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A Qualitative Analysis of Governance and Management Practices of Faith-Based Health Providers and their Implications for Public Financial Management and Service Delivery in Malawi in the Context of Direct Facility Financing

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Abstract

Background: Faith-based healthcare providers (FBHPs) play a crucial role in advancing Universal Health Coverage goals (UHC) in Malawi. As the government scales up the Direct Facility Financing (DFF) reform, understanding governance and public financial management (PFM) practices within FBHPs is critical for informing effective policy and institutional reforms. This study examines how governance structures influence PFM performance and operational responsiveness in Christian Health Association of Malawi and Islamic Health Association of Malawi (CHAM/IHAM) facilities, to improve the effectiveness and sustainability of healthcare services under the DFF strategy.

Methods: An exploratory qualitative design was employed across 40 CHAM/IHAM facilities in 16 districts. Data was collected through semi-structured key informant interviews and focus group discussions involving 17 proprietors, representatives of 5 facility boards, 3 staff from CHAM/IHAM secretariats, 113 Health Center Management Committee (HCMC) members, and 40 facility in-charges ($N = 178$). Guided by the PFM theory of change, centering the PFM cycle and provider management as pathways to UHC service delivery goals and impacts, data were

analyzed thematically to examine governance oversight during budget formulation, execution, and evaluation.

Results: Governance structures were closely associated with variations in PFM performance and financial autonomy. Facilities governed by dedicated, functional boards exhibited stronger PFM practices, including participatory budgeting, strategic oversight, routine board-led budget reviews, and greater discretion over fund utilization. These facilities also demonstrated improved operational responsiveness; managers were able to reallocate resources quickly and address service delivery challenges. In contrast, facilities overseen by centralized governance structures relied on distant hierarchical approvals and strict compliance mechanisms, which often constrained managerial discretion and slowed decision-making. Overall, proximity of governance to service delivery point and clarity of delegation of authority emerged as key enablers of operational responsiveness and accountability. The study found limited community oversight across all stages of the PFM cycle.

Conclusion: Facility-level governance is crucial for shaping PFM performance and service delivery among FBHPs. Dedicated proximate oversight structures, appear essential for balancing accountability and managerial autonomy under devolved financing. These insights provide evidence to guide the design of fit-for-purpose governance models for DFF implementation in varied primary health care systems.

Keywords: Primary Healthcare, Universal Health Coverage, Faith-based Health Providers, Healthcare Governance, Direct Facility Financing, Public Financial Management, Malawi, Low- and Middle-Income Countries

INTRODUCTION

Background

There is a growing consensus on the need to reinvigorate Primary Health Care (PHC) as a vehicle for accelerating Universal Health Coverage (UHC), amid shrinking domestic and donor resources (1,2). Despite widespread agreement on their importance to health equity and efficiency, PHC systems in many low- and middle-income countries (LMICs) fail to meet the demands of both patients and frontline providers, constrained by chronic underfunding, limited facility-level autonomy, and weak accountability mechanisms (3). In response, governments in countries such as Malawi, Ghana, Uganda, and Kenya are implementing health sector reforms that decentralize financial resources and decision-making authority to frontline health facilities to improve efficiency, responsiveness, and accountability in PHC (4,5). These reforms, often operationalized through direct facility financing (DFF), provider payment reforms, or contracting arrangements with faith-based organizations (FBOs), are premised on the assumption that PHCs are better positioned to allocate resources according to local service delivery needs (6).

In practice, however, the outcomes of these reforms vary considerably across settings. Evidence (7–9) suggests that similar financing arrangements can yield different results depending on the structure of health facilities, particularly with respect to public financial management (PFM) practices during the budget cycle presented in Figure 1. These include how priorities are set and resources allocated during budget formulation, how funds are used and controlled during budget execution, and how spending and performance are reviewed and fed back into decision-making during budget evaluation.

Figure 1: Conceptual framework of the factors that influence reliability of the budget formulation and execution process, and its linkage to health system goals



Source: (10)

A growing body of literature further suggests that faith-based healthcare providers (FBHPs) in most LMICs tend to outperform their government counterparts across several key dimensions of service delivery, including efficiency, equity, and quality of care (11–15). In Malawi, (14) attributed this performance advantage, in part, to stronger PFM systems within FBHPs. Unlike government-run hospitals, many FBHPs enjoy greater financial and managerial autonomy; they receive funds directly and can flexibly allocate resources under oversight of their boards and proprietors. Such autonomy, combined with governance structures, has endowed many FBHPs with better accountability mechanisms and the ability to respond more effectively to health needs (16–18). However, these advantages do not uniformly extend to primary care level, where both FBHPs and government health centers exhibit similar PFM weaknesses.

From a theoretical perspective, the Principal-Agent theory posits that autonomy must be accompanied with optimal configuration for the principal (the community or state) to provide effective oversight to the agent (providers) (19–21). Without an optimal oversight configuration, there is a risk of performance outcomes diverging from policy intentions. Despite this, empirical evidence remains scarce on how governance and management arrangements enable or constrain effective oversight across the PFM cycle at the PHC level. This study, therefore, seeks to address this gap by examining governance and management arrangements across faith-based healthcare facilities in Malawi and assessing their influence on PFM performance and service delivery in Malawi. Specifically, the research aims to: (1) assess the structure of the governance arrangements in FBHPs; and (2) examine how heterogeneous ownership and management structures influence oversight across the PFM cycle and service delivery outcomes.

This study offers a timely, policy-relevant contribution to ongoing efforts to strengthen governance of the PHC system in LMIC settings, particularly in sub-Saharan Africa. First, the study provides insights into service delivery improvements within FBHPs, which are integral to health systems in many countries in the region. While the analysis is grounded in the context of Malawi, where faith-based providers such as the Christian Health Association of Malawi (CHAM) and Islamic Health Association of Malawi (IHAM) play a central role in delivering PHC services under formal Service Level Agreements (SLAs), the study addresses institutional challenges that are widely shared across many LMICs (22). Second, the study's relevance extends beyond FBHPs to ongoing public-sector reforms in several countries, including those decentralizing health budgets to primary and secondary health care providers.

Faith-Based Health Providers in LMICs: Key Partners for UHC

Faith-based healthcare providers are considered important partners in health system strengthening and advancing equity of access to healthcare in LMICs (11). Their historical involvement in health care dates back to the eighteenth and nineteenth centuries, when mission societies provided medical aid under colonial governments in Asia, Africa, and Latin America (23). In many parts of sub-Saharan Africa, these missionary societies established some of the first hospitals and clinics, laying the groundwork for modern health systems well before the emergence of formal government-provided services by colonial governments (24). Throughout the colonial era, church-run hospitals and dispensaries were often the dominant providers of western medicine across vast rural areas (25,26). While the role of governments in delivering social services expanded significantly in the post-independence era, FBOs have remained prominent health providers, especially in rural and underserved regions where government infrastructure is often limited (27,28). After independence, the fate of these mission-founded health networks diverged by country. In some nations, including Tanzania, Zambia, Kenya, Malawi, mission hospitals and clinics remained integral to the health system as autonomous non-governmental providers, despite periodic government attempts to integrate or regulate them (29). In other cases, such as post-apartheid South Africa, church health facilities were nationalized into the public system (29).

Over time, many of these providers formalized into coordinated networks, for example, Christian Health Associations, to interface with governments and donors, while preserving their religious missions (30,31). Faith-based providers now constitute a significant portion of the health sector in numerous LMICs. It has been reported that FBHPs deliver between 30% and 70% of all health services in many African countries (32,33). Faith-linked networks are credited with over one-third of health service delivery in countries like Malawi (37%) (34), Tanzania at 41.1% (35,36),

Zimbabwe 35% (37), and around 40% in Kenya (38). This expansive coverage and patient reach make FBOs an important sub-sector in service delivery in many LMICs today.

Over the past few decades, many LMIC governments have recognized the pivotal role of FBOs and moved to formalize partnerships with them (39,40). These public-private partnerships range from memoranda of understanding (MOUs) and service contracts to integration of FBO facilities into national health plans (41). A common model is for governments to subsidize or contract faith-based facilities to deliver services as part of the national health system, often in exchange for providing services at low or no cost to patients. For example, Malawi pioneered Service Level Agreements (SLAs) in 2002, with rollout starting in 2006, as a formal mechanism to partner with CHAM and IHAM facilities after decades of a longstanding informal relationship (42). Under these SLAs, FBHPs provide a package of essential services, notably maternal and neonatal services free of charge to their catchment area populations, and the Ministry of Health reimburses a portion of the costs through a fee-for-service arrangement (15,42). Moreover, the government of Malawi also pays the salaries of CHAM healthcare workers. Building on this model, in 2025, the Government of Malawi also entered into an MoU with the Islamic Health Association of Malawi (IHAM) to formalize collaboration through SLAs (43). This MOU outlined provisions similar to those under the CHAM agreement, and the integration of IHAM facilities into district-level service planning and supervision structures. This effectively integrates FBHPs into Malawi's drive for universal health coverage, with these service points operating as publicly supported providers in rural districts.

Similarly in Ghana, the Ministry of Health and the Christian Health Association of Ghana (CHAG) signed a national MOU in 2003 granting CHAG hospitals the status of district hospitals in the public system (44). Through this partnership, the government pays the salaries of CHAG health

workers and provides other subventions, while CHAG facilities are held accountable for fulfilling service delivery contracts and performance targets just like public facilities (45). This MOU solidified CHAG's role as an agency parallel to the Ghana Health Service, and today CHAG works closely with the government on planning and policy, serving as a model of church–government collaboration. In Uganda, a similar national framework was established in the late 1990s. The government signed agreements to subsidize private not-for-profit hospitals, largely church-founded, and created coordination structures with the Uganda Catholic and Protestant Medical Bureaus, as well as the Uganda Muslim Medical Bureau (46). Kenya and Tanzania have likewise developed policies to contract or financially support FBO facilities. Tanzania's government, for instance, negotiated hospital service agreements with church hospitals as early as 1992, and later introduced a decentralized contracting system post-2005 to fund FBO hospitals in districts lacking public hospitals (36,47). Kenya collaborates with its Catholic, Protestant, and Muslim faith-based health networks, primarily the Kenya Episcopal Conference, Christian Health Association of Kenya, and the Supreme Council of Kenyan Muslims, through national joint forums and, more localized contracting at the county level for health service delivery (48,49). These partnerships acknowledge that faith-based providers are indispensable extensions of the health system.

Governance Structures in PHC Facilities in LMICs

Governance at the facility level is increasingly recognized as crucial for effective primary health care (PHC) delivery in LMICs. Since the Alma-Ata Declaration of 1978, there has been strong support for community empowerment and participation in health governance (50). Consequently, across many low-income countries during the 1990s and 2000s, decentralization reforms led to the establishment of Health Facility Committees (HFCs) as formal mechanisms to co-manage PHC clinics and strengthen links between communities and providers. These bodies are conceptualized

as formal governance structures with community representation, explicitly linked to health facilities and intended to improve service provision and accountability (16,17).

At the operational level, HFCs, also known as Health Centre Management Committees (HCMCs), health unit management committees (HUMCs), community health management committees (CHMC), typically comprise locally elected community members, often with quotas for women, youth, or marginalized groups, some local government or civil society representatives, and facility staff for such as the in-charge or nurse manager (51). For example, Uganda's HUMCs in Health Centers have approximately nine members, including the facility manager, a sub-county assistant, a local school head, and four community representatives from women, youth, and special groups (52). Ghana's CHMCs are volunteer groups of about nine to thirteen members drawn from the community.

In Malawi, membership of HCMCs is set at twelve to fifteen, including elected community representatives and three health facility staff who meet monthly under an elected chair with the facility in charge as secretary for a three-year term period (53). Across countries, these committees are typically advisory and oversight bodies with roles in planning, budgeting, monitoring quality, and linking users with providers (54). For instance, Malawian HCMCs have prescribed duties bridging the communication gap between the community and health staff, overseeing the availability and proper management of essential drugs and supplies through community-based monitoring, mobilising and advocating for resources to support facility operations, and managing patient complaints (53). District-level teams such as the District Health Management Teams generally provide technical oversight and support, but the day-to-day governance interface at clinics is meant to be these community facility bodies.

In addition to community-based committees, many PHC facilities, particularly those operated by faith-based and non-profit providers, are governed by facility boards set up by the proprietors (55). These boards are established to enhance institutional autonomy, promote accountability, and ensure responsiveness to local health needs. They play a central role in strengthening facility-level governance by providing oversight, supporting decision-making, and enabling a more participatory approach to management (56). Governing boards are expected to enhance empowerment by ensuring that facilities deliver a high standard of care aligned with community expectations. Their core functions include facilitating the mobilisation, allocation, and use of resources necessary for maintaining essential health services, and they are mandated to closely monitor the performance of health facilities to ensure alignment with service delivery goals and strategic objectives (57).

METHODS

Study Design

This study employed an exploratory qualitative research design to examine governance and management across CHAM and IHAM facilities, and how they influence PFM practices. The design was appropriate given the limited empirical evidence in this area and the need to generate insights that inform hypothesis development for future quantitative and mixed-methods research (58). Data were collected using semi-structured key informant interviews (KIIs) and focus group discussions (FGDs) to elicit in-depth perspectives from actors involved in governance, management, and community oversight.

Study Setting

This study was conducted within Malawi's mixed-provider health system, where FBHPs play a significant role in service delivery. Malawi's healthcare system is overseen by the Ministry of Health (MoH) and is structured as a triadic framework, comprising primary, secondary, and tertiary levels of care with established referral linkages between levels (59). While the MoH manages the majority of public facilities, service delivery is shared with private and private not-for-profit providers, particularly faith-based organizations. CHAM is the largest private not-for-profit provider network. As of 2021, CHAM comprised 183 health facilities and 11 training institutions run by church organizations, training around 80% of mid-level health professionals (60). Most CHAM facilities are affiliated with the Catholic (48%), Presbyterian (18%), Anglican (11%), and Seventh Day Adventist (10%) churches (60). Faith-based health provision is also represented by IHAM, comprising 21 health facilities.

Malawi has introduced DFF reform designed to allocate resources directly to public primary healthcare facilities, thereby empowering them to manage their funds independently at all public financial management processes of budget planning, execution, and evaluation, aimed to enhance the quality-of-service delivery. DFF was piloted in Rumphi district and is being scaled up to 13 districts throughout the country which are Blantyre, Ntchisi, Chitipa, Nsanje, Neno, Dedza, Salima, Balaka, Machinga, Chikwawa, Lilongwe, Nkhonkotota, and Kasungu, with dedicated domestic and donor resources committed for scale-up (61).

Sampling and Participants

A purposive sampling strategy was employed to identify participants across multiple levels of the health system with direct roles or specialized knowledge relevant to governance, management, and

financial decision-making within CHAM and IHAM facilities (62). Facilities were purposively selected to ensure maximum variation across key analytical dimensions, including geographic region, religious ownership (Catholic, Protestant, and Muslim), level of care, and governance arrangements, particularly the presence or absence of facility boards and HCMCs.

Overall, the study sampled 40 CHAM and IHAM facilities across 16 districts using a multi-level, system-oriented approach encompassing: (1) national-level actors, including 17 proprietors and representatives from the CHAM and IHAM secretariats; (2) intermediate governance actors, comprising members of five facility boards; and (3) facility-level actors, including facility managers and HCMCs drawn from the sampled facilities.¹ Data were collected through semi-structured key informant interviews with proprietors, secretariat representatives, board members, and facility managers, and focus group discussions with HCMC members to capture community-level governance perspectives.

Data Collection

Data collection was conducted between December 2024 and January 2025 using pretested instruments. All interviews and discussions were conducted face-to-face in either English or Chichewa, depending on participant preference, and were audio-recorded with written informed consent to ensure accuracy. Interviews conducted in Chichewa were translated into English during transcription to facilitate analysis. A top-down, sequential data collection approach was adopted, whereby interviews with national- and intermediate-level actors were conducted in December 2024, followed by facility-level data collection with facility managers and HCMCs in January

¹ The sampled districts include: Balaka, Blantyre, Chikwawa, Chiradzulu, Dedza, Dowa, Karonga, Lilongwe, Mangochi, Mchinji, Mzimba, Neno, Ntcheu, Rumphi, Thyolo, and Zomba.

2025. All data collection tools were administered electronically using KoboToolbox to enhance data quality, security, and efficiency.

All interview and discussion guides were designed to elicit participants' perspectives on governance effectiveness, financial decision-making processes, board and HCMC functionality, and mechanisms for community engagement. In addition, basic respondent characteristics (including gender, management role, and education level) were recorded to support contextual interpretation of the findings.

The data collection instruments captured information across four key analytical domains: (i) governance and accountability structures, including the existence, composition, and functionality of facility boards and HCMCs, board involvement in oversight, and alignment with CHAM/IHAM constitutions and national policy frameworks such as the Health Sector Strategic Plan III (HSSP III); (ii) financial autonomy and resource control, including authority over budgeting processes, access to and control of bank accounts, resource reallocation, and revenue management practices; (iii) community participation, focusing on the roles of HCMCs and relationships between communities, facility management, and boards; and (iv) service delivery planning and responsiveness, including involvement of governance actors in facility planning, patient feedback mechanisms, and quality assurance practices.

Analysis

Audio recordings were transcribed verbatim in English by the research team following data collection and managed electronically by PJC using KoboToolbox before being exported to Excel for cleaning and organization by PNM, CW and JMZ. Transcripts were reviewed for accuracy and

completeness prior to analysis. Thematic analysis was then conducted by PNM, JMZ, CW, and PC using Dedoose software, following the approach described by Braun and Clarke (63).

The research team first familiarized itself with the dataset through repeated reading of transcripts. An initial codebook was developed inductively through immersion in a subset of transcripts drawn from each actor group (proprietors, secretariats, board members, facility managers, and HCMCs). Coding was subsequently applied across the full dataset and refined iteratively through team discussions and inter-coder consistency checks. Analysis combined deductive coding, guided by the PFM cycle, with inductive coding to capture emergent themes related to governance, management, and financial practices. Comparative thematic matrices were developed to examine patterns and contrasts across governance arrangements and levels of care. Key illustrative quotations were extracted to substantiate the findings and support policy-relevant interpretation.

RESULTS

This section presents the findings of the study. The results are presented in line with the conceptual framework represented in Figure 1, linking governance and management arrangements to service delivery outcomes through their influence on key stages of the public financial management cycle; budget formulation, execution, and evaluation.

Demographic characteristics of study participants

The study included facility managers, HCMC members, proprietors, and facility board members, reflecting governance and management roles across multiple system levels (Table 1). Most respondents across all categories had held their current roles for between one and five years, reflecting relatively stable governance and management arrangements. Prior management

experience was common among facility in-charges and board members (100%). Facilities represented Catholic (Episcopal Conference of Malawi), Protestant (Malawi Council of Churches), and Muslim ownership structures.

Table 1: Demographic characteristics of Participants

Characteristic	Facility charges	In- HCMC Members	Proprietors	Secretariat	Board
Gender					
Male	22	68	13	2	4
Female	18	45	4	1	1
Education					
Primary	-	32	-	-	-
Secondary	-	70	-	-	-
Certificate	4	3	-	-	-
Diploma	16	6	1	-	-
Bachelor's Degree	12	2	8	3	-
Postgraduate Degree	8	-	8	-	-
Years in Role					
<1 year	6	16	1	-	-
1–5 years	21	85	12	3	5

Characteristic	Facility charges	In- HCMC Members	Proprietors	Secretariat	Board
6–10 years	11	10	3	-	-
11–15 years	2	2	1	-	-
Held Prior Management Position					
Yes	26	71	-	2	5
No	14	42	-	1	-
Religious Denomination					
CHAM: Episcopal Conference of Malawi	21	17 facilities	6	-	3
CHAM: Malawi Council of Churches	17	16 facilities	10	-	2
IHAM: Qadria Muslim Association of Malawi	1	2 facilities	1	-	-

All sampled facilities reported active membership with either the CHAM or IHAM Secretariat, underscoring the central coordinating role played by these umbrella organisations. Membership fee payment arrangements varied by proprietor network, with some facilities paying fees directly, while others were supported by mother facilities or proprietors (Figure 2). Regardless of the payment modality, facilities consistently perceived affiliation with CHAM or IHAM as highly beneficial. Reported benefits included human resource and workforce support (85%), access to medical supplies and medicines (23%), donor linkages (33%), training and capacity building (18%), supportive supervision and technical assistance (13%), enhanced regulatory credibility (8%), and facilitation of infrastructure, equipment, and supplies (38%). In addition, facilities relied on multiple funding streams to sustain operations (Figure 3). User fees (87.5%), service level agreements (97.5%), and government salary grants (80%) were the most commonly reported sources of financing. Donor funding was reported by 62.5% of facilities. In contrast, medical insurance (10%), income-generating activities (15%), and proprietor contributions (5%) were reported less frequently.

Figure 2: Financing arrangements for facility membership fees

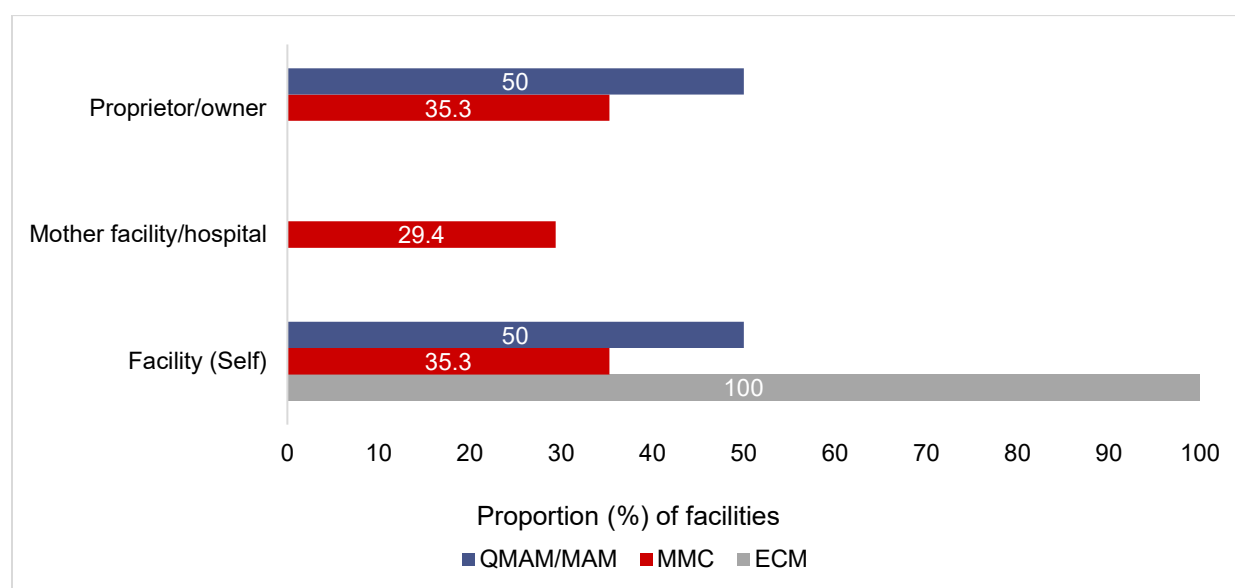
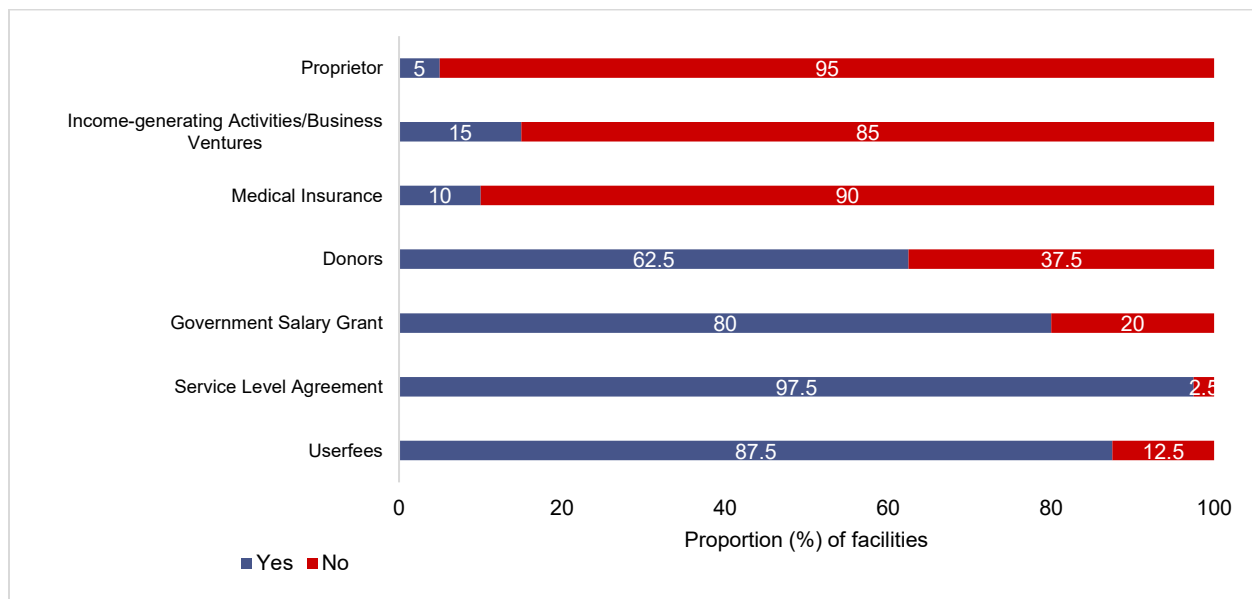


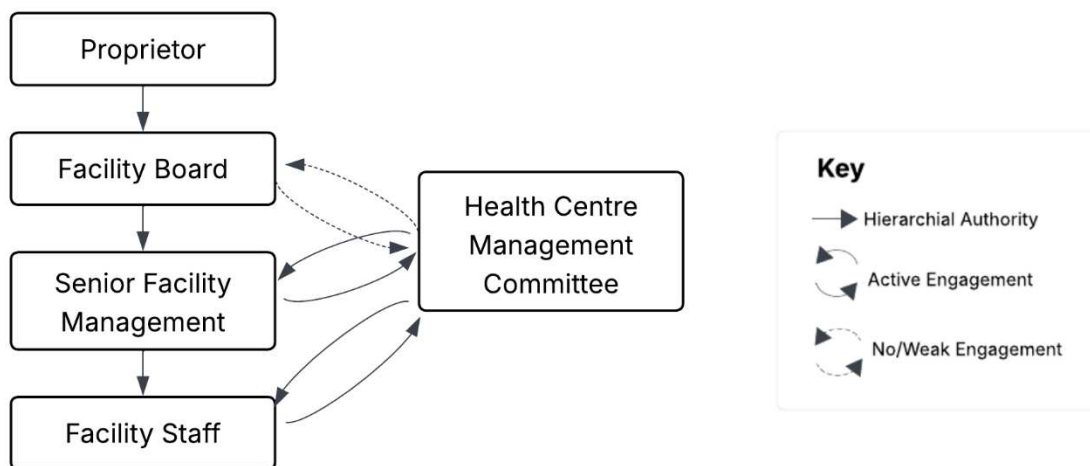
Figure 3: Facility funding sources



Governance Structures and Their Functionality

Governance arrangements across CHAM and IHAM facilities were organised within a broadly hierarchical structure (Figure 4). This structure typically comprised a proprietor at the apex, followed by a board of directors (where constituted), senior facility management, frontline facility staff, and HCMCs. While this formal architecture was largely consistent across facilities, its functional operation varied considerably, particularly in the extent to which boards and HCMCs exercised active oversight and engaged in financial and managerial decision-making.

Figure 4: Common Governance structure



Proprietor

Proprietors are primarily religious entities (e.g., synods, dioceses, charitable trusts and individual philanthropists), who own the facility and serve as its custodians, upholding the facility’s mission. The majority of proprietors reported delegating operational oversight responsibilities to boards of directors, while retaining authority over strategic decisions and policy approval functions.

Facility Board: Composition and Capacities

Board membership is based on technical expertise, alignment with the faith-based values of the institution, and, in some cases, intentional gender inclusivity. Membership frequently represents a blend of diverse professional backgrounds, including medical or clinical background (doctors, nurses, and clinical officers), financial and administrative experts (accountants, human resource managers, and business professionals), legal practitioners, faith leaders (priests and diocesan representatives, and sheikhs), individuals with Non-Government Organizations (NGOs) or public

sector, and ex-officio members from the district, Ministry of Health (MoH), CHAM/IHAM. Key roles in the board include board chairpersons, secretaries, treasurers, and technical experts.

Boards play a critical role in setting the strategic direction of facilities, offering policy and financial oversight, and institutional stewardship. They help ensure compliance with national health policies while upholding the moral and religious principles of their respective denominations. Facility boards often establish specialized subcommittees, commonly technical and financial committees, through which they exercise more granular oversight.

“The board provides guidance on hospital management. The board is divided into a technical committee and a financial committee. In the financial committee, there's a lawyer and an accountant. We present financial reports and budgets. The accountant deals with financial challenges. The lawyer deals with policy issues. The technical committee looks at staff affairs.” [Facility in-charge KII_33]

Facility boards also exercise institutional stewardship through supervision and accountability and enforcing accountability through audits, reviewing clinical and financial performance.

“They oversee disciplinary issues and financial compliance, so since our facility is a paying facility, they come and see if we have made any losses or profits within the months and make recommendations. They also look at the services being provided at (facility) and address any challenges that may pertain to this service delivery. They also oversee the establishments... and they help in conducting interviews; the recruitment happens at (the proprietor) level. [Facility in-charge KII_13]

Facility Board: Configuration

Board types vary, particularly in their configuration. Two board models exist across the sampled facilities: centralized boards, which oversee multiple institutions within a religious network, and decentralized boards, dedicated to a single facility. In the sample, all the secondary hospitals operated under dedicated boards. Within community hospitals, six reported having dedicated boards and four were governed centrally. Among the twenty-one health centers, seventeen had a centralized board structure, while four reported no board at all, as seen in Figure 5.

Figure 5: Governance Structures-Boards

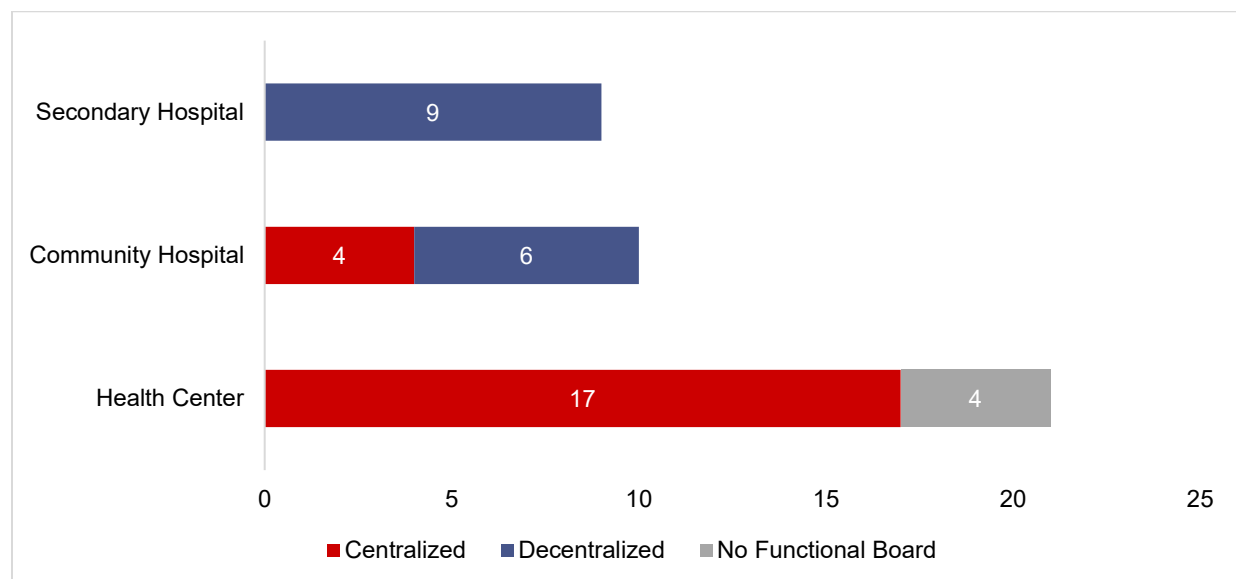


Table 2 presents a comparative synthesis of centralized and dedicated board configurations, drawing on respondents' accounts to illustrate how these governance models differ in strategic alignment and responsiveness, facility engagement, autonomy and decision-making authority, standardization and peer learning, technical capacity, and cost of operation.

Table 2: Comparative Governance Characteristics of Centralized and Dedicated Facility Boards

Feature	Centralized Board	Dedicated Board
Responsiveness	Weak responsiveness; decision-making often delayed due to large oversight scope, heavy workload, and bureaucratic procedures. Emergency responses are particularly constrained. <i>“Facilities that are fast to act on any new policy or project are hindered by delays from other sister facilities as the board cannot allow one facility to be ahead of others”</i> [Facility in-charge KII 27]. <i>“There are delays in handling emergencies due to huge workload”</i> [Facility in-charge KII 33].	Strong responsiveness; boards are more accessible and able to act swiftly on urgent operational and service delivery issues. <i>“The board concentrates much on (the hospital) since it is not overwhelmed with other issues”</i> [Facility in-charge KII 6].

Feature	Centralized Board	Dedicated Board
	<i>“Since we are a small facility their main priority is [bigger facility]”</i> [Facility in-charge KII 15]	
Facility engagement	Limited engagement with facility management; minimal consultation during decision-making processes. Facilities report lack of direct interaction with board members. <i>“They don’t consult us during their meetings to give our views”</i> [Facility in-charge KII 20] <i>“There is no platform to interact with board members...we can only interact with SMT and all issues that SMT cannot do they say they are board issues”</i> [Facility in-charge KII 29]. <i>“The facilities under the mother facility have unique issues which</i>	Strong engagement with facility management; regular interaction and deeper familiarity with the facility’s strengths and challenges. <i>“Being a dedicated board... they rightly intervene to help efficient service delivery when there is a need”</i> [Facility in-charge KII 1].

Feature	Centralized Board	Dedicated Board
	<i>would better be presented by facilities themselves” [Facility in-charge KII 31].</i>	
Autonomy, resource control, and decision-making	Constrained facility autonomy; key decisions centralized, limiting managerial discretion to address gaps. <i>“Even if there is a gap, I can't address the challenges because I have to wait for the decisions to be made centrally and as the in charge, I don't know the operations of the facility, because it all happens at central level”</i> [Facility in-charge KII 26].	Greater facility-level autonomy; boards actively support timely decision-making and resource allocation aligned to facility needs. <i>“The board concentrates much on [the hospital] since it is not overwhelmed with other issues”</i> [Facility in-charge KII 6].
Standardization and Peer Learning	Strong standardization of administrative practices and working conditions; facilitates peer learning and cross-facility knowledge sharing.	Limited peer learning beyond the facility; focus is primarily internal. <i>“Narrow- minded since the board cannot compare to what</i>

Feature	Centralized Board	Dedicated Board
	<i>“...the centralized board helps in standardizing the working conditions for all facilities under them. The board advise facilities in conducting peer learning from sister facilities.”</i> [Facility in-charge KII 27].	<i>other facilities are doing well”</i> [Facility in-charge KII 6].
Cost of governance operation	Economical due to shared governance structures and reduced administrative costs.	Higher operational costs associated with maintaining standalone boards and regular meetings. <i>“Running the board is expensive”</i> [Facility in-charge KII 13]

Facility Management Structures and Operational Coherence

At the operational management level, each facility is led by a facility in charge, supported by heads of departments in medical, nursing, finance, human resources, and environmental services. Facilities reported that this structure enabled clarity in decision-making, streamlined operations,

and enhanced patient navigation across services. The management holds the primary responsibility of ensuring effective daily facility functioning and serves as the implementation arm for governance directives, translating board policies into actionable procedures and service delivery protocols through (1) staff supervision and performance monitoring, (2) maintenance of quality patient care standards, and (3) strategic allocation of resources. Respondents emphasized a functional separation between governance and management, boards provided strategic direction, while management oversaw day-to-day execution.

“The facility board is for policy direction and management team is for day to day operations. Wherever the powers of management cannot reach they refer that issue to board...” [Proprietor KII_3]

“The board looks at strategic matters and policy direction, while management handles implementation.” [Facility in-charge KII_31]

Most facilities (84%) reported having documented annual or multi-year operational plans, with a specified timeframe ranging from one to five years, which serve as primary reference tools to guide management activities. These are typically review during regular management meeting, with differing review frequencies: biweekly (7% of facilities), monthly (39% of facilities), quarterly (32% of facilities), every two months (6% of facilities), semi-annually (3% of facilities), and on need-based meetings (13%). Approximately 82% of facilities used formal governance policies, while 18% rely on informal/verbal guidelines in their daily operations often delivered through verbal instruction during their recruitment stage and meetings. Policies fall into four key categories: human resources, financial and administrative, service delivery, and faith-based. Human resource policies include recruitment, termination, leave, dress code, and code of conduct, some of which are explicitly guided by CHAM, IHAM, Diocese, or MOH; financial guidelines

include financial and administrative manuals, budget submission and fund flow protocols; service delivery guidelines include Malawi Standard Treatment Guidelines, clinical and nursing guidelines, youth-friendly services, and sexual and reproductive health policies (often influenced by religious doctrine). For example, some facilities do not provide modern family planning services following the church's constitution. The findings also revealed that 82% of facilities report alignment of their governance guidelines with Ministry of Health standards. Most facilities base their policies on MoH treatment guidelines, labor laws, and CHAM-MoU agreements, ensuring compliance with national standards.

“Based on the Ministry of Health policies and combined with church policies. We adapt MoH policies and just customize them according to our church policies/beliefs”
[Proprietor KII_6]

“We have Ministry of Health members in our board who provide guidance and for the facility boards, the Director of Health and Social Services also sits on the board to provide guidance and this also ensures alignment to MoH policies” [Proprietor KII_2]

Still, only 32% of the facilities demonstrate a clear understanding of the country's health sector guiding framework, Malawi's Health Sector Strategic Plan III (HSSP III), and have effectively operationalized its objectives within their governance and management.

“I am hoping that we are working in line with the HSSP III unknowingly since we work hand in hand with the Ministry of Health” [Proprietor KII_4]

Community Participation through Health Centre Management Committees

Community participation was institutionalized through the HCMCs which existed in 35 of the 40 surveyed facilities. HCMCs typically comprised elected 11–19 community members, including

youth, women and persons with disabilities. All members serve voluntarily and meet at least once quarterly. HCMCs were widely perceived as a link between the community and health facility staff, facilitating communication, resolving disputes, and supporting service delivery improvements. Across sites, committee members described their primary mandate as one of community representation and advocacy, as well as support to facility operations. Their core responsibilities included supervising sanitation and hygiene, monitoring drug supplies, raising awareness on disease outbreaks such as malaria and cholera, mediating conflicts between health workers and community members, and mobilizing resources for minor infrastructure improvements such as construction of patient and guardian waiting areas and pit latrines. Additionally, 30 of the 35 HCMCs had governing guidelines, ensuring all members understood their roles.

"HCMC is a bridge between the health workers and the community. If the health workers are ill- treating patients or if patients are being violent to health workers, the HCMC investigates... Giving awareness on availability of drugs and awareness campaigns on malaria, cholera, and other outbreaks, sourcing funds for the hospital; they once built the waiting area and pit latrines" [FGD HCMC_1]

"Serving as a bridge between hospital and community members. Overseeing sanitation at the hospital. We are involved in planning developments in the hospital. Communication to the community if there is medicine shortage" [FGD HCMC_5]

The findings, however, further revealed a notable disconnect between these community-level governance actors and the boards but often good relationships with facility management. Despite the formal existence of boards in most facilities, more than half of HCMCs (57%), were unaware

of whether their facility had a board, and only 40% could confirm its existence, and 3% stated explicitly that no board was present at their facility. Importantly, no HCMC members served on the facility boards. Among the respondents who were aware of their facility's board, 57% reported the presence of a dedicated board, and 43% cited a centralized board arrangement. All facilities with dedicated boards were either community or secondary hospitals. Only two HCMCs described regular engagement with their board on a monthly and quarterly basis, respectively.

Oversight in Budget Formulation

Facility Budget Preparation: The analysis revealed that across CHAM and IHAM facilities, budget formulation is primarily a management-led process, coordinated by the facility in-charge and the accounts department. Departmental heads prepare estimates of financial needs based on operational priorities. These inputs are consolidated into draft facility budgets, typically informed by historical expenditure estimates and adjusted for inflation or market price changes, and revisions are made according to current priorities and resource availability.

For facilities with functional boards, these consolidated draft budgets are then reviewed internally in management meetings before submission to a board or governing body for approval. Boards exercise oversight directly or through financial subcommittees, ensuring that proposed budgets aligned with institutional priorities and anticipated resources. Most boards retain exclusive approval rights for major procurement decisions, especially capital expenditures exceeding predetermined thresholds.

“The board provides oversight over the budget and provides checks and balances.”

[Facility in-charge KII_11]

“After the management team has prepared a budget we bring it to the finance committee of the board and they review it and guide on areas for amendments and after they are convinced they bring it to the main board for approval.” [Facility in-charge KII_12]

“The board makes sure we have a budget and we are operating according to plan.”
[Facility in-charge KII_12]

In contrast, facilities operating under centralized governance arrangements reported minimal involvement in budget formulation. In these cases, facility managers submitted estimates of needs to their mother facilities, which retain authority to finalize budgets. Facility teams are only informed of the final approved budget. In extreme cases, respondents reported complete exclusion from budgeting processes or a lack of clarity regarding board roles in financial oversight.

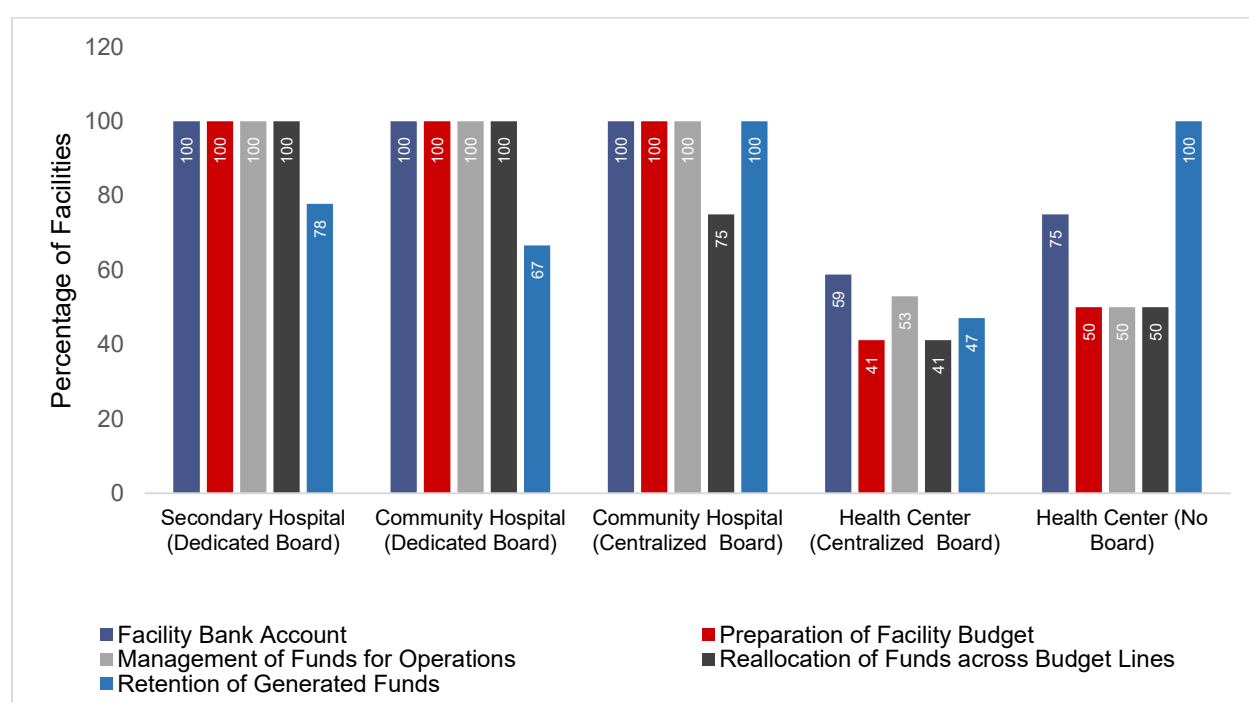
“They are the custodians of all financial decisions made at the facility, the board formulates, reviews and evaluated the budget. We are not involved at facility level.” [Facility in-charge KII_26]

Budget formulation by facility level and board configuration: Differences in budget formulation capacity emerged by level of care and governance structure. Among hospitals, budget formulation was widespread as presented in Figure 4. All hospitals with dedicated and centralized boards prepared their own budgets. Among the 21 health centers, budget preparation was markedly less common. Only 41% of centralized-board health centers prepared their budgets, while 50% of non-governed centers had this capability. In total, only 43% of health centers prepared their own budgets.

The analysis also revealed varying budget flexibility across governance types. All decentralized board secondary and community hospitals demonstrated the ability to move funds across budget

lines especially in emergencies and evolving priority needs across the financial year. Among the centralized-board hospitals, 100% of secondary facilities and 75% of community hospitals maintained this flexibility. Among the health centers, flexibility was significantly more constrained. Only 41% of the centralized-board health centers could reallocate funds across budget lines. For the non-governed health centers, 50% exhibited this capability.

Figure 4: Facility Financial Autonomy by Facility and Board Type



Oversight in Budget Execution

During budget execution, boards are responsible for fiduciary oversight and institutional accountability. Facility boards play financial oversight roles, primarily through compliance checks, expenditure oversight, fundraising and resource mobilization. Quarterly meetings are a common mechanism for oversight.

“They see financial transactions and guide us on how to use and generate income and use the expenditure in a way that will not derail the facility.” [Facility in-charge KII_9]

“The financial subcommittee guides the accounts team in planning and budget execution...They also help in capital expenditure management and loan acquisition procedures with banks.” [Facility in-charge KII_1]

Some boards also played a role in establishing internal control mechanisms, including approval hierarchies and signatory rules.

“They facilitated that the hospital should have a charter document. We designed it based on the one that CHAM has. So not one person can sign vouchers. For example, the voucher has to be approved by the principal administration” [Facility in-charge KII_16]

To access funds, healthcare facilities follow a standard requisition and approval process. Departments submit formal requisitions for necessary expenditures. Authorized personnel review and approve legitimate requests. Payments are processed through cheques, electronic transfers/mobile money, and petty cash for minor expenses. The authorization process requires approvals from multiple signatories, which vary across facilities but typically include a combination of administrative and medical staff, for example, the facility in charge, administrator, matron, medical officer, religious authorities, finance personnel (accountant, finance director, human resource officer). Many facilities have a multi-step approval system based on transaction amounts, where larger transactions demand additional approvals. Multiple approvals, voucher systems, and audits prevent fraud and ensure proper fund use, enhancing transparency and accountability. While this enhances oversight, it was also viewed to cause operational delays when signatories are unavailable.

In health centers, budget execution is highly controlled by external authorities, including proprietors, mother facilities, or secretariats. Facility managers reported limited decision making over expenditures, especially for large purchases or infrastructure projects. This arrangement constrains operational responsiveness, particularly in addressing urgent staffing, drug, or maintenance needs.

“All financial issues are done at [mother facility] by the board.” [Facility in-charge KII_20]

All hospitals, community and secondary facilities, regardless of their board structure, owned their own facility bank accounts and had full autonomy to manage their own funds for various operations as presented in Figure 4.

Oversight in Budget Evaluation

Across the sampled facilities, budget evaluation practices were largely uniform, with minimal variation by facility type or board configuration. Nearly all facilities reported that allocated funds were subject to regular audits and formal financial reviews, typically conducted by actors such as secretariats, proprietors, auditors from mother facilities, or independent auditors, indicating that budget evaluation is largely institutionalized as a routine financial accountability function. These evaluations primarily focused on ensuring adherence to financial guidelines, verifying expenditures against approved budgets, and ensuring compliance with procurement and reporting procedures. Financial performance was commonly assessed through audit reports, routine financial statements, and progress reports

Boards of directors play a role as the formal oversight bodies that hire external auditors and, receive and review audit findings. Their involvement centers on ensuring adherence to financial

rules and recommending corrective actions in response to identified weaknesses, such as documentation gaps or financial control failures.

“At the end of the fiscal year they conduct financial evaluation.” [Facility in-charge KII_32]

“Audits, the board ensures diligent management of resources, formulation of budget and compliance.” [Facility in-charge KII_13]

In some facilities, audit processes were closely linked to donor requirements, with boards ensuring compliance as a condition for continued funding.

“We are required to have audits. Usually because of the donors. They will not provide if these audits are not conducted. We produce the reports and share to the board as well” [Facility in-charge KII_5]

Community Accountability in Budget Formulation, Execution, and Evaluation

Despite the formal presence of HCMCs in most facilities, community actors were largely excluded from budget formulation, execution, and evaluation processes. Seven HCMCs reported some awareness of the facility’s budget; however, none had been involved at any stage of the budget cycle.

Beyond audits, governance structures oversee facility performance through a range of monitoring and accountability mechanisms aimed at service delivery quality and operational effectiveness.

“During quarterly meetings, we present our areas of strength and weakness. The board then provides critical insights and guidance on how best to improve as a facility” [Facility in-charge KII_11]

Performance Monitoring and Accountability Mechanisms

Beyond financing, governance structures oversee facility performance through a range of monitoring and accountability mechanisms aimed at service delivery quality and operational effectiveness.

“During quarterly meetings, we present our areas of strength and weakness. The board then provides critical insights and guidance on how best to improve as a facility” [Facility in-charge KII_11]

Adherence to Clinical Guidelines

In our sample, 98% of the facilities reported having a documented protocol for standardized patient care. Most facilities indicated using Ministry of Health guidelines, CHAM-developed protocols, or program-specific standard treatment guidelines. These protocols are frequently displayed on department walls, kept on desks, or included in service charters for easy reference during daily operations. Facilities also implement standard operating procedures (SOPs), admission sheets, referral guidelines, and patient charts to ensure clinical consistency. Registers such as OPD, maternity, and STI logs serve both as documentation and tools for adherence monitoring

Quality Improvement Initiatives

Quality improvement practices were widely reported across facilities, although their consistency and institutionalisation varied by governance arrangement (Figures 6 and 7). Most facilities conducted internal quality assessments, with higher uptake among those governed by centralized or dedicated boards compared to facilities without boards. Clinical audits were the most commonly reported assessment mechanism, including maternal and neonatal death reviews, general clinical audits focusing on case management, and peer review of medical cases.

Facilities with dedicated boards consistently demonstrated the strongest quality assurance structures. All (100%) such facilities reported conducting internal quality assessments, maintaining functional quality improvement teams, and routinely collecting patient feedback. In contrast, facilities without boards exhibited weaker and less consistent quality improvement systems, particularly in the establishment of quality improvement teams, where only half reported having a functional team.

Across facilities, quality improvement activities were most frequently conducted on a monthly basis, especially in facilities with centralized boards. However, notable variation was observed in assessment frequency, ranging from ad hoc or daily reviews to quarterly or periodic assessments. Facilities without boards were more likely to report irregular or non-existent assessment schedules, suggesting gaps in routine oversight and institutional accountability.

Figure 6: Quality improvement structures and practices by board configuration

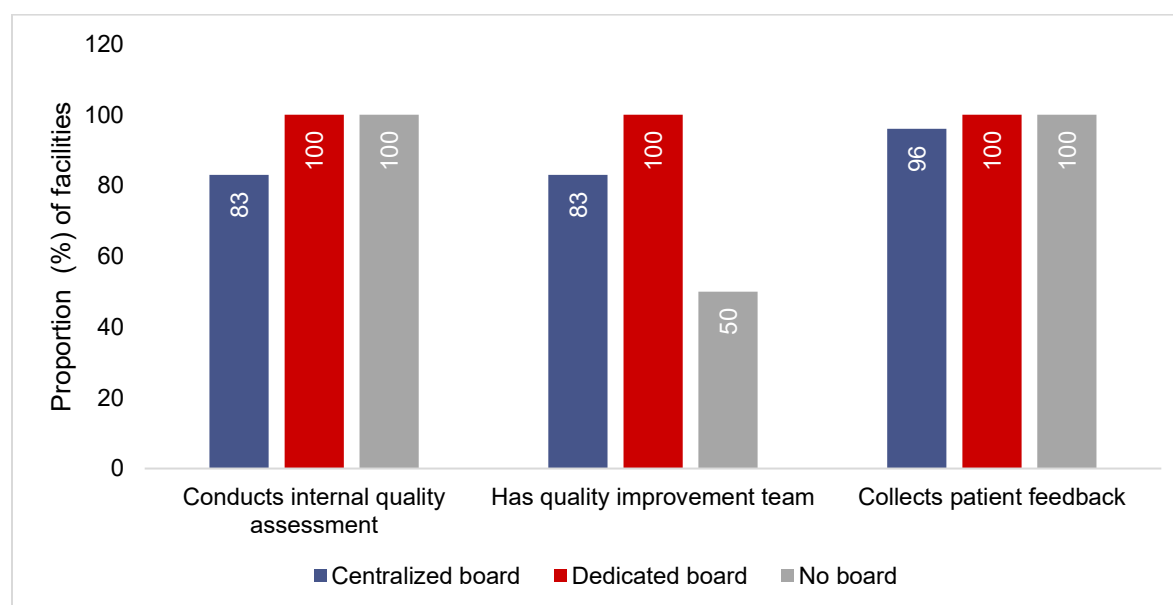
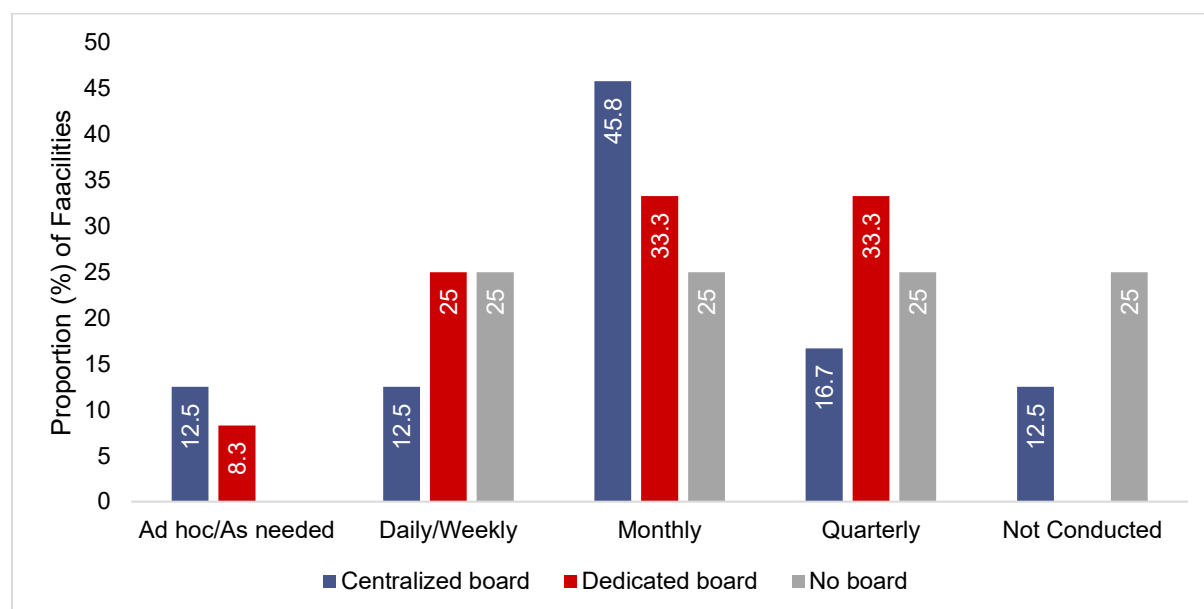


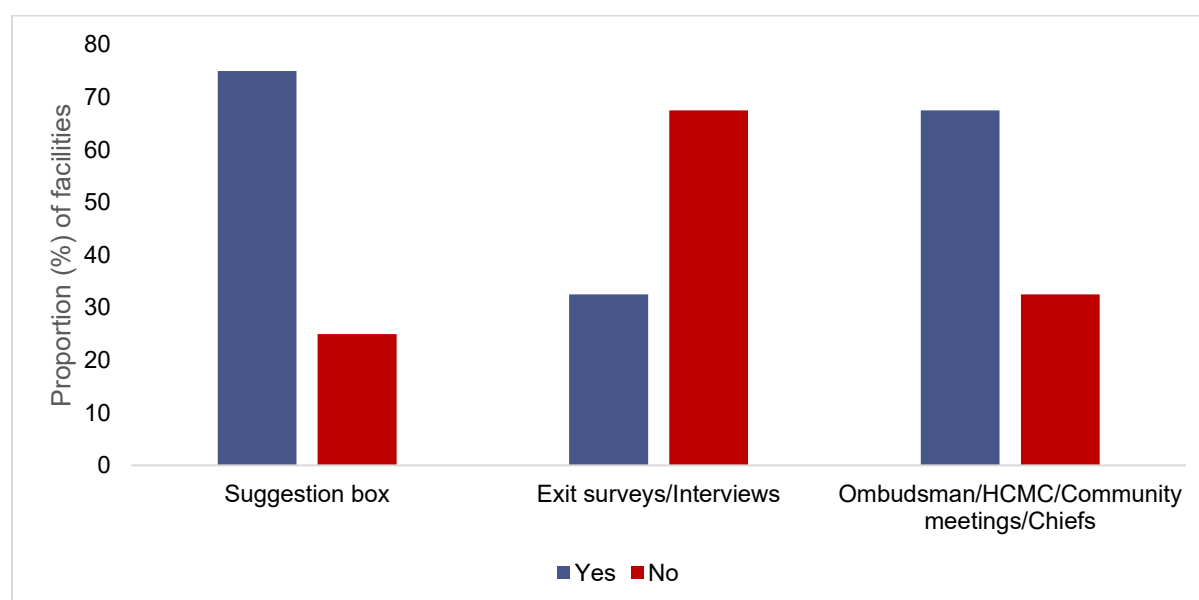
Figure 7: Frequency of quality improvement activities by board configuration



Patient Feedback Collection

Patient feedback mechanisms play a central role in monitoring service quality. Feedback from patients on service delivery is collected in 98% of the sampled facilities. Suggestion boxes were the most commonly reported tool, used by 75% of facilities, while community-based mechanisms (including ombudsman arrangements, HCMCs, community meetings, and engagement with traditional leaders were reported by 67.5% of facilities. Despite the relatively high uptake of feedback mechanisms overall, a substantial minority (32.5%) of facilities reported not using exit interviews. Where feedback mechanisms were in place, respondents indicated that patient concerns were typically reviewed during management meetings and, in some cases, used to inform service improvements or address staff performance issues.

Figure 8: Patient feedback mechanisms used by faith-based health facilities



DISCUSSION

This study explored governance arrangements within faith-based health providers in Malawi and examined how these structures influence public financial management (PFM) practices and managerial autonomy at the facility level. Governance in most facilities follows a tiered structure in which proprietors entrust strategic oversight to boards who provide policy direction and fiduciary supervision to the facility's management team, which handles daily operations. At the community interface, HCMCs provide community oversight.

The findings reveal that facility boards play an active and substantive role across the PFM cycle, including budget formulation, authorization of expenditures, and financial oversight. These results are consistent with broader evidence in LMICs. For example, a systematic review (22) examining governance in faith-based hospitals across sub-Saharan Africa found that facilities with inclusive, accountable board structures establish a shared strategic direction with management essentially

aligning the facility's mission with extensive health system goals and improved overall performance. In the Malawian context, facility boards typically comprise a multidisciplinary mix of clinical professionals, legal and financial experts, religious leaders, and, in some instances, government representatives from the Ministry of Health. This diversity affords both technical competency and moral legitimacy, an observation aligned with (64), who underscore the importance of incorporating voices from across management, medical, nursing, and the community to promote policy alignment.

A critical insight that emerged from the research was the differentiation and implications of board model configuration on facility performance. Two governance models were identified: decentralized boards were present at hospital level while centralized board operated from the proprietor or parent hospitals. Facilities with dedicated, facility-level boards demonstrated greater financial responsiveness, operational flexibility, and more engagement across all stages of the PFM cycle. In contrast, facilities under centralized governance experienced more bureaucratic delays and limited managerial autonomy. These findings align closely with decentralization theory and principal-agent models, which posit that devolving decision-making authority to the point of service delivery enhances responsiveness and accountability by reducing information asymmetries and strengthening principals' (boards or communities) capacity to monitor agent (facility managers) behavior. In our context, facility boards act as principals overseeing facility managers enabling closer supervision and faster corrective action, shortening information asymmetries. The "close to the ground" governance especially with dedicated boards allows boards to better understand local needs and adapt strategies and resource allocation accordingly (65). Situated within Malawi's decentralization and health financing reforms, these findings offer policy-relevant insights for strengthening governance and service delivery across diverse health systems. They

also contribute to a growing body of literature that challenges assumptions of organizational homogeneity among faith-based providers within decentralized health systems.

Furthermore, the study identified that board oversight critically determines how facilities engage in budget formulation. Facilities with dedicated boards reported active board participation in setting annual priorities. While management typically led the drafting process, boards provided strategic review and approval, helping to align budgets with actual service delivery needs. In facilities with centralized boards, planning processes were more top-down where facility staff submitted proposals but exercised limited influence as final decisions were made at higher administrative levels. This limited input weakens the relevance of plans to community needs. Consistent with the public finance literature, participatory budgeting and decentralized planning are associated with improved allocative efficiency, particularly when local managers and communities are involved in priority-setting (66,67). Furthermore, the type of board and level of facility was associated with financial autonomy during formulation. Hospitals, whether governed by dedicated or centralized boards, generally manage their own bank accounts and revenues, allowing them to negotiate budget allocations and plan expenditures using generated funds. In contrast, health centres across different governance arrangements had more restricted roles.

Similar governance-related differences emerged during budget execution. Although all facilities formally complied with PFM rules such as authorization hierarchies and multiple signatory requirements, execution capacity varied markedly by governance model and facility level. Higher-level facilities with dedicated boards and delegated financial authority, often operating their own accounts, exhibited greater flexibility in reallocating resources, managing operational risks, and responding to emergent needs. This translated into faster procurement processes and improved operational efficiency. In contrast, health centres under centralized governance or where

proprietors retained financial control faced constrained spending authority and frequent delays in critical decisions. Budget evaluation practices across faith-based facilities were predominantly upward-oriented, with audits and financial reviews typically conducted by boards or board-appointed auditors and focused primarily on financial compliance.

Another prominent finding from the study was the disconnect between formal governance structures and community-level actors. While formally, HCMCs are designated as community oversight structures, their linkage with facility boards ranged from minimal to non-existent. Many HCMC members were unaware of the existence of facility boards or their roles and activities, and had no meaningful involvement in governance or decision-making processes. This exclusion represents a breakdown in vertical accountability, through which community perspectives are expected to inform facility management and, ultimately, interface with proprietors and health regulatory authorities. Given that HCMCs are meant to represent community interests, their marginalization constitutes a missed opportunity to strengthen demand-side accountability and enhance responsiveness. The study further revealed that HCMCs in Malawi had virtually no role in facility financial management; they were not involved in budgeting, expenditure decisions, or financial evaluation oversight.

Study strengths and limitations

A central strength of this study is its systematic examination of the relationship between governance configuration and PFM performance within FBHPs in a low- and middle-income country context. Although prior literature has explored the contribution of faith-based organizations to service delivery and contracting arrangements, far less attention has been given to how internal governance structures shape financial autonomy, PFM processes, and operational

responsiveness. Therefore, this study advances a novel institutional perspective that bridges health governance and PFM scholarship.

Nonetheless, one key limitation should be considered when interpreting the findings. The qualitative design does not permit causal inference regarding the relationship between governance structures and PFM performance. Although the findings reveal consistent patterns linking board configuration to financial autonomy and operational responsiveness, these associations are interpretive rather than statistically tested. Future quantitative or mixed-methods research is needed to formally examine the hypotheses generated in this study and assess the magnitude and direction of these relationships.

CONCLUSION

Overall, the findings reinforce the value of strengthening proximate, facility-level governance in primary health facilities. Institutionalizing inclusive, accountable, and functionally empowered oversight boards can improve the efficiency, responsiveness, and credibility of public financial management. As Malawi continues to implement decentralized health reforms, embedding strong governance arrangements will be essential to ensuring that financial autonomy translates into tangible improvements in service delivery and health outcomes.

Drawing on the study findings, the following recommendations are proposed to enhance institutional effectiveness and sustainability within both CHAM/IHAM and government healthcare systems. For CHAM and IHAM facilities, governance restructuring should prioritize adoption of a hybrid model that combines centralized strategic oversight with facility-level operational autonomy. Centralized boards can guide long-term planning and resource allocation, while dedicated boards retain authority over day-to-day decisions, thereby maintaining

responsiveness to community needs. In addition, formal mechanisms for stakeholder engagement should be institutionalized to strengthen coordination among proprietors, boards, facility management teams and community members, enhancing alignment of priorities and collective accountability.

For government healthcare facilities, this study recommends that the Ministry of Health institutionalize facility boards in public facilities, adopting a phased approach. This recommendation entails implementing a four-step process to ensure effectiveness, scalability, and sustainability. The Ministry of Health should begin by systematically drawing lessons from the governance experiences of faith-based providers, particularly CHAM and IHAM, whose models provide practical insights into board composition, oversight structures, and accountability mechanisms. These lessons should inform the piloting of facility boards in selected public facilities across diverse contexts to allow for structured testing and contextual refinement. Following successful piloting, facility boards should be formally integrated into the DFF framework to strengthen financial oversight, enhance transparency, and align resource allocation with community health priorities. To sustain reform momentum, comprehensive monitoring and evaluation systems with clearly defined performance indicators should be institutionalized, enabling continuous assessment, iterative learning, and the long-term consolidation of governance improvements within the public health system.

Abbreviations

CHAM Christian Health Association of Malawi

DFF Direct Facility Financing

FBO Faith Based Organisations

FBHP Faith Based Healthcare Providers

HCMC Health center management committee

IHAM Islamic Health Association of Malawi

PFM Public Financial Management

PHC Primary Healthcare

SLA Service Level Agreement

UHC Universal Health Coverage

Declarations

Ethics approval and consent to participate

This study received an ethical waiver from the National Health Sciences Research Committee (NHSRC) in Malawi, Protocol 23/02/3174. All respondents were asked to provide written informed consent to participate in the study and for audio recording of the interviews. To ensure confidentiality, all transcripts and qualitative data were anonymized and stored securely and participants' identity numbers were used in place of names during the data cleaning process. The study was conducted following the Declaration of Helsinki guidelines and regulations.

Consent for publication

Not Applicable

Availability of data and materials

The datasets supporting the conclusions of this study are available from the corresponding author upon reasonable request. All data analyses are presented in this article.

Competing interests

The authors declare that they have no competing interests

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Authors' contributions

Conceptualization: DN, JMB, JMZ, PNM, GM. Methodology: JMZ, PNM, DN, PC, PJC, CW, JMB, IKC, GM, EC, DEN. Data analysis: PNM, JMZ, PC, CW, DN. Writing-original draft: PNM, JMZ. Writing-review and editing: DN, PNM, JMZ, PC, CW, PJC, JMB, IKC. Supervision: DN, JMB, GM, EC, DEN. All authors critically read and approved the final manuscript.

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