes.

2. Build on the investment of nurse and midwife leaders as mentors to strengthen workforce capacity, and contribute to strengthening the nursing profession, demonstrating leadership and advocacy.

3. Collaboration between countries (such as Kenya and Malawi) should be prioritised at the level of the regulatory council, enabling both organisations to develop, share and learn from each other.

Summary and Next Steps

The Malawi Nursing and Midwifery Leadership Programme **successfully delivered a blended leadership development model combining residential training, structured mentorship, and applied quality improvement planning.** Fifty mid-level nurse and midwife leaders and ten senior mentors were trained through a nationally representative and gender-responsive selection process. The programme strengthened leadership confidence, advocacy capacity, professional identity, and self-efficacy, with 86% of participants reporting measurable increases in self-belief and problem-solving capability.

QI projects functioned as practical leadership laboratories, enabling participants to translate theory into action across seven key service areas, including maternal health, infection prevention, workforce supervision, and clinical documentation. Ten high-potential projects received Ministry backing, strengthening alignment with national health priorities and sustainability beyond the grant period.

Sustainability was embedded into the project design from the outset through strong national ownership and institutional alignment. The Nurses and Midwives Council of Malawi (NMCM) acted as co-lead partner, ensuring strategic alignment with national priorities and political acceptability of participant selection. Engagement of senior stakeholders, including the NMCM Registrar and the Ministry of Health's Director of Nursing and Midwifery Services, strengthened system-wide visibility, legitimacy, and learning. The leadership programme was also aligned with Malawi's new Nursing Leadership Initiative, reinforcing its relevance and creating a foundation for longer-term institutional integration.

Sustainability was further supported through capacity strengthening. Local faculty co-facilitated the programme and received additional coaching through a train-the-trainer model, building in-country delivery capacity. The Ministry of Health committed to supporting implementation of the ten highest-potential QI projects beyond the grant period. In addition, experienced nurse leaders who had previously completed leadership training through the Nursing Now Challenge were engaged as mentors, creating a reinforcing cycle of leadership development within the health system.

Together, these measures position the programme not as a standalone intervention, but as a catalyst for sustained leadership development and system-wide strengthening within Malawi's nursing and midwifery workforce.

Overall the programme suggests that strengthening mid-level nursing leadership is a feasible and high-impact strategy for improving service quality and workforce performance within resource-constrained settings.

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