Original Article

The Interactions of Public Health Organisational Leadership with its Environment: A Case Study of the Sally Mugabe Central Hospital in Harare, Zimbabwe

Tonderai I. Kasu, Solomon Mungure, Girma Menelik and Sungano Mharakurwa

College of Health, Agriculture and Natural Sciences
Africa University

ABSTRACT

Introduction and Background: This paper presents a case study from Sally Mugabe Central Hospital; that examines the interactions of public health organisational leadership with its environment, within the context of Zimbabwe's unique social, economic and political circumstances.

Objective: To investigate how the local context and local environment of Zimbabwe's unique social, economic and political situation have interacted with the leadership of Sally Mugabe Central Hospital as a Zimbabwean public health institution.

Methods: A combination of semi-structured interviews and document analysis were used to conduct the research. Purposive sampling and expert sampling were used to select respondents for interviews. Content analysis of relevant administrative and management documents kept at the participating institution was carried out. This research is located within the theoretical framework of Health Policy and Systems Research (HPSR); and examines the institutional level or meso-level of the healthcare system.

Results and Discussion: Research findings are discussed under subheadings that correspond to the interactions of social, economic and political factors with public health institutional leadership.

Recommendations: Based on the research findings of this case study, recommendations are made on relevant and effective changes to practice, for the leadership of Zimbabwean public health institutions, recommendations that may have some applicability elsewhere as well, on the basis of lessons learnt.

Conclusion: The problem of chronic underfunding; as well as the social, economic and political challenges that have been experienced at the institutional level in the Zimbabwean public health system; require innovative and adaptive public health leadership that can confront adversity in a complex environment.

Corresponding Author:
Dr. Tonderai Irvine Kasu
126 Kwame Nkrumah Avenue
Harare, Zimbabwe
Email: dr.tonykasu@hotmail.com
Telephone: +263772375284

INTRODUCTION

Sally Mugabe Central Hospital (SMCH), formerly known as Harare Central Hospital (HCH); is one of six central government hospitals in Zimbabwe[1]. Zimbabwe is a country which, since the start of the 21st century, has experienced immense social, economic and political challenges[2-4]. These challenges have included: international isolation, political polarization, hyperinflation, liquidity constraints, deflation, high inflation, as well as social and economic malaise[5,6]. These challenges have been felt and appreciated in all aspects and spheres of life in Zimbabwe with the public health sector not being an exception[7].This paper presents a case study of Sally Mugabe Central Hospital; a case

Keywords: *Public Health, Organisational Leadership, Environmental Factors, Practice and Policy Making Responses.*

study that examines the interactions of public health organisational leadership with its environment, within the context of Zimbabwe's unique social, economic and political circumstances. This case study investigates how the local context and local environment of Zimbabwe's unique social, economic and political situation have interacted with the leadership of this public health institution (SMCH). This case study also proceeds to make recommendations on relevant and effective changes to practice, for the leadership of Zimbabwean public health institutions, recommendations that may have some applicability elsewhere as well, on the basis of lessons learnt.

The hospital (SMCH) was founded in 1958 and since 1966 it has been a teaching hospital for the University of Zimbabwe's Medical School. The hospital has 1200 beds and sits on 96 hectares of land. The hospital is situated in the Southerton area of Zimbabwe's capital city, Harare; an industrial zone where the hospital is surrounded by factories and industrial enterprises. The hospital was built by the previous colonial white settler minority government in order to service the black Africans that necessarily provided the cheap labour for white-owned industrial concerns. The hospital was meant and intended to service the low income blacks that lived in the poorer high density areas that are located on the southern side of Harare; where these blacks provided the cheap labour in the factories of the aforementioned white-owned industrial concerns[8]. Even in post-independence Zimbabwe, the hospital has continued to carry this legacy and reputation, of being known, in local parlance, as the poor people's hospital.

METHODS

The research design was that of conducting a case study, and in academia there has been a well-established history and practice of using the case study method as an investigative tool when conducting research into public health institutional leadership[9,10].Case studies have been shown to be useful in elucidating multiple contextual factors and in the interpretation of complex phenomena[11].This research was located within the theoretical framework of Health Policy and Systems Research (HPSR)[12]. This research examinedthe institutional level or meso-level of the healthcare system[13,14], by investigating and interrogating the leadership of a public health institution that has been key to Zimbabwe's public health sector, being a central government hospital.

A combination of semi-structured interviews and document analysis were used to conduct the research. An interview guide was used to give direction to interviews, but the interviewing style was open ended and exploratory in nature. Content analysis of any relevant documents kept at the institutions under study was undertaken to corroborate data obtained from interviews. Documents analysed included administrative and/or management records at the public health institution that was studied, spanning the period from the year 2000 to the present, and no other documents. Medical records of individual patients at the participating institution were not studied, as they are not part of the inclusion criteria for this study.

Research participants were selected that representedsix (6) functional areas of public health institutional leadership, namely: Human Resources Management (HRM), financial management, operational management, nursing management, clinical (medical) management and executive oversight. Thus a sample consisting of one representative from each of these six (6) functional areas of institutional leadership was obtained from the participating institution, meaning that there was a total sample of six (6) research participants for this case study. Purposive sampling and expert sampling of respondents for interviews were used because the study intended to examine institutional leadership, and so the target rich sources of data are concentrated amongst the leadership echelons of the institution; thus the characteristics of the population in terms of individual research participants for this study lend themselves to purposive sampling and expert sampling, because it is a population composed of individuals that have specialised and technical knowledge and that have particular and specific expertise.

Ethical approval for the study was obtained from the Africa University Research Ethics Committee (AUREC), the Medical Research Council of Zimbabwe (MRCZ) and from the participating institution. The medical confidentiality of the patients at the health institution that was studied was not at risk at any time as individual patient's medical records were not examined, the inclusion criteria for the study did not include individual patient's medical records. Research participants that were interviewed as part of the study were given ethical protection through not being specifically identified by name. They were only identified through functional aspects of specific leadership functions; namely, executive oversight; clinical (medical) management; nursing management; financial management; human resources management; and operational management. Participation in the research was voluntary and subject to the granting informed consent.

RESULTS AND DISCUSSION

General Observations:

There have been challenges with respect to SMCH obtaining supplies, including surgical supplies and medical consumables, because of insufficient financial resources. There have been problems with respect to maintaining and upgrading electricals, the plumbing system and other physical infrastructure. Sally Mugabe Central Hospital relies on a system of steam conveying pipes to drive machines and processes at the hospital; in the main hospital kitchen, the hospital laundry, and the Central Sterile Stores Department (CSSD). This is an old system of steam pipes, and the pipes have suffered and succumbed to corrosion. The system of water pipes at SMCH is also in an old and dilapidated state and in need of replacement.

There has been a bureaucratic system of governance at the hospital that resulted in procurement delays and in long turn-around times when it comes to ordering and obtaining supplies. Clinicians, although being end-users of procured equipment and supplies, have been excluded from procurement processes and this has been detrimental to the efficient and effective functioning of the hospital.

The hospital (SMCH) has been short staffed. Over the time period that is of interest to this study, there has been brain drain of professional staff and high staff turnover at the hospital. Staff have been unable to report for work daily because of poor remuneration. The government circular allowing some employees to have flexible working hours was meant to address this but has also had its own unintended consequences, in terms of decreased efficiency and lower performance in the work place. Introduction and implementation of the flexible hours working system; while bringing some relief to employees; was a bad, damaging and destructive policy for the patients, for the hospital, and for the public health care system; because of extensive and considerable disruptions to continuity of care in providing health care services; and because it resulted in the quality of health care services being severely compromised.

The hospital's staff have been demotivated because of poor remuneration. The hospital (SMCH) has been using an old staff establishment from the time of Zimbabwe's Independence; given the growth in the population that the hospital caters for since then, the hospital's staff establishment needs to be revised upwards as a matter of urgency.

The Interaction of Social Factors with Public Health Leadership:

The hospital (SMCH) services a largely poor population, and this is a major social issue with respect to how the hospital conducts its operations. A large proportion of the population that the hospital is meant to serve are not able to afford to pay for medication and medical consultation. For the hospital (SMCH), the debtor's figure is always rising, and this affects the hospital's viability, because cost recovery is not achieved and then it becomes difficult to replace consumables.

There has been an increase in the numbers of young people being treated at the hospital for substance abuse disorders. Zimbabwe has a highly educated but largely unemployed youth population; and this is both a social and an economic problem.

Another social problem that was identified was an increase in the number of very young (below legal adult age) mothers presenting to the hospital (SMCH) either pregnant or with sick babies. It was noted with concern that another social problem that was observed is that there are always some mothers that deliver babies at the hospital when, at the time of delivery, they do not even have baby clothes to use to dress their babies. Another related social issue is that it has also been a common occurrence at the hospital that some new mothers end up staying at the hospital longer post-delivery and post-discharge; because of inability to pay hospital bills that are due at discharge.

The Interaction of Economic Factors with Public Health Leadership:

Research participants reported that: following Zimbabwe's experience of hyperinflation in 2008; there was relative price stability from 2009 onwards; and/but that there has been a resurgence of high inflation with respect to the last three months of 2018 and the whole of the year 2019 and beyond. With respect to the two time periods of high inflation in Zimbabwe; firstly the period of hyperinflation in 2008; and secondly the period of high inflation that characterised the last three months of 2018, the whole of the year 2019 and beyond; during both of those two periods, the hospital experienced profound and complex difficulties in procuring supplies because of price variations; with prices changing on a daily (in 2008) or weekly (in 2019 and 2020) basis.

Policy inconsistency with respect to the central government's monetary policies has caused harm to the hospital in particular and to the nation's economy in general. The frequent changes in currency regimens over the last decade, at the instigation of monetary authorities, have been midwives to economic instability and economic uncertainty. It is to state an inconvenient truth to say that the monetary authorities have been reactive rather than proactive. It is lack of policy consistency, and continuous flip-flopping at the national level with respect to monetary policy, that research participants described as having damaged the national economy, and as having wreaked havoc on the finances of the hospital (SMCH). In practical terms, this meant that the salaries, savings and pensions of employees of the hospital were eroded in value and wiped out; and that procurement of supplies become a conundrum because of price variations (increases) from suppliers.

It was the view of research participants that, because of the government's policy inconsistencies and policy missteps; with respect to the central government's monetary and fiscal policies; Zimbabweans had lost faith and confidence in the country's banking system; and that this only served to exacerbate the country's economic problems.

Zimbabwe's hyperinflation of 2008 caused economic and psychological hardships among the hospital's employees. During that time, hospital employees retired with worthless pensions and then became destitute. In 2008, the then Harare Central Hospital (HCH) practically closed; and as well all other government hospitals and all government schools in the country were also all practically and effectively closed; because of the complete collapse of the socio-economic fabric of the country as a whole. In 2008, political turmoil gave rise to unprecedented and obscenely severe economic hardship.

The high inflation that characterised the last three months of 2018 and the whole of the year 2019 and beyond had a severe negative impact on the welfare of staff at the hospital (SMCH). These inflationary pressures, as a ubiquitous economic factor, resulted in the rapid erosion of disposable incomes for staff working at the hospital. This meant that things reached a point whereby staff could not afford the transport costs associated with coming to work. This also meant that things reached a point whereby members of the hospital's staff could not afford the basic necessities of life. Employees found it difficult or impossible to pay for expenses such as food, rentals, and school fees. Employees at SMCH were understandably demoralized, demotivated and disgruntled by this situation. Also, absenteeism became common due to poor pay.

The high levels of demotivation among hospital employees at SMCH led to labour unrest and high levels of staff turnover; and this in turn led to high staff training costs, since the hospital was always having to re-train new cadres that were replacing those that were leaving.

The 2019 national budget, by reducing and/or containing salaries for civil servants, and by reducing and/or containing government spending on social services such as health services, in an environment characterised by high inflation, had the net effect of devastatingly damaging the welfare of the hospital's employees by turning their livelihoods and incomes into a pittance.

Financial support for the hospital from the fiscus has generally been inadequate. The hospital is wholly public; and what that has meant in practical terms is that the central government often withholds approval for any increase in user fees, while not giving enough financial support to the hospital. Monies allocated to the hospital in the national budget are not being fully disbursed to the hospital. There is late disbursement of funds to the hospital from central government, which means that the value of the money will have been eroded by inflation by the time some of it is disbursed. The fact that the payments from treasury are not processed in good time results in delays in paying suppliers, with suppliers then demanding price variations (increases).

Much of the hospital's (SMCH's) equipment has deteriorated from overuse and has now outlived its useful lifespan. Some of the hospital's equipment can only be described as being antiquated. The hospital (SMCH) itself is now very old and there is a need for substantial investment to be made into renovation and refurbishment of the hospital. There is also a need for expansion of the existing facilities through the creation of new buildings.

The Interaction of Political Factors with Public Health Leadership:

Non-clinician (non-medically trained) managers reported that political policies such as offering free medical treatment to those below five years old, those above sixty five years of age, and the scrapping of maternity fees, were policies that had had a negative and undesirable impact on the hospital; since offering services for free when there was a cost attached to being able to provide these services had made hospital operations financially unsustainable. Clinician managers (medically trained managers) however, in contrast to their non-medically trained counterparts, were in favour of government policies giving the aforementioned categories of patients access to free medical treatment; as they saw or perceived it as a mechanism to address and ameliorate inequalities in access to health care. In particular, clinician managers were of the view that making maternity services for free had contributed towards reducing maternal mortality. This clear distinction in approach and perspective to the same issue between medically trained and non-medically trained managers may reflect the fact that medical professionals, collectively and individually, acquire through their training and their professional ethics, a deeper compassion towards relieving human suffering which their non-medically trained manager counterparts may lack.

There was unanimous agreement among research participants that there has been some unwelcome political interference in the day-to-day operations of the hospital. For example, there have been numerous instances whereby Members of Parliament (MPs) and traditional leaders (Chiefs) have intervened to try and shield and protect patients, in order to prevent these patients from having to pay their hospital bills to the hospital. In many instances, those being shielded would include relatives, friends and partisan hangers on of these MPs and Chiefs. Politicians are alive to their constituencies; and as such, many requests and demands made by politicians on the hospital's administration were not professional in nature. There was unanimous agreement among research participants that such a culture of political interference in the day-to-day operations needs to come to an end.

There was unanimous agreement among the research participants that there should be more inclusive political dialogue in the country, as a way

of helping to solve and resolve some of the problems being faced in delivering health and other social services in the country.

Research participants expressed the view that the indigenisation policy was bad politics because it chased away foreign investors. Research participants expressed the view that the political leadership of the country should formulate and implement policies that would help citizens to create wealth for themselves while still promoting instead of discouraging foreign investment.

There was unanimous agreement among research participants that the Government of Zimbabwe should find the political will to meet the commitments made under the Abuja Declaration, that is to set aside at least fifteen percent (15%) of the national budget for funding health.

RECOMMENDATIONS

The former Harare Central Hospital should shake off its historical colonial legacy and reputation as the poor peoples' hospital; through having a robust and effective organisational rebranding and marketing strategy.

SMCH should replace its old outdated system of steam conveying pipes with newer, more modern and more efficient technologies, so as to overcome the operational challenges being experienced because of a breakdown of the old system.

Consideration should be given to construction of a district hospital for the Harare urban area so as to decongest SMCH, since the hospital is currently congested and overwhelmed with cases that should be seen at a lower level of care.

Given that public health services at central government hospitals are being overburdened and overwhelmed as a result of the phenomenon of rural-to-urban migration; the central government should have a renewed policy thrust of ensuring equitable development throughout the country through accelerated devolution.

In future, unworkable and unsound policies such as the flexi-hours or flexible-working-hours system should not be imposed on the public health system through a top-to-bottom approach, as was the case. Wide consultations need to be done before the implementation of national policies, in order to assess their feasibility, and in order to ensure stakeholder buy-in.

There should be more training, and higher levels of skilled manpower, provided for procurement at this hospital (SMCH) and as well as at other central hospitals.

Clinicians, as end users of the goods and products obtained through procurement processes, should be more directly involved in procurement processes; so that their technical input can give rise to operational efficiencies and better results from the aforementioned procurement processes.

In future, there should be timeous and prompt disbursements of monies allocated to central government hospitals in the national budget; given that in the past, late disbursements have universally and uniformly translated into erosion of value in a high inflation environment. Also, the central government should be amenable, receptive and responsive with respect to central government hospitals having supplementary budgets when such measures become necessary.

The Government of Zimbabwe needs to strive to formulate and implement prudent monetary and fiscal policies that ensure macroeconomic stability and that contain inflation within low, narrow and acceptable limits; so that central government hospitals are able to adequately remunerate their staff and do not face impractical and unreasonable challenges when conducting procurement and tender processes.

In the future, the Government of Zimbabwe should strive to achieve policy consistency and policy coherence with respect to formulating, pronouncing and implementing its economic, monetary and fiscal policies; as the constant flip flopping on the policy front that has characterized the past has had a deleterious and damaging effect on the national economy.

The hospital's (SMCH's) old and outdated staff establishment needs to be revised upwards as a

matter of urgency; and the way the issue of the hospital's staff establishment is perceived and acted on at the national level needs to urgently change for the better.

With respect to the issue of ensuring adequate remuneration of health professionals, the way this issue is perceived and acted on at the national level needs to urgently change for the better.

The fact that doctors and nurses throughout Zimbabwe's public health system have been going on strike many times over several decades shows that there is a permanent and persistent problem that is not being solved and has never been solved; the Government of Zimbabwe should holistically and comprehensively address and resolve once and for all the issue of poor remuneration of health professionals in the country.

In order to address the social problem of a rise in substance abuse cases among the youth; consideration may be given to raising the age restriction for access to alcohol and bars from 18 to 21 years of age. Legislative changes to the Legal Age of Majority Act and the Constitution of Zimbabwe may also be considered in order to give effect to the aforementioned recommendation.

In order to address the social and economic problem of the fact that Zimbabwe has a highly educated but largely unemployed youth population, it is recommended that there needs to be revival of industrial production and increasing capacity utilization in industry; so as to provide employment for the youth.

Given that the long held government policy thrust of promoting indigenization and entrepreneurship as the solutions for the problems faced by the country's youth has not been a helpful approach because it has not been applicable to everyone; there is instead a need for a jobs growth policy hinged on reviving industrial production through Foreign Direct Investment (FDI).

Central government policy makers should be proactive in planning and implementing economic strategies and policies that include and incorporate financial forecasting and inflation targeting.

The Government of Zimbabwe should formulate and implement policies that effectively deal with the major drivers or causes of high inflation in Zimbabwe; i.e. the government should stop repeating the same mistakes, as has been the case, of causing unrestrained money supply in the absence of increases in productivity.

Conditions of service for health professionals working in Zimbabwe's public health sector need to be and should be improved, and health professionals should be appreciated and acknowledged through the improvement of their remuneration.

Both monetary and non-monetary incentives, should be introduced for health professionals working in Zimbabwe's public health sector. Examples of such incentives include: provision of affordable accommodation; school fees assistance; provision of car loans; duty exemption when importing vehicles; and housing mortgage loans. The central government needs to ensure that there is adequate funding for the proper remuneration of health professionals.

There needs to be long term planning at national level for equipping public hospitals for efficient service delivery.

The central government should address and resolve, once and for all, the problem of chronic underfunding of the hospital (SMCH) by ensuring adequate and timely financial provision for the hospital by government.

There is a need for substantial investment to be made into renovation and refurbishment of the hospital (SMCH). There is also a need for expansion of the existing facilities through the creation of new buildings.

The hospital (SMCH) should continue to foster and grow partnerships with existing donors that have been assisting with renovation and refurbishment of physical infrastructure at the hospital. The hospital (SMCH) should be active and proactive with respect to resource mobilisation and the hospital should take the initiative in looking for new donors and new partners.

Consideration can be given to private sector involvement in funding and financing the hospital (SMCH). The hospital can consider entering into Private Public Partnerships (PPPs) as a way for looking for and making up for missing resources. In order to make PPPs useful, it would be advisable if they were of limited life span and if they resulted in hand over of assets and infrastructure to the hospital (SMCH) at the end of the lifespan of the agreements. PPPs are particularly needed with respect to the renovation and refurbishment of the hospital (SMCH).

There needs to be a proactive policy or strategy, of roping in the industrial concerns that are within the vicinity of the hospital (SMCH); such that these moneyed neighbours start contributing to the financing of the hospital; given that, in any case, their employees utilize the services of the hospital.

Consideration should be given to setting up a national health insurance scheme as a way of ensuring universal health coverage; as this would kill two birds with one stone; namely, providing for the funding of hospital services while making sure that no one is left behind.

In terms of economic policy at the national level that would have a positive influence on the public health sector, there is a need for the central government to have a more robust and aggressive approach towards promoting and seeking Foreign Direct Investment (FDI). FDI is an engine that can drive the development of the local industry; that is rebooting a local industrial sector that has been on the decline for many years; and by rebooting this sector using FDI, there can be creation of employment, and the creation of wealth that could be spread around for the benefit of social services sectors such as health and education.

Consideration can be given to effectively implementing a pre-paid financing model for services rendered to free categories of patients, such that these services are funded for by the government; in a scenario whereby the government would avail funds for free patients in advance; and the hospital would then draw down on these pre-paid funds.

The culture of political interference in day-to-day hospital operations needs to come to an end.

There should be more inclusive political dialogue in the country, as a way of helping to solve and resolve some of the problems being faced in delivering health and other social services in the country.

The indigenisation policy needs to be reconsidered as a political strategy because it has had the undesirable effect of causing the flight of foreign investors.

The political leadership of the country should formulate and implement policies that would help citizens to create wealth for themselves while still promoting instead of discouraging foreign investment.

Free user fee policies, such as the free maternity services policy, can be used as effective tools to ensure equitable access to health care; and as well they can be used as a means by which to reduce morbidity and mortality; but where such policies are applied, the central government must ensure the provision of adequate funding for these initiatives from general taxation and other revenue sources, in order to guarantee the long term sustainability of such policies and programmes.

The Government of Zimbabwe should find the political will to meet the commitments made under the Abuja Declaration, that is to set aside at least fifteen percent (15%) of the national budget for funding health.

in order to solve Zimbabwe's economic problems, it is first necessary to solve the country's political problems; and it isn't practically feasible to change Zimbabwe's economic fortunes without first addressing and resolving the country's political challenges.

CONCLUSION

The problem of chronic underfunding; as well as the social, economic and political challenges that have been experienced at the institutional level in the Zimbabwean public health system; require innovative and adaptive public health leadership that can confront adversity in a complex environment.

Acknowledgement of Funding Sources: This research work was funded entirely by the corresponding author. There are no other institutional, private or corporate funders for this research work.

Compliance with Animal/Human Ethics Guidelines: This research was approved by the Medical Research Council of Zimbabwe (MRCZ), the Africa University Research Ethics Committee (AUREC) and the Organisation where the research was conducted.

Conflict of Interest: There is no conflict of interest to declare.

REFERENCES

1. Adamchak, S. E. An institutional analysis of the Zimbabwe Ministry of Health and Child Welfare. United States Agency for International Development (USAID). 1995.
2. Davies, B. Dying for dignity. *Community Practitioner*. 2006; 79: 9
3. Musemwa, M. From 'sunshine city' to a landscape of disaster: The politics of water, sanitation and disease in Harare, Zimbabwe, 1980–2009. *Journal of Developing Societies*. 2010; 26: 165-206
4. Mandizha, B. Inflation and exchange rate depreciation: A Granger Causality Test at the naissance of Zimbabwe's infamous hyperinflation. *Economics and Finance Review*. 2014; 3: 22-42
5. Mahoso, T. Reading the 2005 Tibaijuka report on Zimbabwe in a global context, in Vambe, M. T. (Ed.), *The hidden dimensions of Operation Murambatsvina in Zimbabwe*. 2008. African Books Collective, ISBN 1779220715, 9781779220714
6. Hanke, S. H. and Krus, N. E. World hyperinflations, in Parker, R., and Whaples, R., (eds.): *The Handbook of Major Events in Economic History*. 2012. Routledge Publishing, Summer 2013; Cato Working Paper, Forthcoming. http://ssrn.com/abstract=2130109 Accessed 13 October 2015
7. Masuka, N. *An evaluation of the access to public health care for diabetics in Zimbabwe*. 2008. Master's in public health specialising in health economics dissertation, faculty of health sciences, University of Cape Town, Cape Town, South Africa
8. Mutizwa-Mangiza, D. *The medical profession and the state in Zimbabwe: A sociological study of professional autonomy*. 1996. Doctoral Dissertation, University of Warwick
9. de Andrade, L. O. M., Pellegrini Filho, A., Solar, O., Rígoli, F., de Salazar, L. M., Serrate, P. C. F., and Atun, R. Social determinants of health, universal health coverage, and sustainable development: Case studies from Latin American countries. *The Lancet*. 2015; 385: 1343-1351.
10. Rowitz, L. *Public health leadership*. 2013. Burlington, Massachusetts: Jones and Bartlett Publishers.
11. Hendrikx, T. F. C. *Why do some innovations fail and others succeed? Obstacles and drivers for patient-centred innovation*. 2014. Thesis, Utrecht University. https://dspace.library.uu.nl/bitstream/handle/1874/301609/Thesis%20USG%2021092014_%20Thomas%20Hendrikx_DEF.pdf?sequence=2 Accessed 22 March 2020.
12. Gilson, L. *Health Policy and Systems Research: A Methodology Reader*. 2012. Alliance for Health Policy and Systems Research, World Health Organisation. http://r4d.dfid.gov.uk/PDF/Outputs/HealthPolicy/Alliancehpsr_Reader.pdf and http://www.who.int/alliance-hpsr/alliancehpsr_reader.pdf Accessed 23 April 2020.
13. Fulop, N., Allen, P., and Clarke, A.*Studying the organisation and delivery of health services: Research methods*. 2001. London: Routledge
14. Van Damme, W., Pirard, M., Assefa, Y., and Van Olmen, J. *How can disease control programmes contribute to health systems strengthening in Sub-Saharan Africa?*2010. Studies in Health Services Organisation and Policy, Working Paper Series, Working Paper Number 1. Antwerp, Institute of Tropical Medicine. http://www.itg.be/itg/GeneralSite/default.aspx?WPID=756&L=e&miid Accessed 15 July 2020.