



**FAITH-BASED ORGANISATIONAL MANAGEMENT:
STRENGTHENING CHURCH-LED HEALTHCARE
PROVISION IN MALAWI AND ZAMBIA**

By
Edward Nondo
212561364

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Prof. Fayth A. Ruffin**

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DECLARATION

I, Edward Nondo, do hereby declare that:

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28th February, 2018

DEDICATION

To God be the glory in whom we have our being!!

This doctoral thesis is a special dedication to my dear parents; Laban Nondo (1928-2010) and Martha ‘George-Chileshe’ Nondo (1933-2014), who groomed eleven independent-thinking children, each of whom grew up into all that tends towards a true Christian manliness – the state of being ‘God-fearing’ men and women. It is further dedicated to my first-born sister Mrs Alice Shitindi (1954-1998). Her passing on to the Lord left me encouraged by the first cross-national trip into Tanzania with her (and much later culminating into the study of this magnitude), and then being hosted by my second-born sister Mrs Elizabeth Mtungujah (1956-2016). Elizabeth remained and lived in the diaspora since 1969 when the entire family immigrated back to Zambia after 21 years of Dad’s work in the then East Africa Posts & Telecommunications Corporation Limited as well as the Zambian High Commission based in Nairobi, Kenya and Dar es Salaam, Tanzania respectively. I am further compelled to dedicate this postgraduate study to my third-born sister, Mrs Rhoda Chisanga (1958-1996), as well as my sixth-born brother Stephen ‘Mulenga’ Nondo (1967-2013), for their love, care and support. You all share in this accomplishment eternally.

May their thrift souls rest in peace!

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LIST OF ACRONYMS

AU	African Union
CCAP	Church of Central Africa Presbyterian
CEVAA	<i>Communaute d'Eglises en Mission</i> (Community of Churches in Mission)
CHAM	Christian Health Association in Malawi
CHAs	Community Health Assistants
CHAZ	Churches Health Association of Zambia
CHIs	Church Health Institutions
CORAT	Christian Organisation Research & Advisory Trust
CWM	Council for World Mission (Global ecumenical network)
DFID	Department for International Development (United Kingdom government)
EHP	Essential Health Package (Ministry of Health, Malawi)
EHS	Essential Health Services (Ministry of Health, Zambia)
FBO	Faith-based Organisation
GRZ	Government of the Republic of Zambia
HSSP	Health Sector Strategy and Policy (Ministry of Health – Malawi)
MDGs	Millennium Development Goals
MLC	Management and Leadership Centre
MoH	Ministry of Health
NGO	Non-governmental Organisation
NHP	National Health Policy (MoH – Zambia)
NHSP	National Health Strategic Plan (MoH – Zambia)
NIPA	National Institute of Public Administration
PMTCT	Prevention of Mother-to-Child Transmission
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SMAGS	Safe Motherhood Action Groups
TBAAs	Traditional Birth Attendants
UCZ	United Church of Zambia
UCZU	United Church of Zambia University
USAID	United States Aid for International Development (American government)
WCC	World Council of Churches
WHO	World Health Organisation

WMC	World Mission Council (Church of Scotland)
ZISSP	Zambia Integrated Systems Strengthening Program
ZMLA	Zambia Management and Leadership Academy

ABSTRACT

Collaboration between government, faith-based organisations (FBOs) and local communities for healthcare management and delivery in southern Africa or continentally, are seldom the focus of empirical study. The core work of churches is pastoral care. Literature searches reflect that pastoral care characterised by congregational governance lacked healthcare management strategies and stakeholder inclusivity in church-led management of local healthcare. With this point of departure, the current cross-national study of four mission hospitals explored challenges and opportunities for church-led hospitals to perform healthcare management functions in collaboration with government and communities. Driven by the transformative worldview, this qualitative study used multi-grounded theory and case study strategies in tandem with a design of meta-conceptual framework in stakeholder-congregational style.

Two Malawian mission hospitals in Ekwendeni and Embangweni led by the Church of Central Africa Presbyterian (CCAP), and two Zambian mission hospitals in Mbereshi and Mwandu led by the United Church of Zambia (UCZ), provided units of analysis for the intra-country and international study. Combined study participants included 38 interview informants and 144 focus group participants across 13 focus groups comprising a range of diverse stakeholders. Data sets were analysed through a combination of content, thematic and matrix approaches. Findings revealed the need for secular management training to be integrated with pastoral care approaches; that hospital workers perceive themselves minimised from inclusivity in management decision-making, and that members of civil society believe themselves marginalised from participation in operation and management of healthcare delivery. Recommendations for systems strengthening are made such as reformation of formal mission hospital management and administration structures to allow wide stakeholder participation. Further, local people should be empowered with capacity and skills to participate in preventive and curative interventions to make meaning from ‘community-based’ healthcare. The study contributes a conceptual model towards this end. Re-visiting collaborative arrangements between church, mission partners and government with stakeholder inclusivity and community voices in mind would help reconstruct the meaning of faith-based community participatory healthcare in this era of a globally networked society, and for southern Africa countries in particular.

TABLE OF CONTENTS

Dedication	III
Acknowledgements	IV
List of Acronyms	V
Abstract	VII
Table of Contents	VIII
List of Figures	XI
List of Matrices	XIII
List of Tables	XVI
CHAPTER ONE: INTRODUCTION AND STUDY OVERVIEW	1
1.1 Introduction.....	1
1.2 Background to the Study.....	1
1.3 Research Problem	2
1.4 Research Question and Objectives.....	5
1.5 Ontological and Epistemological Perspectives	5
1.6 Why this Study?.....	7
1.7 How will New Knowledge from the Study help Faith-Based Organisations in Malawi, Zambia and other Countries?.....	9
1.8 Research Design and Methods.....	11
1.9 Conceptual Definitions	13
1.10 Layout of Chapters	16
1.11 Chapter Summary.....	19
CHAPTER TWO: PUBLIC GOVERNANCE AND NON-GOVERNMENTAL ORGANISATIONS	20
2.1 Introduction.....	20
2.2 Concept of theory, framework and model	20
2.3 Governance Theories	21
2.4 Theory of Corporate Governance System.....	29
2.5 Community-based Healthcare.....	31
2.6 Non-governmental Organisation (NGO) Theories	36
2.7 Church Governance (Systems) Theories	38
2.8 Faith-based Organisational (FBO) Governance System Theories	40
2.9 Chapter Summary	44
CHAPTER THREE: MANAGEMENT OF MISSION HOSPITALS FOR IMPROVED HEALTHCARE	45
3.1 Introduction.....	45
3.2 Churches and Philanthropy	45
3.3 Emerging Challenges and Opportunities for Collaboration.....	47
3.4 Church and Government Collaboration	52
3.5 The Quest for Improved Healthcare	55
3.6 Building a Complementary Conceptual Framework	60
3.7 Meta-conceptual Framework	62
3.8 Chapter Summary	68

CHAPTER FOUR: RESEARCH DESIGN AND METHODS	69
4.1 Introduction.....	69
4.2 Research Design	69
4.3 Philosophical Worldview.....	70
4.4 Transformative orientation.....	71
4.5 Research Strategy	74
4.6 Sampling	81
4.7 Case, Site and Participant Selection.....	87
4.8 Data Collection and Instruments.....	90
4.9 Data Analysis.....	102
4.10 Data Quality Assurance.....	109
4.11 Ethical Considerations.....	113
4.12 Limitations of the Study.....	114
4.13 Chapter Summary.....	115
CHAPTER FIVE: CASE OF THE CHURCH OF CENTRAL AFRICA PRESBYTERIAN IN MALAWI.....	116
5.1 Introduction.....	116
5.2 Country of Malawi.....	116
5.3 The Malawian Church of Central Africa Presbyterian in Context.....	122
5.4 Primary data presentation and interpretation for CCAP Synod and Ekwendeni Mission Station.....	125
5.5 Primary data presentation and interpretation for Embangweni Mission Station	143
5.6 Chapter Summary	152
CHAPTER SIX: CASE OF THE UNITED CHURCH OF ZAMBIA	153
6.1 Introduction.....	153
6.2 The Country of Zambia.....	153
6.3 The United Church of Zambia in Context	159
6.4 Primary data presentation and interpretation for UCZ Synod and Mbereshi Mission Station.....	163
6.5 Primary data presentation and interpretation for Mwandu Mission Station	179
6.6 Chapter Summary	191
CHAPTER SEVEN: COMPARATIVE FINDINGS, INTRA-COUNTRY AND CROSS-NATIONAL.....	192
7.1 Introduction.....	192
7.2 Cross-case comparative analysis of intra-country findings for Malawi.....	192
7.3 Cross-case Comparative Analysis of Intra-country Findings for Zambia	197
7.4 Emerging Themes from the Study	203
7.5 Meta-conceptual Framework and Transformative Worldview	205
7.6 Cross-national Comparative Analysis in Malawi and Zambia	211
7.7 Demonstrating Meta-conceptual Model with Research Questions and Objectives	218
7.8 Chapter summary	238
CHAPTER EIGHT: CONCLUSIONS, RECOMMENDATIONS, POLICY AND KNOWLEDGE PRODUCTION	240
8.1 Introduction.....	240
8.2 Recapitulation of Research Questions and Objectives	240
8.3 Summary of Chapters	241
8.4 Findings and Conclusions.....	244
8.5 Recommendations and Policy Implications.....	246
8.6 New Knowledge Produced in this Study	249
8.7 Concluding Statement.....	252
References.....	253

Appendices.....	264
Appendix A – Semi-Structured Interview Guide (Malawi)	264
Appendix B – Semi-Structured Interview Guide (Zambia)	267
Appendix C – Study Recruitment Informant’s Consent.....	269
Appendix D – Focus Group Discussion Guide	272
Appendix E – Study Recruitment Focus Group Participant’s Consent.....	277
Appendix F – Alignment of Challenges with Emerging Factors / Themes	280
Appendix G – Alignment of Opportunities for Collaboration with Factors / Themes.....	296
Appendix H – Alignment of Improvements with Factors / Themes	304
Appendix I – Ethical Clearance Approval	315

LIST OF FIGURES

Figure 2-2: The selected theories of Non-profit organisation governance.....	31
Figure 2-1: The organisations’ expression of religious identity – 3 System Styles	43
Figure 3-1: Health system cube.....	57
Figure 3-2: Stakeholder theory mirrored in a congregational environment.....	63
Figure 3-3: Integrating meta-conceptual framework in view of challenges and opportunities collaboration.....	65
Figure 4-1: Rudiments of transformative worldview related to the Study.....	73
Figure 4-2: The 3 perspectives of Multi-Grounded Theory	78
Figure 4-4: Generic stages of a format test for data collection tools	101
Figure 4-3: MGT as dialectical synthesis – inductivism & deductivism	104
Figure 4-5: Rationality - integrated data analysis	107
Figure 5-1: Location of Malawi among southern African countries.....	117
Figure 5-2: Organisation Structure at the Synod of Livingstonia	124
Figure 5-3: Location map of Ekwendeni in the town of Mzuzu, Malawi	126
Figure 5-4: Organisation structure at Ekwendeni mission hospital	128
Figure 5-5: Location map of embangweni in Mzimba district, Malawi	144
Figure 6-1: Location Map of Zambia in the Southern Africa sub-region (SADC).....	154
Figure 6-2: The current UCZ organisational structure.....	162
Figure 6-3: Location of Mbereshi in Mwansabombwe district, Luapula Province (among other UCZ presbyteries).....	164
Figure 6-4: Current organisation structure at Mbereshi mission hospital.....	165
Figure 6-5: Location of Mwandu study site in Zambia.....	180
Figure 6-6: Historical bill board that depict the character of Mwandu (along Livingstone Sesheke Road).....	181
Figure 6-7: Current organisational structure of mwandu mission hospital.....	183

Figure 7-1: Integrating meta-conceptual framework in view of challenges and opportunities
collaboration..... 205

Figure 7-2: Transformative worldview reform agenda and voices of stakeholders 208

Figure 7-3: Recasting research objectives embedded with the key research questions 220

Figure 8-1: New Stakeholder-congregational model for strengthening management of Church-led
healthcare 251

LIST OF MATRICES

Matrix 5-1: CCAP Synod Perspectives On Healthcare Management Challenges	130
Matrix 5-2: CCAP Synod Perspectives On Healthcare Management Collaboration	132
Matrix 5-3: CCAP Synod Perspectives On Healthcare Management Improvements	134
Matrix 5-4: Ekwendeni Mission Station Interview Perspectives On Healthcare Management Challenges	135
Matrix 5-5: Ekwendeni Mission Station Interview Perspectives On Healthcare Management Collaboration.....	136
Matrix 5-6: Ekwendeni Mission Station Interview Perspectives On Healthcare Management Improvements.....	137
Matrix 5-7: Ekwendeni Mission Station Fgd Perspectives On Healthcare Management Challenges	139
Matrix 5-8: Ekwendeni Mission Station Fgd Perspectives On Healthcare Management Collaboration.....	141
Matrix 5-9: Ekwendeni Mission Station Fgd Perspectives On Healthcare Management Improvements.....	142
Matrix 5-10: Embangweni Mission Station Interview Perspectives On Healthcare Management Challenges	146
Matrix 5-11: Embangweni Mission Station Interview Perspectives On Healthcare Management Collaboration.....	147
Matrix 5-12: Embangweni Mission Station Interview Perspectives On Healthcare Management Improvements.....	148
Matrix 5-13: Embangweni Mission Station Fgd Perspectives On Healthcare Management Challenges	150
Matrix 5-14: Embangweni Mission Station Fgd Perspectives On Healthcare Management Opportunities For Collaboration	151
Matrix 5-15: Embangweni Mission Station Fgd Perspectives On Healthcare Management Improvements.....	151
Matrix 6-1: UCZ Synod Perspectives On Healthcare Management Challenges.....	167

Matrix 6-2: UCZ Synod Perspectives On Healthcare Management Collaboration	169
Matrix 6-3: UCZ Synod Perspectives On Healthcare Management Improvements	170
Matrix 6-4: Mbereshi Mission Station Interview Perspectives On Healthcare Management Challenges.....	172
Matrix 6-5: Mbereshi Mission Station Interview Perspectives On Healthcare Management Collaboration.....	173
Matrix 6-6: Mbereshi Mission Station Interview Perspectives On Healthcare Management Improvements.....	174
Matrix 6-7: Mbereshi Mission Station Fgd Perspectives On Healthcare Management Challenges	176
Matrix 6-8: Mbereshi Mission Station Fgd Perspectives On Healthcare Management Collaboration	177
Matrix 6-9: Mbereshi Mission Station Fgd Perspectives On Healthcare Management Improvements	178
Matrix 6-10: Mwandu Mission Station Interview Perspectives On Healthcare Management Challenges.....	185
Matrix 6-11: Mwandu Mission Station Interview Perspectives On Healthcare Management Collaboration.....	186
Matrix 6-12: Mwandu Mission Station Interview Perspectives On Healthcare Management Improvements.....	187
Matrix 6-13: Mwandu Mission Station Fgd Perspectives On Healthcare Management Challenges	188
Matrix 6-14: Mwandu Mission Station Fgd Perspectives On Healthcare Management Collaboration	189
Matrix 6-15: Mwandu Mission Station Fgd Perspectives On Healthcare Management Improvements	190
Matrix 7-1: Aligning Categories To Key Informant Questions With Emerging Themes	194
Matrix 7-2: Aligning Categories To Key Fgd Questions With Emerging Themes.....	196
Matrix 7-3: Aligning Categories To Key Informant Questions With Emerging Themes	200
Matrix 7-4: Aligning Categorical Responses To Key Fgd Questions With Emerging Themes	202

Matrix 7-5: Aligning Meta-Conceptual Framework In Rudiments Of Transformative Worldview In Light Of Emerging Themes	207
Matrix 7-6: Aligning Malawian Stakeholder Perspectives In Respective Categories With Emerging Themes	212
Matrix 7-7: Aligning Zambian Stakeholder Perspectives In Respective Categories With Emerging Themes	215
Matrix 7-8: Aligning Stakeholder Perspectives On Healthcare Management Challenges With Emerging Factors	221
Matrix 7-9: Aligning Stakeholder Perspectives On Healthcare Management Challenges With Emerging Factors	224
Matrix 7-10: Aligning Stakeholder Perspectives On Healthcare Management Challenges With Emerging Factors	225
Matrix 7-11: Aligning Stakeholder Perspectives On Healthcare Management Collaboration With Emerging Factors	228
Matrix 7-12: Aligning Stakeholder Perspectives On Healthcare Management Collaboration With Emerging Factors	230
Matrix 7-13: Aligning Stakeholder Perspectives On Healthcare Management Collaboration With Emerging Factors	231
Matrix 7-14: Aligning Stakeholder Perspectives On Healthcare Management Improvements With Emerging Factors	233
Matrix 7-15: Aligning Stakeholder Perspectives On Healthcare Management Improvements With Emerging Factors	235
Matrix 7-16: Aligning Stakeholder Perspectives On Healthcare Management Improvements With Emerging Factors	236

LIST OF TABLES

Table 3-1: Emerging Challenges And Opportunities Ahead In Faith-Based Healthcare.....	52
Table 3-2: Typical Government-Run Health Systems Challenges And Opportunities.....	55
Table 4-1: Units Of Analysis And Proposed Sample Size.....	81
Table 4-2: Sampled Units Of Analysis (Actual).....	84
Table 4-3: Principles Used For Framing Study Phases.....	91
Table 6-1: The UCZ Statistics For Zambia As At December, 2010.....	161
Table 8-1: Research Questions And Objectives.....	240
Table 8-2: Challenges Of Church-Led Healthcare Management And Administration.....	244
Table 8-3: Faith-Based Organisations And Government Collaboration.....	244
Table 8-4: FBO Management Reforms For Healthcare Management And Administration.....	245
Table 8-5: New Knowledge Produced In The Study.....	250

CHAPTER ONE: INTRODUCTION AND STUDY OVERVIEW

1.1 Introduction

This chapter introduces the study by considering the background and offers a rationale prompted by the over-arching question, ‘Why this study?’ Why investigate Faith-based organisational (FBO) management, as a means to strengthening church-led healthcare provision particularly in Malawi and Zambia?

Among others, the problem includes the evidence of chronic health complications such as maternal health given the vulnerability of women and children with statistics that demonstrate this as a challenge in many countries on the African continent. Preliminary literature searches particularly, Bielefeld and Cleveland (2013: 455) show that there has been lack of research on the management of FBOs until a great deal of concern was raised about how faith entities should be studied and how different methods could be used. There is a thread missing confirmed through literature that the study seeks to tie-up in an attempt to provide remedy. Identified differences and imbalances related to healthcare systems manifested through religion and health in the management of service delivery in healthcare can be problematic. The difference with this study is that its point of departure is with particular ontological and epistemological assumptions which contribute to filling the gap. The ontological and epistemological perspectives of the study within the Malawian and Zambian context are brought to the fore whilst showing the study contribution, namely, new knowledge gained from the research undertaking, which will help FBOs providing healthcare for Malawi, Zambia and other global South, African countries in this field. Furthermore, this introductory chapter focuses on the research problem, key research questions and respective research objectives that are central to the study in view of the research design and methods used. Conceptual definitions of key terms used in the study and the layout of chapters are included, with a summarised version of conclusions provided at the end of each chapter.

1.2 Background to the Study

The international community, particularly the United Nations (UN), had prioritised the issue of health and well-being on the global agenda for development from the Millennium Development Goals (MDGs) of the year 2000, and re-established in the post-2015 development agenda. Key findings in the MDG Gap Task Force Report (2015) show that formal development assistance increased by 66 percentage points from the time of inception of MDGs in an effort to hasten the pace of pursuing the development agenda.

Nevertheless, major gaps persist in development aid to Least Developed countries (LDCs) and developing countries. Designing the post-2015 development agenda gave rise to 17 sustainable development goals (SDGs) that would guide action for the next 15 years to transform our world.

Consequentially, the SDGs have been set in three priority areas and this study seeks to examine health as it stands out in the first set of SDG priorities in the new path of development. The need to think about why its delivery management should be strengthened is compelling. Thus, every country with a particular healthcare system is guided by a national health policy and various instruments that point to sustainable development. Improvements scored in the national healthcare system are measured through its performance which otherwise assesses the progress made by its health institutions such as hospitals, district health offices, rural health centres, health posts and training institutions (National Health Policy, 2013:7). In order to administer this policy's implementation process, the provincial health office, which is a supervising arm of the health sector at sub-national level, gathers data. Data sets are analysed for making decisions and offering suggestions on how the identified gaps could be addressed. The objective of assessing performance particularly in general administration, systems strengthening and governance is to strengthen health facility operations, financing arrangements and governance for the purpose of better delivery of healthcare.

The scenario does not exclude religious organisations which provide other philanthropic services than the faith-oriented in the form of education and health. Clarke and Ware (2015: 39) posit that “religious groups have long provided education and health facilities in both their home countries but some also in their foreign countries – often long before nation-states provided such institutions.”

The background and context of the study is typical to the Church of Central Africa Presbyterian in Malawi (CCAP) and the United Church of Zambia (UCZ), which both own two mission hospitals each namely; Ekwendeni and Embangweni of Malawi and Mbereshi as well as Mwandu of Zambia covered as units of analysis in this research undertaking and this is briefly discussed as part of Section 1.8.2 and explained fully in Section 4.7.1.

1.3 Research Problem

There are statistics that show that some of the diseases from which African people are dying, people on other continents are receiving sufficient health care delivery and living. For instance, WHO (2016: 46) states that globally, in 2013, an estimated 73% of maternal health related cases were attended to by skilled staff during childbirth while 27-40% were not.

Those in the latter category apply largely to people in the developing world. This suggests a disparity in health-care delivery in different continents.

In other words, health care provision on the African continent exhibits inequalities. WHO (2016:110) recently measured progress on the sustainable development goal associated with health-related targets. Comparative statistics between African countries and those on other continents are noteworthy. This is particularly true, thinking of women and children as vulnerable populations. For example, life expectancy between regions show that in Africa, women often only live until age 58 whereas the general lifespan of European women is 80 years. Comparing Japan and Malawi, the life expectancy of Malawian women is 59 years, whilst the life expectancy of Japanese women is 86 years; a 27 year difference in life spans of the women in the two countries. The difference of life expectancy between Zambian and Japanese women is higher, with the life span of Zambian women being 43 years compared to that of Japanese women at 86.

Regarding children, Marmot (2008:5) posits that maternal health risk is 3-4 times higher in poor countries than in rich countries. For children under five years in Africa there are about 28 deaths per every 1000 live births, translating into 26 more deaths than in Europe where only 2 children under age five die per every 1000 live births. Considering Malawian and Japanese, the WHO (2008) report shows that for every 1000 live births, about 64 Malawian children die under the age of five, compared to 2 Japanese children per 1000 live births.

Moreover, the countries from sub-Saharan Africa record most health-related deaths compared to rich nations of Europe and other parts of the world. Healthcare delivery is a complex phenomenon sitting in African societies characterised by the poor state in which healthcare service delivery is either non-existent or underdeveloped.

Consequentially, a universal call to strong national health systems to address the disease burden and health related issues becomes pertinent. Clearly, government alone cannot provide sufficient public and curative health services delivery. As such, there is need for NGOs and other sectors to be involved in collaborations with government.

FBOs whose core-work is pastoral try to play a pivotal role in the provision of healthcare globally, particularly FBOs associated with mission hospitals – developed by missionaries during colonisation. Experience of FBOs in Christian pastoral care does not necessarily mean that FBO management of healthcare facilities is intact. In addition, there remain inequalities and considerable disparities between developed and developing countries characterising compromised healthcare service delivery.

This suggests that various types of healthcare delivery need to be properly managed. At national level, health disparities exist between urban and rural areas. Questions arise as to how to improve management of healthcare delivery, especially in rural areas. Simultaneously, many underserved and marginalised African communities such as those covered in this study do not seem to fully participate in the delivery of healthcare services. Rather, they tend to perceive themselves to be on the margins of society and alienated by existing healthcare management systems.

To help address these complex problems, this investigation used four rural case study sites in two different developing countries to ascertain social and management factors associated with imbalances and pertinent differences in the delivery of healthcare services. Asomugha, Derose, and Lurie (2011: 50) advance that research literature on church-led healthcare is growing because there are inadequate evaluations on the effectiveness of interventions provided in addressing health and its outcomes. Although this may be true, Lipsky (2011: 26) maintains that there are insufficient benefits brought by FBOs in the delivery of health and related services.

In specific terms, inconsistencies and complexities in religion standing, health and its management systems related to faith-based healthcare service delivery become pertinent. Firstly, religious wise, FBO service delivery is characterised by the tendency to use teachings about faith in God to compliment the service of healthcare which is less manifested in government-led service delivery. There is a common belief in the ecclesiastic society which claims that knitting of service and faith together tends to accrue more preventive and curative benefits to recipients overtime than mere healthcare service delivery. Secondly, questions arise about public administration-related institutional arrangements between government and FBOs on the one hand, and FBO management of healthcare facilities on the other hand. Thirdly, clinical wise, considering pitfalls of marginalisation and alienation of historically disadvantaged groups, questions arise as to how to reverse from the apparent top-down approach to a bottom-up approach so as to encourage community participation and integrated solutions to common healthcare service delivery problems. Failure to address such interdisciplinary problems can obstruct meeting SDG health-related targets.

1.4 Research Question and Objectives

In light of the research problem, certain research questions and research objectives were formulated, as stated next.

1.4.1 Research Questions

- What are the challenges that Faith-based organisations face in managing church-led healthcare services for its health facilities?
- How do Faith-based organisations, particularly the church-led management, work with government to improve healthcare provision in its health facilities?
- How can church-led healthcare management and administration services be improved?

1.4.2 Research Objectives

In line with the key research questions, the study seeks to fulfil the following set objectives:

- Deeply explore challenges and opportunities for church-led healthcare management and administration services.
- Examine in depth the ways in which church-led management works with government to improve healthcare provision in its health facilities.
- Determine strategies for Faith-based organisational healthcare management and administration reform.

Having considered the vital elements in the problem prompting the study, research questions central to the study and research objectives, the next section discusses related ontological and epistemological perspectives.

1.5 Ontological and Epistemological Perspectives

Creswell (2014: 5) points out that the term ‘worldview’ means a certain set of beliefs that guides action; further stating that other points of view refer to this basic set of beliefs as paradigms or epistemologies and ontologies. It follows that ‘paradigm’ is a term that may be used for description of types of methods. Therefore, the perspectives of a study, according to Denzin and Lincoln (2009: 105), define the paradigm as a certain belief system or worldview which guides the researcher, in not only choices but also in fundamentally ontological and epistemological ways. Creswell (2009: 6) maintains that the “approach to research involves philosophical assumptions as well as distinct procedures”, and emphasises the need for a study to be explicit on the philosophy (or simply the ideals it espouses), which explain the choice of approach to the research.

Lately, there are paradigms that have competed for acceptance as methods of choice in informing and guiding investigations, especially qualitative inquiry. These paradigms or worldviews are positivism, post-positivism, critical theory, social constructivism and transformative worldview.

Positivism is rarely associated with qualitative inquiry, given its feature of absolutism. Rather than perceiving these paradigms or worldviews as being basically competitive, some researchers use multiple paradigms or philosophical worldviews in interchangeable ways.

In this study, a combination of social constructivist and transformative (to mean advocacy-participatory) worldviews are used. Social constructivism, according to Creswell (2014: 248), holds a view that individuals seek to understand the world in which they live and work, while the transformative worldview holds that “research needs to be intertwined with politics and an action agenda for reform that may change the lives of people and institutions (Creswell, 2014: 250)”. These paradigms were selected to understand how service recipients of healthcare who are community members construct their world and to give them a voice in terms of how the disconnect between the need for better FBO management and for optimum healthcare provision, could be bridged. Research inquiry paradigms define for inquirers what it is that they are about, and what falls within and outside the limits of legitimate inquiry. The basic set of beliefs that define inquiry paradigm can be summed up by responses to three questions pertinent to the study: ontological questions, epistemological questions and methodological questions.

In other words, the study seeks to understand ontologically and epistemologically ‘reality constructed’ by people in relation to the management environment of healthcare provided by Ekwendeni and Embangweni facilities in Malawi, as well as Mbereshi and Mwandu health facilities in Zambia. The ontology and epistemology of the study is that people can construct their own reality to the extent of how they perceive the world they work and live in. The aim of the study was to understand how FBO management capacity contributes to strengthening healthcare provision at national and local levels, so that it could be re-modelled regionally, continentally and globally in the wake of sustainable development goals (SDGs).

For the purposes of this study, two questions were asked in an interconnected way to gain understanding on the subject under investigation. These, in the words of Guba & Lincoln (1994: 108) as follows:

1. Ontological question – “what is the form and nature of reality and therefore what is there that can be known about it?”

2. Epistemological question – “what is the nature of relationship between the knower or would- be knower and what can be known?”

The ontology and epistemology in which the research design is embedded entails defining classes, relationships and instances in management approaches found in church-led health care provision, particularly in Malawi and Zambia, in fulfilment of prudent leadership and governance functions. Systems strengthening opportunities ensure sound FBO management for improved healthcare as emphasized in the WHO six building blocks (WHO, 2009: 7) one of which is service delivery. The study attempted to ascertain FBO service delivery management and development challenges as well as opportunities, in light of the collaborative partnerships between church and government, especially service provision, within the context of the social constructivist paradigm integrated with transformative worldview, previously tagged as advocacy-participatory (Creswell, 2014: 9).

Given the focus of this study on strengthening healthcare provision in Malawi and Zambia, the argument of Lumsdel, Hall and Cruickshank (2011: 248) that developing ontology can be helpful in designing and implementing integrated systems, is valid. Health care systems that are available and related service delivery to clients from surrounding as well as outlying communities, using the ‘top-down’ approach, do not seem to be working anymore. There is a need to bring in the ‘bottom-up’ approach to attempt strengthening healthcare service delivery provided by mission hospitals.

Therefore, in tackling the research problem better, the study uses bigger lenses to employ an ontological and epistemological focus then brings in afterwards the transformative worldview to link with different parts covered in the research undertaking. Simply put, an ontological and epistemological perspective is a bigger focus than the transformative worldview, and is further discussed in Chapter Four on research design and methods.

1.6 Why this Study?

While Faith-based organisations (FBOs) play a leading role in healthcare delivery across the African continent, there is little information on FBO service delivery management and development challenges, as well as opportunities. In addition, collaborative partnerships between government and FBOs in Malawi and Zambia as well as other countries in Southern Africa have quite often not been the focus of empirical study. Savage, Bunn, Gray and Williams (2010: 21) posit that “social partnerships are ‘collectivities’ of organisations that come together to solve problems that cannot be typically solved by an organisation alone”.

Specifically, there is a knowledge gap related to theory and practice in the management of healthcare provided by the Church of Central Africa Presbyterian (CCAP) in Malawi and the United Church of Zambia (UCZ) in Zambia, whose core work is ecclesiastical business (generally viewed as pastoral care in this study). Furthermore, Lumsden, *et al.* (2011: 249) advance that at the moment, there is lack of state of knowledge in inter-related systems and their processes for ensuring adequate epistemology. Further, it takes a practitioner to adopt a systematic approach to in-house ontology design that brings together theoretical underpinnings and its application. This study seeks to establish existing knowledge which may assure sufficient epistemology for church-led healthcare management systems and the subsequent careful adoption of in-house ontology that pacify the gaps between theory and practice in Sub-Sahara African countries on the regional and continental end.

Globally, scholars such as Chee, Pielemeier, Lion and Connor (2012: 85) state that “there is increasing recognition that efforts to improve global health cannot be achieved without stronger health systems”. While this study is aimed at making a proactive contribution towards strengthening church-led healthcare provision in Malawi, Zambia and other countries in Southern Africa, it is also targeted at strengthening systems of healthcare provision in the African continent.

Consequently, Lumsden, *et al.* (2011: 248) and Chee, Pielemeier, *et al.* (2012:85) observe that there is a relationship in the need for the study between lack of information on the role of FBO management theory as well as practice and the need for improved service delivery through stronger health systems that call for enhanced collaboration with various stakeholders.

Therefore, the study of management of mission hospitals in an integrated manner with relevant stakeholders for improved healthcare provision is both necessary and important. If most not-for-profit and faith-based organisations (FBOs) like the Church of Central Africa Presbyterian in Malawi and the United Church of Zambia in Zambia could learn from the findings, then challenges and opportunities determined from this study could help the mission hospitals target innovative management interventions and development-set strategies better.

According to Bielefeld and Cleveland (2013: 455), lack of research on FBOs and how they could be studied, ties in with Asomugha, *et.al* (2011: 50), who argue that there is not much rigor in their effectiveness in tackling health outcomes. Lipsky (2011: 26) further maintains that little thorough research has been done to determine advantages that come with service delivery. One therefore asks; what would happen if the current study was not conducted and what is it that could get worse?

Putting it differently, what issues will continue to persist if the existing problem is not resolved? If the problem is not resolved, the work of FBOs in healthcare service delivery challenges and opportunities would firstly, get worse and go unappreciated, while the eminent lack of rigorous study would be on the increase creating a wider gap in the literature. Secondly, there will be weak integrated government and FBO management, resulting in poor healthcare service delivery and this will affect the SDGs on health, especially for the countries covered in the study.

Most important, the literature search above shows a knowledge gap about prior studies conducted without strong designs, limiting the ability to interpret what works and what does not work in an integrated government and Church-led healthcare system. Understanding what works calls for an interdisciplinary approach. Vigoda (2002:3) advances that an interdisciplinary approach attempts to provide an oversight into complexity of the field of public administration in broad terms by combining different levels of analysis into an integral whole, which better accords with reality. Further, Vyas-Doorgapersad, Tshombe and Ababio (2013) further posit that the interdisciplinary approach involves a view of multiple disciplines. This study therefore entails an interdisciplinary approach by considering FBO-led health care, management of that health-care delivery as well as the religious tenets of the church as these pertain to management of health-care delivery. This is worth studying because churches are generally more concerned with pastoral care than management of health care delivery.

The next section reviews how the new knowledge generated from the study will help FBOs in countries under investigation and other developing states in the sub-region of southern Africa.

1.7 How will New Knowledge from the Study help Faith-Based Organisations in Malawi, Zambia and other Countries?

Implementing the outcome of better Faith-based organisational management and development strategies from the study, could make a significant difference in the way the church supports the provision of healthcare service delivery to people in communities around its mission hospitals in Malawi and Zambia, as well as other countries in Southern Africa such as South Africa. Nolte (2010: 894) states that the way in which governance is designed and instituted has a significant bearing on power-sharing in the region.

Thus, this is a cross-national study undertaken in the interest of development and cooperation, for Malawi and Zambia being sovereign states to various regional bodies, significantly the Southern Africa Development Community (SADC), while being part of the overall continental body, the African Union (AU).

In addition, Duff (2015: 1792) observes that delivering on the global goal of healthcare for poor people and the marginalised can be realised through the engagement of concerned stakeholders through close collaborative ties between public sector and faith-based entities as critical players. In engaging public sector and faith-based groups for collaboration, Lentz (2010: 282) adds that FBOs have contributed a great deal in providing health services especially in rural places with no prior access to health services. Further, despite the pressure in both high rate of HIV/AIDS infection and pockets of high level poverty, Zambia's fight against the pandemic resulted in a decline from 15.6% in the year 2001 to 14.3% in 2007. It is against this background that the Malawi and Zambia governments leverage funds they receive from international partners and distribute them. The recipients are indigenous government organisations and FBOs which deliver health services and whose partnership contributed immensely to the prevalence rate reduction country-wide and ultimately, to the sub-region of southern Africa.

Furthermore, while regional integration and globalisation are appreciated, Nolte (2010: 891) maintains that countries that are with strong governance systems in the region form structures and regulate tools that tend to be in their favour while making other countries fragile as in weaker states. Yet, weaker states take rules which offer opportunities, namely, for challenging the sovereignty of stronger countries based on founded rules as well as procedures, for sharing common concerns and garner support of other countries, and for an allowance that facilitate building coalitions to put up norms for restraining influence of stronger countries.

The significance of the study is that the recommendations drawn from the challenges established from the investigation could provide a pathway towards opportunities for optimum service provision, sustainable collaboration and improved healthcare. This can only be achieved if indigenous religious organisations such as churches, its FBOs, government partnership and community-opinion leadership could enhance working together in an integrated way to expand the message of strengthening church-led healthcare provision through tested community-based approaches.

1.8 Research Design and Methods

The study is characterised by a particular research design and methods. This section focuses on the philosophy of the research underpinned in an interpretive qualitative design with an exploratory investigation. Sampling is considered in line with case, site and participant selection followed by data collection, presentation and analysis, while quality control dimensions are laid to assure quality in the data. Ethical considerations are then highlighted, ending with limitations to the study. The research design and strategy are further discussed in Chapter Four, showing how the case study strategy was used, and including the need for multiple cases. The multiple perspectives gained made a study of this magnitude richer.

1.8.1 Research design

The design and philosophical worldview underpinning the study employed an interpretive qualitative enquiry pointing to exploratory research in the end. The qualitative study design is supported by the sub-paradigm of the transformative worldview to explore and use with an appropriate research strategy.

1.8.2 Research strategy

In this research, a case study strategy was employed which included multiple cases during case, site and participant selection. Multiple cases formed up the units of analysis according to stakeholder segments; healthcare workers, church and community members, and Synod clergy with the laity. Furthermore, justification of case, site and participant selection is discussed briefly in Section 1.8.4 and fully in section 4.7. The case study strategy was used in tandem with multi-grounded theory (MGT) based on background understanding to grounded theory.

1.8.3 Sampling

The study used non-probability technique in light of purposive sampling. Purposive sampling was adopted in this research on the grounds that the strength of qualitative research in an exploratory-driven approach tends to be more flexible in terms of the accessing a specified sample and sample size.

Meanwhile, a total of 182 people participated in the study, with 38 Interviewees (mainly the Clergy and Laity) and 144 focus group participants (who met in 13 focus groups characterised by health workers, church and community members).

1.8.4 Case, site and participant selection

In this study, there were two cases covering four mission stations taken as study sites, involving Malawi and Zambia as countries selected on the basis of geographical location to each other. Also, CCAP and UCZ are FBOs that own mission hospitals with a similar community advantage of having two mission hospitals each. The four study sites are Ekwendeni and Embangweni of Malawi as well as Mbereshi and Mwandu Mission Hospitals for Zambia.

In the selection of participants, proximity was pertinent to church and community members, health workers and church synod officials for both countries.

1.8.5 Data collection and instruments

Data collection was done between January and March, 2014, from multiple study sites in each synod head office and respective mission stations. The data collection assignment was informed by the cross-national itinerary between the two countries chosen in the study. The process of administering the data collection instruments involved conducting in-depth interviews with selected members of the clergy and the laity at the two Synod offices using the approved semi-structured interview guide (in Appendix A). Focus group discussions were conducted with selected health workers and church as well as community members in line with the FGD guide (in Appendix B).

1.8.6 Data analysis

At the time of data presentation and interpretation, using the memoranda review for Multi-grounded theory, data was analysed in line with content, matrix and thematic analysis.

1.8.7 Data quality assurance

This section will discuss quality control measures used for data validation and ensuring reliability in line with dependability and credibility as basic criteria for ascertaining the soundness of research undertaken in view of the variations in quantitative and qualitative methods. The data validation process is further used as an appropriate control measure applied to assure quality of data for the qualitative study covered in this research under faith-based organisational management, particularly in the provision of church-led healthcare.

1.8.8 Ethical considerations

The study will discuss how research is guided by the Humanities and Social Sciences (HSS) Committee through the School of Management, Information Technology and Governance of the

University of KwaZulu-Natal, with its code of ethics for research on human and related subjects. In light of the full ethical clearance approval in the appendices page (Appendix I – Protocol HSS/1141/013D), the study was undertaken in strict conformity to the code.

1.8.9 Limitations to the study

The study will discuss two limitations encountered. Some participants were known to the researcher, affecting the way certain responses could have emerged and reluctance to disclose all material facts vital to answering to key research questions. The other is long distance travel. Strict conformity to ethical rule and being flexible in the field helped to avert the said limitations.

1.9 Conceptual Definitions

This section reveals the working definitions used as key terms in light of concepts, theories, frameworks and models used in the study. These conceptual definitions as they relate within broad sense of administration are defined, explained, justified and applied in Chapters Two and Three, while linking them with parts of other chapters constituting the study with focus on FBO management for strengthening healthcare service delivery.

1.9.1 Civil society

Civil society is described as a type of social movement, organisation, group of people and individuals, who do things together in order to transform the communities where they work and live (Kaldor, 2010:12). The term ‘civil society’ is sometimes used interchangeably with the term ‘community’. In this study, church and community members constitute a part of civil society.

1.9.2 Community-based healthcare

This may be seen as a system where lay members of the society participate in promoting health-seeking behaviours among members of the society, using various activities from extended clinical care to people who are felt to be at a health-risk or community members in need of healthcare, to undertake prevention (Scott and Shanker, 2010:1607). Simply put, this is the mobilisation of community relationships influencing local healthcare.

1.9.3 Faith-based Organisation

A religious entity, according to Kondra and Hurst (2009:38), is governed by a system that is based on the intentionally-shaped culture of congregations (or faith communities) from which they were

initiated to provide philanthropic service or for supporting development. Most FBOs are non-governmental and are seen as such for the purpose of this study.

1.9.4 Health system

This is also referred to as healthcare system (or simply healthcare), and is described as the mobilization of people, institutions and resources that provide health services to meet the health needs of a targeted population (Armstrong-Mensah, 2017: 131).

Similarly, WHO (2007) maintains that a health system constitute an arrangement of people, institutions and resources according to established policies with the primary intent to improve health of target populations. Improvement of health is the core-function of a given government guided by policy implemented to address essential care services especially at a national and sub-national level. In particular, the division of strengthening of health services in WHO has always been policy concern associated with the development of health systems that are based on primary healthcare (WHO, 1991:17).

1.9.5 Non-governmental Organisation

Kaldor (2010:15) describes an NGO as any organisation that is seen as a mechanism that is vital for providing social services without involving government. It includes providing training on democracy and citizenship. In this study, NGOs are taken as non-state actors that provide checks and balances on abuse of authority as well as bad governance in especially developing countries.

1.9.6 Public administration

This is described as a group effort in a public set-up covering all three branches of executive, judicial and legislature, and their inter-relationships for public policy in government (Stillman II, 2010: 2). Earliest and founding scholars in the discipline, such as Wilson (1887: 197) called public administration as an apparatus for performing numerous tasks of government which emerged as a result of perceived deficiencies in decisions. Most recently, other scholars like Dahiya and Singh (2014:57) posit that this is the process of taking decisions by government premised on facets of the broad approach to administration to run the state.

In view of the three conceptual definitions, this study is motivated by Stillman II (2010: 2) whose stance entails the use of teamwork through the three arms of government through necessary coordination to enact, interpret and carry out public policy to manage affairs of the state

1.9.7 Public governance

This is an approach that involves the processes of providing administration and management services in a setting that is characterised by various actors in society (DeGroff, 2009: 2). There is a thin line between governance in public organisations and government.

Additionally, Government refers to functional structures of public settings in which they operate while governance refers to the system by which government gets work done (Kettl, 2015: 5). In this study, the concept of public governance is informed by the context in which relationships largely exist for engaging government with its administrative, social and political structures, in countries such as Malawi and Zambia.

1.9.8 Public management

Roman and Esau (2012:116) describes public management as an international move of public sector reforms inspired by neo-liberal ideology towards greater efficiency and effectiveness by the supposed benefits of introducing business management principles and practices. According to Peters (2010:314) public management is a reforms process to include transfer of operational management and implementation from traditional and highly centralised civil service departments into relatively autonomous and decentralised agencies. The new approach, Public Management, was developed as a response to what was said to be a governance system that is inefficient and ineffective (Anheier, 2014: 346). In this study, the approach is adopted in view of contestations that have said to have, since the 1990s, transformed the way public administration works.

1.9.9 Stakeholders

These are a group of “people or organisations that have a real, assumed or imagined stake in the organization, its performance and sustainability” (Anheier, 2014: 308). They can be in the form of internal and external stakeholders such as health workers (internal) and civil society (external) in this study. Both internal and external stakeholders are crucial and vital segments of the study.

1.9.10 System strengthening

In the context of healthcare, this is a process of making “comprehensive changes to performance drivers such as policies and regulations, organisational structures and relationships across the health system to motivate changes in behaviour and allow more effective use of resources” (Chee, Pielemeier, Lion and Lion, 2012: 86).

The intervention is said to bring about improvements to outcomes of multiple healthcare services such as malaria, reproductive, maternal, newly-born care and child health, HIV/AIDS and Nutrition, among others.

1.9.11 Task-shifting

This is a process that involves “reviewing and delegating some tasks away from clinical staff to non-clinical staff, such as those designated to work in community-based healthcare” (Zulu, Kinsman, Michelo and Hurtig, 2014: 13). Simply put, the practice task-shifting is a process that is said to enable clinical staff to concentrate on the core areas of their vocational expertise especially when they delegate work to other staff such as classified employees (CEs).

To sum up, management and administration of FBOs and Non-government entities which are characterised by the application of some of these conceptual definitions include the international Christian communities such as the Council for World Mission (CWM) and the World Council of Churches (WCC) who provide development and humanitarian assistance. Others include the Council for Churches Health Associations and various global development aid organisations namely United Nations Development Program (UNDP) who comes with development aid, World Health Organisation (WHO) are said to provide service related to health. Collaboration of the FBOs, governments and stakeholders covered in this cross-national resonate with the development assistance sometimes from World Bank, USAID (from the Government of America), DFID (from the Government of the United Kingdom).

1.10 Layout of Chapters

The study is organised into eight chapters. These chapters are chronologically arranged and laid out as follows:

Chapter One – Introduction and Study Overview

The chapter introduces the research and provides an overview in terms of the response to the overarching question ‘Why this study?’ The ontological and epistemological perspectives of the study are premised within the Malawian and Zambian context. Thereafter, the chapter shows how new knowledge from the research will help Malawi, Zambia and other countries. Chapter states the research problem, key questions underpinning the study and research objectives informed by a specific design and strategy, which is further discussed in Chapter Four.

It discusses conceptual definitions to highlight key terms used to describe certain features that are instrumental and the organisation of chapters in the study, ending with a summary.

Chapter Two - Public Governance and Non-governmental Organisations

The chapter introduces public governance theories with particular focus on government administration. It brings out current perspectives on public administration, public management as well as public governance, in tandem with community-based healthcare while highlighting the appropriateness of a specific stakeholder approach. Non-governmental organisations theories are brought to the fore, highlighting the work of FBOs in healthcare. The theory of corporate governance in light of Non-profit organisations and Faith-based organisational systems of governance eminent in the management of mission hospitals for better healthcare delivery, particularly for Malawi and Zambia, are examined.

Chapter Three – Management of Mission Hospitals for Improved Healthcare

This chapter discusses FBOs, particularly the church and government philanthropy relationships, giving historical perspectives with emerging challenges and opportunities that lie ahead. Church and government collaboration is further explored in the quest for improved healthcare provision while engaging systems strengthening as a management intervention for better healthcare outcomes. Envisaged improvements and why we should strengthen healthcare systems is also addressed. In this chapter, the meta-conceptual framework driving the study is discussed against multi-grounded theory as an extension and alternative to grounded theory.

Chapter Four - Research Design and Methods

Research design embedded in the qualitative form of inquiry is discussed in the wake of the transformative (previously coined as advocacy-participatory) philosophical worldview, with the appropriate research strategy. The case study approach with a focus on multiple case studies is evident. The case study (or telling the story) in light of grounded theory and multi-grounded theory, gives helpful insights into the units of analysis. Case, site and participant selection, including sampling, are highlighted before a discussion on conducting a format fitness test for data collection instruments: semi-structured interviews, focus groups and documentary evidence as well as observations. Data analysis is discussed in line with content, thematic and matrix approaches.

Chapter Five - Case of the Church of Central Africa Presbyterian in Malawi

The chapter focuses on the country context of Malawi and that of the Church of Central Africa Presbyterian in Malawi.

Further, data presentation and interpretation for both Ekwendeni and Embangweni Mission Hospitals in Malawi through interviews and focus group discussions is presented for different stakeholder segments, whilst interrogating the literature in Chapters Two and Three, as well as other parts of the study.

Chapter Six - Case of the United Church of Zambia in Zambia

This chapter focuses on the country context of Zambia before that of the Church of the United Church of Zambia. It includes data presentation and interpretation for both Mbereshi Mission Hospital and Mwandu Mission Hospital in Zambia, using interviews and focus group discussion meetings by segmentation of different stakeholders. Data sets are analysed in line with content, matrix and thematic analysis while interrogating literature.

Chapter Seven - Comparative Findings, Intra-country and Cross-country Analysis

The chapter considers a cross-case comparative analysis of intra-country findings. The intra-country cross-case comparative analysis of findings in Malawi's Ekwendeni and Embangweni Mission Hospitals is proactively followed up with the help of relevant tables of matrices. Similar cross-case analysis was comparatively made for Zambia against Mbereshi and Mwandu Mission Hospitals. Cross-national comparative analysis is then interrogated between two countries: the country of Malawi within the context of Ekwendeni and Embangweni mission stations as well as Zambia with the context of Mbereshi and Mwandu mission stations.

Chapter Eight - Conclusions, Recommendations, Policy Implications and Knowledge Production

The study conclusions and fulfilled objectives are firstly presented here in a threefold approach by deeply exploring challenges faced by the FBOs and opportunities available now and ahead in performing management functions for improved healthcare delivery. Secondly, the study also provided an in-depth examination of the extent to which the government of Malawi and Zambia work together with the church for improved healthcare delivery. Third and lastly, what the study produced as the foundational factors such as clinical, doctrinal and structural perspectives that

contribute to FBO management reform in healthcare administration and development, particularly the UCZ of Zambia and CCAP of Malawi, are discussed. A set of recommendations with related policy implications and knowledge produced thereof, are the ultimate highlights and concluding statement of the research.

1.11 Chapter Summary

This chapter has considered the overall question ‘Why the study?’ outlining some of the ontological and epistemological perspectives evolving around the question, the historical background to FBO work particularly of the church and the discharge of its related philanthropic mandate. The issue of how new knowledge generated from the research will contribute to the development of countries has been explored, explored for Malawi and Zambia, including for the Southern Africa sub-region.

Furthermore, the research problem in line with the literature review unveils the knowledge gap in theory and practice of the management of healthcare delivery provided by the Church of Central Africa Presbyterian in Malawi and the United Church of Zambia, whose core work is pastoral care. The central questions and pertinent objectives around the research problem were explored whilst tackling the issue of making this study a proactive contribution towards strengthening church-led healthcare provision in Malawi, Zambia and other countries in Southern Africa, as significant outcomes of the study.

CHAPTER TWO: PUBLIC GOVERNANCE AND NON-GOVERNMENTAL ORGANISATIONS

2.1 Introduction

The study has two chapters on the review of literature. Chapter Two covers public governance and Non-governmental organisations (NGOs) and Chapter Three focuses on management of mission hospitals and the quest for improved healthcare. The review of literature has a purpose in providing a contextual framework for the investigation into resolving the key research questions.

This chapter discusses public governance and NGOs in a contemporary context narrowed down from the broad discipline of administration set in the literature review Chapter One. It reflects on the discipline of public governance which is preceded by discussions on public administration and public management theories and community-based healthcare. The discussion on NGOs initially focus on corporate governance in non-profit entities and thereafter on how the theory relates to Faith-based organisations (FBOs), particularly church governance systems in relation to healthcare provision. This flow creates a base for discussing the management of mission hospitals and the quest for improved Church-led healthcare provision (covered in Chapter 3).

2.2 Concept of theory, framework and model

This section defines what a theory is and how is this said to be used within a framework and model. De Coning, Cloete and Wissink (2011: 32) define theory as “a comprehensive, systematic and reliable explanation as well as prediction of relationships among specific variables”. Further, a framework is a set of beliefs, ideas or rules that is used as the basis for judging and deciding. This can be a process marked by a form of change which points to a particular result. In this study, the term ‘theory’ may be used interchangeably to imply framework or both in an integrated manner for the expression of such theoretical framework. In addition, a model is basically said to be a pattern. Meanwhile, a detailed explanation on the term ‘model’ is required. According to De Coning et al. (2011: 32), it is “a representation of complex reality that has been oversimplified in order to describe and explain the relationship among variables and sometimes to prescribe how something should happen”. Complex reality entails an array of different interconnected parts or things that are not easily understood in an actual (or not imagined) situation. For instance, an Architect may design a 3-storey house but to envision how a real building will look like, this may be made simple to

understand if interpreted with a toy ‘wire-made and board-crafted’ 3-upstaired house. For the purpose of this study, a model shall imply a simplified version of complex reality.

The section that follows discusses governance and other theories, some of which are pertinent to this study about faith-based organisational management for strengthening church-led healthcare service delivery.

2.3 Governance Theories

Maldonado (2010: 4) advances in the African study of World Bank’s dynamic “concept of good governance”, that governance is “the exercise of political power to manage a nation’s affairs”. Today, political power, according to Rose and Miller (2010: 272), “is exercised through a provision of shifting alliances between diverse authorities in projects to govern a multitude of facets of economic activity, social life and individual conduct”.

Anheier (2014: 231) asserts that governance is about attaining a balance between the mission of an organisation and how it performs is ascertained with its activities. In some circles, the word ‘governance’ is used interchangeably with ‘government’ to imply that there is a thin line with no much difference. In this study, a distinction is drawn between governance and government. The distinction is adopted, according to (Kettl, 2015: 5), because “government refers to structure and function of public institutions while governance refers to the way government gets the job done”.

In light of Anheier (2014: 231) and Kettl’s (2015: 5) assertions, governance theories will be discussed in three strands: public administration, public management and public governance. Public governance will in this study be amplified by the perspective of community-based healthcare in order to further broaden the service delivery basis thereby allowing participation from the closest people who seek and receive the quality of care. This, in a way, is one system in which government gets the work done.

2.3.1 Public Administration

There are many contestations around the definition of the discipline of public administration. As earlier stated in the prior chapter, Stillman II (2010: 2) maintains that public administration is a group effort in public institutions of government being executive, judiciary and legislature with their inter-disciplinary approach for carrying out public policy. As a broad concept within which the study is specifically embedded, group effort as a concept is a unique approach that is thus part of politics-administration dichotomy in the running of the affairs of the state. In this dichotomy, the

government affairs of say Malawi and that of Zambia are run by politicians and administrators. Scholars such as Peters (2010:37) in the politics of bureaucracy posit that political leaders and government administration managers are inseparable in their bid to provide service delivery. In this study, the broad and similar view that politicians such as a Minister of Health in Zambia make policy pronouncements related to government intensions for instance the National Health Policy is concomitant to implementation. Implicitly, any policy formulation without action amounts to nothing. To remedy this, Pollitt (2006:41) adds, it is the role of an essential public manager such as the Permanent Secretary of say the same Health ministry to ensure implementation is carried out within the bureaucratic confines of government administration.. In stressing the importance of the understanding administrative institutions of government, Wilson (1887) maintains that the discipline of public administration is intended to “strengthen the paths of government, make its business less un-business like, strengthen and purify the way it is organised and crown its duties with dutifulness” it deserves (p. 201). For the purpose of this study, the conceptual definition is adopted to cover broadly the three branches of government which provide public goods and services to members of the community who are in need. This includes the challenges faced in the delivery of health goods and services.

Nevertheless, Vyas-Doorgapersad, Tshombe and Ababio (2013: 7) posit that the organisation of government at large scale is an extremely complex activity that is categorically influenced by issues such as political ideology, level of constitutionalism, societal democracy, economic situations and geographical considerations. In addition, some functions are centrally carried out at national government while others are decentralised to regional and local levels for the people requiring the service.

Blair (2015: 789) asserts that “there are serious problems in how the federal government of the United States of America (USA) manages failures ranging from the launch of the Affordable Care Act through healthcare government sites to hacks in the government staff and security system databases”. This entails that the said challenges in this system show that managing the delivery of health care services can have adverse effects on the way government works leading to decrease in trust that people has in government. In light of Blair’s (2015: 789) assertion, Kettl (2015: 3) further states that “public trust in government has been in steep decline, a condition that government seems better at aggravating than remedying”. The problem of mistrust could be further exacerbated by the attitude and style of work by government workers which develop over a period of time in the administration of public service affairs.

To avert some of the public service challenges, governments globally are merely “muddling through,” a reaction of public service workers to an exposition that will be less new approaches than being better acquainted with the old method of doing work (Lindblom, 1959: 88). Furthermore, by becoming more conscious of their practice of this method, administrators in public service practise it skilfully and know when to apply it or not. This entails that some governments around the world use experienced public administrators who skilfully try what works and what does not – they are merely ‘muddling through’. The case in point which may be typical of traditional public administration is the government of Zimbabwe, with a prolonged stay of its president in office for several decades. The presidency of that country apparently became more acquainted with less-known methods, regardless of whether they are applied or not. They have tried what works and what does not.

Over time, Lindblom’s ‘theory of muddling through’ has been challenged by the cornerstones of public administration. In contrast, while Kettl (2015: 3) maintains that the situation of fast-running trust decline lacking remedial measures and the not just historical but traditional theory and practice of ‘muddling through’ (Lindblom, 1959: 88) in public administration.

The Blair (2015: 790) study suggests ways in which the programme management experts and the National Academy of Public Administration recommended how to strengthen government’s ability to manage large-scale and complex change interventions for a number of projects. Conditions under which the recommendations would strengthen programme management practices, among others, included an integrated approach to the development of policy related to government-wide programme management. Furthermore, oversee implementation while integrating programme management with strategic planning, goal setting and performance improvement processes. Others include, organising program management officials from national-level government to subnational for advice on government-wide policy and share lessons of good practices including overseeing resources.

In line with interventions to contribute to remedying government mistrust, knowing where it likely stems from, is vital to existing theory and practice of public administration. Cook (2012: 8) in the study on George Washington’s American public administration, states that understanding historical development of public administration enhances knowledge of current theory as well as practice. Three areas were established: the revolutionary, the reform/progressive and the modern era. The revolutionary era included in this period of continental congress through George Washington’s second presidential term of office, while the reformer/progressive era conformed to the reformation

of the mid- to the late nineteenth century. The modern era included the mid- to the early twentieth century from progressive times to the present.

Clearly, at the core of the evidence of a theoretical gap between government and governance (Kettl, 2015: 5), where government refers to structural function of public organisations while governance refers to the system by which government gets work done, the theory and practice of public administration has evolved over time. The scenario could have given rise to other disciplines such as public management and most recently, public governance. The subsequent sections discuss public management and public governance, as earlier stated in the contemporary context.

2.3.2 Public Management

Recent scholarly assertions such as Pollitt (2006:27) posit that public management comprises a shift from inputs and processes towards outputs and outcomes. This entails a focus on not just what government puts in and the processes that come with it but move on to quantification of outputs that translate into service delivery outcomes. For instance, would government's intentions to build more health facilities at every 100km radius as a matter of health policy in Zambia help to reduce congestion of people seeking health services at the district or provincial level hospital? In addition, Anheier (2014: 346) maintains new public management approach was developed as a move to respond to what was seen as inefficient and ineffective government bureaucracy and one which has, since the 1990s, evolved the way public administration works. It has, among others, doctrines of re-organization of the public sector into corporate units organised along product and service lines. This includes having placed emphasis on the use of private sector styles of management practice, including more flexible hiring and firing, greater use of marketing and improved budget policies, and finally, foregrounded output rather than input controls.

Overtime, various studies have been conducted and in countries such as South Africa where public management has been introduced Roman and Esau (2012:118) advance that the global move to reform public sector has had a wide ranging impact on all aspects of public service provision. With particular reference to financial management, the application of principles of the new liberal ideology has emphasised prudence in value for money, delivering more services for less tax money, increased accountability for results, greater transparency and devolved financial responsibility as espoused in the Public Financial Management Act 1999. In addition, the Ruffin (2010: 69) study on hybrid governance and network management advances that public management is not solely intra-organisational; rather, it is like public service delivery and policy making as well as implementation

that is accomplished through networks of meta-sectors, particularly multi-organisations, to which business improvement districts (BIDs) are no exceptions. With this in mind, Vyas-doorgapersad et al. (2013: 127), in a related study, point out that a government should address society's problems and achieve certain objectives on the basis of four things: the most effective way to establish order, cooperation and coordination between as well as among organisations at different spheres of government; ascertaining command chain allocation of resources with a system of cooperation and inter-government relationships; location of power and authority to carry out various functions to particular entities at national, provincial and local sphere of government, and the manner in which complex institutions of this magnitude are organised into especially line and support functions.

Further, this entails that public management taps into well-established principles of management such as the need to build effective accountability mechanisms, most of which are drawn from the business world. Most business entities in private sector focus efforts on profit as the ultimate while public sector focuses on service delivery. Murray, Islam and Pirola-Merlo (2012: 522) state that public management resonates with what may be termed as generic management, and is important in many ways because government and non-governments (NGOs) for which the church as a Faith-based entity (an FBO) in particular is, and are, organisations like any other which may require these practices. Practices entailing that the focus is more on quantification of outputs than inputs and this is done as if they are providing service to the people in light of not having skewed results.

Lewis (2010: 338) adds that related public management concepts include development management which draws lessons from implementing poverty reduction efforts of different kinds such as the techniques of micro-credit programs, organising community-based self-sustaining groups or lobbying policy makers in support of poverty reduction. More recent focus on new public management is pressing for change in the relationship between the state and society, and according to DeGroff (2009: 4), this reflects the broader relationships that exist between government and its political, administrative and social environments where, within government framework, government work is done through interdependent networks rather than the traditional hierarchy alone.

Here, government work is done via networks that depend on one another and are more inclined to turn to corporate units for managing output of public affairs than the traditional public administration approach that focuses on input controls for results.

In contrast to Kettl (2015: 8), who maintains that while administration theory is built on the foundation of hierarchy and authority where "policy makers elected by citizens would craft public

decisions and delegate responsibility to administrators”, Lewis (2010: 340) takes a different standpoint, which states that many of the principles of public management – such as the need for strongly-built systems of accountability - would be drawn upon by government (as well as non-government) organisations, particularly those which are engaged in the delivery of public services. In other words, the structure of public service has become less and less hierarchical, and therefore managers in the new public management environment manage less through authority and more through a wide range of other strategies such as stressing the borrowing and use of certain private sector styles of management practice. Until recently, Hughes (2012: 8) posited that “it is remarkable how far [that] public management has moved away from public administration”. Simply put, global trends suggest that there is a paradigm shift from the traditional model of public administration to public management, while public governance is perhaps gradually coming to the fore as is now discussed in the next section.

2.3.3 Public Governance

DeGroff (2009: 2) states that governance involves the processes of administration and management in an environment that is characterised by multiple forces of society in a context where broad relationships exist between government and its political, administrative and social environment. This entails a governance process that involves society networks rather than its formal institutions that are a dominant part of public policy for government, and are increasingly becoming responsible for the delivery of public service. Similarly, Anheier (2014: 416) stresses that governance refers to “the process whereby elements in society wield power and authority, and influence and enact policies and decisions concerning public life, and economic and social development”. This implies that people in society have the ability to influence policy decisions and direction as well as enact them to regulate public life in a given socio-economic environment for developmental purposes.

In contrast to DeGroff (2009: 2) and Anheier’s (2014: 416) views, which address governance as the process used to address concerns pertinent to the public through interactive engagement with societal elements while resulting in service delivery, Kong (2010: 4) takes a different stand point.

The new governance theory (or experimentalism) is meant to “assess how institutions can be designed so that actors are motivated, for public-regarding reasons, to provide opportunities for public involvement and monitoring, and to facilitate explicit deliberation about these reasons and about evolving institutional practices”.

Furthermore, Kong (2010: 6) contends that in the view of the pragmatist, “a consensus among members of a community facilitates pragmatic deliberation, and such deliberation is regulated by a particular definition of truth”. The study views pragmatic consensus in governance of certain communities of people as being vital and the historic evolution of public administration theory and practice as being dynamic. In light of this study, public governance theory is said to manifest itself as an alternative to contemporary strands of new governance orientation that could apply in Canadian public law but may not obtain in developing countries such as Malawi, Zambia and other SADC states in the sub-region. This entails that in this study, the theory of public governance may be more applicable in Canada but less applicable in Malawi and Zambia on grounds that they are developing countries whose statecraft in terms of national law and public institutions may be differently influenced compared to developed countries.” However, Lindblom (1958:80) maintains that all countries whether developed and developing have governments that all seek to test out concepts of governance as they evolve in what works and what doesn’t work.

Consequently, misrepresentation of context poses a weak theoretical stance in which new governance theory or experimentalism (Kong, 2010: 4) in the Canadian public law context could be compared to the public governance theory advanced by DeGroff (2009: 2) and Anheier (2014: 346) in a public service delivery context.

With reference to success stories, Arifeen, Christou, Reichenbach, Osman, Azad, Islam, Ahmed, Perry and Peter’s (2013: 2012) study “explored strategies in health-service delivery that have maximised and improved health outcomes through three distinct features: firstly, experimenting with large-scale community-based approaches especially investing in community health-workers using a door-step delivery approach; secondly, experimenting with partnership arrangements that capitalise on the ability of NGOs to generate community trust and thirdly; rapid adoption of context-specific innovative technologies and policies that identify with country-specific systems and mechanisms”. Bankauskaite and Novinsky (2010: 388) advance the use of a stewardship framework with six sub-functions for analysis, looking at the ministry of health’s ability to: first, develop policy guidelines within the strategic design – this is formulating a policy framework which entails a primary approach used for making a policy; second, attain a balance between objectives of policy and structure as well as culture of the organisation – which entails finding a fit between the intention of policy and how it relates with existing structures; third, ascertain tools for action – implying instruments for carrying out policy are available.

Then fourth, create networks for collaboration – which entails having cooperating arrangements to strengthen policy direction whilst fifth, bring about intelligence – which implies finding intellectual capacity to probe issues comprehensively and six as last, attain an accountable environment – which entails giving an account of what is and was entrusted in someone. The study yielded that the ministry of health progressed well in generating intelligence as well as formulating a strategic policy framework, but does not have enough power to drive healthcare in an efficient way and to ensure self-regulated communities act on policy that works within the objectives of the national-wide health system.

Meanwhile, Santiso (2015:3) further asserts that governing to deliver requires specific focus on key issues for reinventing government and they manifest in three key dimensions to getting government right; harness effective governments, promote efficient governments and foster open government. First, harnessing effective government implies starting with two areas that are crucial: increase the capacity of executives and put statistics in the forefront of policy design in order to steer government. Second, promote an efficient government, which implies improving efficiency in service delivery, and third, fostering a government entails application of new technologies to make a government more open and accountable. Bankauskaite and Novinsky's (2010:386) study on Spanish national health system point out that stewardship along with resource mobilisation, financing and service delivery is a key health system function.

Further, the study assessed the role of Ministry of Health's as a steward on the national health system after 2001 decentralisation reform of healthcare management to autonomous communities. The stewardship being key function of a health system entails caretaking of the management of services from national level, whose ownership and delivery goes down to evolve within communities at grass root where people exist. Managing service delivery pertaining to a country's health system is a preserve of government and as such there is a delegated responsibility to bureaucracy to carry out the responsibility. In most developing countries like Zambia, decentralisation has not gone down well due to various reason stemming from different political orientations to structural misunderstandings between political leadership and administration as further expounded in Section 2.3.1

Meanwhile, the context in which public governance has been discussed is that of contemporary governance and revolved around the broad discipline of public administration and that of the new public management. The discussion which now follows in the next section is about another strand of governance in this study referred to as 'theory of corporate governance' within the broad

spectrum of the discipline of public administration while focusing on the context of managing healthcare service provision.

2.4 Theory of Corporate Governance System

The term ‘governance’, according to Anheier (2014: 230), comes from the business world, and has a meaning which has taken it far beyond the confines of a single corporation to be applied to entire societies. Corporate governance is one of the systems by which organisations are directed and controlled. In the corporate governance system, structure spells out sharing of rights and responsibilities among various participants such as the board, managers and stakeholders, and specifies rules and procedures for arriving at decisions related to corporate affairs in every organisation setting.

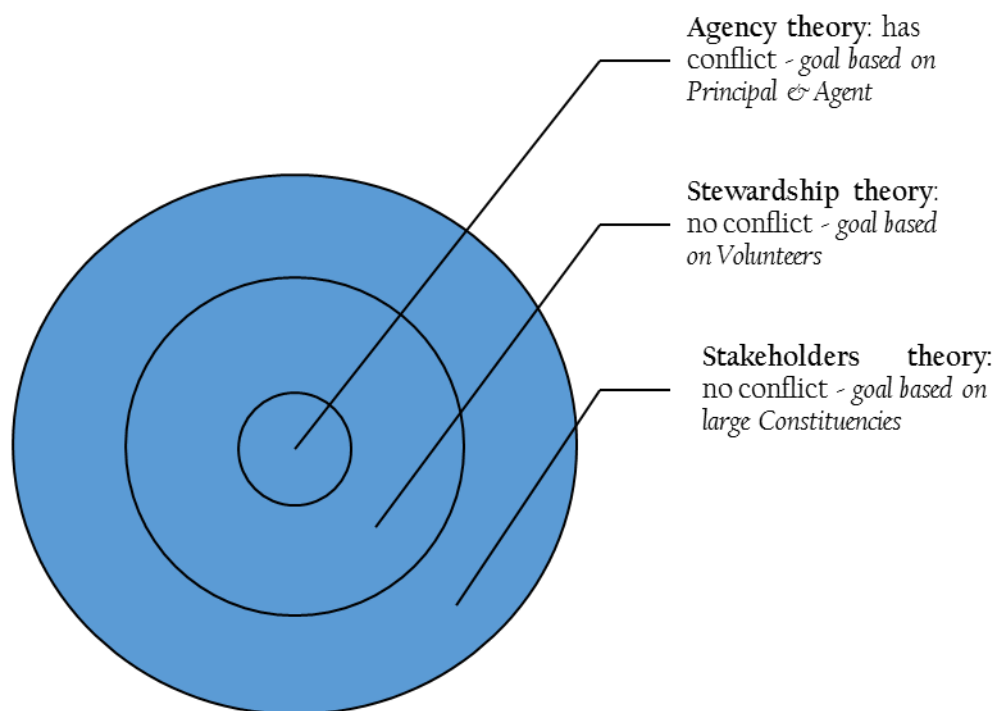
In non-profit organisations, Eller (2014: 141) suggests three basic aspects in managing corporate governance; agency theory, stewardship theory and stakeholder theory. The common theory to explain corporate governance is agency theory in for-profit organisations. The theory assumes a goal conflict between the principal and the agent as both parties are said to be utility maximisers and pose misleading interpretations in not-for-profit organisation. Stewardship theory is rated to be the most important of the three because it is characterised by volunteers resulting in no goal conflict despite interests being vested in maximising the principal’s ideals. The stakeholder theory assumes organisational goals driven by large groupings as principal, and ideals are not maximized for the benefit of a principal but for a constituency of those who have perceived ownership. The stakeholder theoretical concept is structured in bigger constituencies than agencies, as well as stewardship and its governance as found in political groups, communities and even government.

In addition, Savage *et al.* (2010: 22) posit that by examining inter-organisations’ collaborative relationships in social partnerships, elements of both descriptive and instrumental stakeholder theory come into play. In view of the emerging stakeholder theory elements, descriptive stakeholders refers to the model by which the stakeholder is narratively described, while instrumental stakeholders is the model associated with meeting stakeholder needs through goals and objectives in the organisational relationships. In a similar fashion, Henjewe, Fewings and Rwelamila (2013: 218) maintain that descriptive stakeholder theory is that perspective that describes what the organisation (or project) is, in relation to who the possible stakeholders are, and the interactions between the organisation and the stakeholders. In the meantime, instrumental stakeholder theory is the perspective that examines the consequences of corporate shareholding and

does not necessarily give a voice to stakeholders. It is characterised by one-way communication as well as unequal balance of power.

Consequentially, Murray, Islam and Pirola-Merlo (2012: 523) define Non-profits as systems organised around social mission; they embrace values such as philanthropy and voluntarism, and their independence provides opportunities to act as advocates and to work to obtain services for their clients or members. Anheier (2005: 301) states that 'Non-profit organisation' (NPO) is the term used by the United Nations (UN) system of National Accounts and emphasises that they exist primarily not to generate profits for their owners. For the purpose of this study, the meaning ascribed to NPOs is that of Murray *et al.* (2012: 523), which advances that these are systems organised around social mission which promote philanthropy, and whose opportunities advocate and work towards the satisfaction of its members or clients. Further, Shuyang, Sheela and Sanjay (2015: 5) researched whether there is a non-profit advantage by examining the impact of institutional context on individual-organisational value congruence. Shuyang, et al. (2015: 5) maintain that non-profit organisations have the advantage because institutional differences between the two sectors become manifest through non-profit status and the extent of external control, control which influences organisational goal ambiguity, and work autonomy. In turn, these three organisational characteristics shape individual-organisational value congruence.

FIGURE 2-1: THE SELECTED THEORIES OF NON-PROFIT ORGANISATION GOVERNANCE



Source: Adapted by Researcher from Eller (2014: 147)

Most significantly, the blend of stakeholder theory which was isolated from the three selected theories according to Eller (2014: 147) is depicted in figure 2-2. This is according to empirical evidence adduced by Sinha (2012) and Zeze (2012) to show governance systems found in congregational FBOs are covered in this section. The blend underscores the theoretical framework driving the study. The interplay between stakeholder theory and empirical engagement in congregational circles investigated entails complementarity, as such underpins this study about FBO management for strengthening Church-led healthcare. Next in the discussion is healthcare at the doorstep of community.

2.5 Community-based Healthcare

The Arifeen *et al.* (2013:2012) exploratory study conducted in Bangladesh contends that continued development of innovative, community-based strategies and changing to modern trends in technology is required to address challenges emerging from the improvement of healthcare service delivery. In contrast, Kaplan, Ruddock, Golub, Davis, Foley, Devia, Rosen, Berry, Barretto, Carter, Irish-Spencer, Marchena, Purcaro and Calman (2009: 1120) argue that establishing a meaningful

relationship with community is over time, build trust and encourage interactive engagement. This was a case study that provided a mid-term assessment of a US health faith-based initiative in its implementation. The qualitative study identified lessons and reflected on the problems and benefits of adopting a community-based approach to create and evaluate faith-focused programs that have been developed to respond to disparities in the health system.

The findings of the study related to the significance of pastoral leadership in providing a religious context for health promotion messages that emphasise equality and the need for management support to the lay staff coordinating implementation of the programme. Further, the Kaplan, *et al.* (2009: 1120) study identified challenges ahead which include issues of programme institutionalisation and its sustainability pertaining to participatory ways in which communities become a part and parcel. This involves mobilising programs within communities and ensuring they remain working to benefit the concerned community over a period of time. In light of community engagement and the time it takes to build ties between the people with their commitment to serve as part of their investment in the intervention, sustainability is said to be attainable.

Meanwhile, the situation in the Malawi study about informal healthcare here below explored the results overtime of a ban of a community intervention as a unique scenario. For a long period of time, the national health system saw the use of informal healthcare providers in especially rural facilities where it was said that there was lack health staff to supplement service delivery. The use of informal providers called Traditional Birth Attendants (TBAs) in assisting with deliveries was a community intervention to avert effects that come with health services dispensed at facilities which were said to be understaffed such as congestion, long waiting time and poor healthcare. This situation in Malawi was relatively similar to what was obtaining in Zambia and perhaps many other sub-Saharan African countries in the Southern region. Later the government of Malawi made a decision to ban the service and after a certain period of the ban, there was need to check what was working well and what was not working well. Using a difference-in-difference strategy to study the effect of a ban of Traditional Birth Attendants (TBAs) by the government of Malawi in the year 2007 because they are mainly not licensed and regulated, leading to concern that their services are not effective and in some cases, harmful to quality of care.

Further, Godlonton and Okeke (2016: 112) found a decreased use of informal (traditional) health providers by 15 percentage points. Notwithstanding the rather large shift from informal to formal providers over time and space in the intensity of the exposure to the ban, the study could not generally find any evidence of statistically significant reduction in neonatal (new-born) mortality.

New-born deaths would entail that the concern by government related to these informal service provider said not to have been regulated for fears of ineffective services and some instances harmful were not attributed to TBAs. The reduction could have meant that using these informal providers would have been the cause.

In contrast, the Singal (2013:4) qualitative case study argues the importance of TBAs to reduce the difficulties between home and the formal health system. Further, the Community Health Assistants (CHAs) and TBAs have complementary skills that can be used collaboratively to deliver healthcare services such as preventing mother-to-child transmission (PMTCT). Using the task-shifting and sharing framework, TBAs and CHAs can improve the delivery of maternal health services by strengthening the link between community and health facility. Further, integrate TBAs rather than exclude the traditional services as informal healthcare in the national system. The integration could work better if collaborative arrangements with community are in place to deal with the attainment of better healthcare, as may be the subsequent case of India.

Consequentially, Scott and Shanker (2010: 1611) posit that government in India has adopted the community health worker program in the national healthcare system on grounds that this would contribute to better health outcomes in the rural north of the country despite institutional obstacles to its success. One obstacle of which is the dearth of involvement by members at community level due to misunderstandings between government and members of society in the health system. The study related other limitations to outcome-based payment modalities where a designated community health activist is remunerated per number of institutional deliveries facilitated. Other limitations are poor institutional support in terms of health staff and medicine shortage at the health centre, the existence of a rigid structure in the hierarchy of the health system characterised by the perceived bad top-down approach with poor flow of information.

In another study about practices of effective collaboration by three urban Faith-based organisations in North America, Rogers (2009: 326) advances three effective categories for collaboration; communication, sharing resources and common goals as well as values. A basic lesson drawn from the study is that the cumulative effect of simple practices is central to successful collaborative arrangements. The Rogers (2009: 327) study maintains that “while literature abounds with practice wisdom about what congregations and religiously-affected non-profit organisations should do and ought to do to develop effective partnerships, relatively few research studies have concentrated on religiously-affiliated non-profits, which are also referred to as Faith-based organisations (FBOs)”. Gray and Wood (1991: 5) defines collaboration as “a process through which parties who see

different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible.” This appears a fairly wide and old definition in its applicability to the study.

Rosenthal (2015: 1) advances a more challenging definition of inter-professional collaboration as being the efforts of different professions working together to positively impact healthcare process and outcomes.

To the contrary, a study by Haynes (2013: 49) on FBOs, development and the World Bank argues that the main reason for the Bank in engaging with faith-based organisations lies in disappointing results of prior secular strategies and the feeling that religion had a positive role to play in fighting poverty. However, diverse perceptions about poverty and development between states and religious entities, alongside lingering perceptions among state officials about dealing with faith in the public domain, derailed the collaboration.

As a result, the study found these as some of the reasons underlying Banks’ interest in faith between the years 1995 and 2005, and its sudden disappearance, are explained differently: collaboration is not always seen as a way to constructively explore differences and an attempt to resolve limitations.

Nevertheless, Owens and Yuen (2012: 422) point out that distributive politics of “Compassion in action” in the case of federal funding, Faith-based organisations and election advantage. Using statistical inference of dependent and independent variables, the study argued that a “Compassion strategy” to influence the behaviour of voters during elections while being responsive to need-based social welfare demands, affected the federal discretionary grants to FBOs during the administration of George W. Bush. Domestic funding mechanism of FBOs may have involved the tactical use of grants for both electoral purposes (i.e. producing and retaining votes) and the reduction among needy-states.

Stakeholder theories have benefits such as the strength to introduce tripartite ‘principal-provider-recipient’ relations over the basic theoretical problem and go beyond the simple ‘principal-agent’ relationship with associated issues on the one hand. In this study, tripartite relations are represented by CCAP and UCZ as principals, while health workers at the four mission hospitals are taken as providers and church as well as community members are said to be recipients. The simple ‘principal-agent’ relations lie in CCAP and UCZ as owners with health workers as agents of service provision. The study seeks to emphasise the significance the service recipients as stakeholders in

the theories that formed the conceptual framework. On the other hand, the weaknesses, such as limiting the scope of theory to experience of information challenges faced by deeply concerned stakeholder members. As stated earlier in Chapter One, stakeholders are “people or organisations that have a real, assumed or imagined stake in the organization, its performance and sustainability” (Anheier, 2014: 308).

However, collaboration in communities could be harnessed through civil participation and advocacy, in the view of Anheier (2005: 105), who maintains that “providing opportunities for involvement builds civil society and social capital, while giving voice is one of the key roles non-profit organisations are expected to play in society”. Kaldor (2010: 12) describes civil society as a type of social movement, organisation, group of people and individuals, who act together to bring about transformation in a community. Social capital, according to Anheier (2014: 10), is the sum of actual and potential resources which can be mobilised through membership in social networks of individual actors and organisations.

Meanwhile, Putnam and Feldstein (2009: 4) argue that “building social capital is not free of conflict and controversy”. Some people build social capital because it can empower disadvantaged groups in their struggle for significant effect of influence. Social capital represents a way of making controversy productive. Even when effects of community collaborative ties are entirely admirable at times, the means by which they work can be quiet unsettling. This implies that social capital mainly relies on sanctions that are deemed informal, like gossip, and not just on fellowship and emulation. Put differently, Fukuyama (2002: 24), in rethinking development, defines social capital as “a means of understanding the role that values and norms play in economic life”.

In concluding this section on public governance in relation to community-health, the national health policy (Zambia NHP, 2013: 29) advances that “the over-arching objective is targeted to reduce the burden of disease, maternal and infant mortality, and increase life expectancy through the provision of continuum of quality effective health care services as close to the family as possible in a competent, clean and caring manner”. Contrary to this, Singal (2013: 4) argues that the shortage of facility-based staff led to traditional birth attendants (TBAs) carrying out deliveries, acknowledging limited provision of healthcare close to people particularly maternal health as further discussed under the themes established in findings chapter seven.

In addition, Mutale, Bond, Mwanamwenge, Mlewa, Balabanova, Spicer and Ayles (2013: 3) point out that “shortage of qualified health workers, bad staff attitude, and poor relationships between

community and health workers, long waiting time, confidentiality and gender of health workers, are some of the barriers hindering access to health services” by the local community.

Regarding this variation between Singal (2013: 4) in the limitation to maternal healthcare, Mutale et al. (2013: 3) on barriers to community health access and some of the national health policy (Zambia NHP, 2013: 29) promise to provide a continuum of care demonstrate a gap in relation to healthcare provision to the wider society in terms of community-based participation. Most importantly, demands imposed by the growing HIV pandemic, infectious diseases, non-communicable diseases and general health coverage inequalities especially in rural areas, have triggered renewed interest in community-based healthcare (Zulu *et al.* 2014: 6).

Other than government, the renewed interest in community-based healthcare has overtime been characterised by non-government organisations and the next section discusses some of the theories pertinent to contemporary NGOs in relation to FBOs in countries covered in the study.

2.6 Non-governmental Organisation (NGO) Theories

There are many contestations about the terms used to describe Non-governmental Organisations (NGOs). The term ‘NGO’, according to Kaldor (2010: 14), was first used in “article 71 of the UN charter, where the Economic and Social Committee is empowered to make arrangements for consultations with organisations that are fundamentally non-government”. After the establishment of the UN charter particularly in relation to the article 71, the number of NGOs formed to operate globally increased substantially during the post-war period, not only under the stimulation of new social movements but also as former missionaries and colonial administrators sought new occupations. By the year 1980, development and humanitarian NGOs began to be seen as partners of government and international institutions for various reasons: because of their investment in local knowledge over a certain period of time, the need to bypass certain ineffective or authoritarian governments and the need to find ways to implement programmes in a global way, such as the structural adjustment programmes (SAP). SAP is said to be a World Bank/IMF policy intervention which was used in early 1990s as funding mechanism to allow least developed states embark programme that put them on a perceived path to recovery (World Bank, 2015)

In view of this, the study about NGOs is not just taken as part of an arrangement to partner with government for consultations that foster development and humanitarianism, but also social movements that motivated the beginning of occupations for those who previously worked as missionaries and administrators in foreign countries. While NGOs are considered theoretically in

this study, the section that follows shows NGOs as networks that may be seen as platforms for fostering development.

2.6.1 Non-governmental Organisation (NGO) Networks

Equally important, the study of theorising the organisation and management of NGOs by Lewis (2010: 326) shows another reason for the rise of developmental NGOs: the sense of disillusionment felt with the performance record of 'government to government' assistance for development purposes, which was characterised by lack of clear results and many incidents of corruption. Kaldor (2010: 15) maintains that NGOs have lately been seen as an important mechanism for implementing new policy because: they provide a social safety net without extending the role to government, provide training on democracy and citizenship, and check on abuse and poor governance especially in developing countries. Most importantly, they are seen to push corporation's onwards an agenda of corporate social responsibility. For instance, Kaldor (2010: 15) argues, the perceived disillusionment led to a need for non-state actors in development that provided new and alternative vehicles for international aid, prompting policy changes informed by the ideologies of privatisation in the 1980s.

The agendas for privatisation are said to have strongly resonated with neo-liberal paradigms that emphasised free markets, and reduced state involvement and institutional reforms designed to facilitate 'good governance'. In view of World Bank's evolving concept of good governance, Maldonado (2010: 5) defines good governance as "the manner in which power is exercised in the management of a country's economic and social resources for development".

The other set of reasons, according to Lewis (2010: 327), "lies outside the aid industry and relates instead to the growth of the new popular development concerns such as gender, environment and social development, often expressed through the growth of 'social movements' which have evolved into, or developed relationships with, NGOs". Murray, Islam and Pirola-Merlo (2012: 525) assert that NGOs play various roles in advocacy issues like lobbying in human rights, conflict resolution, public education and health, while service provision involves performing functions such as relief in emergencies, primary healthcare, non-formal education, housing, legal and micro-credit for wider communities.

While Kaldor (2010: 14) and Lewis (2010: 326) argue on similar noble causes for the "establishment of non-governmental organisations as stimulation for new social movements and alternative vehicles for international aid, the intention of their origin could be seen, on the one hand,

as primary platforms on which those who served as missionaries and colonial administrative staff could have jobs in various occupations”. On the other hand, the continued work of NGOs could be seen as a means through which perceived corrupt bureaucracy could be avoided if international assistance has to reach intended recipients. Murray *et al.* (2012: 525) view the establishment of NGOs as advocacy vehicles for recipient communities to ride on for development especially in developing countries.

The Church (herein to imply all Christian church organisations or simply churches) is part of a system from which the FBO sector originates. Within the Church context, different church governance system theories have existed and crystallised over time.

2.7 Church Governance (Systems) Theories

Zeze (2012: 46) describes various forms of church governance systems, including the Episcopalian, the Presbyterian and the congregational systems. The congregational system has been discussed in detail under FBO theories section 2.7.2 to form a vital component of the conceptual framework. This section therefore, discusses two systems, Episcopalian and Presbyterian.

2.7.1 The Episcopalian System

The Episcopalian system of church governance is characterised by an organisational hierarchy with principal authority over a local Christian church vested in a Bishop. It is mainly practised in various churches such as the Roman Catholic, Eastern Orthodox and those in clear linear with some Anglican Church. In the Episcopalian (hereafter referred to as episcopal) system, the Bishop acts as the principal and key figure at the helm of hierarchy, performs the ordination of priests, consecration of sacraments and supervises the clergy within his ecclesiastical jurisdiction (the parish, diocese or synod). The bishops in episcopal churches are subject to higher-ranking bishops called Archbishops, Patriarchs or Cardinals, depending on their specific tradition. The higher-ranking bishops gather at meetings which are named councils or synods. Synod comes from the Greek word "sunodos" which, according to Zeze (2012: 46), entails "coming together". The synod at that level is presided over by a much higher-ranking bishop whose judicatory consists of representatives from archdioceses and dioceses. Such council and synod adjudicatory gatherings are said to be mainly advisory.

2.7.2 The Presbyterian System

The Presbyterian church Polity or Presbyterianism (again, in this study simply stated as Presbyterian system) is a form of church governance driven by the elders of the church in their assemblies. The name Presbyterian is added to the name CCAP to indicate the system by which it is governed. According to Zeze (2012: 54), the Presbyterian Church governance manifests itself in the following characteristics: firstly there is one basic office, the eldership comprising teaching elders and ordained elders as well as ruling elders. Secondly, there is an ecclesiastical arrangement of assemblies in a hierarchical order (being church council as a lower court, followed by a presbytery council as a basic governance unit and a synod as the highest court). Thirdly, these courts have the main task to emphasise the local authority (ruling power) of the elders.

In view of the three governance systems discussed, Congregational and Presbyterian systems are relatively similar church governance forms for the reason that centrality of power lies in the people who are members. The Congregational system emphasises the location of power with the eligible voting-members at local level congregation, while Presbyterian governance vests the ruling power in the organised team of elders in their assemblies – the presbytery judicatory courts.

For the purpose of this study, congregational governance will be at the core of discussion in complementing existing theories.

However, congregational church governance whose authority and power lies in the people at lower level of congregation, is fundamentally different from the Episcopal Church governance, where the authority and power to govern lies in a person such as a Bishop. In the Roman Catholic Church, globally, the Pope is in charge. The pope is chosen from the rank of cardinals who are promoted from archbishops who were promoted from Bishops.

Meanwhile, the next section discusses some of the governance systems obtaining in FBOs. Some scholars such as Kondra and Hurst (2009: 38) state that as organisations grow in size, they tend to develop their own collective meaning structures, in certain circumstances through intentional shaping of the culture they have. Similar to secular organisations, FBOs also vary in how they grow and are connected to the congregations or faith entities that initiated their beginning, including the level of control of established denominational networks.

2.8 Faith-based Organisational (FBO) Governance System Theories

Bielefeld and Cleveland (2013: 455) point out that research on FBOs was lacking until the upswing precipitated by ‘charitable choice’, and that there was much concern about how FBOs should be studied and how different methodologies could be used.

Charitable choice, according to Anheier (2014: 448), refers to a “provision (Section 104) in the 1996 Personal Responsibility and Work Opportunity Act (PRWORA)”. This allows religious entities to compete for funds in “the state Temporary Assistance to Needy families (TANF) block grants without the need to establish separately incorporated, secular, 501(c) (3) non-profit organisations”. Further, recent studies have shown that there is no evidence that FBOs are more effective at providing social service than secular organisations and that the opposite seems true. This also includes the notion that congregational leaders lack enough knowledge to attain a constitutionally set of appropriate skills for acting on programme management.

One of the studies undertaken used fundamental considerations including appropriateness of a positivistic methodology to investigate aspects of religion that welfare reform discussions of the 1990s fostered: a debate about a proper relationship between government and FBOs.

While Bielefeld and Cleveland (2013: 455) maintain the notion that leaders of congregations do not have sufficient legal know-how to ensure constitutionally appropriate program management actions, Haynes (2013: 56) takes a different view.

Further, program implementation designed under charitable choice conditions, he notes, “Showed bottom-up pressure on policy makers and consequential influence on policy formation as well as either bringing together or dividing communities along faith-lines”. This goes to show how that the bottom-up pressure is felt even in FBOs operating in local communities of countries covered in this study such as Malawi and Zambia for as long as they are beneficiaries of the charitable choice support. Given organizational practices and religious identity, Sinha (2012: 569) states that organisations vary in governance style, size, complexity, funding mix and other characteristics. Kondra and Hurst (2009: 38) maintain that the growth of organisations is based on the intentionally shaped culture of congregations (or faith communities) from which they were initiated. Thus, FBOs with doctrinal orientations of especially the governance systems of the church which sponsor them, do emphasise the resource of human dignity as pivotal to the development of given communities.

In a nutshell, Zeze (2012: 46) maintains that church governance theories of the Episcopal, the Presbyterian and the Congregational systems, can influence the type of governance adopted by a particular church organisation. The Sinha (2012: 566) point of view describes organisation's expression of religious identity in three system-types as institutional systems, congregational systems and networked systems.

In the world of dynamism, it is possible that these system-types can manifest in a various forms: 'one-in-one', as in one system fits one organisation, which entails the Episcopal system existing in the Catholic Church or 'two-in-one', implying that a combined approach of two systems working at the same time in different ways for a particular organisation such as Presbyterian and Congregational system levels of the organogram in CCAP as one church organisation. FBOs as church organisations adopt what system theories (discussed in section 2.6) work for them. This discussion takes us into systems that may obtain in a historically typical Christian-faith founded church.

2.8.1 Institutional System

Institutional systems are said to be found within Jewish and Catholic traditions, where governance, collection and distribution of resources and service provision are highly centralised through adjudicatory and federal bodies connecting local and national levels.

The Institutional system is a type of organisation governance associated with the Episcopal Church polity (Zeze, 2012: 46) includes the Anglican tradition.

2.8.2 Congregational System

The Congregational church polity or Congregationalism (herein simply referred to as congregational system), is a form of governance where elected leaders receive authority from people who put them in office for a term to carry out their mandate over a specific period of time. According to UCZ Constitution, rules and regulations (2014:18), the congregational system of governance has characteristics of extreme democracy in the sense of dealing with matters affecting the church such as nominating leaders, appointing leaders, protecting doctrine and worship, exercising discipline and participating in major decisions. Most important in this system of governance, a minister is prohibited to carry out functions that come with decision-making without the consensus of the local congregation leadership or committees of the bottom units of the church. Within a local church, elected leaders receive power from the people who voted them into office to

be the final authority over issues or concerns of the church. This is usually subjected to a majority vote of the members of a particular local congregation. Among the major protestant church traditions that underpin congregational governance systems, are those that descend from the Anglo-American puritans of the 17th century such as the Baptist Church (Zeze, 2012: 54).

Equally important, sovereignty is embedded with the congregational form of church governance in which every local congregation is ecclesiastically free-standing. The congregational system of governance espoused in this section is typical to the United Church of Zambia as one of the FBOs in the countries covered in the study. In addition, congregational systems are characterised by mainline protestant, evangelical and other traditions such as the Anglicans and Zionists. Contrary to this, Zeze (2012: 49) argues that while the Roman Catholic Church has adopted the Episcopal form of church governance formally known as the 'Episcopal polity'. Further, the Anglican Episcopal polity which comes with some congregational characteristics is different from the Catholic because the Roman Catholic Bishops who are the principals and central figures are considered 'monarchical'. In other words, they have absolute power and authority compared to those of the Anglican tradition. Thus, a quite common type of governance is the congregational, by virtue of its people-embracing properties and close association with community-focused service initiatives. Arifeen et al. (2013: 201) add that well-organised systems for governance and service initiatives of FBOs are best carried out at local or community level. By the same token, the governance systems of the FBOs in countries covered in this study are associated with both congregationalism and the Presbyterian Church polity (Zeze, 2012: 46).

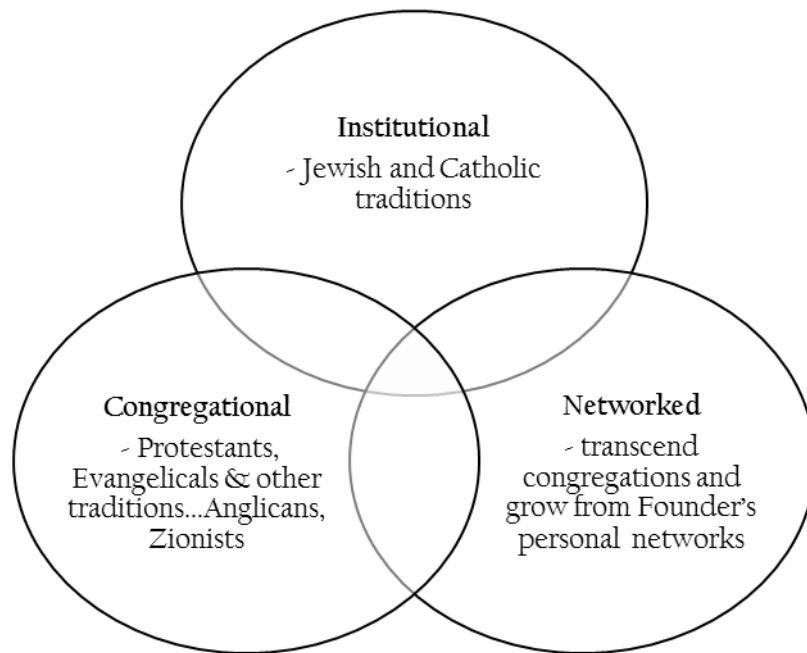
The next subsection discusses the networked system of governance.

2.8.3 Networked System

The Networked system has characteristics capable of transcending the sovereignty of independent congregations and growing from a Founder's personal networks. The FBO inclines its entire mission towards the Founder's aspirations and related networks. Thus, the networked system is yet another unique type found in independent churches and other faith-based communities.

Figure 2-1 below illustrates an environment where intentionally shaped organisations by their own supporting church governance polities, are inter-related and their religious identities.

FIGURE 2-2: THE ORGANISATIONS' EXPRESSION OF RELIGIOUS IDENTITY – 3 SYSTEM STYLES



Source: Adapted from Sinha (2012)

Figure 2-1 shows how that most organisations are governed in different ways and are sometimes referred to as systems of governance. Like in NGOs, FBOs and similarly placed organisations, most churches of which FBOs are part, generally have governance systems that are typically institutional, congregational and networked.

This section focused on characteristics that manifest Faith-based organisation governance theories. James (2009: 4) states that faith with related links between belief and development work is a factor that differentiates FBOs from NGOs. From long ago, the factor of faith is what has been the motivation in most development aid work.

Faith can influence methods used to implement development through the use of prayer. This thus refers to entities that are not governed by the state; are seen to provide service in a philanthropic manner or do so with a certain doctrinal orientation of faith in God for supporting development. These are said to be Faith-based organisations (FBOs).

Further to FBO systems, the next section discusses corporate governance theory as it pertains to contemporary governance in secular. This is intended to complement the study in relation to faith-based organisational management for strengthening church-led healthcare service delivery with focus on Malawi and Zambia but experiences are similar to other countries such as South Africa.

2.9 Chapter Summary

The review of literature has a purpose in providing a contextual framework for an investigation into resolving the key research questions with their respective set of objectives. This chapter discussed public governance and NGOs in a contemporary national and cross-national context. It reflected on the discipline of public governance which was preceded by discussions on public administration and public management theories. This reflection was done in the context of community-based healthcare.

With particular reference to church governance, two out of three systems; episcopal and Presbyterian types were discussed. FBO systems (in this study used synonymously to cover church organisations) include institutional, congregational and networked types. It is seen that the congregational aspect of the theory has notably emerged as a people-driven form of governance in manifesting the committee (or constituency) ownership characteristics. This chapter has endeavoured to emphasise its significant contribution to the meta-conceptual framework underpinning the study, which is further discussed in Section 3.9 of Chapter Three

The discussion on NGOs focused on corporate governance in non-profit entities. Thereafter, the chapter engaged in how the theory relates to Faith-based organisations (FBOs), particularly church-led governance systems insofar as healthcare provision is concerned. The review of literature in light of the theoretical base formed in chapter two created a context for discussing the management of mission hospitals and the quest for improved Church-led healthcare provision in the next chapter.

CHAPTER THREE: MANAGEMENT OF MISSION HOSPITALS FOR IMPROVED HEALTHCARE

3.1 Introduction

Chapter Three discusses the management of mission hospitals and the quest for improved healthcare generally. In particular, the chapter focuses on churches and philanthropic causes covering the historical background, emerging challenges and opportunities, church and government collaboration, the need for improved healthcare, and the development of a meta-conceptual framework that was aimed at driving the study about faith-based organisational management for strengthening church-led healthcare.

3.2 Churches and Philanthropy

The existence of churches and their philanthropic services such as healthcare through mission hospitals started long before governments in Malawi and Zambia as well as other countries in southern African began providing education and health interventions. This section discusses the history of the church and philanthropic services. Philanthropy gave rise to healthcare provision by the mission hospitals which (after independence of both countries from the British colonial government), has become a complementary responsibility for government-run healthcare system.

3.2.1 Historical Perspectives of the churches under study

According to Hall (2009: 33), in the middle eighteenth century, the work of charity and activities related to education which were primary responsibilities of the church in England were devolved to various colonies. This entailed parcelling out of the responsibility of charitable and educational nature following a pattern in which Britain colonised certain African countries under an arrangement of regionalism. For example, African countries such as Northern Rhodesia (later called Zambia), Southern Rhodesia (later called Zimbabwe) and Nyasaland (Malawi), were under one governance system in a regional arrangement called the Federation of Rhodesia and Nyasaland. In the year 1963, Nyasaland gained independence and broke away from the federation later named Government of the Republic of Malawi. One year after, Northern Rhodesia also attained independence on the 24th October, 1964 and was later named Government of the Republic of Zambia.

This left only Southern Rhodesia under the British colonial government of administration for 17 years after the start of the dismantling of the federation in 1963 by Malawi. Southern Rhodesia only attained independence in the year 1980 and was later called Zimbabwe.

As for one of the churches under this study, Zeze (2012: 31) observes that the Church of Central Africa Presbyterian in Malawi is divided into three synods: the Synod of Livingstonia found in the northern region, Blantyre Synod in the southern region and Nkhoma Synod in the central region. Although political boundaries do not overlap exactly with synod boundaries, it is of particular interest to note that geographical demarcations of the governance of Malawi into regions and those of the Church of Central Africa Presbyterian (CCAP) governance into synods are relatively similar. The administrative headquarters of synods are situated in the districts where the administrative centres of government for regions are also located: for the Northern Region, it is Mzuzu town where the CCAP Synod secretariat is based; for the Southern Region, it is Blantyre where CCAP Blantyre Synod is based and for the Central Region, it is Lilongwe, which is now the capital city of Malawi where the CCAP Nkhoma Synod is found.

Similarly, Nondo (2010: 7) observes that the United Church of Zambia has its synod headquarters based in Lusaka, the capital city of Zambia. Further, UCZ was established on the 16th January, 1965 as a result of a union of three churches: the Church of Central Africa in Rhodesia (itself being a subsequent coming together of the Church of Scotland and the London Mission Society with the Union Church of the Copperbelt, Congregations of the Copperbelt Free Church Council) and, the Church of Barotseland and the Methodist Church (UCZ Guide for Catechumens and Church Members, 2001: 4).

Since inception, UCZ operates under 10 presbyteries situated in 10 provincial government administration headquarters: Northern Presbytery which is based in the town of Kasama; Southern Presbytery based in Choma; Eastern Presbytery based in Chipata; Western Presbytery based in Mongu (currently sitting in Livingstone for convenience); Central Presbytery based in Kabwe; North-western Presbytery based in Solwezi, Luapula Presbytery based in Mansa; Lusaka Presbytery based in Lusaka; Copperbelt Presbytery based in Kitwe (a 'birth place' where the union to establish UCZ on 26th January 1965 occurred), and North-eastern Presbytery now called Muchinga, based in the provincial town of Mpika (UCZ Synod Monthly Bulletin, 2015). A presbytery is a court which, within its duties and powers, supervises the life and work of the UCZ area gazetted by the state as a Province (UCZ Constitution, Revised 2014: 13).

It is interesting to note that while the North-eastern presbytery has existed since the formation of the United Church of Zambia in 1965 and has had the 10 presbyteries, the government of the republic of Zambia had only 9 provinces. Following the change of government in 2012, a new province called Muchinga was established, splitting it from Northern province which was said to be too geographically wide to govern and falling in line with the already- established North-eastern Presbytery of the UCZ. This development by government prompted the UCZ synod to later change its name to Muchinga Presbytery, matching the new and recent government-pronounced name. In view of Hall (2009: 33), Zeze (2012: 31) and Nondo (2010: 7) research, which addresses historical linkages of responsibilities of charitable service delivery through Church and government similarities of physical presence geographically, such collaborative engagements have contributed to harmonised relations with not just government but religious structures as well.

3.2.2 Philanthropic Services

The efforts to deal with issues evolving around poverty by religious entities and individuals who are inspired by religious charitable causes have been observed for many years. These religious causes provided material care and comfort in an attempt to reduce poverty. Clarke and Ware (2015: 39) maintain that religious entities have for a long time provided education and health facilities in a combination of both their home and foreign countries – mainly long before the existence and subsequent provision of such services by the states. Anheier (2014: 8) points out that philanthropy is a service “involving practices of individuals reflecting a ‘love of humanity’ and a voluntary dedication of personal wealth and skills for the benefit of specific public causes”, insofar as it refers to private efforts to resolve common problems of society such as poverty and ignorance.

This entails the creation of wealth in societies and could involve, among other things, social action needed to effect a form of fairness among people in a particular community rather than mere assistance of grants by sympathetic organisations to address complex social problems. Investing in philanthropy could also entail raising awareness for capacity building and organisational learning among providers and recipients as well as supporting partners in the production of public goods aimed at innovation or increased effectiveness in community efforts.

3.3 Emerging Challenges and Opportunities for Collaboration

The history behind the establishment and spreading of philanthropy through churches and other institutions reveals that this has not been without challenges and opportunities as discussed below.

Table 3-1 at the end of the section sums up the eminent challenges and opportunities in faith-based healthcare provision in relation to government-based health systems.

3.3.1 Challenges

Management of Faith-based organisations particularly in church circles is such that the practice is heavily dependent on volunteer services from professional manager-members and this tends to perpetuate the problem of little information on management challenges and opportunities of mission hospitals for providing improved healthcare (Nondo, 2010: 26). Some of the emerging and notable challenges relate to, among other things, reliance on donations, two-way accountability and service charges, as detailed in the following sub-sections:

3.3.1.1 Donor dependency

As earlier stated, Clarke and Ware (2015: 39) maintain that entities with religious affiliations have long provided education and health services in both home and foreign countries before any particular states took over such institutions of care. Ascroft, Sweeney, Samei, Semos and Morgan (2011: 5) add that some churches have access to other sources of funding. The sources of funding come through its various branches of ministry and networks which fund them indirectly through church partnership programmes. Meanwhile, gaining data on this funding is said have proven difficult in most arrangements with these churches, in part due to inadequate records and in other instances, a desire not to reveal the extent of non-government funding. Non-government funding may have poured into the mission hospital to implement particular programmes under different conditions to that of government whose collaborative ties and support are essentially to supplement the national health system.

This has led to some of churches who own mission hospitals that heavily depend on external donor support, opting to have two but distinct form of accountability for funds they receive from both the state and donors organisation, as discussed in the next subsection.

3.3.1.2 Dual responsibility

Given the historical understanding that church-led healthcare provision by the mission hospitals has become a responsibility for complementing government-run health systems after political independence of both Malawi and Zambia from the British colonial government, we observe that there is a relationship between government and the church as well as the donors who continue to support healthcare provision.

While external donors contribute in a non-government funding indirectly through church partnership arrangements, Ascroft *et al.* (2011: 5) posit that medical and supply of drugs for both government and church facilities are done centralised manner. This entails that the church-led institutions such as mission hospitals have a responsibility to account for not only medical supplies and drugs but also funding to government and the donor who provided the support. This in essence forms two reporting lines (to government and collaborating partners) for accountability.

In Zambia, a Ministry of Health study about management and leadership skills, gap analysis shows that most managers are not trained in management concepts and the existence of an unclear reporting hierarchy at provincial and district level exacerbates the situation (Moonze, Muchengwa, Tembo, Nondo, Sililo, Mukelebai, Mundende and Kaluba, 2010: 7). To avert the challenge, opportunities to build capacity of key managers through training while working in collaboration with human resource to develop clear organogram and orient staff to lines of reporting were deemed appropriate. The Management and Leadership Academy (ZMLA) intervention was developed by the Zambia Integrated Systems Strengthening Program (ZISSP) in conjunction with Broach-Reach Institute of Training and Education (BRITE). The intervention funded by the United States Agency for International Development (USAID) was rolled out countrywide within health sector as a ZISSP performance Management Specialists' approach to systems strengthening under the auspices of the National Institute of Public Administration (NIPA) for improved health service provision (ZMLA Evaluation Report, 2014: 4). The systems strengthening programme in the Ministry of Health is a typical example of a complex intervention that demonstrate dual reporting where ZISSP was responsible to government on how well capacity building worked for managers and USAID as an agency that funded the training.

For the purpose of this study, the situation creates a dual reporting line from the Church as principals who own mission hospitals especially on the part of people in authority at Synod to both government and the donors who funded them. Dual responsibility in this study is noted as part of the many challenges that may have besieged church-led healthcare provision.

3.3.1.3 User fees

Until recently, many church and government facilities raised revenue through user fees and although they represent only a small portion of the total cost that goes into the provision of healthcare, they are quite common and an important source of operational funding (Ascroft *et al.* 2011: 5).

Furthermore, Meessen, Gilson and Tibouti (2011: ii1) posit that there is evidence that user fees are a barrier to users, particularly the poor. McPake, Brikci, Cometto, Schmidt, and Araujo (2011: ii104) argue that removing fees could improve service coverage and access among the poorest social economic groups but quick action without prior preparation could lead to unintended effects such as deterioration of quality of care and excessive demands on health workers. Debate has continued for either the removal or non-removal of user fees as both sides have valuable characteristics, despite Meesen *et al.* (2011: ii3) maintaining that international organisations and development partners do not only have a major responsibility in terms of knowledge management but to support fee removal and improvements in financial access. Further, Powell-Jackson, Hanson and Kara (2012: 1) add that free quality of care in Ghana improved health-seeking behaviour, and lowered out-of-pocket spending and anaemia among children who were ill at the time of study.

3.3.2 Opportunities

While there are many ways in which some entities could manifest as FBOs, certain attributes attest that FBOs are trusted entities, have a legacy of caring partnership and serve as a spiritual refuge:

3.3.2.1 Trusted entities

Faith-based organisations are said to be trusted because they share “characteristics of being independent, not-for-profit, voluntary and are distinguished through their religious structure, doctrine or community” (Clarke and Ware, 2015: 40). Similarly, Kaldor (2010: 16) asserts that FBOs are trusted entities and show that this is demonstrated particularly by “concepts like ‘social capital’ that contributed to the newly found enthusiasm for NGOs by development institutions like the World Bank, United Nations and other global institutions in the peace and human rights field. In addition, Clarke and Ware (2015: 37) contend that while religious groups are primarily concerned with the spiritual well-being of their members generally, many have also been long interested in further addressing the physical well-being of their communities as well.

3.3.2.2 Caring partnership

The Sanders (2014: 13) exploratory qualitative study on the formation of faith-based cross-sector partnerships, asserts why and how faith-based organisations build partnerships with cross-sector organisations.

Moreover, a framework for the development of successful faith-based cross-sector partnerships through two case studies was devised. Through the use of “grounded theory and comparative method, five key constructs emerged for the formation of a successful faith-based partnership: progressive faith-based social mission, partnership initiator, assessment of qualifications, mission overlap and potential benefit to each of the partners”. By taking into consideration the mission of Faith-based organisations’, the presence of a partnership initiator, mission overlap, assessment of qualifications and partner benefits was ascertained. Further, the two case studies found that “equitable faith-based cross sector partnerships can form and help to transform communities” (Sanders, 2014: 23). This study seeks to explore the opportunity that lies in a people-driven partnership with government and communities for organisational change as espoused by the transformative worldview in tandem with the meta-conceptual framework discussed section 3.9 of this chapter.

3.3.2.3 Spiritual refuge

According to Segal (2009: 4), religious belief is relevant to both social and private realms. He maintains that in addition to the worship of deity, it also involves belief in “a revealed scripture, a divinely ordained code of laws and an assortment of institutions and communal structures in which religion are observed”. Clarke and Ware (2015: 39) further state that “religious teaching also contains precepts on how to live a righteous life, including responding to those that are materially poor”. There is an opportunity in religious entities to grow the base at which people can seek and find refuge when spiritually challenged at personal and organisational levels. Clarke and Ware (2015: 37) maintain that FBOs have a legacy of being trusted entities, supported by Sanders (2014: 13), who argues that they have a caring partnership. Segal (2009: 4) further states that they serve as a spiritual refuge, hence FBOs can be said to demonstrate these characteristics as strengths in the arena of healthcare provision.

TABLE 3-1: EMERGING CHALLENGES AND OPPORTUNITIES AHEAD IN FAITH-BASED HEALTHCARE

FAITH-BASED HEALTHCARE	
CHALLENGES	OPPORTUNITIES FOR COLLABORATION
Funding is donor dependent	Church-led organisations are trusted entities
Pressure of dual responsibility (to government and church donors)	Legacy of caring partnership in the community
User fees are pertinent	Provide spiritual refuge

Source: Adapted from Ascroft *et al.* (2011: 5), Meessen *et al.* (2011: iii), Powell-Jackson *et al.* (2012: 1) and Clarke and Ware (2015: 37), Sanders (2014: 13), Segal (2009: 4).

The Figure 3-1 depicts problems and benefits typical to a Faith-based setting in line with literature search engaged for the purpose of ascertain emerging challenges and opportunities that lies ahead in a given national health system such as Malawi, Zambia and other Southern Africa countries.

3.4 Church and Government Collaboration

On the issue of collaboration between public sector and faith-based organisations such as the church universal, Duff and Buckingham (2015: 1787) advance that “sharpening focus on global health and the growing recognition of the capacities and scope of faith-based groups for improving community health outcomes suggest an intentional and systematic approach to forging strong, sustained partnerships between public sector agencies and faith-based organisations”. In addition, Ascroft, Sweeney, Samei, Semos and Morgan (2011: 15) point out that effectively integrated church health services offer reduced administrative and management load on government working with individual entities. At the level of the African continent, collaboration is said to have worked in different ways. For instance, collaboration involving hybrid governance between African regional organisations and central level government as well as local government culminated into substantial financial support for grass root level development, exists. In this instance, Ruffin (2010: 44) posits that regional organisations are not just supporting local development on their own geographical turf. With the help of government and donor support – for instance in pursuit of metropolitan regionalisation, where the eThekweni Municipality of Durban, KwaZulu-Natal in South Africa, provided the bulk of capital and operating funding. The funding was for a 5 year Area-based management and development programme where the EU contributed Euros 35 million to support Area-based management and development on the African continent.

Over and above, although the said financial resources mobilised for local government support worked in a hybrid form of governance, it is possible that church organisations such as CCAP and UCZ cannot just look to supporting themselves internally and locally in their own countries, but that meaningful integrated linkages can motivate external donor support through an effective collaboration mechanism.

While Duff and Buckingham (2015: 1787), Ruffin (2010: 44) and Ascroft *et al.* (2011: 15) are advancing integrated approaches for services and systems that help to foster strong collaboration, there are a number of management approaches which are used. In this study, they may be construed as strengths by FBO at local, national and regional level and can add a different dimension to sustainable integration between church and government. For better collaboration outcomes in terms of financial, human and other support, it is important that the right people skills and systems are in place. If there is an emergency that requires collaborative effort to respond to, there is one advantage for FBOs. The use of staff at the forefront of service delivery is a big factor. The strengths of staff managing church health services could include effective utilization of the skills to meet the needs of the system, the ability to attract as well as retain staff and the capacity to respond positively in emergencies and in conflicts (Rasheed and Karpf, 2010: 10).

In light of this, it is possible that staff commitment in fostering collaboration under faith-driven systems can be pivotal to better provision of services such as healthcare.

Sections 3.6.1 and 3.6.2 now discuss church-led healthcare and government-run healthcare services respectively.

3.4.1 Church-led (Faith-based) Healthcare

Asomugha *et al.* (2011: 51) point out that over the last three decades, there has been increasing interest in the role that FBOs can play in promoting health and healthcare access among the underserved populations. WHO (2007) advances that a well-performing team of health workers work in ways that are responsive, fair and efficient to achieve the best health outcomes, given available resources and circumstances.

In faith-based health services, there is more flexibility in hiring and dismissing staff than in government services and Bloom, Kanjila, Lucas and Peters (2013: 13) argue that this has led to more discipline among their workforce.

To this end, this is also the general perception about the church-led health workers who are said to be self-motivated, willingness to serve in rural parts of the country, a non-bureaucratic but flexible work style, and their close proximity in work relationships with the community as well as an ability to innovate with quality but low costs of service provision. In contrast to Bloom et al. (2013: 13), who maintain that flexible health services result in a more disciplined workforce, Rasheed and Karpf (2010: 10) argue that “in some church health organisations recruitment and promotion of staff are restricted by religious affiliation, which creates difficulties for the government sector-wide planning of human resources”. This tends to frustrate collaborative efforts between government and church organisations.

3.4.2 Government-run Healthcare

In this study, health services provided in public health facilities are synonymous with government-run healthcare systems. In a case-based health systems analysis, Topp, Chipukuma and Hanefeld (2014: 8) posit that a set of characteristics common to most health facilities pointed to weak continuity of care as well as substandard clinical and administrative practice influenced by delayed discretionary funding. Further, in rural health scenarios, Lentz (2010: 298) advances that “facility deficits could be improved if donors foster relationships with corporations to provide rural health clinics with equipment, medications and trained staff” as one of the opportunities to harness collaboration.

Even in government-run healthcare systems, challenges exist and sound collaboration could result in donor contribution especially medical equipment and infrastructure improvements as one way to avert challenges. In further discussing issues characterising the government-run health, McParke *et al.* (2011: 104) posit that hastened pace of removing user fees in public health facilities without adequate preparation could affect the quality of care on patients and creating unwarranted demands on health workers. The consequential effect is unequal distribution of workers government facilities. A government-run health care system tends to have opportunities that outweigh challenges for survival as a vast and complex entity in the country compared to challenges and opportunities in the church-led healthcare system (in Table 3-1 of section 3.5). The Zambia National Health Policy (2013: 18) observes that the current critical shortages of health workers has led to abnormal staff to patient ratios and un-equitable distribution of available health workers leading to imbalances in meeting workers’ needs.

TABLE 3-2: TYPICAL GOVERNMENT-RUN HEALTH SYSTEMS CHALLENGES AND OPPORTUNITIES

GOVERNMENT-RUN HEALTHCARE	
CHALLENGES	OPPORTUNITIES FOR COLLABORATION
Delayed funding	Sustainable funding
Lack of repair – infrastructure & equipment	Modern infrastructure & equipment
Reduced local running funds	User fees prohibition
Poor distribution of workers	Availability of medical doctors

Source: Adapted from Topp, Chipukuma & Hanefeld (2014: 8), Zambia NHP (2013: 7); NHSP (2011: 18); Malawi HPS (2014: 12)

From the table above, government-run healthcare services delivered through public hospitals is characterised by sustainable funding, modern infrastructure and equipment, prohibition of user fees and availability of medical doctors. Challenges range from delayed funding, lack of infrastructure maintenance, reduced local running costs, and poor distribution of health workers.

3.5 The Quest for Improved Healthcare

The literature review in section 3.6.1, citing Rasheed and Karpf (2010), Bloom *et al.* (2013) and Asomugha *et al.* (2011) points out that Faith-based organisational management as well as leadership strengths and weaknesses, as applied in non-government and government sectors, is about the positive motivations of people in organisations for better outcomes in healthcare service provision. However, common challenges and opportunities for collaboration identified in FBO management of healthcare based on the review of literature, point to issues such as donor reliance, the pressure of dual reporting and the service being ‘not-free of user fees’ but integral to opportunities such as trust, caring and spiritual refuge for people at the core of service delivery. The quest for improved healthcare is best established and reflected upon in light of available healthcare systems and the need to strengthen them, as discussed next.

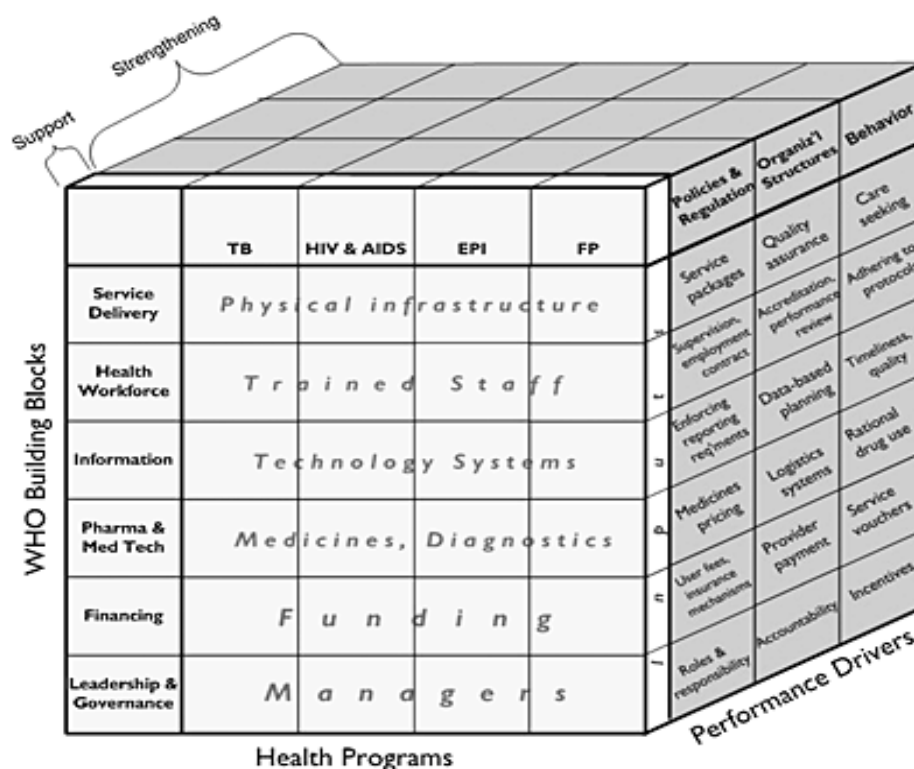
3.5.1 Healthcare Systems

Topp, Chipukuma and Hanefiled's (2014: 3) framework on understanding dynamic interactions driving health centre performance posit that systems performance is the product of interactions between tangible or material resources such as infrastructure, drugs, information systems and human resource (said to be the hardware system) and intangible components such as values, power dynamics and norms (said to be the software system), to shape the decisions, behaviours and relationships of actors within healthcare. This performance interaction between the tangible and intangible resources mean that any health system in especially developing countries the world over, have their own challenges associated with people in relation to services rendered. In the process, challenges may affect sustainability of the system for healthcare provision and so the need for a hedge-intervention by way of strengthening mechanisms. The World Health Organisation (2009: 21) posits that the six building blocks suggest systems thinking before undertaking health systems strengthening. When trying to define healthcare systems strengthening, many refer to the World Health Organisation (2007: 8) framework for describing functions of a healthcare system as shown in Figure 3-1 below. The WHO (2007: 8) framework's six building blocks are service delivery, health workforce, information, medical products, vaccines and technology, financing, and leadership and governance.

- Service delivery – entails service packages, quality assurance and care seeking behaviours.
- Health workforce – entails providing supervision, enforcing employment contracts and adhering to protocols.
- Information – entails enforcing reporting requirements, data based decisions and timeliness in relation to quality.
- Medical products, vaccines and technology – involves medicine, pricing and logistics systems and rational use of drugs.
- Financing – encompasses user fees, insurance mechanisms, payments and service vouchers.
- Leadership and governance – borders on roles, responsibility, accountability and incentives.

The WHO framework further proposes that any program making improvements in any block in any way is said to be doing “system strengthening”. To put it in another way, putting systems strengthening into practice has ramifications of linkages between service delivery and other WHO building blocks (Mutale, Bond, Mwanamwenge, Mlewa, Balabanova, Spicer and Ayles, 2013: 8). But Chee, Pielemeier, Lion and Lion (2012: 25) argue that strengthening health systems require proactive engagements between each building block and ensure there are sustainable improvements across health services as well as its related health outcomes.

FIGURE 3-1: HEALTH SYSTEM CUBE



Source: Adapted from Chee *et al.* (2012)

Figure 3-1 illustrates the health system cube, where the health system is about health program inputs driven by the six WHO building blocks support interventions such as tuberculosis (TB), HIV and AIDS, EPI and family planning (FP) and the use of performance drivers such as policies and regulations, organisational structures and behaviour to strengthen the whole healthcare system.

However, there are many contestations about the interpretation of systems support and systems strengthening. In view of this, Chee *et al.* (2012) state that it is important to distinguish activities that support a health system from those that strengthen the health system. From Figure 3-1, supporting the health system constitutes interventions that point to improvement of service delivery such as distributing health promotion materials such as information and other communication (IEC), mosquito nets and drug supplies. As earlier discussed in section 2.3.1, the activities improve outcomes primarily by increasing inputs pointing to typical public administration.

According to Chee *et al.* (2012: 86), strengthening the healthcare system “is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organisational structures and relationships across the health system to motivate changes in behaviour and allow more effective use of resources” in order to improve multiple healthcare services such as malaria control, tuberculosis, HIV/AIDS, maternal, newly-born and child health, to name a few. In relation to section 2.3.2, this scenario is looking into improving outcomes with a view of maximising the use of inputs provided while pointing to the concept new public management.

3.5.2 Why Strengthen Healthcare Systems?

Chee, Pielemeier, Lion and Lion (2012: 93) point out that health system strengthening is “the process of identifying and implementing the changes in policy and practice in a country’s healthcare system, so that the country can respond better to its health and health system challenges”. Chee *et al.* (2012) further state that a systems strengthening process could tackle some of the problems facing the international community in delivering healthcare services. This entails having an array of approaches that improve one or more of the functions of a sound management system that leads to better healthcare through enhanced access, coverage and quality improvement.

Further, the international community particularly the United Nations (UN) has placed the issue of health and well-being as part of its priority on the global agenda for development from the Millennium Development Goals (MDGs) established in the year 2000 to the post-2015 development agenda. Key findings according to the MDG Gap Task Force Report (2015), show that formal development assistance had increased by 66 percentage points from the time of inception of MDGs. Nevertheless, major gaps persist in development aid to Least Developed countries (LDCs) and in elimination of barriers to trade for developing countries. Designing the post-2015 development agenda gave rise to 17 sustainable development goals (SDGs) that would guide action for the next 15 years to transform our world. The UN through its development programme (UNDP) envisages that the recently established 17 SDGs would transform the world by embarking on a new path to improve the lives of all people.

SDGs have been set in three priority areas; first, 1-6 (poverty, hunger + food security, health, education, gender equality + women empowerment, water + sanitation); second, 7-12 (energy, economic growth, infrastructure industrialisation, inequality, cities, sustainable consumption + production) and third, 13-17 (climate change, oceans, biodiversity including forests as well as diversification, peace as well as justice with strong institutions, partnerships).

This study therefore seeks to set out health as it stands on the first set of SDGs priorities on a new path of development and hence the need to think about why its delivery management should be strengthened.

However, Chee *et al.* (2012: 6) maintain that strengthening health systems to improve health outcomes describes leadership and governance as espoused in “the most complex but critical building block of any health system”. Healthcare system strengthening is about making the system function better in the long term run, if not permanently, and not merely filling gaps or supporting the system to produce better short-term outcomes of healthcare services. In view of this study, healthcare system strengthening is best understood by analogy that illustrates the difference between health system support and health system strengthening activities. Mutale *et al.* (2013: 291) add that strengthening a health system through the six World Health Organisation (WHO) building blocks can be a complex intervention, in that it requires an integrated but comprehensive systems approach to healthcare service delivery.

In demonstrating the making of the system function better, Chee *et al.* (2012: 4) further posit that for a person who upon physical examination is found to be overweight with evidence of hypertension (or high blood pressure). A quick fix would be to simply prescribe medicines that will work on reduction of blood pressure with related risks. This analogy is closely associated with an intervention of system support. While the intervention responds to tackling the problem, it does not actually improve the person’s health because blood pressure will come back if medication is discontinued. In contrast, systems strengthening would entail a person engaging into shedding of weight, embarking on better diet and regular exercise. Engaging on in all of these interventions would fundamentally improve the health of a person.

The interventions would require long term investment with a great deal of more commitment from the person being treated and would ultimately show the outcome that may point to making the body system stronger than mere system support (such as the medication for hypertension). Putting it differently, a strong system entails improving the respiratory function, immunity, overall levels of energy and related improvements of the body.

Nevertheless, the heart of strengthening of a health system that will contribute to FBO management reform is pertinent to the mission hospitals owned by the Church of Central Africa Presbyterian in Malawi and United Church of Zambia. Here management reform entails turning around systems in FBO health administration for development and sustainability in the long term.

3.6 Building a Complementary Conceptual Framework

This study is generally underpinned by multi-grounded theory for developing a new theoretical base. Goldkuhl and Cronholm (2010: 191) have challenged some cornerstones of grounded theory approach by proposing an extended and alternative approach for data analysis as well as theory development coined as multi-grounded theory (MGT). Unlike grounded theory which is an inductive method for generating theory out of data analysis whereby the researcher enters the field without a theoretical framework in mind (Andrews and Scott 2013: 8), MGT entails that a researcher seeks to apply an extended approach with some existing theoretical basis. There is also a benefit that arises when collecting data and analysing transcripts, as preliminary themes tend to contribute in thickening out a new theory and this is further explained in Section 3.7.3.

It therefore follows that theories driving the study are characterised but grounded on Eller's (2014: 141) organisational theory on Agency, Stewardship and Stakeholder assumptions. In agency theory, the agent (person or entity) is engaged by the principal to render service to the client by focusing on maximising shareholder's wealth. The agency theory further states that because of motivation and controls, the agent will not always act in the interest of the principal because the goals weigh more on their personal interest and less for the organisation they serve. For stewardship theory, the manager (person) is engaged as a steward and services clients with a view to maximise shareholder's wealth where in terms of motivation and controls, there is a balance in personal goals and that of the organisation. In stakeholder theory, the caretakers serve clients as stakeholders and so there is motivation because the principal lies in more constituencies such as political groups, communities, employees and government.

In relation to MGT, governing organisation's systems of institutional, congregational and networked types were integrated with related perspectives as advanced by Sinha (2012: 566), who maintains that "the institutional system centralises this relationship, while congregational systems retain the most autonomy at the level of the congregation (which in this study implies a large gathering), and networked system which form and operate independently from a congregation or regional religious body". In an institutional system, the organisation's controls are in the allegiance of the principal's power such as the Pope in the Catholic setting, while in the congregational system, the organisation works and power is vested in committees of decentralised local bodies for instance the protestant, evangelical and other churches, such as the Anglicans and the Zionists.

The networked system has controls and power vested in the founder, and does not require further lines of responsibility due to the independent nature of the system typical of the Pentecostal organisational set-up.

The bringing together of Eller's (2014) stakeholder organisation theory and further grounding of Sinha's (2012) congregational organisation system gave rise to a meta-conceptual framework which guided but also complemented this study.

3.6.1 Fitness of the selected theories for the study

Congregational systems are people-driven and therefore, they embrace many stakeholders who have vested interests which translate into stakeholder theory. As reviewed from the previous literature chapter, the organisation of NGO sector particularly FBOs, is characterised by a people-consensus. In another dimension, stewardship theory may apply in congregational type of governance because leaders and members could be caretakers in certain pockets of society where volunteerism is evident, especially when, for example, health advisory committees exist in a particular national health system. This study concentrated on the stakeholder approach to underscore how the congregational theory essentially fitted-together as Stakeholder-congregational meta-theory in the investigation of Faith-based Organisations (FBOs), as it relates to the management of healthcare services delivery in mission hospitals.

3.6.2 Problem of the 'Stakeholder-congregational' meta-theory

While, the use of consensus in the congregational governance system entails wider participation of various groups with vested interests, the problem with the joined-up theory is that consultative processes to meet consensus are likely to take a long time and tend to stifle initiative. Further, bringing in the stakeholder picture may make the consultation process even lengthier.

The Church which owns mission hospitals has many committees through which issues should be exhausted and debate in the process could be confined to longer periods as it involves service recipients to arrive at decisions. Clearly, this may not be too helpful to healthcare service delivery, which sometimes requires prompt but prudent management decisions.

3.6.3 Attractiveness of the theory

The attractiveness of the theory is premised on the understanding of the lines of responsibility that management of church-led healthcare and the quest for improved healthcare provision lies in the interests of stakeholders.

In other words, Stakeholders imply interest groups represented by the church synod as principals, Board of Governors, Hospital management and community members from where the mission hospitals are situated. Therefore, there is motivation to work collaboratively to attain overarching goals of the Faith-based Organisations (FBOs) under investigation.

3.6.4 Benefits of using the theory

The theory was deemed beneficial for the study as it best fits the definition of the necessary elements of any group or person who can affect or is affected by achievements of the organisation's objectives (Freeman, 2010: 46). Learning will take place when an agglomeration of the two theoretical concepts stakeholder and congregation work in tandem with governance systems identified in the sections 2.6 and 2.7 of the preliminary literature review in Chapter Two. The benefits derived from the meta-theory include firstly, the strength attained in the threading two concepts together. And secondly, that the meta-theory scoped from the stakeholder and congregational perspectives resonates with the philosophical worldview selected in section 4.4 of Chapter Four.

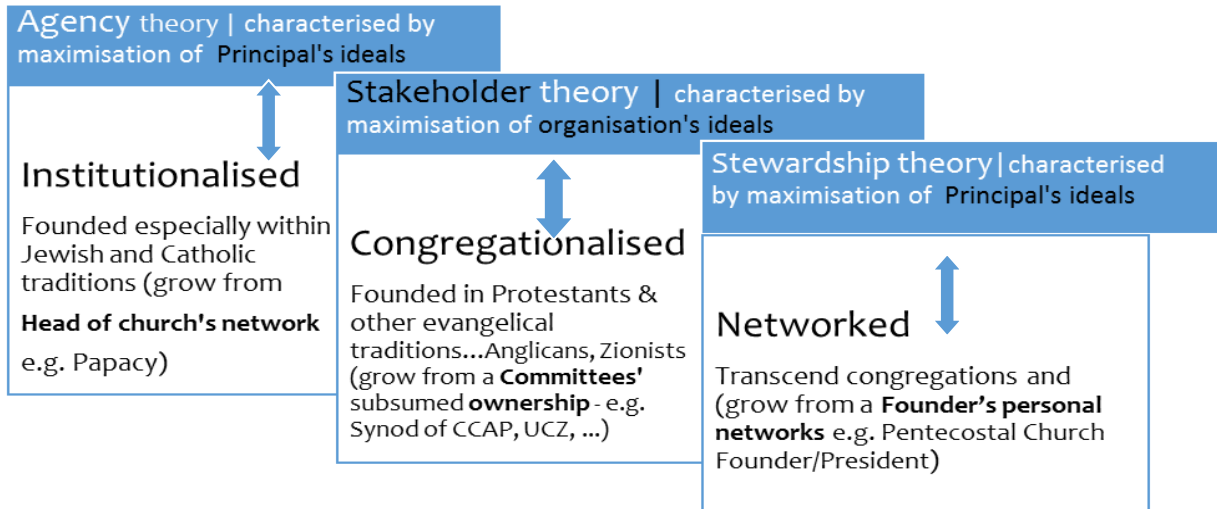
3.7 Meta-conceptual Framework

The over-arching aim of the study was to investigate management of Faith-based organisations and underscore the quest for improved healthcare provided by the Church through its faith-based facilities (herein generally called mission hospitals).

Sinha (2012: 569) maintains that three organizational system types can be used to differentiate expression of religious identity through service provision within FBOs as institutional, congregational and networked systems. Equally important, Eller's (2014: 147) maintains that the three theoretical concepts are commonly used to explain corporate governance in both for-profit and non-profit organisations are agency, stakeholder and stewardship theories.

Reinforcing the perspective of Eller's (2014: 147) stakeholder theory and Sinha's (2012: 566) congregational system (which is in tandem with Zeze, 2012: 46), this study advances the development of a complementary conceptual framework, hereafter referred to as a meta-conceptual model (Figure 3-2 below), as central to driving the study.

FIGURE 3-2: STAKEHOLDER THEORY MIRRORED IN A CONGREGATIONAL ENVIRONMENT



Source: Adapted from Eller (2014) and Sinha (2012)

To emphasise, Figure 3-2 seeks to show that agency theory when applied in an institutionalised environment such as those founded on Jewish and Catholic traditions, is characterised by maximisation of the principal’s ideals. Firstly, members work to the satisfaction of the authority vested in the head of the institution who is guided by the agreed aspirations of the general membership constituting the Catholic tradition such as papacy – where the Pope is final authority. Secondly, when stakeholder theory is integrated in a congregationalised environment founded on Protestant, evangelical and other traditions such as the Anglicans and Zionists, it is characterised by the maximisation of organisation’s ideals. Members work to the satisfaction stakeholders whose authority lies in the way the organisation is governed. Governance in a congregational setting is such that it is enshrined in the aspirations of the people entrusted in the work of committees (such as the Synod) or Board in large constituencies. Thirdly, when stewardship theory is applied in a networked environment which transcends congregations and grows from a Founder’s personal networks, it is characterised by maximisation of principal’s ideals.

Similar to agency theory, the people involved in the growth of an institutionalised environment are merely taking care to satisfy the aspirations of the head of networks in which authority is vested as founder.

In contrast to agency theory and stewardship theory, both of which hold the view of maximising the ideals of the principal, stakeholder theory advances maximisation of ideals of an organisation as collective effort. In this study, stakeholder is mirrored with congregational system of governance to underpin the basis on which to drive the study. It may well be that as the organisation seeks to grow, as both stakeholder theory and congregational system-theory embrace the character of ‘group-drive’ or being people-centred in outlook.

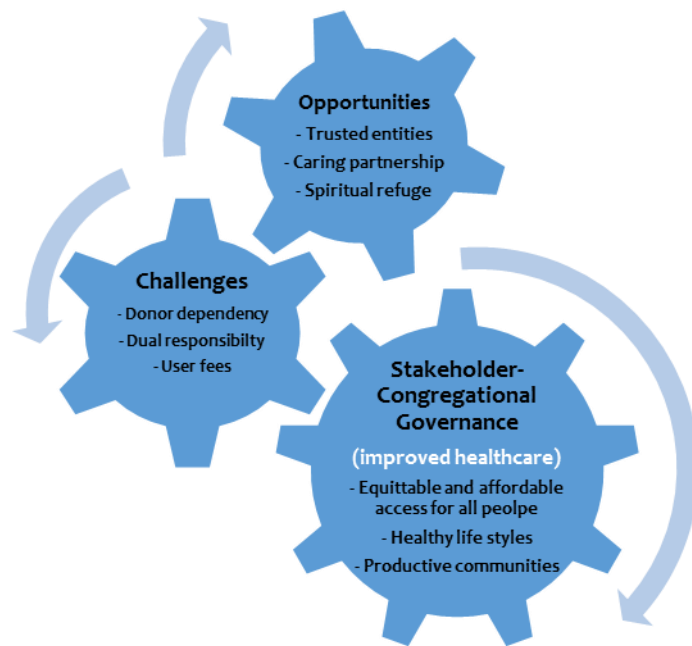
The illustration of the complementary conceptual framework used as a vehicle to drive the study elaborates a three thronged approach that demonstrates stakeholder theory in an environment at the core of a congregational governance style. At the core (to imply centre) of the meta-conceptual framework and based on research objectives embedded in the key questions of the study, is the stakeholder theory and the congregational system of governance as to how that the two proactively talk to each in an integrated way (as in Figure 3-2 above).

3.7.1 Scoping stakeholder theory in congregational governance

The review of literature engaged different theories to reveal and create a suitable conceptual framework that is at the centre of the study. The meta-conceptual framework for the study was the basis on which characteristics for collaboration between faith-based healthcare delivery management and government were derived. The meta-conceptual framework for the study was fundamental to the relationship of challenges and opportunities of faith-based organisational management as experienced by mission hospitals, in the quest to provide improved healthcare.

To demonstrate, Figure 3-3 (below) illustrates the researcher’s reflection of the meta-conceptual framework which shows the amalgamation of Sinha’s (2012: 569) organisation systems theory in a ‘congregationalized’ governance environment with one of Eller’s (2014: 147) three theoretical concepts commonly used to explain corporate governance in both for-profit and non-profit organisations, namely, stakeholder theory. The amalgamation is aimed at answering key research questions, bearing in mind research objectives of the study which point to healthcare service delivery management. Management of healthcare is discharged with a view to contribute to improved service delivery in line with a country’s health policy requirements.

FIGURE 3-3: INTEGRATING META-CONCEPTUAL FRAMEWORK IN VIEW OF CHALLENGES AND OPPORTUNITIES COLLABORATION



Source: Adapted from Sinha (2012), Eller (2014) and Zambia NHP (2013)

Figure 3-3 seeks to illustrate the integration of the stakeholder theory with congregational framework. In the diagram, the first ‘gear-circle’ of challenges; such as donor dependency, dual responsibility and user fees, among others identified in the literature, show problems that inhibit potential to transcend into a circle of opportunities; as trusted entities, caring partnership and spiritual refuge (lying above challenges) derived similarly from literature, these systems are associated with the management of healthcare services provided by CHIs being FBO entities. If the situation lies unchecked and unsupported, the challenges can pull down opportunities that lie ahead, but the depiction above posits the ideal to use the meta-conceptual framework (stakeholder-congregational) gear to engage with and drive challenges downwards, while pushing opportunities upwards for better health outcomes (improved healthcare). Particularly, Figure 3-3 shows the biggest ‘gear-circle’ of the stakeholder-congregational meta-conceptual framework underpinning the study, which explores the quest for better management in the provision of healthcare befitting the guidelines to a sound national health policy for improved healthcare service delivery. Thus, if one cranks the bigger gear-circle clockwise, the gearing-up of the bigger circle of the stakeholder-congregational meta-theory underpinning the study can transform identified challenges into opportunities that can culminate into improved healthcare.

Improved healthcare in this study entails using an integrated (joined up) approach to attain an atmosphere that contributes to equitable and affordable access for all people, translating into healthy lifestyles for all and, as a result, a productive society (The Zambia NHP, 2013: 9).

To clarify, there are linkages between providing equal access of healthcare which people can afford for them to live healthily, so that they contribute to a country's productivity.

Having explored the meta-conceptual framework in a stakeholder-congregational framework at the core of the study and further theorising this via a range of challenges and opportunities for improved healthcare, the next discussion is on multi-grounded theory (MGT) with preliminary reflections on grounded theory (GT). In order to tackle the issue of MGT, it is important to gain some background understanding of the GT.

3.7.2 Grounded theory reflections

There are various contestations about the definitions of grounded theory. According to Charmaz (2014: 9), grounded theory refers to a set of systematic inductive method for conducting qualitative research aimed towards developing a theory. Andrews and Scott (2013: 13) observe that grounded theory is a research method that will enable one to develop a theory which offers an explanation about the main concern in the area of study. Other grounded theorists like Rhine (2013: 3), argue that grounded theory is the study of a concept but not a descriptive study; he further states that the concept means a pattern. In a pattern, the researcher attempts to see if its core categories have general implications. For instance, the concept of super normalising, where people with a problem act more than normal to prove that they do not have a problem and yet the problem is there. In contrast, Andrews and Scott (2013: 13) maintain that grounded theory entails not just developing a theory but providing an explanation of a concern in a particular substantive area and how that concern can be processed or resolved. In light of the many contestations within the scope of grounded theory, recent studies show that there are alternatives such as multi-grounded theory which have emerged, and this is further discussed in the next section.

3.7.3 Multi-grounded theory

Goldkuhl and Cronholm (2010: 187) have challenged some cornerstones of grounded theory approach by proposing an extended and alternative approach for data analysis, as well as theory development coined as multi-grounded theory.

As an idea, multi-grounded theory (MGT) approach “involves three types of grounding processes; empirical grounding, theoretical grounding and internal grounding”. Firstly, empirical grounding entails finding facts based on what various sources of data say in order to adduce evidence. This may further require that a researcher reviews what other studies have found about the subject under investigation. Secondly, theoretical grounding, means exploring existing theories and how they related to the study being investigated. Third and lastly in this study, internal grounding is an integrated process that facilitates development of concept in the voice of the researcher and participants’ views. MGT is further discussed in Section 4.8.5 and Section 4.9.3 to demonstrate how the three grounding processes were applied during data collection and data analysis phases respectively.

In multi-grounded theory, the approach for analysis data involved going into the process with an already existing idea which require deepening, established prior empirical study and developing a new idea at the same time. This study already had some distinct but similarly placed theories adapted from Eller (2014: 147) and Sinha (2012: 569), while conceptualising the model that befits the study in order to develop and strengthen an emergent theory.

When situating the discovery of grounded theory, Locke (2005: 17) observes that “grounded theory style of qualitative research has travelled extensively for example, to psychology, to information science, to education, to many communities of practice within health care, and, of course, to management and organization studies”. Consequently, Gibbs (2013: 3) states that grounded theory is the most popular approach to qualitative analysis and the trend tends to be inductive as a way of discovering theories that are grounded in the data based on the subject.

There are various versions of grounded theory as perceived by different theorists. Glacier, one of the original theorists in the 1980s, states that any sound theory should emerge by interpretation. Others like Strass and Corbin (2005: 45) similarly state that theory emerges from data by cross-comparison and in a structured approach to interpretation of things. Charmaz (2014: 19) asserts a constructionist view to grounded theory, that categories and theory are constructed by the researcher. Researchers construct categories and this entails that we construct our own world; it is the way we grapple with construction that matters. Gibbs (2013: 3) maintains that critiques of grounded theory say that there is no neutral observation in grounded theory and that theoretical sampling takes too long to complete.

In providing an explanation on how to use grounded theory in research, Hall (2014: 17) states that in social science study, inductive method of reasoning represents a bottom-up approach in which theory emerges from a process of data collection, coding and analysis. Rather than the top-down approach to hypothetical reasoning used in most empirical inquiry, grounded theory assumes that theory is contained in the data collected, collated and analysed. According to Hall (2014: 17), “uncovering the theory involves a process of writing memos in which a researcher articulates emerging ideas that become the basis of a theory”.

Some of the methodological stages according to Creswell (2009: 184) and Hall (2014: 17), include identifying a substantive area as in area of interest, collecting data pertaining to the substantive area, open coding data as it is collected, writing memos throughout the process, conducting a selective coding and then doing theoretical sampling when the core and main categories are recognized. Sorting memos and finding theoretical codes which organise substantive codes, finally reading literature and integrating with theory by selective coding and then writing up the theory.

The context in which grounded theory is discussed was intended to lay the foundation for fulfilling the overarching aim of multi-grounded theory.

3.8 Chapter Summary

Chapter Three has fulfilled putting the study into context and discussed management of mission hospitals and the need for improved healthcare generally. In particular, the chapter paid attention to churches and their philanthropic causes covering the background in terms of pertinent history. Next in the discussion, was emerging challenges which evolved around donor dependency, dual responsibility and user fees. Concerning opportunities, FBOs as noted have been discussed as trusted entities, which have a legacy of caring partnership and spiritual refuge. Further, collaborative engagements between churches and government were explored, as was the need for improved healthcare and lastly, the development of a meta-conceptual framework in stakeholder-congregational context that underpinned the study, in tandem with multi-grounded theory.

CHAPTER FOUR: RESEARCH DESIGN AND METHODS

4.1 Introduction

This chapter presents the research design applied to the research problem, research questions and research objectives. The philosophical worldview underlying the study is indicated and research strategies identified. The case study strategy was combined with a multi-grounded theory approach to undertake the study. The case, site and participant selections are included in this chapter. In addition, data collection techniques and instruments employed, such as semi-structured interviews, focus groups and documentary evidence as well as naturalistic observations, are highlighted. Data analysis is discussed in line with content, thematic and matrix approaches.

4.2 Research Design

Research design, according to Leedy and Ormond (2010: 88), is “an operational framework within which facts are placed so that their meaning can be seen more clearly” in the study. Further, research design is a plan while methods are processes of carrying out that plan. The plan entails a framework for determining what to observe, analyse and show why, using a particular method of enquiry. Research design focuses on end product while research methods focus on what kind of tools and procedures were used in the study (Saunders, Lewis and Adrian, 2009: 380). The end product in light of the case under investigation, what is known and resources available to solve the problem may be exploratory, interpretive or explanatory. This entails that research design in a particular case had the strategic intension to explore, interpret or explain outcome of the study. In this study, research design and strategy may be used interchangeably to refer to a case study in multiple cases as further discussed in Section 4.5.

Meanwhile, there are two types of research enquiry – qualitative and quantitative. Creswell (2009: 14) further identifies a third enquiry, namely, mixed methods. Qualitative research can be a type of enquiry that places emphasis on quality (expressed in words) rather than quantification (expressed in numbers). In addition to qualitative research, Merriam (2009: 169) states that placing emphasis on words in an enquiry entails an inductive mode of analysis embedded in the relationship that lies between theory and research, and further strengthens generation of theories. Bryman (2012: 39) states that quantitative research is said to be an investigation strategy that stresses quantifying of numbers when collecting and analysing data, with a deductive approach to theory and practice.

According to Creswell (2009: 14), mixed methods “involve gathering both numeric information as well as text information so that the final database represents both quantitative and qualitative information.” This entails that mixed methods use a combination of qualitative and quantitative enquiry to undertake the study.

Consequentially, Merriam (2009: 18) maintains that qualitative inquiry has characteristics that resonate with quality (based on nature, essence) and goes with a relatively small but reasonable sample, as opposed to quantity (based on how much, how many), which relates to large samples in representation. In this study, the researcher adopted a qualitative method of enquiry embedded in an interpretive case study design which was used to determine and understand phenomena of faith-based organisational management with a view to strengthen church-led healthcare provision in Malawi and Zambia.

4.3 Philosophical Worldview

Creswell (2014: 6) posits that the term ‘worldview’ means a basic set of beliefs that guide action and that others refer to this set of beliefs as paradigms (or ontologies and epistemologies). This is a way of thinking, and different paradigms to research, particularly qualitative inquiry, open up choices.

Lumsden *et al.* (2011: 248) maintain that a basic approach to generation of ontology is considered helpful in designing and implementing integrated systems targeted towards resolving a given research problem better. The first chapter pointed out that the current study is using bigger lenses to focus on ontology and epistemology, thereafter bringing in particular aspects, which the researcher may term a sub-component of the advocacy-participatory worldview to link with other parts of the research. The ontological and epistemological viewpoints have a broad focus as compared to the sub-assumptions of the advocacy-participatory worldview. This is supported by Creswell (2014: 5), who posits that the “approach to research involves philosophical assumptions as well as distinct procedures” and implores the need for a study to be explicit on the philosophy (or simply the ideas it espouses) on the choice of approach to the research.

Further, the first chapter of this study stressed that these paradigms have, until lately, competed for acceptance as methods of choice in shaping and guiding qualitative inquiry. The paradigms in question here are: post-positivism, social constructivism, transformative and pragmatism worldviews. Further, post-positivism, which represents scholarly thinking after the phase of positivism, traditionally challenges notions of absolute truth or knowledge claim.

Also, it holds the assumption that we cannot be positive about truth or knowledge when studying behaviour and human actions. Social constructivism holds the view that individuals seek to understand the world in which they live and work, while the transformative (which was previously referred to as advocacy-participatory) worldview argues that research needs to be intertwined with politics and an action agenda for reform that may change the lives of people and institutions. Rather than perceiving these worldviews (or paradigms) as competitive, some researchers use multiple paradigms or philosophical worldviews.

For the purposes of this study, the term ‘philosophical worldview’ is commonly used. Consequentially, a combination of social constructivist and transformative worldviews has been adopted and are used. This is in view of the relationship between each worldview and the wider view of ontology and epistemology obtaining in the study.

These worldviews were selected to understand how service recipients of healthcare who are community members construct their world and to give them a voice in terms of how the disconnect between the need for better FBO management and the need for optimum healthcare provision could be bridged. Creswell (2009: 6) maintains that worldviews are a general orientation about the world as well as the nature of study that a researcher holds, and further discusses other worldviews such as pragmatism. While the pragmatic views place emphasis on understanding the problem and use pluralistic approaches to derive knowledge about that problem, there are other worldviews such as interpretivism and structuralism based on historical realism, crystallised over a period of time due to limitations in research associated with other worldviews.

Guba and Lincoln (2005: 8) observe that transformative characteristics from the advocacy-participatory worldview “emphasise the agency for change rests in the persons in the community working side by side with the researcher towards the goal of social transformation.” This then takes us into characteristics that agitate for and place emphasis on change with the involvement of people working as a community to transform the world they live in through the advocacy-participatory orientation.

4.4 Transformative orientation

Creswell (2014: 9) claims that the transformative worldview in applied research should focus on the needs of groups and individuals that are marginalised in communities.

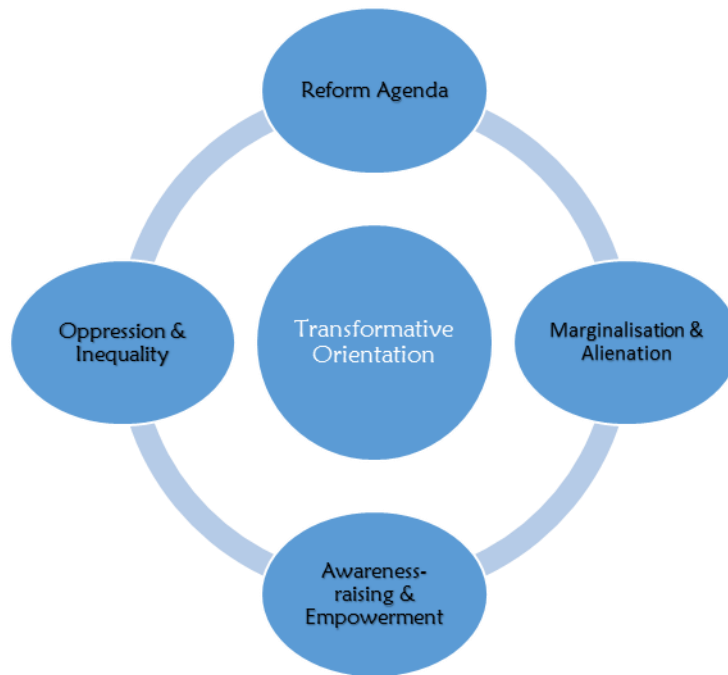
In the meantime, the understanding is best drawn from the segments that are rudimentary to the transformative orientation: the reform agenda, averting oppression and inequality, reversing marginalisation and alienation, and raising consciousness and empowerment. Adopting the transformative worldview which retains characteristics of advocacy-participatory was firstly as a result of shortcomings in other worldviews that do not demonstrate how stakeholder concerns could be addressed for the marginalised and alienated groups of people, in communities where FBOs provide church-led healthcare. In this study, marginalised and alienated people refer to church and community members who receive health services from the four study sites of Ekwendeni, Embangweni, Mbereshi and Mwandu.

Secondly, the transformative orientation is compatible with qualitative, quantitative and mixed methods research. For the purposes of this study, the transformative worldview was adopted within the qualitative research design (section 4.2). The assumption is that the transformative worldview constitutes elements of being political, empowerment-focused as well as justice-oriented, collaborative and change-oriented. It is concerned with issues of empowerment and inequality; it confronts social oppression, domination, suppression and alienation, issues that need to be addressed in society.

Further, the transformative orientation holds the view that research must be intertwined with politics and a political agenda for reform that can change the lives of participants and their institutions. Politics and political agenda are a common feature in places of work, such as the health sector, especially mission hospitals where employees perform their duties while desiring better work conditions, and communities where members press for freedom from marginalisation and other disenfranchising limitations, in a way that can transform their lives. It is thus a united voice for reform and change (Creswell (2014: 10).

Of significance, is that there is a relationship between performance of duties by health workers such as health promotion, and the change orientation effect on community members. When health workers implement health promotion through awareness campaigns taking the form of health talks and various health education materials modified to accommodate local languages, communities are likely to appreciate the messages they carry. Health promotion as part of the reform agenda with organisational values and based on collaboration, can be used as a means to awaken the community to press for change and transform the way they live. Figure 4-1 further shows other important rudiments that evolve around transformative orientation as a selected worldview.

FIGURE 4-1: RUDIMENTS OF TRANSFORMATIVE WORLDVIEW RELATED TO THE STUDY



Source: Adapted by the Researcher from Creswell (2009: 9)

This illustration shows the relationship between the transformative worldview action agenda for reform with minimised people in workplaces, as in the four mission hospitals, and marginalised and discriminated groups of people. Embarking on transformative orientation, the participant-members (from the four communities taken as cases) who access healthcare provision under the study, point to raised-consciousness and empowerment as a desired end state. At the fore would then be a socially transformed world in Malawi, Zambia and other Southern Africa countries in the region.

For the purposes of the study, the philosophical worldview of transformative orientation is adopted by virtue of its emancipatory effect on the people in the four study sites, such as health workers operating in minimised but oppressive environments, with the socially disadvantaged people who are discriminated and suppressed as well as alienated in communities. The goal is freedom from this state.

According to Creswell (2014: 10), the transformative orientation has an emancipatory character that exhibits the potential for helping people to unshackle themselves from unjust structures that promote discrimination but prevent personal determination and development.

Conversely, there is increased advocacy by the WHO (2007) on the role of task-shifting as a means of reducing the burden on an overstretched healthcare system in a bid to promote and decentralise service delivery. The worldview comes in by creating a more liberal and inclusive yet empowered environment for the four cases covered by two countries in the study where, according to Mutale *et al.* (2013: 9), lay people in the community may not be allowed to carry out even simple clinical tasks, although this works with classified employees (CDEs) in exceptional circumstances under the task-shifting model as the implementation of the community health worker programme is still grappling with acceptance in the national health system. Emancipation and empowerment are at the core of Malawi and Zambia's independence which ultimately led to the autonomous operations of the Church of Central Africa Presbyterian in Malawi and the United Church of Zambia after 1963 and 1964 respectively.

In an integrated manner, mission hospital workers are said to play a significant role of providing healthcare services from all four mission stations to surrounding communities and beyond. Zambia's MoH national health policy (2013) assert that all people receive equitable and affordable access to healthy lifestyles, while demonstrating that they are productively empowered communities. Further, Zulu *et al.* (2014: 13) add that renewed interest to promote community-based healthcare has led to an increase in the number of countries adopting decentralised healthcare policies and strategies, as well as community partnership policies.

Thus, emancipation of people and empowerment of communities in the four case study areas mean enhanced ownership of the four mission hospitals through involvement on the part of health workers as providers of the much needed Church Health Institution (CHI) services and service recipients as part of civil society in Malawi and Zambia, as well as other global South African countries.

In view of this, the research design and philosophical worldview for the study were established, and then the researcher found the need to determine an appropriate research strategy.

4.5 Research Strategy

The strategy of enquiry in this qualitative study employed an interpretative meta-conceptual framework (in Section 3.7) with a case study involving multiple cases. The case of the Church of Central Africa Presbyterian in Malawi with two study sites covering Ekwendeni as well as Embangweni, and the United Church of Zambia also with two study sites incorporating Mbereshi and Mwandu mission stations, were thus selected.

Strauss and Corbin (2005: 9) define interpretivism as any kind of research that produces findings not arrived at by means of statistical procedure or other quantification. While the interpretative meta-conceptual framework aims at building theory, it is highly subjective. This is in the sense that the text is analysed and written up by an individual and so is not only prone to misrepresentation but misinterpretation, too.

That being the case, this qualitative study used the inductive perspective of case study strategy as a complete approach that provides a structure for procedures followed by the researcher to collect and analyse data, in order to resolve the main research problem (Leedy and Ormond, 2010: 88). In the structure for procedures lie the context of a case (with multiple cases) in this study, as informed by Yin (2012: 195), on the basis of the sample size and procedure employed.

Having tackled the strategy of enquiry underpinning the study – case study with multiple cases - grounded theory is discussed in the next section with intent to lay a foundation for fulfilling the over-arching aim of multi-grounded theory in this qualitative research.

4.5.1 Grounded Theory Versus Multi-grounded Theory

This section discusses grounded theory (GT) versus multi-grounded theory (MGT). It attempts to show how MGT can be an alternative to and has challenged some corner stones of grounded theory.

4.5.1.1 Grounded Theory

There are many contestations around the definitions of grounded theory. In situating the roots of grounded theory, Charmaz (2014: 9) refers to a set of systematic inductive methods for conducting qualitative research aimed towards developing a theory. Glacier (1980), one of the original theorists in the 1980s, states that any sound theory should emerge by interpretation. Others like Strauss and Corbin (2005:9) similarly find that theory emerges from data by cross-comparison and in a structured approach to interpretation of things. Consequently, Gibbs (2013:7) states that grounded theory is the most popular approach to qualitative analysis and the trend tends to be inductive as a way of discovering theories that are grounded in the data based on the subject. Andrews and Scott (2013: 3) observe that grounded theory is a research method that will enable one to develop a theory which offers an explanation about the main concern in the area of study. Other theorists like Rhine (2013: 3) argue that grounded theory is the study of a concept but not a descriptive study; he further states that the concept means a pattern. In a pattern, the researcher attempts to see if its core categories have general implications.

For example, the concept of super-normalising. In super-normalising, people with a problem act more than normal to prove that they do not have a problem, and yet the problem is there. This is a typical example of super-normalising. Andrews and Scott (2013) assert that grounded theory is not just about developing a theory but further providing an explanation of a concern in a particular substantive area and how that concern can be processed or resolved. Gibbs (2013:13) maintains that critiques of grounded theory say that there is no neutral observation in grounded theory and that theoretical sampling takes too long to complete.

While situating the discovery of grounded theory, Locke (2005: 5) observes that “grounded theory style of qualitative research has evolved extensively for example, to psychology, to information science, to education, to many communities of practice within health care, and, of course, to management and organization studies.” Charmaz (2014: 19) maintains a constructionist view to grounded theory, that categories and theory are constructed by the researcher. Researchers construct categories as we construct our own world and it is the way we grapple with construction that matters. In providing an explanation on how to use grounded theory in research, Hall (2014) states that the inductive approach to social science research represents a bottom-up method in which theory emerges from a process of data collection, coding and analysis. The top-down hypothesis testing approach used in most scientific inquiry, grounded theory assumes that theory is contained in the data collected.

According to Hall (2014: 17), “uncovering the theory involves a process of writing memos in which a researcher articulates emerging ideas that become the basis of a theory”. Some of the methodological stages, according to Creswell (2009: 184) and Hall (2014: 17), include identifying a substantive area as an area of interest, collecting data pertaining to the substantive area, open coding data as it is collected, writing memos throughout the process, conducting a selective coding and then doing theoretical sampling when the core and main categories are recognized, sorting memos and finding theoretical codes which organise substantive codes, reading literature and integrating with theory by selective coding and finally, writing up the theory.

The context in which grounded theory is discussed was intended to lay a foundation for fulfilling the overarching aim of multi-grounded theory.

4.5.1.2 Multi-Grounded Theory

Equally important for the study, Goldkuhl and Cronholm (2010: 187) have challenged some cornerstones of the grounded theory approach by proposing an extended and alternative approach for analysis data, as well as development of a theory called multi-grounded theory. As an idea, the multi-grounded theory (MGT) approach “involves three types of grounding processes; empirical grounding, theoretical grounding and internal grounding”.

This entails that in multi-grounded theory, the approach for analysis of data involves going into the process with an already existing idea which requires deepening an established prior empirical study and developing a new idea at the same time.

This study has already established certain distinct but similarly placed theories that have been adapted from Eller’s (2014: 147) stakeholder organisational theory and Sinha’s (2012: 569) congregational organisation system, while conceptualising the model that befits the study in order to make theoretical propositions. Simply put, there is a need to develop a whole new theory. Goldkuhl & Cronholm (2010: 191) advance that MGT takes a combined view – a synthesis that is based on the three facets of grounding: empirical, theoretical and internal grounding. Grounding processes are involved: firstly, empirical grounding which is a thesis process based on evidence from an empirical undertaking mainly coming from a specific to a general perspective, entails having researched evidence processed using inductive reasoning from a specific idea to the general outcome/understanding. Secondly, theoretical grounding is where the antithesis involves the grounding process whose evidence is based on existing theories, from a general to a specific perspective.

This entails having theoretical evidence processed using deductive reasoning, from a general idea to a specific outcome/understanding. Goldkuhl & Cronholm (2010: 188) maintain that existing theory can be used as a building block that supports the empirical data forming the new but emergent theory. Thirdly and lastly, the internal grounding process, where there is an explicit congruence within the theory itself (that is between elements in the theory), is an option. In this study, internal grounding entails a co-created perspective of the researcher’s voice grounded in the participants’ views.

FIGURE 4-2: THE 3 PERSPECTIVES OF MULTI-GROUNDED THEORY



Source: Adapted from Goldkuhl and Cronholm (2010: 191)

Motivated by Goldkuhl and Cronholm (2010: 191), multi-grounded theory in data collection and analysis was employed in an integrated manner for this study, as a ‘joint’ approach with the organised case study. To put it in another way, the qualitative study used an integrated approach of multi-grounded theory with a case study in multiple cases to collect and subsequently analyse necessary data for results.

4.5.2 Case Study Approach

Creswell (2009: 13) defines case study as a strategy in which the researcher explores a programme, event, activity, process, or more individual cases in depth. Thomas (2011: 118) asserts that the researcher needs to think about how the study would be done, whether s/he is going to try to build her own set of ideas from the scratch (theory building) or test ideas one would have come across elsewhere (theory testing). In a theory building case study, the researcher aims at developing ideas, while in testing a theory, there is already some sort of explanatory framework available for the phenomenon or situation on which one is focusing. Theory is tested by discussing the matter with people, watching people’s behaviour, listening to them and hearing official as well as unofficial messages during committee, group and other meetings. The theory being tested would have, in other words, emerged, or ‘thickened around’, an idea the researcher had at the out-set, which has been reinforced as s/he have looked into the issue further. If, on the one hand, one starts with a firm idea or set of premises, one could be said to be testing a theory. If, on the other hand, one prefers to see what ideas emerge as one is immersed in the situation being studied, one is said to be building a theory. Alternatively, the researcher aimed to illustrate something (*interpretive*).

This study opted for theory building because little is known about theories evolving around studies in faith-based organizational management. In the role of theory in case study, Yin (2012: 39) states that one purpose served by theory, as with any empirical study, is to consider how the case study might relate to appropriate literature so that the case study's findings may more readily advance knowledge. It is envisaged that this study with two cases (see Figure 4-1 elaborated in 4 clusters, referred to as stakeholder segments - two in each country) on FBO management and the quest for improved church-led healthcare in Malawi and Zambia.

4.5.2.1 Organising the Case Study

Organising a case study (otherwise telling the story) entails that the data pertaining to a particular case study can be ordered and presented in different ways. One of the aspects of communicating an ultimate reality is through telling stories – they compel us to examine reality. Case studies are presented as narratives; they tell a story of a particular a person, a programme, an organization or an event. Such stories might be arranged chronologically, thematically or through a combination of the chronological and thematic order (John & Rule, 2011: 121). Chronological arrangement refers to a kind of ordering that arranges a case study according to the sequential order in which happenings within the case occur.

Chronological order means adopting the order or logic of time to arrange an account. Such studies pay careful attention to continuity and change over time. Thematic arrangement refers to an ordered structure which entails identifying the main themes or issues within a case and using them to organize and present a case.

Consequentially, the study adopted the thematic arrangement because “themes may arise from a variety of sources; the key research questions and purposes; the conceptual framework; the data; or a combination of these” (John & Rule, 2011: 124). Themes can be illustrated using quotations and exemplars that bring them to life.

Themes in a story expose us to an alternative worldview and a different perspective that expresses a basic sense of reasoning reality. In this study therefore, themes stemming from challenges, opportunities for collaboration as well as areas of improvements from research questions, research objectives or meta-conceptual framework, for example, are discussed in the chapters incorporating multiple cases in the Malawi and Zambia examples, to illustrate its features.

4.5.2.2 Multiple Case Studies

The study was undertaken using a multiple case study approach. In view of this approach, Yin (2012: 131) points out that although the case study has typically been associated with a focus on single cases, a stronger and potentially more desirable use of the method is in conducting multiple-case studies,— that is, a single empirical inquiry or study that contains two or more cases. The advantage of using multiple-case studies is a broader array of evidence than in single cases. Also, there are greater chances of producing credible results which are likely to be better than using a single-case design.

Conversely, the case study strategy with a multiple case studies approach allows for cross-national and cross-case analysis. In this study, there were two cases involving Malawi and Zambia with two mission hospitals each, Mbereshi and Mwandu Mission Hospitals for Zambia and Ekwendeni and Embangweni Mission Hospitals for Malawi. Multiple cases are further discussed in Chapter Five in the case of Malawi and Chapter Six for the Zambia case.

4.5.2.3 Units of Analysis

Units of analysis refer to elements targeted in the study for analytical purposes. As maintained by Yin (2012: 6), a case study is defined as an exploration of a bounded entity over a period of time through detailed, in-depth data collection involving multiple sources of information, and should be consistent with context. A bounded entity entails a unit being explored that may take the form of an organisation, a person, behavioural condition, event, product, service delivery or even other social phenomena.

In this study, the units of analysis will refer to selected organisations of Christian faith, namely the Church of Central Africa Presbyterian (CCAP) Synod of Livingstonia in Malawi and the United Church of Zambia (UCZ) in Zambia (with realisation that there was also the United Church of Zambia in the Democratic Republic of Congo, a cross-national missional growth intervention which has since been closed). Meanwhile, justification for selection of countries, FBOs and stakeholder segments are further explained in section 4.7

The units of analysis referred to in the study evolved around four clusters based on UCZ in Zambia and CCAP in Malawi while the sample size of people from four mission hospital who participated in the study is further detailed in Table 4-1 (Units of analysis and sample size).

TABLE 4-1: UNITS OF ANALYSIS AND PROPOSED SAMPLE SIZE

Malawi: Church of Central Africa Presbyterian		Zambia: United Church of Zambia		Overall Sample size
Cluster C (Interview - CCAP)	Cluster D (Focus Group - CCAP)	Cluster A (Interview - UCZ)	Cluster B (Focus Group - UCZ)	
15 – 20 Informants = 20 (Clergy and Laity)	3 – 5 groups = 50 (Health workers from two hospitals)	15 – 20 Informants = 20 (Clergy and Laity)	3 – 5 groups = 50 (Health workers from two hospitals)	140
	4 – 6 groups = 60 (Church & Community members)		4 – 6 groups = 60 (Church & Community members)	120
20 Informants	110 Participants	20 Informants	110 Participants	260

Source: Researcher conceptualised table based on selected sample by cluster (2013)

There is a relationship between the established units of analysis and the case study strategy. Section 7.6 of Chapter Seven characterised by comparative findings further provides a discussion on the cross-case analysis parameters which have been segregated, based on the identified stakeholder segments. The stakeholder segments provided pathways for the generation of themes that led to the development of a new model for the study.

4.6 Sampling

This section on sampling first discusses target population in the catchment areas of study sites and is further explained in section 4.7 on case, site and participant selection. Second, sampling strategies with techniques used supported by the literature are reviewed and lastly, I focus on the access population to demonstrate what was achieved as actual units for analysis.

4.6.1 Target population

The target population is said to be a set of elements about which information is wanted and estimates are required (OECD, 2013: 11). Practical steps may require that some elements (in form of persons) are excluded (such as the homeless).

Further, this entails a summation of people living in the surrounding areas proximal to selected study sites as obtained in the four cases under investigation in both Malawi and Zambia. From the discussions during data collection, the proposed sample of 100 workers for interview and focus group meetings was scoped from the target population of approximately 544 health workers from all four study sites (constitutes as Ekwendeni: 274 health workers, according to CHAM, 2014); Embangweni: 130 members of staff (Embangweni Hospital, 2015), Mbereshi: estimated at 65 members of staff; Mwandi: estimated at 70 staff members) in addition to the approximately 40 clergy and lay workers from both synods, CCAP and UCZ. The proposed sample of 120 FGD discussants was representative of the estimated 345 000 target population of community members from respective catchments covered in four sub-areas of the study. The target population is represented by first, Ekwendeni, 74 048 dwellers (according to HSA 2007 headcount, CHAM, 2014) and serves a referral for a population of over 200,000 people from the neighbouring areas, districts in the northern region of Malawi, neighbouring countries of Tanzania and Zambia; second, Embangweni – 100 000 people (based on Embangweni Community Journal, 2014) inclusive of referral cases from Eastern region of neighbouring Zambia, and Mbereshi: 18 000 people (based on the researcher’s field work, 2014 scoping at 65 000); third, Mwandi – 8 000 dwellers (based on Mwandi Board, 2014) in the mission station vicinity, while 25 000 people (researcher’s field work, 2014 scoped at 75 000 in the catchment) includes the catchment area in outlying communities. The total proposed sample of 260 participants was therefore a representative sample of the target population of 440 000 seeking healthcare provision.

In this study, target population relates to a proposed sample based on the population from where the actual sample was finally drawn. In view of this, the population where the sample was finally drawn shall serve a basis for sampling population. Sampling population is further discussed below and shown in Table 4-2.

4.6.2 Sampling strategies and techniques

The main thrust of the qualitative enquiry aims to understand the “meaning of a phenomenon from the perspective of participant” (Creswell, 2009: 12). In qualitative design as a means of inquiry, the study used a non-probability technique for purposive sampling. Purposive sampling was adopted in this research on the grounds that the strength of qualitative research in the discovery-based approach tends to be more flexible regarding accessibility to sample and sample size.

As a result, this feature makes a purposive approach more appropriate for this research. Bryman (2012: 108) identifies three main types in this form of sampling: convenience, snowball and quota. Further, purposive sampling emphasises a criterion-based selection of information rich cases from which a researcher can discover, understand and gain more insight into issues crucial for the study.

In view of Creswell's views (2009: 12) supported by Bryman (2012: 108), the study used purposive underlying non-probability sampling techniques relevant and available to the employed case study strategy by virtue of accessibility. Accessibility was made possible because of the prior open relationship of the researcher with the clergy and general membership after being associated with the work of the church in Malawi and Zambia. During the term of office I served as Area Coordinator for central and southern Africa region countries under the auspices of the Global Fellowship of Christian Youth, an umbrella organisation for The Boys Brigade International, where the study was administered.

4.6.3 Access population

With regard to sampling, access population (or simply sampled population) refers to the portion of the population to which the researcher has reasonable access (OECD, 2013: 11). Access population may be a subset of the target population. In this study, sampled population is the set of units from which the final sample was drawn based on target population. Table 4-1 in section 4.5.2.3 highlighted the target population identified in the four cases scoped on the basis of the catchment population (meaning the headcount of people living in a particular area).

It therefore follows that the researcher scoped an access population of 68/100 out of the estimated 544 service providers as target population working from all four study sites (represented by Ekwendeni: 274, Embangweni: 130, Mbereshi: 65, and Mwandani: 75). The target of 260 participants out of 440 000 people (represented by Ekwendeni catchment estimated at 200 000, Embangweni at 100 000, Mbereshi at 65 000 and Mwandani at 75 000) from four catchment sites was targeted.

In line with the access population, table 4-2 below attempts to illustrate actual sampled units of analysis and further depicts the figures as actually achieved from the target population initially proposed in table 4-1. The sampled population of 182 participants were reasonably accessed against the envisioned 260 people as the target population in the catchment of 440 000 people from all the four sub-areas covered in the study.

TABLE 4-2: SAMPLED UNITS OF ANALYSIS (ACTUAL)

Malawi: Church of Central Africa Presbyterian				Zambia: United Church of Zambia		
Cluster C (Interviews - CCAP)	Cluster D (Focus Groups - CCAP)			Cluster A (Interviews - UCZ)	Cluster B (Focus Groups - UCZ)	
Synod 6 interviewees	Sub-area	Ekwendeni	Embangweni	Synod 9 interviewees	Mbereshi	Mwandi
Ekwendeni 4 interviewees	Health- workers	1 FGD with 16 participants	1 FGD with 14 participants	Mbereshi 8 interviewees	4 FGDs for combined total 36 participant s	4 FGDs for combined total 53 participant s
Embangweni 6 interviewees	Church & Community	2 FGDs for combined 17participants	1 FGD with 8 participants	Mwandi 7 interviewees		
14 Interviewees (Clergy and Laity)	55 FGD Participants (Health workers, Church & Community)			24 Interviewees (Clergy & Laity)	89 FGD Participants (Church & Community)	
Total number of participants 182						

Source: Researcher’s fieldwork based on actual units sampled by cluster (2014).

The table shows outcome of what was actually achieved numerically. The targeted informants, in in-depth interviews and participants in the focus group discussions have been highlighted in bold (as illustrated in the organogram) within the sampled units of the structure of the church.

In order to corroborate the findings within cluster A (which included Bishop North-western Presbytery overseeing UCZ health facility called Jagaimo RHC, as well as the Executive Director at Mukinge Mission Hospital as part of an independent respondents' view) and C, focus group (in cluster B and D) discussions were conducted with church health workers and local community members at Mbereshi and Mwandi Mission in Zambia, as well as Ekwendeni and Embangweni Mission Hospitals in Malawi.

The study nominated ordained ministers serving in designated synod departments, presbyteries and congregations in selected consistories for an in-depth interview and was classified as a stakeholder segment (herein referred to as cluster A). The study selected engaged with 24 out of the proposed 20 informants and the selection was based on the degree of their engagement in terms of gender, experience, seniority in areas of qualification and position of authority in the church hierarchy. The sampled population based on informants with whom in-depth interviews were conducted are highlighted in bold font (of the UCZ organogram illustrated). The access (sampled) population for interviews included the:

- General Secretary or the proxy,
- Mission and Evangelism Secretary,
- Secretary – Health Department,
- Secretary – Education Department,
- Secretary – Community Development & Social Justice,
- Principal or proxy – UCZTC,
- Bishop or proxy of Luapula Presbytery,
- Bishop or proxy of Southern Presbytery,
- Chairperson or proxy of the Consistory in Mbereshi,
- Chairperson of the Consistory in Mwandi,
- former Synod Bishop, former General Secretary,
- Minister in-charge of Mbereshi Mission Station,
- Minister in-charge of Mwandi Mission Station.
- Hospital Administrator of Mbereshi Mission Hospital and
- Hospital Administrator of Mwandi Mission Hospital.

In another sample which was referred to as cluster B, the researcher interacted with a total of 89 out of 110 participants (no group meeting with health-workers from two hospitals referred to as 'Church health-workers', but 8 groups with church and community members).

This was with group size of about 6-10 participants each as suggested by Bryman (2009: 189), while observing gender balance. The Church health-workers imply serving members of healthcare staff from the two main mission hospitals in Zambia (and rural health centres attached to these main hospitals) run by UCZ in two presbyteries – Mbereshi Mission Hospital in Luapula Presbytery and Mwandishi Mission Hospital in southern Presbytery.

The third sample target (cluster C) engaged with 14 out of the proposed 20 informants as highlighted in bold font (in the CCAP organogram) and these are the general secretary, synod moderator, health department director, Livingstonia AIDS programme (LISAP) director, director of the literature centre, director of youth work, moderator of Ekwendeni Presbytery (in this study referred to as head of mission station – Ekwendeni), moderator of Loudon Presbytery (also referred to as head of mission station – Embangweni), hospital administrator of Ekwendeni Mission Hospital, hospital administrator of Embangweni Mission Hospital, matron of Ekwendeni Mission Hospital, matron of Embangweni Mission Hospital and other key program officers at Ekwendeni and Embangweni mission stations as well as hospitals.

Similarly, in another sample which was referred to as cluster D, the researcher interacted with a total of 55 out of 110 participants (set in 6 focus groups, with church health-workers from two hospitals having roughly 60 church and community members), and group size of 6-10 participants each, with gender balance observed.

The church-health workers imply serving members of healthcare staff from the two main mission hospitals in Malawi (and rural health centres attached to these main hospitals) run by CCAP in two presbyteries – Ekwendeni Mission Hospital in Ekwendeni Presbytery and Embangweni Mission Hospital in Loudon Presbytery.

Having clusters A and C (Informants' interviews) and clusters B and D (Focus group discussions) enabled an interface of data from these groupings to enable cross comparison. Further, clustering parameters were reorganised into stakeholder segments and the comparative study ultimately provided an opportunity to gain a better and deeper understanding of challenges experienced in church-led management of healthcare and how opportunities facilitated working collaboratively with government in order to deliver improved healthcare.

4.7 Case, Site and Participant Selection

According to Merriam (2009: 60), the selection of a research site, time, people and events in a field research can be defined as a form of sampling in a particular case. In understanding classifications in more than one case, Bazeley and Jackson (2013: 492) assert that each has its own attributes of gender, age and or group. This calls for creating classes, attributes and values so that the study is able to compare subgroupings in the sample (Table 4-2 in section 4.6.3), depending on the stake they hold in the arrangement.

It is envisaged that the inclusion of church membership in the sample served as part of civil society. Civil society was taken as the key stakeholders grouping, with church and community members from within the vicinities where these hospitals and health facilities are situated. Other church members than those in the vicinity of health facilities were engaged as necessary.

4.7.1 Case Selection

Selecting cases for a case study should be based on a clear, if not strong, substantive rationale (Yin, 2012: 33). In order to have a substantive rationale and attain a balance in the case selection that cuts across countries for a fair comparison, the study chose CCAP Synod of Livingstonia which owns Ekwendeni and Embangweni Mission stations as potential study sites for Malawi, as well as UCZ Synod, which owns Mbereshi and Mwandu Mission Hospitals as potentially suitable sites for Zambia. The case of the Church of Central Africa Presbyterian in Malawi and the United Church of Zambia were selected for two reasons; firstly, because CCAP and UCZ are similarly placed FBOs managing community-advantaged mission hospitals. Secondly, the choice was based on geographical proximity between Malawi and Zambia, which are neighbouring member countries of SADC (Figure 5-1 of Chapter Five and Figure 6-1 of Chapter Six).

As demonstrated in Chapters Five and Six, on the case of CCAP for Malawi and UCZ for Zambia respectively, Malawi's colonial rule and ultimate independence including historic church autonomy is similar to that of Zambia's context. CCAP health mission in Malawi is affiliated to Christian Health Association of Malawi (CHAM), CHAM is an umbrella organisation which supports the work of mission healthcare in Malawi. CHAM (2014) posits that being a coordination arm of faith-based healthcare in Malawi, it frequently touches base with the health department of the CCAP Synod of Livingstonia, which exists to provide health care services, promote health and proclaim a clear Christian witness.

In order to achieve its mission objective, the health department of CCAP Synod of Livingstonia operates three hospitals, the David Gordon Memorial Hospital in Livingstonia, Ekwendeni Mission Hospital and Embangweni Mission Hospital.

Similarly, in Zambia, UCZ is affiliated to Churches Health Association of Zambia (CHAZ), CHAZ is an umbrella organisation which supports Church Health Institutions (CHIs) in healthcare services such as those provided by Mbereshi and Mwandu Mission Hospitals. The United Church of Zambia and the Church of Central Africa Presbyterian in Malawi were selected in a multiple-case scenario for better but well-balanced cross-national comparisons.

4.7.2 Site Selection

The study should select final sites based on the thoroughness of the documentation and accessibility of the site (Yin, 2012: 36). According to CHAM (2014), the mission hospitals and their clinics provide curative, preventive, health promotional and rehabilitative services to patients in their catchment area, irrespective of their religious affiliation. Curative services involve the treatment of infectious diseases such as malaria, tuberculosis and other common diseases. This is achieved by maintaining a high level of quality curative healthcare services. Preventive services involve a strong primary health care (PHC) component in all the hospitals and health centres for services provided, such as immunization for under-five children and ante-natal mothers.

With a health promotional approach, it involves empowering communities to identify their own health problems and take relevant action through behaviour change information. Lastly, the mission hospitals provide rehabilitative services such as orthopaedic, anti-retroviral (ARVs) drugs as well as mental health services.

While, government-run hospitals confine themselves to curative and preventive services, the study chose mission hospitals because the literature reviewed suggests that Faith-based particularly church-led healthcare provision goes beyond curative and preventive care to render health promotion and rehabilitative services. Therefore, four sites were selected in the case study strategy employed. Two in each country were selected, Ekwendeni and Embangweni Mission stations of Malawi, as well as Mbereshi and Mwandu Mission stations of Zambia.

The four sites were selected for two reasons; firstly, because CCAP and UCZ are historically similar mission hospitals which were meant to offer community-advantaged healthcare in their catchment areas.

Secondly, the choice of CCAP's Ekwendeni and Embangweni sites in Malawi was based on their geographical proximity within the CCAP synod of Livingstonia (Figure 5-4 of Chapter Five). This meant that gate-keepers access and data collection exercises were made easier because distance between them was not a deterrent. As for the selected UCZ sites of Mbereshi and Mwandu in Zambia, they are scant and located quite far apart. What was significant is that the chosen mission stations were established in the almost similar manner to the case of Malawi; they also offer essential health services which are both preventive and curative to clients in their catchments irrespective of their religious affiliation.

Selection of the said sites made the cross-case comparison richer and more challenging than a single case (Yin 201: 131). As discussed in section 4.4.2.2, there is an advantage in a multiple-site selection because it highlights a broad array of evidence that would otherwise not be provided in a one-site selection. The other advantage lies in multiple chances of yielding credible results which are likely to be better than using a one-site selection.

4.7.3 Participant Selection

The study could begin by contacting numerous individuals in the field and consulting available reports and literature while these sources are used to suggest candidates that fit into the selection criteria resulting in a list of nominees (Yin, 2012: 35). The participants here were selected because of proximity. They are said to be the closest clients to faith-based healthcare provision in the communities where these hospitals are situated. Supported by Creswell's views (2009: 175), the researcher kept a focus on learning the meaning that participants hold about the problem of church-led healthcare in their communities and not what writers bring out in the literature. Literature, according to CHAM (2014), maintains that church-led healthcare services go beyond curative and preventive care to provide health promotion and rehabilitative services to surrounding communities and beyond, regardless of their faith belonging. Yin (2012: 35) maintains that individuals contacted in the field could form part of the criteria for nominated participants, while Creswell (2009: 175) asserts that the participants consider the meaning of issues and how they affect wellbeing. CHAM (2014) affirms that faith-based healthcare is targeted at communities where they are located bearing in mind that members have a grassroots understanding of health and other issues affecting them.

Based on the grassroots understanding by the targeted participants, the study purposefully identified a conveniently selected sample of 182 out of the proposed 260 participants broken down in 4 clusters – A, B, C and D, as illustrated in Table 4-2.

This is further discussed in the section on sampling that follows. According to Merriam (2009: 62), the number of participants in a sample depends on questions being asked, data being gathered, the analysis in progress, and the resources available to support the study.

4.8 Data Collection and Instruments

The study conducted data collection between January and March, 2014 from multiple sources in each synod head office and respective mission stations. The data collection assignment constituted the itinerary between the two countries chosen for the study. The itinerary entailed a travelling plan which after prior arrangement with the host country synods was first proposed to the University of KwaZulu-Natal within the School of Management IT and Governance under the Discipline of Public Governance, and was endorsed by the supervisor for data collection implementation.

Consequentially, analysed data was collated and a meta-conceptual model developed, which was used during the data analysis. The approach for developing a theory out of data collected and analysed initially via background reflection on grounded theory, entailed the unfolding of an organic product of the research process which essentially began with a clear research purpose. Existing theories went into further grounding while working to develop own theory, thus pointing to multi-grounded theory (as illustrated in Figure 4.2 of section 4.4.2).

Meanwhile, a set of principles (detailed in Table 4-3 below) was used to frame each study phase and format fitness test conducted to affirm instruments for gathering data (in Figure 4-4 of section 4.9.5) summarises data collection and sampling approach for the study.

TABLE 4-3: PRINCIPLES USED FOR FRAMING STUDY PHASES

Study Phase	Principles guiding the study	Approach/method
Design	Meta-conceptual framework	Conceptual framework adapted from Sinha (2012) and theories of NGO/FBO work in a multiple case study of four mission hospitals.
Justified case selection	Philosophical worldview	Transformative – each of the four mission hospitals selected on assumption that they are non-governmental and being faith-based, they have adopted congregational type of governance from the organs that own them.
Data Collection	Strategy/approach – method/sources	Case study with multiple cases – each mission station: key informant interviews and FGD meetings with synod, healthcare workers and community members.
Qualitative method	Sampling/Procedure	Was based on a multiple case study of four mission hospitals including synod head offices/representatives of the churches in Malawi and Zambia.

Source: Researcher conceptualised, 2013

To this end, a semi-structured interview guide was developed by amplifying key research questions and prior to this, the researcher subjected data collection tools to a critique of questions and their relevance (see suggested Interview Questions in Appendix-B) during a format fitness test. The fitness for purpose was carried out with two retired senior UCZ ordained clergy, one retired laity from UCZ Synod (to also have a feel of what the retired clergy and laity could say in a mock in-depth interview). The mentioned format fitness test to data collection tools of the study undertaken is credit-worthy because it provided the researcher with useful insights, and enabled him to follow the expected line of thought in semi-structured interviews and focus group discussion meetings.

Purposefully, the format fitness test was done with a view to capture diversity of perspectives because “an in-depth interview probes, questions and checks what is relevant” (Creswell, 2009: 89), while “a focus group provides a rich and detailed set of data about perceptions, thoughts, feelings and impressions of group members in the members own words” Barbour (2008: 33). This further means that a guide to a focus group can be in a pattern to follow as adopted in this study during data collection: first engagement, then exploratory and lastly exit questions. In the wake of a format fitness test to validate the relevance of interview questions, critiqued by experienced but forward thinking retired members of the clergy, the designed interview questions were administered to have comments from two ministers in Malawi and three in Zambia. Furthermore, a critique on the data collection tools was done and it was generally observed that they would most likely bring out reasons underlying the challenges as well as opportunities that underscore management of mission hospitals owned by the Church of Central Africa Presbyterian in Malawi and the United Church of Zambia in Zambia respectively. The comments on the format fitness test for purpose determined that the data collection tools would be able to provide space that could be used for suggested interventions such as policy guidelines on the management of improved health care. It is envisaged that findings could thereafter point to the need to further strengthening of healthcare systems in not just mission hospitals but other non-governmental organisations and various church-led health institutions, such as that of training schools to improve upon the provision of healthcare.

In essence, the word ‘challenge’ is prominently used throughout the study to point to a problem, gap or lack of a particular competency need because this is what is commonly used among the health workers and the community members (in this study sometimes referred to as civil society), based on the format fitness for purpose of sharpening data collection tools undertaken prior to this ultimate study. The critique was conducted to check the format and relevance of questioning tools developed for the interview guide. It would therefore be prudent to use terminology that will most identify with the stakeholders who, in this case, are the clergy and wider civil society in CCAP circles of Malawi and UCZ circles of Zambia.

During data gathering interviews and focus group meetings, this approach was used because Lipsky (2010: 26) maintains that like NGOs’ potential comparative advantages, FBOs may have a better understanding of the local context and greater flexibility. This resonates with the stock of skills that an organisation could be holding within its own staff and would be pertinent to the identification of needs, priorities, proper planning and coordination of services being rendered to the wider community.

However, as stated earlier, implementation of the itinerary below was conducted with support from the School of Management, IT and Governance in five strands over the aforesaid period of time, because of changes in appointment arrangements with study sites.

The itinerary pertinent to data collection for the cross-national doctoral inquiry was undertaken on the basis of the researcher's ethical clearance approval for the study, Faith-based Organization (FBO) management with specific focus on strengthening Church-led healthcare provision in Zambia and Malawi. The following constituted a tentative but intensive time-plan for at least four weeks:

1. Strand One with Durban – South Africa

Wed 15.01.2014 | Day 1 – At UKZN, did registration & met with supervisor Dr F. Ruffin
 Thu 16.01.2014 | Day 2 – Further met with supervisor for fieldwork, write up & other guidelines pertaining to the cross-national study
 Fri 17.01.2014 | Day 3 – Last meeting; NVivo orientation & ethical clearance – authenticity

2. Strand Two with Mwandini – Zambia

Tue 21.01.2014 | Day 4 – Paid a courtesy call on the Synod Bishop/Health Secretary – UCZ
 Wed 22.01.2014 | Day 5 – Travelled day to Mwandini (in Livingstone) Zambia
 Thu 23.01.2014 | Day 6 – Met with Bishop & key informants – presbytery & consistory
 Fri 24.01.2014 | Day 7 – Proceeded to Mwandini mission hospital – interviews & focus groups

3. Strand Three with Ekwendeni – Malawi

Wed 29.01.2014 | Day 8 – Paid a courtesy call on Synod Moderator and the General Secretary of Livingstonia CCAP Malawi
 Thu 30.01.2014 | Day 9 – Met with Presbytery Moderator for Ekwendeni, key informants – presbytery interviews & focus group discussions (FGDs)
 Fri 31.01.2014 | Day 10 – Proceeded to Ekwendeni mission hospital – interviews & FGDs

4. Strand Four with Embangweni – Malawi

Sat 01.02.2014 | Day 11 – Met with Presbytery Moderator for Embangweni, key informants – presbytery interviews & FGDs
 Sun 02.02.2014 | Day 12 – Proceeded to Embangweni mission hospital – interviews & FGDs

5. Strand Five with Mbereshi – Zambia

Wed 05.02.2014	Day 13 – Paid a courtesy call on the Bishop’s office – Luapula presbytery
Thu 06.02.2014	Day 14 – Met with Consistory Chair for Mbereshi, key informants & FGD participants
Fri 07.02.2014	Day 15 – Proceeded to Mbereshi mission hospital – interviews & FGDs

The itinerary was tentative and in some areas was modified with express permission of church’s focal point persons at CCAP and UCZ to suit certain local conditions, timing and arrangements with the host country.

On the overall in the study, information was obtained from primary and secondary sources. Most important, primary sources included data mainly drawn through key informants’ interviews and focus groups discussion with the clergy, the laity, Church health-workers and member networks from both the local Church of Central Africa Presbyterian in Malawi (as highlighted in CCAP organogram Figure 5-2 of Section 5.3, including Hospital’s HR & Finance, Clinical Care and Public Health units) and United Church of Zambia (also in the UCZ organogram Figure 6-2 of Section 6.3). To ensure corroboration, data was cross checked between interviews and focus groups with MGT in mind while keep verifying between and among segments; principals, providers and recipients. To triangulate findings, responses in the methodological perspective related to shortage of staff, financial insufficiency and transport showed convergence in various FGDs while recruitment criteria and remunerations in the interviews were brought out as divergent views.

Equally important, secondary source documents were from the books, journals, pamphlets, and website extracts, including articles pointing to pressing need for understanding phenomena of faith-based organisational management, again with a focus on strengthening healthcare provided by the mission hospitals in Malawi and Zambia.

4.8.1 Documentary Evidence

Documentary evidence was about various pieces of documents pertaining to the case of Malawi and Zambia in relation to CCAP Synod of Livingstonia at Ekwendeni, as well as Embangweni mission stations and UCZ of Zambia at Mbereshi, as well as Mwandu mission stations respectively. Documents analysed related to National Health Sector Strategy and Policy of Malawi, CCAP Synod of Livingstonia Panoramic Status, the Church’s CHAM Service Level Agreement (SLA) with the Government of Malawi through the ministry of health on the Malawian side. On the Zambian side,

documents such as the National Health Strategic Plan 2011, the National Health Policy 2013, and the revised UCZ Constitution, Rules and Regulations (2014) of the United Church of Zambia.

Related documents included the UCZ Summary Strategic Plan 2011-2015 and 2012 Operational Plan, the UCZ mid-term Performance Review of the Strategic Plan 2011-2015 and Performance Improvement Plan 2014-2015, and the UCZ Guide for Catechumens and Church Members.

Other documents provided information on government efforts for healthcare improvement in Malawi including the health sector strategy and policy (HSSP) 2014, as shall be discussed further in section 5.2 of Chapter Five.

4.8.2 Semi-structured Interviews

The research method included in-depth interviews with a proportionate sample of interview participants at synod with the clergy, lay officials as well as hospital management members of staff (as discussed in section 4.6). The process of administering the data collection instruments involved instituting interviews which were conducted in terms of; holding an in-depth interview with selected members of the clergy at Synod offices, in charge of mission stations where healthcare is provided or at least served in the office of the church's highest court before or who may have retired from active service of the church organisations covered in the study.

4.8.2.1 Interviews at the CCAP Synod Secretariat

In-depth interviews at the CCAP Synod of Livingstonia were conducted with members of the senior management team; the General Secretary (who is the Chief Executive Officer), the Synod Moderator, who according to Zeze (2012: 31), is said to be the church's spiritual figure and at the same time the head of department as Education Director, the head of health department, the Health Director, and other heads of department whose offices were physically located at the Ekwendeni mission station in the town of Mzuzu.

For the purposes of this study, the grouping of synod officers potentially constituted a different stakeholder group because of vested interest by the church in owning the healthcare facilities under the study.

4.8.2.2 Interviews at the Ekwendeni Mission Station

In Mzuzu, the researcher visited Ekwendeni Mission station with a courtesy call on the Head of Station who is the presbytery moderator, and held in-depth interviews with selected informants, including the office of the head of station itself.

4.8.2.3 Interviews at the Embangweni Mission Station

In Embangweni, the researcher visited Embangweni Mission station with a courtesy call on the Head of Station and held in-depth interviews with selected informants, including the office of the head of station, too. In-depth interviews in Embangweni were further conducted at the mission station with the presbytery moderator (who represents synod at mission station level), the manager Donald Fraiser, Hospital administrator and other members of the hospital management team.

4.8.2.4 Interviews at the UCZ Synod Headquarters

In-depth interviews at the United Church of Zambia were conducted with members of the senior management team of UCZ synod; the General Secretary (who is the chief executive officer of the church), the Synod Bishop who, similar to the CCAP structural set-up and Zeze's views (2012: 31), is said to be the church's spiritual figure but is also the Board Chairperson for both Mbereshi and Mwandu Mission Hospitals, local boards, the head of health department, Health Secretary and other heads of department such as the Administration Secretary based in the capital city of Lusaka, Zambia, before proceeding to Mbereshi Mission station in Luapula Presbytery and Mwandu Mission station in Southern Presbytery. Similarly, for the purposes of this study, the grouping of synod officers potentially constituted a different stakeholder group by virtue of vested interest by UCZ in owning and managing the two mission hospital facilities covered in the study.

4.8.2.5 Interviews at the Mbereshi Mission Station

In the Luapula Presbytery (otherwise province) of UCZ Zambia, the researcher visited Mbereshi Mission station with a courtesy call on the Head of Station (although reportedly out of office at the time).

In-depth interviews were conducted with informants: the medical officer in-charge (outgoing), medical officer in-charge (in-coming), hospital administrator, HR Officer, Health mission partner and other stakeholders such as the deputy head of Mbereshi Mission's Marble Shaw Girls Secondary School.

4.8.2.6 Interviews at the Mwandu Mission Station

At Mwandu mission, in the Western Presbytery (otherwise situated in southern province) of UCZ Zambia, the researcher visited the mission hospital with a courtesy call on the Head of Station (who is said called the consistory chairperson).

Also, in-depth interviews were conducted with the Medical Licentiate, Health Mission Partner, Hospital Administrator, Public Health Officer, Accounts Officer and other stakeholders such as traditional leaders, in this case, His Royal Highness, the Senior Chief Inyambo Yeta of the Lozi-speaking people, with prior appointment at the Royal Palace through the Head of Station.

Additionally, the qualitative study used data collection means that involved interviews, which according to Leedy & Ormond (2010: 33), ought to be semi-structured in nature, evolved around the key research questions. This is further confirmed by the accompaniment of a semi-structured interview schedule that is centred on the concept of a prompt. Semi-structured interviews tend to be open-ended questions such as why, what, who and where. In order to ultimately create new knowledge, the study targeted a total of 260 participants (Figure 4-1 showing proposed sample size), while achieving a total of 182 participants (also illustrated in Figure 4-2 as size actually sampled).

Most importantly, Raddon (2011: 28) states that a semi-structured approach refers to the capacity of interviews to elicit data on perspectives of salience to participants rather than the researcher dictating the encounter, as is the case with more structured approaches. The category of informants who participated in the interview was preferred because the study takes the view that these are people of influence in the Church of Central Africa Presbyterian and the United Church of Zambia. The same goes for FGD meetings because participants are said to be people of commitment to the call of grassroots interventions, as discussed in the next section.

4.8.3 Focus Group Discussions

The data collection instruments employed included discussions in focus groups. While in-depth interviews were conducted based on a proportionate sample of synod as well as other Church officials and members of the hospital management team, the focus group discussions were held with healthcare workers as well as community members. The study facilitated discussions with a target of 22 focus groups (of approximately 6-10 members), with 220 healthcare workers and church members from the community to form the basis of research instruments. Motivated by Raddon (2011: 28), the category of participants in the focus groups was equally preferred because the study

takes the view that health workers from target hospitals and community members are people of influence in the selected sites of Ekwendeni and Embangweni of Malawi and Mbereshi, as well as Mwandi of Zambia.

Equally important, the FGD meetings in all the four selected sites were driven by the focus group guide and actual focus group questions (see Appendix C), which included a welcome to participants, introduction by parties (research team and participants), followed by a statement of purpose of meeting as well as sharing ground rules, and finally, the discussion. During deliberations moderated by the Researcher, the Assistant Researcher took notes and where possible, recorded discussions while the Research Assistant obtained signed participant consent forms and distributed water/snacks, when and where necessary. With prior authorisation, the purpose of the study enshrined in the research objectives was shared, followed by ground rules such as assured participation, recording and confidentiality.

Thus, using actual focus group questions (Appendix C) to ignite discussion, participants were further encouraged to talk and fully explain answers with probes such as, ‘could you please talk a bit more about that; could you give an example...’ and so on. Finally, closure was then achieved by thanking all participants for their time and valued input.

Subsequently, FGD meetings were conducted in the manner outlined below:

4.8.3.1 FGD Meetings with Ekwendeni Health workers and Community members

In Ekwendeni, the researcher visited and held focus group discussion meetings with participants at the mission hospital, and the health-workers and the members of the Ekwendeni mission station community who access healthcare services. The people who participated were a combination of CCAP church members and community members of Ekwendeni locality, regardless of their denominational and political affiliations. In prior stakeholder segment considerations, focus group discussions were held at the mission hospital with health workers who are said to be service providers and mission community members who seek healthcare services from the mission hospital.

4.8.3.2 FGD Meetings with Embangweni Health workers and Community members

In Embangweni, the researcher visited and held focus group discussion meetings with participants at the mission hospital, and the health-workers and the members of the Embangweni mission station community who access healthcare services. Like in Ekwendeni, the participants were a combination of CCAP church members and community members, regardless of their denominational affiliations.

In line with Ekwendeni Mission station, prior stakeholder segment considerations became significant; focus group discussions were held at the mission hospital with health workers who are said to be service providers and mission community members who seek healthcare services.

4.8.3.3 FGD Meetings with Mbereshi Community members

In the Luapula Presbytery at Mbereshi Mission station, the researcher held an FGD meeting at the Hospital-affiliated Health Centre with members from the mission station community and later with outlying community members of Fishiki Rural Health Centre (32 km away from Mbereshi Mission Hospital) for focus group discussions.

4.8.3.4 FGD Meetings with Mwandu Community members

In Mwandu, the researcher could secure an FGD meeting with health workers but the hospital's Out-patient Department (OPD) clinic based at the mission station was visited and later Mabumbu UCZ congregation (27km away from Mwandu Mission Hospital) as an outlying community for focus group discussion meetings with participants. The people who participated were a combination of UCZ church members and community members of Mwandu locality, regardless of their denominational and political inclinations.

A number of observations were made as discussed in the next section.

4.8.4 Naturalistic Observations

Creswell (2009: 191) posit that one way to convey findings is by the use of thick description based on observations. The description may accelerate the reader to the natural setting and provide a view of shared experiences which makes the results more realistic and richer, thereby adding to the validity of findings. The close information from the field, particularly at the site, was gathered by actually talking directly to the people and seeing them behave as well as act within their own context.

Consequentially, after ethical approval of the study, the researcher with the help of an Assistant Researcher and Research Assistant as a trio travelled to Malawi. In Malawi, the researcher, with the help of the team, made due observations during deliberations at the head office of CCAP Synod of Livingstonia, Ekwendeni Mission station office, and held in-depth interviews with selected informants and focus group discussions with participants at the Mission Hospital. Ekwendeni Mission station community and traditional authority from the outlying community within Ekwendeni chiefdom was also part of the areas investigated under this study. In Embangweni, the

researcher and team visited Embangweni Mission station office for a courtesy call and subsequently held in-depth interviews with selected informants and focus group discussions with participants at the Mission Hospital and the Embangweni Mission community.

In Zambia, the researcher and team travelled to designated areas of study. The different places we visited while making observations included the UCZ synod headquarters situated in Lusaka, and Mbereshi Mission station. We then held interviews and focus group discussion at the Mission Hospital, Mbereshi Health centre-affiliated Clinic community and Fishiki rural health post outlying community. In Mwanzi, the researcher visited Mwanzi Mission station office for a courtesy call and held in-depth interviews with selected informants and focus group discussions with participants at the Mission Hospital, Mwanzi Mission community and Mabumbu congregation outlying community.

Details of further observations are highlighted in the respective case study Chapters, Five for Malawi and Six for Zambia. In the process, ‘memo-ing’ in the field was being conducted for multi-grounded theory (MGT).

4.8.5 Memoranda in the Field for Multi-grounded Theory

Memoranda in the field for MGT included memo-ing steps during and after data collection. This entails the researcher first collected data during agreed business hours, and in the evening, reviewed the data collected each day. To make meaning of the theoretical and internal grounding for MGT, the researcher was already thinking about what literature says. Some categories were provisionally made while seeking variations which were possible to condense and thus never went into an interview blank-minded. After data collection, the data sets were further analysed for matrices, content and themes in line with theoretical framework driving the study to develop a new conceptual model.

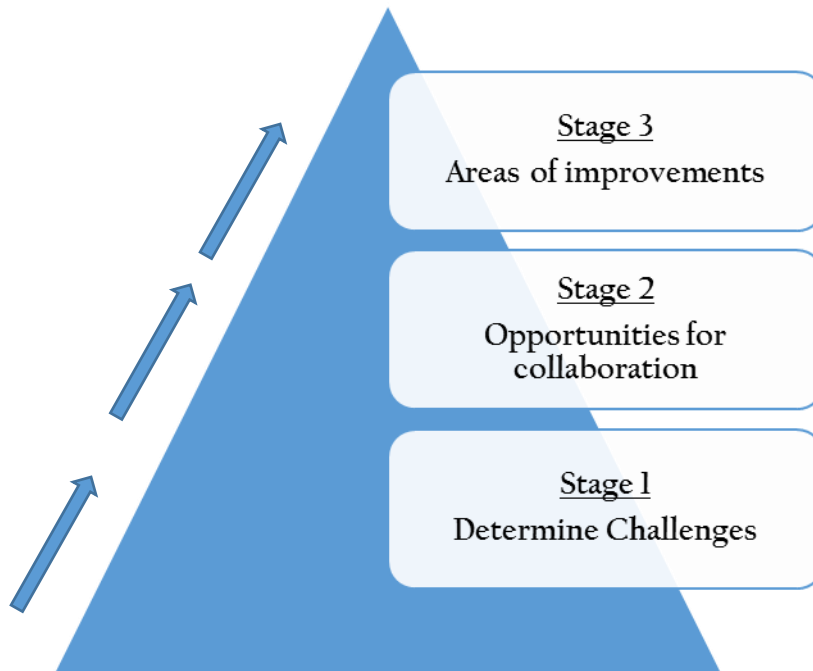
The process that was followed before undertaking data collection was conducting a format fitness test for data collection instruments.

4.8.6 Format Fitness Test for Data Collection Instruments Conducted

There are various techniques of testing fitness of the format adopted for the study in the data collection process, depending on the context and strategy employed in the study. Brander, (2011: 3) suggests that the process generally followed involves three key stages. “The first is to determine what are the challenges, second stage is what are the reasons behind the challenges and, third stage

is to analyse results and determine systems mechanisms needed” (p.3) as illustrated (in Fig. 4,4 below). This was conducted with senior retired clergy for comment on the appropriateness of the instruments for data collection and not necessarily asking questions.

FIGURE 4-3: GENERIC STAGES OF A FORMAT TEST FOR DATA COLLECTION TOOLS



Source: Conceptualised by Researcher and Adapted from Brander (2011: 3)

The initial outcome of the test on the appropriateness of the data collection instruments without having to ask questions determined the fitness of key and actual research questions which required comments. After the relevant comments, alignment was done particularly for interventions that point to the improvement of healthcare.

Data collection therefore followed the outcome of the critiqued questions for the study subject to the experienced hands of the retired clergy, who were selected according to gender, age and qualification. This was conducted by asking the retired clergy to review the questions and comment on their relevance to the study and how they would speak to the research objectives. For interview questions, the retired clergy provided feedback that informed the way questions were asked (Appendix A), based on a semi-structured interview guide.

Similarly, focus group questions were also reviewed on their relevance to the study and were only then used for the study as actual focus group discussion questions (Appendix B).

Through an interface of interviews and focus group facilitations based on the semi-structured interview guide and focus group guide, data collection was undertaken.

4.9 Data Analysis

There are different approaches used to begin the data analysis process. Saunders *et al.* (2009: 381) observe that the nature of qualitative data has implications for both its collection and analysis. The implications for data collection and analysis may rest on deductive and inductive lines. Should the researcher commence from a deductive position, they will seek to use existing theory to shape the process of analysis. In contrast to deductive implications, if the researcher adopts an inductive approach, s/he will basically seek to develop a theory emerging from the analysis of data.

Analysis begins with identification of the themes emerging from the raw data, a process sometimes referred to as “open coding”. During open coding, the researcher must identify and tentatively name the conceptual categories into which the phenomena observed will be grouped. The goal is to create descriptive, multi-dimensional categories which form a preliminary framework for analysis. Words, phrases or events that appear to be similar can be grouped into the same category. These categories may be gradually modified or replaced during the subsequent stages of analysis that follow (Strauss and Corbin, 2005: 12).

Following this, the next stage of analysis involves re-examination of the categories identified to determine how they are linked, a complex process sometimes called “axial coding”. The discrete categories identified in open coding are compared and combined in various ways as the researcher begins to put together the “big picture” (Strauss and Corbin, 2005: 21). The process below will form part of data analysis and its rationale was adopted in an integrated fashion for this study, as further illustrated in Figure 4-5 under section 4.9.2.

4.9.1 Data Reduction

Data reduction refers to the process of selecting, focusing, simplifying, abstracting and transforming ‘observations’ into ‘data’. Qualitative research inquiry often produces a large set of data. In this particular case of multiple cases, the large data sets manifest in the form of transcripts and field notes taken by the researcher. It is important to perform reduction continuously throughout the life of the study to take advantage of recent memory and this is part of the memoranda review conducted in the field for MGT.

In this study, summaries for responding to what constituted challenges, collaboration and improvements data in line with key research question will be taken from time to time as a way to attain objectives of the study.

Of significance, Miles and Huberman (1994: 17) point out that even before the data collection begins, 'anticipatory data reduction' occurs as the researcher decides things such as which conceptual framework to use and which research questions to ask.

4.9.2 Data Display

Data display refers to organising and compressing data sets in a way that allows drawing conclusions and action. The process of organising the data and making connections between various forms 'telling of stories' is often the principal challenge of qualitative data analysis. Miles and Huberman (1994: 22) assert that extended text quickly overloads humans' information processing capabilities. The two scholars advocate other types of displays such as matrices, graphs, charts and networks that organize information into an immediately accessible but compact form.

To emphasise, the study using a case study strategy for data collection adopted multi-grounded theory for theory development through an inductive lens and was reviewed in the manner that is consistent with a memo-ing process in grounded theory as part of MGT for data collection (Section 4.8.4) and now amplified in the section that follows.

4.9.3 Memoranda Review for Multi-grounded Theory

Different experiences have become a basis for developing extended and alternative approach for data analysis and theory development, multi-grounded theory (MGT). As earlier stated in Section 3.7.3 of chapter three, the extended but alternative strategy for analysing data, multi-grounded theory was based on three grounding processes: empirical, internal and theoretical (Goldkuhl and Cronholm, 2010: 189). The researcher used multi-grounded theory to enhance the scope of an extended procedure to grounded theory development using the three perspectives as follows: empirical grounding, the voice of data from the four mission hospitals in Malawi and Zambia was pertinent; internal grounding, facilitated development of conceptual framework in the voice of the researcher and participants' views with theoretical grounding, this being the voice of existing organisational system theories driving the study.

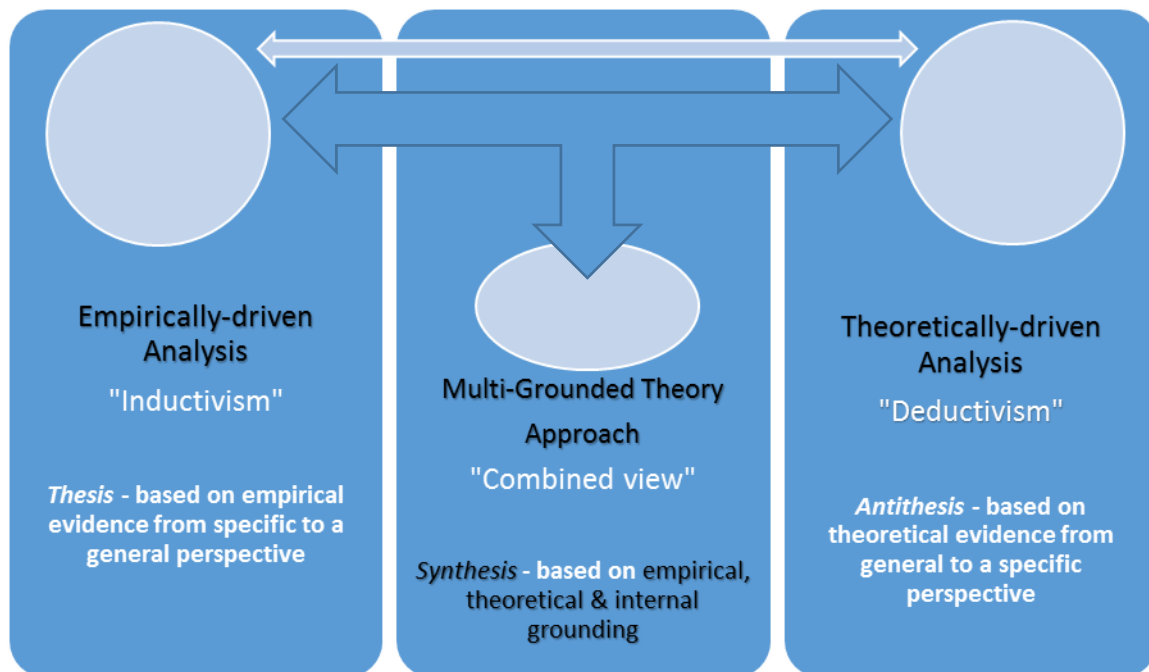
Nonetheless, while grounded theory merely served as a foundation for departure to underpin MGT in the study, Creswell (2009: 189) contends that in a grounded theory method, there is

encouragement for seeking variation among concepts and condensing categories. Data analysis is a creative and iterative process including categorisation and validation.

Therefore, within this process there is an element of theoretical sampling which provides an opportunity not only to enrich categories but also to achieve an improved and deepened understanding of earlier utterances. During the theoretical sampling process, new data is gathered to enrich evolving theory.

According to Goldkuhl and Cronholm (2010: 190), grounded theory has the strength of being a systematic procedure of data analysis – a method which supports ordering of data and offers traceability between data and categories. The dialectical synthesis of MGT in Figure 4-3 below depicts how the ordering procedure may offer traceability when working between data and categories as part of the ‘memo-ing’ process.

FIGURE 4-4: MGT AS DIALECTICAL SYNTHESIS – INDUCTIVISM & DEDUCTIVISM



Source: Adapted from Goldkuhl & Cronholm (2010: 190)

As far as the memoranda review for Multi-grounded theory is concerned, Goldkuhl and Cronholm (2010: 190) maintain that deductive content analysis is deductivism in outlook.

While deductivism is characterised by theoretically-driven analysis on the one hand, inductive content analysis is a special feature in inductivism on the other hand. This is motivated by empirically-driven analysis. Under deductivism, there is already existing data on which to base the study, or at least the researcher moves into the study with a theory to prove or indeed disprove. Under inductivism, there is little or a lack of data on the subject matter in the study. The content analysis in this study tended towards inductive reasoning in light of little information on the matter under investigation. The process of reviewing transcribed data was a collaborative effort by the key researcher, assistant researcher and the research assistant. The integrated manner in which the process worked, served as checks and balances thereby creating a well-balanced environment for sharing differed but sound ideas for the study.

Therefore, multi-grounded theory supports discovering of new ideas and relations among categories and properties in extending work around and as not only an alternative but extended grounded theory due to its multi-faceted character. This ‘multi-facetedness’ is seen in its integrated view which offers a synthesis that is based on empirical, theoretical and internal grounding in the process of data analysis. Getting to a stage of theory development entails tackling three phases: engaging the key research questions, demonstration of content in tables of matrices and initiating themes which signify the characteristics of qualitative responses. The next section discusses the phases as generic approaches to content, matrix and thematic analysis.

4.9.4 Generic Approaches to Content, Matrix and Thematic Analysis

The generic approaches involved were on content, matrix and theme. Saunders *et al.* (2009: 392) maintain that “where the researcher adopts the inductive approach, they must be guided by the design from data collection into data analysis stage”. Data analysis was conducted in three phases.

Incidentally, phase one was carried out concurrently with data collection, as collated field notes and summaries of evidence were generated for each of the four mission hospitals. While data was being collected, preliminary categories were isolated and potential thematic areas noted from data being collated in form of field notes and summarised evidence from in-depth interviews and focus group discussions. Some transcribed interviews and FGDs were imported into NVivo (version 10) QSM for electronic coding, and the rest were mainly manually coded to help with the analysis of data. The bulk of the work was manual coding.

In phase two, data was organised to produce categories (Creswell, 2009), which Yin (2009) refers to as a case description for each mission hospital. Qualitative data including observational data was synthesised and compared in order to come up with as comprehensive a picture as possible of the

operational reality at each mission hospital. This phase involved comparison and cross-checking of all data to generate cohesive and consistent categories and to identify unusual or exceptional experiences. Preliminary categories were used to solicit feedback from mission station managers and synod officials.

Meanwhile, phase three focused on cross-case comparisons using inductive analysis. Inductive analysis was guided by codes developed from the meta-conceptual framework including congregational governance embedded in the stakeholder interactions between and among segments of the principal, Synod level body guides over-riding Church policy; the agent or hospital workplace where management and health workers' service enforcement happens, and lastly, clientele, involving the church and community members' expectations about improved healthcare. Codified text and its (anonymous) sources were collated and printed to enable synthesis of major findings related to stakeholder interactions and their impact in the mission hospitals as well as on congregational governance occurring within the Church of Central Africa Presbyterian in Malawi and the United Church of Zambia in Zambia.

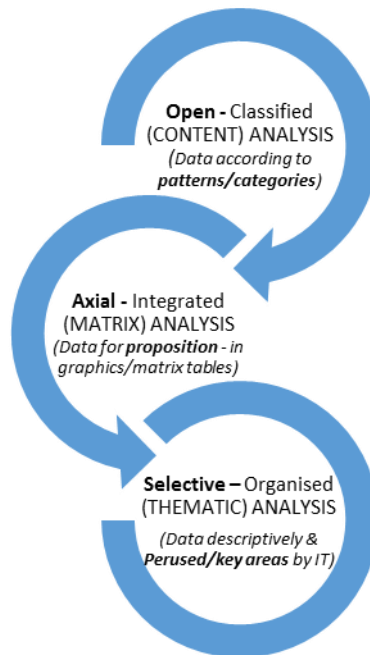
Imperatively, a comparison in the theoretically generated codes was made and commonalities thereof were identified across the four cases. Negative case analysis was conducted by use of experiences (or interactions) identified, which appeared to contradict the theoretical assumptions driving the study. Results and discussions presented in the study most heavily were drawn from the naturalistic observations in-depth interviews and focus group engagements, which are critically, informed by key informants and a wide participation of selected focus group participants respectively. When analysing talk and text, Denzin and Lincoln (2011: 869) assert that there are two much-used but distinctive types of empirical materials in qualitative research: interviews and naturally occurring materials (voice recordings of mundane interactions, the written texts). They constitute specimens of the topic of the research. Therefore, reading and re-reading empirical material enabled the researcher to pin down key themes and thereby draw a picture of presuppositions as well as meanings that constitute textual material in data (or specimen).

To add, Creswell (2009: 184) suggests a data analysis spiral which involves going through data several times, taking steps such as (a) Organise data descriptively using Microsoft Word; (b) Peruse through data several times and note down preliminary interpretations; (c) Classify data according to themes getting a general sense of patterns named to mean coded, and (d) Synthesise (or integrate) data for propositions in form of graphical presentations to the organization, in this case the Church of Central Africa Presbyterian and United Church of Zambia in Zambia. The data sets gathered

from each of the four cases, Ekwendeni and Embangweni in Malawi as well as Mbereshi and Mwandu in Zambia were analysed to enhance diversity of ideas in accordance with key points in the interviews and desired pieces of information retrieved. Data could be analysed via deductive or inductive means.

Consequently, to achieve the means of data analysis, data collected in the qualitative study, the researcher, based on the large portion of data, “will use inductive reasoning, sort and categorise it and gradually boil it down to a small set of abstract, underlying themes” (Leedy and Ormond, 2010: 160). Thus, based upon data collected, the researcher sorted out and put in categories data on the basis of inductive reasoning which entailed breaking down an idea from specific to general thematic areas. The process resonated with the rationale of classifying, integrating and organising collected data sets (as conceptualised in Figure 4-5 below).

FIGURE 4-5: RATIONALITY - INTEGRATED DATA ANALYSIS



Source: Researcher conceptualised from Creswell (2009); Leedy and Ormond (2010)

The above illustration integrates the three generic approaches to data analysis: content, matrix and thematic phases, based on Creswell (2009) as well as Leedy and Ormond’s (2010) rationale of analysing large qualitative data sets.

4.9.4.1 Content Analysis

Lentz (2010: 289) states that content analysis of data can be used in either qualitative or quantitative studies as well as a mixed type of study (a combination of qualitative and quantitative). The approach emphasises and goes beyond mere reviewing and coding of the collected data and their ultimate meaning for specific research purposes.

Further, a content analysis approach goes far beyond counting of words, patterns that may be latent or manifest in a given text and extracting relevant themes. The approach for analysing data content allows the researcher to engage with text in a manner that is worth inculcating deep understanding of social phenomena in a scientific way despite the subjectivity aspect that comes with content analysis. Content analysis gives the researcher in-depth and real-life experiences from the selected data collection sites. There are two approaches inherent to content analysis: deductive and inductive content analysis.

4.9.4.2 Matrix Analysis

According to Yin (2012: 32), a cross-case synthesis is a study (or empirical inquiry) that contains two or more cases. Multiple cases (when preferred to single) provide a broader array of evidence. Using matrices (herein illustrated by way of matrix tables), the researcher took the view that cross-case synthesis between Zambia and Malawi permitted the study to cover either the same issues more intensely or a wide range of issues.

To ensure corroboration in findings, the data integrated was compared against prior findings yielded in empirical studies in South Africa (Barker, 2008) and Zambia (Nondo, 2010), including other sources that were deemed relevant. Possible contradictions between findings and data sources may have arisen but the researcher attempted to re-assess the accuracy of the sources and provided a synthesis that informs the study.

4.9.4.3 Thematic Analysis

During data analysis, collected data was analysed for themes (in this study, 3-5 minor emerging themes). This approach, according to Creswell (2009: 189), is said to be basic qualitative analysis; today, researchers go beyond this generic analysis to add a procedure within the chosen qualitative strategy of inquiry. The procedure involves systematic steps (Creswell, 2009: 184) which involve generating categories (open-ended coding), selecting one of the categories and placing it within the

theoretical model (axial-oriented coding) and then explicating a story from the interconnection of these categories culminated into selective coding.

Significant to this, the use of categorical codes led to generation of emerging themes (in this study said to be based on foundational factors), which ultimately appeared as major findings resulting in headings/sections in the study (section 7.4).

With the use of an integrated MGT approach emphasised during content analysis for data categories, the interconnections data sets prompted to establish preliminary themes resulted in a story for developing a new theoretical model.

4.10 Data Quality Assurance

This section will discuss quality control measures used for data validity and reliability in line with dependability and credibility as basic criteria for ascertaining the soundness of research undertaken, while considering variations in quantitative and qualitative methods. There are many arguments around the quality assurance check in the name of generalisability and this is taken as another control measure taken that may be used to sum up the parameters employed to assure quality of data for a qualitative study. The study will not discuss generalisability.

To ensure an accurate outcome (trustworthy) and consistency (dependable) of measurable results, the researcher here engaged with the process of triangulation, an interface of findings with similar prior studies; Barker (1998) and Nondo (2010). In some instances, the researcher solicited feedback from informants and FGD participants via a member-check process. The approach is motivated by Simon (2011: 201) who maintains that member checking is the process of verification of information with target groups. The qualitative method of enquiry used in this study further allowed participants in different stakeholder groups in the two church synods as perceived owner representatives, health workers as service providers as well as church and community members and services recipients in the four cases, the chance to correct errors of interpretation.

In view of the interface of findings, Bryman (2012: 73) maintains that triangulation procedures and integration with other empirical studies allow the researcher to gain insights and gain better understanding of the matter investigated particularly applicable to this cross-national case study, interrogating challenges and opportunities for strengthening the management of healthcare provision of faith-based health providing entities in Malawi and Zambia.

4.10.1 Validity and Reliability

There are many contestations about studies conducted to judge how sound research may be and scholars such as Rao (2009: 14) point out that “validity refers to the degree to which a study accurately reflects the specific concept that the researcher is attempting to measure, while reliability is concerned with the accuracy of the actual measuring procedure.” This is about how real the results of what has been investigated can be and be depended upon as well.

Logically, validity is the aspect that “deals with the question of how research findings match reality” (Merriam, 2009: 201). It is a check as to whether the data collected does represent what was actually obtaining on the ground. According to Leung (2015: 326), validity refers to the appropriateness of tools, processes and data used in qualitative research. This entails checking if the research questions used were appropriate for the desired outcome, if the chosen methodology was appropriate for addressing research questions, if the sampling and data analysis was appropriate and finally, if the result and conclusion was appropriate for the sample as well as context.

Meanwhile, reliability refers to “the extent to which research findings could be replicated” (Merriam, 2009: 27). This is an attempt to verify how consistent the result of findings of the research could be if the study was repeated. Leung (2015: 325) argues that in quantitative research, reliability refers to exact replicability of processes and results, while in qualitative studies with diverse paradigms, this form of definition can be epistemologically challenging. In quantitative research, for instance, reliability entails the ability to replicate the results of a study, which is not expected in a qualitative study. Simon (2011: 201) observes that there are various approaches a researcher can use to address validity (rigor, trustworthiness) and reliability (consistency, how dependable); the most popular include triangulation of information among different data sets, member checking which involves receiving feedback from informants and expert review.

This follows that, validity and reliability are “concerns that can be approached through careful attention to a study’s conceptualization and the way in which data sets were collected, analysed and interpreted, and the way in which the findings are presented” (Merriam, 2009: 199). Leedy and Ormond (2010: 115) maintain that “the best way to establish the reliability and validity of the methods employed is to follow the accepted process and use established tools as they were designed to be used.”

On the whole, different terms like ‘credibility’ to imply ‘how truly-valuable’ and dependable and ‘consistent’ results are, were purposefully used in this qualitative study. This is different from validity and reliability as associated with quantitative studies.

4.10.2 Credibility and Dependability of the Study

It is generally difficult to ensure that the outcome of a qualitative study is accurate. Aspects such as credibility (true-value or trustworthiness), dependability (consistency), transferability and confirmability, need to be put into context when undertaking qualitative research of any magnitude (Trochim, 2006: 6).

Additionally, Lincoln and Guba (1994: 113) maintain the use of these terms is not intended to replace ‘reliability’ and ‘validity’ which are usually linked to quantitative research. Credibility is a process that seeks to establish that the results of a particular study are believable. This instance may be a particular example of ‘quality not quantity’, while dependability is referred to as a process that ensures that the study findings are consistent and could be repeated. This is gauged with the standard by which the research is undertaken, analysed and presented. Each aspect in the study should be reported in detail to enable another researcher to repeat the study and achieve relatively similar results facilitated by the voice of multiple constructions. The process also enables researchers to understand methods used and their effectiveness. Results of a study depend more on the richness of the readily available information rather than the amount of data collected from passionate participants.

However, there are many ways of checking the accuracy of study findings, such as triangulation, triangulation through multiple analyses and member-checks with participants, as well as conducting an audit trail in the study. Motivated by earlier voice positions constructed on practical issues, as asserted by Guba and Lincoln (1994: 113) as well as Trochim (2006: 6), this study opted for credibility and dependability, among other criteria for judging the soundness of qualitative research. This is because the quality checks resonate with validity and reliability respectively when applied in terms of quantitative research interventions, thereby implicitly serving the same internal purpose.

In reality, the participants are the key stakeholders who can reasonably judge how credible and dependable the results are. Stakeholders who are key and passionately participated in the study are the health workers who are said to be service providers, and the church together with community members who are service recipients as well as the synod officials (who represent owners) from the two churches in Malawi and Zambia, covering the four mission hospitals. Carrying out member-

checks to verify unclear positions of construct during and after the data collection exercise ensured that the outcome is not only credible but dependable, in terms of the results of the study.

Overall, the results of the member checking procedure did not alter credibility of the sources of data involving informants.

4.10.3 Confirmability and Transferability

Confirmability is the process that questions how the research findings are supported by the data collected. This is a process that establishes whether the researcher had a bias during the study, due to the assumption that in qualitative research, the researcher is allowed to bring a unique perspective to the study. An independent researcher can judge if this is the case by studying the data collected during the initial inquiry. Further, to increase chances of confirmability of the initial conclusion, an audit trail (also referred to as an audit log meant to provide documentary evidence) can be conducted throughout the study to demonstrate how each decision was arrived at. Thomas and Magilvy (2011: 154) advance that confirmability occurs by immediately following each individual and focus group interview participants when a researcher will write or audio-tape records field notes regarding feelings, biases and insights. In addition, the researcher should make a conscious effort to follow, rather than lead, the direction of interviews by asking participants for clarification of definitions, of slang or words and metaphors. This may be done by letting someone who knows the subject matter in the area of study, check it.

In particular, transferability refers to the degree by which the study can be transferred to other contexts while being defined by participants identified and engaged in the research. The participants note specific details of the situation and methods in the research, and compare them to a similarly placed situation with which they are more familiar. Where specifications are compared equitably, the original research would be deemed more credible. It is therefore essential that the original researcher furnishes a relatively high detailed description of the situation and methods used.

4.10.4 Authenticity

Besides credibility and dependability as well as confirmability and transferability as the well-known and long established quality assurance approaches, Cope (2014: 89) posits that authenticity was recently added as a fifth criterion to develop and assure soundness in qualitative research. The criterion of authenticity refers to the ability and extent to which the researcher expresses the emotions of the participants' experiences in a faithful manner (Polit and Beck, 2014: 154). The

implication is that by reporting this approach, the reader grasps the essence of the experience through participants' quotes. The study highlights how the researcher has applied this authenticity to express emotional experiences of participants through various quotations cited in Chapters Five and Six in between various matrices.

In the meantime, other data control approaches such as generalisability have not also become pertinent to this cross-national study because the results about Faith-based organisational management for strengthening church-led healthcare provision between Malawi and Zambia are not quantitative.

To emphasise, while meta-conceptual framework underpinning the study was used in tandem with multi-grounded theory (MGT) defined and explained in section 3.9.3 of Chapter Three as well as justified and applied in Section 4.10 of Chapter Four, different models have been made available for addressing data quality checks, these being credibility (for ascertaining true-value), dependability (for ensuring consistency), confirmability (for assuring neutrality) and transferability (for being certain with applicability). Authenticity (for assuring genuineness) is also included.

4.11 Ethical Considerations

In order to make informed but vital ethical considerations, the study adopted Olsen's view (2012: 39), that in the transcripts, writing can be in the original language or translated, but it may be necessary to use abbreviations or pseudonyms (codified names) to adequately protect the confidentiality of respondents. Throughout the study, the researcher endeavoured to ensure the significance of anonymity of interview informants and focus group discussants who participated in the research. Participants were disguised in codified identities (pseudonyms).

Equally important, the study was guided by the Humanities and Social Sciences (HSS) Committee through the School of Management, Information Technology and Governance of the University of KwaZulu-Natal on the code of ethics for research on human and related subjects. In light of the full ethical clearance approval (Appendix I – Protocol HSS/1141/013D), the researcher ensured strict conformity to the ethical requirements. Both a digital technology (Digi-tech) voice recording device and field notes were used to capture discussions with prior formal permission sought from informants and focus group participants. Where permission was granted, assurance was given that because the recording of voices by the Digi-tech device (or electronic voice recorder) and field notes by handwritten scripts as well as MS word text would be used for academic purposes only.

Further, assurance was such that all recordings were to be either surrendered to concerned authorities to be archived or destroyed after a specified period of intended academic use.

4.12 Limitations of the Study

As mentioned, the researcher may have been known to some participants in the sampled units of analysis. Therefore, the possibility of being biased in the study is likely. This could mainly be attributed to the fact that the researcher worked for a period of 3 years constantly engaging with the members of clergy and fraternity covering all the four mission stations while discharging duties as Regional Development Officer for the Global Fellowship of Christian Youth (formerly called The Boys Brigade International, United Kingdom).

In particular, the period of work for this FBO entailed providing development consultancy services in Central and Southern Africa member states: DR Congo, Malawi, Lesotho, South Africa, Swaziland, Zimbabwe and Zambia. Given the level of interaction and the nature of investigation in this study, some informants who were interviewed in the United Church of Zambia and the Church of Central Africa Presbyterian in Malawi are known to the researcher and so may have been in a way, reluctant to disclose all material facts which could have been vital to responding to key research questions.

However, to mitigate the impact of bias and encourage enhanced open-ness, the researcher stringently applied himself to the ethical code of the University of KwaZulu-Natal, Durban, South Africa, governing research on human and other subjects based upon full ethical approval granted by the Human and Social Sciences (HSS) Committee. The researcher stressed confidentiality and assured informants and respondents of anonymity through the use of pseudonyms.

To add, the other limitation to the study was the issue of long distance and extensive travel by road especially from the home town of Solwezi in Zambia where the researcher mobilised himself with a team of assistants to Mbereshi in senior Chief Mwata Kazembe's chiefdom. Then the team had to make its way through Mwandî in senior Chief Inyambo Yeta's chiefdom of Zambia to the Ekwendeni study site in the city of Mzuzu, and finally to the central business district (CBD) of Mzimba in Malawi. The main bituminised standard road from Mzuzu town of Mzimba is half-way done. Mzimba CBD lies many kilometres away with travel by gravel road surface which was in a very poor state, to Embangweni Mission station. The distance covered in the round trips to the four study sites in Malawi as well as Zambia and back was in excess of 6,968 km (as clocked on the motor vehicle used).

To avert effects of this limitation, enough rest coupled with flexibility to the data collection itinerary for Malawi and Zambia was exercised. Further, adjustments in scheduling informants' interviews and focus group discussion meetings were made, owing to long distances and related cross-border travel challenges.

4.13 Chapter Summary

This chapter presented the research design in light of the research problem, key research questions and research objectives. The philosophical worldview underlying the study is indicated on the basis of advocacy-participatory together with research strategies identified.

Furthermore, the case study strategy incorporated multiple cases that worked in combination with a multi-grounded theory approach to undertake and ascertain the outcomes of the study. Details on the case, site and respondent selections have been included in this chapter. In addition, data collection techniques employed such as semi-structured interviews, focus groups and documentary evidence as well as naturalistic observations were highlighted. Data analysis was discussed in line with content, matrix and thematic approaches. Lastly, in this chapter, ethical considerations and limitations to the study were propounded to evoke the scenario in which the investigation was conducted. It also highlighted the nature of enquiry that the researcher pursued while observing quality assurance standards of validity and reliability, credibility and dependability, as well as confirmability, transferability and authenticity for this type of qualitative study.

CHAPTER FIVE: CASE OF THE CHURCH OF CENTRAL AFRICA PRESBYTERIAN IN MALAWI

5.1 Introduction

Chapter Five focuses on the context of the country of Malawi, documentary evidence and field observations, the Church of Central Africa Presbyterian at the Synod of Livingstonia, and data presentation as well as interpretation for the selected hospitals. The chapter then proceeds to highlight Ekwendeni Mission and later, Embangweni Mission within Malawi through interviews and focus group discussions by stakeholder segmentation.

Consequentially, stakeholders who participated in the study were segmented according to interest, the position of responsibility and roles they play in the church to make the delivery of healthcare services possible. The segments included interview participants at the church's synod – the Synod of Livingstonia with the laity and clergy (who represent the church as owners), the focus group discussions at the mission stations with the health workers (who represent the service providers) and members of the community who access healthcare services (as service recipients).

5.2 Country of Malawi

Malawi is a land-locked country, located south-east of the African continent and shares borders with three countries: Mozambique, Tanzania and Zambia. It has a surface area of 118 480sq km with a total population of 16.7 million people. The literature review in Section 3.2.1 has highlighted historical perspectives of the country of Malawi as a former British protectorate.

FIGURE 5-1: LOCATION OF MALAWI AMONG SOUTHERN AFRICAN COUNTRIES



Source: Adapted from Google Maps (www.googlemapsmalawi.com), 2014

5.2.1 Malawi National Healthcare

The health sector strategy and policy (Malawi HSSP, 2014-2016: 12) explicitly outlines goals of healthcare improvement efforts in Malawi based on four key outcomes: first, increased coverage of high quality essential healthcare package (EHP) services; second, strengthened performance of health system to support the delivery of EHP services; third, reduced risk factors to health and fourth; improved equity and efficiency to the delivery of quality EHP services. Through the said outcomes and related outputs, the range and quality of health services for mothers and children under the age of 5 years has expanded, strengthened and integrated to almost the entire population. This means better health care provided in all facilities, equitable resource allocation is realised, access to health care facilities and basic health services improve, well trained human resources, better and equitable distribution of supplies, strengthened collaboration and partnership, and so there is an increase in overall human, financial and material resources in the health sector generally. The objectives of the HSSP (2014:12) seek to address health system improvements in various ways. In the year 2002, Malawi published the Poverty Reduction Strategy which included the essential healthcare package (EHP). The EHP was derived from estimates of the most significant burdens of disease in Malawi and was provided by the World Health Organization (WHO cooperation strategy 2008-2013, Malawi).

Currently, the situation characterising derivation of vital elements of EHP based on WHO (2013) in line with Malawi, HSSP (2014:12) has not changed substantially because health with related estimates of most significant burdens of disease are now integrated in the first set of three priority areas of the 17 SDGs in the newly found path of global development. The central focus of the EHP was to combat 11 health issues identified as the most which greatly affect the poor. Later in 2004, the government of Malawi, in collaboration with cooperating partners, developed a six-year Program of Work (POW) that evolved around the key elements of the EHP. The POW was adopted to guide implementation of the EHP using the Sector-wide Approach (SWAp) in public healthcare. SWAp is generally used as a cross-cutting tool for smooth implementation in line with other government ministries like the ministry of education in Malawi. By 2007, POW was transformed to become the Health Sector Strategic Plan (HSSP) under the ministry of health and took effect from 2007 to 2011 (WHO Cooperation Strategy 2008-2013, Malawi).

Moreover, working in conformity with HSSP (2007 – 2011) means functioning according to the guidelines of implementation of activities embedded in the annual work plans (in which the health budget is enshrined). Work plans are developed and implemented yearly based on the master plan – the national health strategic plan including other parent documents such as Vision 2030 issued by the government of the Republic of Malawi (Malawi, National Health Sector Strategy and Policy, 2014) and will for the purposes of this section, focus on country's health budget, staffing and access to health facilities.

5.2.1.1 Health budget

According to the World Health Organization's (2013) statistics on Malawi, there has been a sharp increase in health expenditures in the past decade. From 2002 to 2011, the per-capital total expenditure on health increased from \$27.2 to \$77.0 and per capita government expenditure on health increased from \$16.4 to \$56.5. These statistics indicate that healthcare in Malawi is receiving greater attention and resource allocation. Statistics also reflect the increased health focus of the government of Malawi. From 2002 to 2011, the percentage of total government expenditures allocated to health increased from 13% to 18.5%. Malawi's increased government expenditure on healthcare has coincided with a decrease in the country's dependence on external healthcare resources, such as international and non-governmental aid.

5.2.1.2 Health staffing

In Malawi's health profile, the World Health Organization [2013] reported that there were only 2 physicians per 10,000 population and 3.4 nurses and midwives per 10,000 population. Malawi's shortage of healthcare personnel is the most severe in the region. Additionally, the minimal body of health workers are not evenly distributed in the healthcare system.

Challenges that lead to this shortage are low outputs of medical training institutions, health worker retention, and disease (WHO cooperation strategy 2008-2013, Malawi). In the 1990s, Malawi stopped training auxiliary nurses and medical assistants. In 2001, this training was resumed in an effort to increase human resources for health care.

In 2005, Malawi began to implement its emergency human resource program which concentrates on increasing output of trained medical personnel, improving health worker compensation and retention (WHO cooperation strategy 2008-2013, Malawi).

5.2.1.3 Accessibility to healthcare facilities

Limited access to health services in Malawi affect a large number of Malawians. Despite most public health services being free for the patients, there are often costs associated with transportation to and from a facility. These costs deter many individuals that may be in dire need of care but cannot afford to assume the costs of transportation. Additional transportation needs complicate matters when an individual is referred from either a rural hospital to a district hospital or a district hospital to a central hospital (WHO cooperation strategy 2008-2013, Malawi)

However, according to the Malawi HSSP (2011: 75), the goal of healthcare service provision in Malawi is "to establish POW through the joint health SWAp, a better health system that is responsive to the needs of the people, especially the women and children including vulnerable groups such as the poor." Healthcare is provided through primary, secondary and tertiary levels of the health system. Primary healthcare is provided through community-based outreach programs at the health posts, and health centres, including dispensaries and community hospitals. Secondary level healthcare is provided through district hospitals, and non-profit mission hospitals under Christian Health in Malawi (CHAM). Others are profit hospitals in the private sector. Tertiary level of healthcare is provided by central hospitals which render advanced specialised as well as sub-specialised services including research and tertiary teaching services.

As a result, Malawi HSSP (2011: 77) states that common challenges especially in the health sector include poor infrastructure due to bad road network, inadequate health workers due to brain drain and a weak monitoring and evaluation framework due to poor data management and coordination resulting in inconsistent reporting and information sharing.

5.2.2 Documentary evidence from Malawi

As secondary evidence, the researcher reviewed documents availed by the CCAP Malawi and these are: the revised Service Level Agreement (SLA) Guidelines 2012-2015 between Ministry of Health and CCAP through the Christian Health Association of Malawi (CHAM); the service charter embedded in Malawi national HSSP (2014-2016) and the Summary of the Panoramic Status of the CCAP Synod of Livingstonia. Each is discussed in turn.

5.2.2.1 Service level Agreement

The Service Level Agreement (SLA) is part of the service charter embedded in Malawi national HSSP (2014-2016). The charter seeks to implement a contractual agreement signed (SLA) for the delivery of essential health services with the respective district health offices – particularly where the CHAM-supported health facility is geographically situated. In contrast, at the central level for Zambia the GRZ/MoH has signed at national level undertaking that takes a uniform assumption for all CHI's supported by CHAZ throughout the country regardless of geographical locations. The SLA seeks to be implemented at district or local government level in the wake of the current decentralised governance structures in Malawi. In terms of operationalizing the agreement, the SLA is further interpreted with a summary of the CCAP Synod of Livingstonia's panoramic status, which places emphasis on services and related reimbursement costs from government of Malawi to CHIs. Key elements emphasized in the SLA include a reimbursement mechanism: paying for health services covered in SLAs, selection criteria and initiation process for SLA, monitoring of SLA, quality of health services and standardized costing for Malawi.

In contrast to the SLA which is apparently the key document signed by the church with government in line with the panoramic status of CCAP synod of Livingstonia. Malawi, the MoU which CHAZ seeks to harmonise with the proposed draft Ethos and Ethics for staff the Church Health Institutions places emphasis on the promotion of Christian values in all its member facilities.

Accordingly, the SLA is the service agreement for the delivery of essential health services (EHS) between the government of Malawi through the Ministry of Health (MoH) and the association of Christian health in Malawi.

The evidence of documents reviewed at CCAP Malawi on the Synod of Livingstonia panoramic status, shows the life and work of the church as a whole, particularly how CCAP is making progress with community, partners and the government of Malawi.

Moreover, the government SLA with CHAM outlines pertinent clauses agreeing on what and how member organisations will ensure EHS is provided throughout the country. For the purposes of this study, all documents reviewed were done so in the context of the Church of Central Africa Presbyterian within the Synod of Livingstonia.

Documentary proof provided for Embangweni Mission related to the SLA being the service agreement between government-run EHP services delivery and CHAM for church-led basic healthcare at Embangweni in northern Malawi, which was basically the same as that of Ekwendeni Mission. Furthermore, this was the same even for the organisational structure which does not show major functional relationships and reporting differences in the hospital hierarchy.

5.2.2.2 The Malawi National Health System Strategy and Policy (2014-2016)

The Health System Strategy and Policy (HSSP) of Malawi showed that it covers the period 2014 to 2016. It is a two-in-one document which serves as a policy guide to national health and long-term planning. It may be that the policy guidelines in the Malawi HSSP emphasise planning and strategy formulation focusing on the period of 2014-2016 covered in the strategy document, with most clauses making extensions and assumptions that the national health system is continually guided beyond 3 years. Comparably, in the case of Zambia in section 6.2.2.2 of Chapter Six, Zambia has two independent documents: a national health policy and the national health strategic plan (NHSP, 2011 - 2015), which are used interchangeably to guide policy and nation health planning. This entails that periodic planning is continually guided by the national health policy (NHP, 2013) established by government through the Ministry of Health. It was not immediately clear if the national health policy of Malawi has always come as a concomitant document to the strategic plan. Furthermore, while a review of the Malawi (HSSP, 2014-2016) showed that it covers a strategic period of 3 years, the Zambian NHSP (2011-2015) has a span of 5 years.

5.2.2.3 The Panoramic Status of the CCAP Synod of Livingstonia

The CCAP Synod of Livingstonia has in place a document entitled ‘The Panoramic Status’. Review of the documentary evidence showed that it depicts long-term intentions and highlights progress made thus far on interventions made through various programmes such as health, education and development. This is an ‘all-in-on’ document. In contrast, the UCZ case in section 5.2.2.3 of Chapter Six produced it as separate document; the Church’s strategy covering the period 2011-2015 which highlights progress split by two performance review documents (mid-term and end of term).

‘The Panoramic Status’ is authored by the General Secretary of CCAP Livingstonia Synod while in Zambia; the UCZ strategic plan is authored by the Strategic Planning Committee appointed by the Synod.

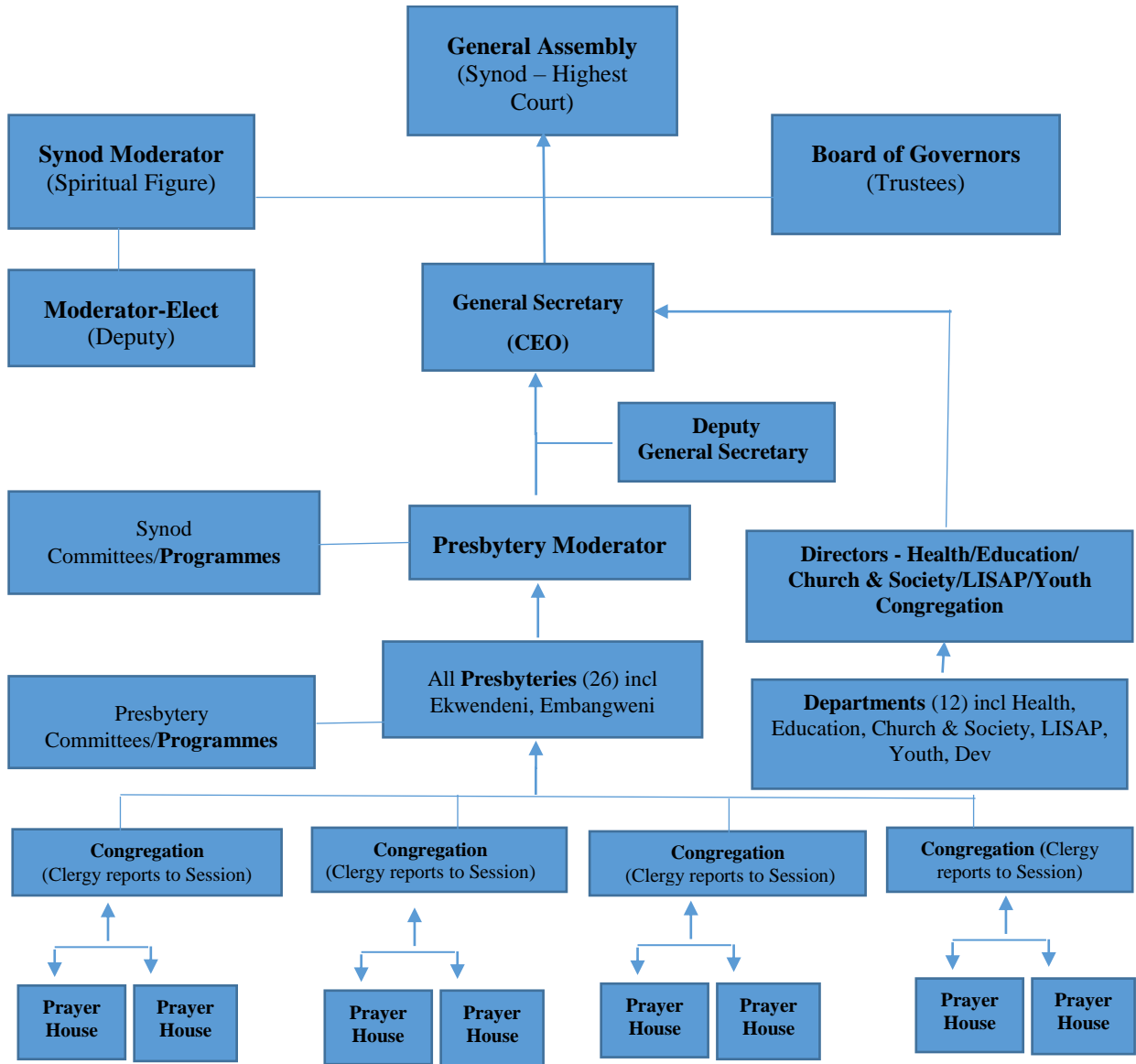
5.3 The Malawian Church of Central Africa Presbyterian in Context

According to Zeze (2012: 52), the Presbyterian Church governance system in Malawi was introduced by the missions of the Church of Scotland and the Free Church of Scotland. The two missions founded respectively; the Blantyre mission (which was later called the Blantyre Synod) and the Livingstonia mission (which was also later called the synod of Livingstonia, simply put, Livingstonia Synod). In the year 1924, they were joined together to form a federation of churches (or federated church) called the Church of Central Africa Presbyterian (CCAP). Later in 1926, the federation was joined by Nkhoma Synod (formerly the Reformed Dutch Church Mission – RDCM). Emphatically, the study focus is on the CCAP Synod of Livingstonia.

In that view, the CCAP Synod of Livingstonia (2015) indicates that the CCAP Synod of Livingstonia is one of the oldest and biggest churches in Malawi. Zeze (2012: 54) maintains that after the conclusive formation with the three synods in 1926, further efforts to expand mission work resulted in the establishment of the mission stations such as the Ekwendeni mission (in the year 1889) and the Loudon mission station (in 1889 which was later named Embangweni). The CCAP Synod of Livingstonia (2015) further states that it has 205 congregations and more than 1,000 prayer houses throughout the Northern region of Malawi. With about 200,000 adult members, the church reaches about 25% of the adult population in the Northern region. In its ministry, CCAP Synod of Livingstonia in Malawi does not only reach out to communities with spiritual care but it is also involved in development projects for education, healthcare, HIV&AIDS, water and many other interventions.

In this way, the Synod has become an important civil society organisation in Malawi, touching the lives of many. Besides the research objectives, this study focuses on the Church's contribution to development in healthcare provision as part of part civil society's role.

FIGURE 5-2: ORGANISATION STRUCTURE AT THE SYNOD OF LIVINGSTONIA



Source: Researcher’s fieldwork based on Synod interview (2014)

Nyondo (2013: 7) maintains that the growing and dynamic Church of Central Africa Presbyterian in the Synod of Livingstonia has since 1956 expanded from three presbyteries to now 25 presbyteries with 200 congregations accommodating a total Christian community of over 800 000 people.

By 1980, the Synod had established few departments which to date have grown to 16 functional departments providing social services ranging from health and education to agriculture and human rights. The church’s Synod provides service through its departments as programmes to communities is without any regard to denominational affiliation or bias.

5.4 Primary data presentation and interpretation for CCAP Synod and Ekwendeni Mission Station

Prior to presenting and analysing data, it is worth noting the context of the hospital facility and population of the area. Christian Health Association in Malawi (CHAM, 2014) states that Ekwendeni Mission Hospital was initially established as a dispensary in 1889. The hospital has a 230-bed capacity hospital owned by CCAP Synod of Livingstonia since 1962. Contrary to this, CCAP Synod of Livingstonia, according to Nyondo (2013: 2), became autonomous in 1965 from the Church of Scotland. Ekwendeni Mission Hospital has since then been registered under the Christian Health Association of Malawi. It is located in Northeast part of Mzimba (said to be largest district in Malawi), about 25 kilometres from Mzuzu city, along the M1 road to Karonga district. It has a catchment of 600 square kilometres, serving a population of 74,048 people (HSA headcount 2007 – CHAM, 2014). It also serves a referral for a population of over 200,000 people from the neighbouring areas, districts in northern region of Malawi, Tanzania and Zambia. It has 274 staff members working in clinical, nursing, primary health care, administration, maintenance and chaplaincy departments. These departments provide preventive, curative and rehabilitative health services to patients and the community.

Figure 5-3 below depicts the location of Mzuzu town where the Ekwendeni Mission station as a study site is situated in the case of CCAP Synod of Livingstonia, Malawi.

FIGURE 5-3: LOCATION MAP OF EKWENDENI IN THE TOWN OF MZUZU, MALAWI



Source: Adapted from Google Maps (www.googlemapsmalawi.com), 2014

The Preventive health services are provided by the primary health care department through 14 programmes which is said to have a strong community partnership and focus, mainly on maternal and child health, HIV/AIDS control, reproductive health, child survival, saving newly born lives, malaria, tuberculosis, food and healthy communities, micronutrient (MICAH), fertilizer revolving fund, community grain banks, women savings and credit schemes, water and sanitation and mental health (Nyondo, 2013: 4).

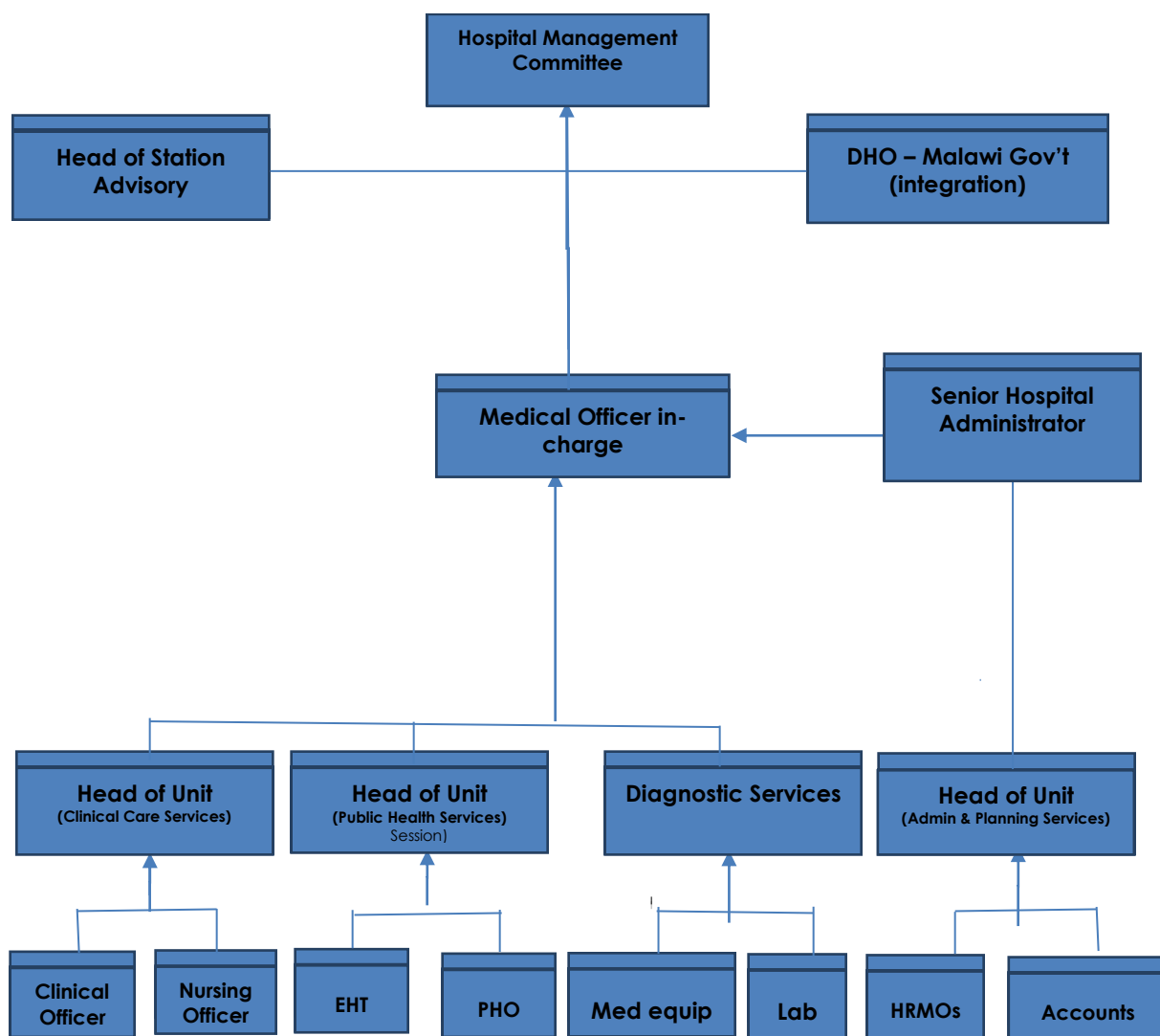
Equally important, curative services are provided by clinicians and nurses working in a busy outpatient department and wards. There are 210 beds in Children (42), Maternity (72), Male (25), Female (25), TB (24) and new Private (10) wards. 7451 patients out of 17756 seen in OPD were admitted in these wards in 2006, with 3012 deliveries being conducted.

As a consequence, other services offered by the hospital include rehabilitative services such as physiotherapy, Orthopaedics (e.g. Jaipur limb workshop), which produce artificial limbs and the nutrition unit for malnourished children. The hospital income derives from the following sources: 50% from government of Malawi (through CHAM), 37% from donations, 11% from patients' fees and 2% from income generating activities. In Malawi, the researcher and team visited the head office at CCAP Synod of Livingstonia, proceeded to Ekwendeni Mission station and held in-depth interviews with selected informants and focus group discussions with participants at the Mission hospital, Ekwendeni Mission community and traditional authority from the outlying community within the Ekwendeni chiefdom.

Figure 5-4 below illustrates how the hospital at Ekwendeni Mission Hospital functions through its organisational structure. It has three levels of reporting highlighted: health workers (in white), heads of units (in black – supervisory level) who report to the third level the hospital management (in black). The hospital is managed in the day-to-day operations of healthcare delivery by the senior hospital administrator whilst the medical officer in charge takes care of all clinical and public health issues. A combination of Senior Hospital Administrator, Medical Officer in-charge, other key players like the Presbytery Moderator who serves as Head of Station at Ekwendeni mission and a representative of the District Health Office from the Government Ministry of Health is said to constitute a senior management team of the hospital. The functions in the organogram flow bottom-up – from health workers, through supervisors and then to management.

Most significantly, governance connections related to the church through the head of station who also works as the moderator in the vicinity of Ekwendeni Presbytery. The hospital also works with government through the District Health Office of the Ministry of Health in Malawi.

FIGURE 5-4: ORGANISATION STRUCTURE AT EKWENDENI MISSION HOSPITAL



Source: Researcher’s fieldwork based on Synod interview (2014)

Furthermore, Figure 5-4 illustrates the relationship in the organisational functions between management and governance whereby advisory support is received from Church ownership through the Head of Station as well as health systems technical support from Government integrated through DHO. In one part, the organogram has depicted the management reporting flow in bottom up way – from workers (e.g. clinical officers) via supervisors (head of clinical care) to hospital management committee (through medical officer in-charge/hospital administrator). The hospital management committee is a platform of heads of units and other specialised staff chaired by either medical officer in-charge/hospital administrator where progress on healthcare service delivery is shared.

In the other part, governance in relation to the church is seen through the head of station who advises the hospital on matters related to ownership as well as chaplaincy matters while working within the vicinity of Ekwendeni Presbytery as minister in-charge of the mission congregation.

Equally important, while the hospital closely works with the church authorities on one end, there is a collaborative engagement with government through the District Health Office of the Ministry of Health in Malawi on the other end.

In the next discussion, data is presented in form of matrices covering interview and focus group discussions with interpretation. The order of presentation is such that interviews come first, segmented according to the Church's synod secretariat and related mission hospitals, followed by focus group discussions whose responses are categorised according to key research questions. The matrices depict CCAP Synod interview perspectives on healthcare management in line with challenges, collaboration and ways of improvements. The data sets are discussed in relation to literature presented in chapters two and three as well as documentary evidence and field observations.

5.4.1 Interviews for CCAP Synod Secretariat in Malawi

The interviews constituted all in-depth interactions between the researcher and informants with responses which formed excerpts as contained in matrices. These formed the process which helped to establish categories. Categories became a special feature for processing preliminary themes in the context of the CCAP Synod Secretariat, Malawi. To reiterate the relationship between synod and mission station, the synod is the supreme governing body of the CCAP church in the Synod of Livingstonia and is in the discussion placed before the first mission station though the synod oversees both mission stations (Zeze, 2014: 7). The similar arrangement and flow applies in Chapter Six for the case of the United Church of Zambia.

The matrices 5-1 to 5-3 under discussion in this section show the interview responses from the CCAP synod of Malawi in the perspective of informants who participated in this study on Faith-based organisational management for strengthening church-led healthcare. The matrices reflect responses from interviews conducted in terms of challenges, opportunities for collaboration and ways of making improvements.

The flow of the discussion starts with data presentation in the form of matrices based on synod level interview responses, followed by both interview feedback and FGD meetings responses with Ekwendeni Mission and finally Embangweni Mission station. Matrix 5-1 depicts the perspectives on challenges of healthcare management by CCAP Synod of Livingstonia Secretariat mainly related to insufficient finances and other problems such as the independent operations of the hospitals from each other despite being sister CCAP health facilities, and the lack of medical equipment as well as facilities. Identification of systems that govern management, administration and the lack of medicines as well as qualified staff are eminently shown in the matrix to underscore how some of the challenges speak to literature in light of the study.

MATRIX 5-1: CCAP SYNOD PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES

Challenges	Interview responses from Malawi Synod
Finances (3)	“Unattractive salaries and wages have a negative impact because many staff members leave for greener pasture.” M-SoL-SM Sustainability of hospitals due to inadequate funds despite salaries paid by government, though not on time. M-SoL-GS, M-SoL-HD
Autonomy (1)	Hospitals work independently with employees not transferable ... autonomy negatively affects service, limits new ideas. M-SoL-YD
Equipment/Facilities (1)	“The hospital facilities bother me as many patients are told by Doctors; we have no equipment to do this...” M-SoL-SM
Management and administrative systems (1)	“... Management, administrative and accounting systems that we have in place – so these are major ones.” M-SoL-HD
Shortage of Medicines (1)	“...they don’t have all the drugs so people go to central hospital. Sometimes they prescribe drugs they don’t have...” M-SoL-APD
Shortage of Staff (1)	“...then sometimes they don’t have specialised doctors.” M-SoL-APD
Unqualified Staff (1)	“...personnel are not fully qualified. We have some personnel that fail to diagnose some diseases.” M-SoL-SM

Source: Researcher’s fieldwork based on interview responses to challenges of healthcare (2014)

Certain informants felt uncomfortable with the existing system of managing the hospital at the mission station: "...something to do with the management, administrative and accounting systems that we have in place – so these are the major ones" Informant (**M-SoL-HD**). The system seems not open enough for others to present other opinions or ideas and literature according to Kaplan *et al.* (2009: 1120), whose study identified challenges of program institutionalization and sustainability as it pertains to participatory ways in which communities become part and parcel. Mobilising programs within communities and ensuring they remain working to benefit the concerned community over a period of time and this could contribute significantly to the way a system may be appreciated as working well or not working well. To add, others like informant **M-SoL-YD** (2014) argue that the independence of the mission hospitals because they work at one for themselves, and are its employees, is not transferable. This is an indication that autonomy negatively affects service delivery because there is limitation to new ideas from employees where improvements are concerned. There is simply no job rotation where employees change/swap jobs after a specific period of time to promote innovation.

The next matrix 5-2 displays opportunities that demonstrate collaboration between government and the mission hospitals arising from interviews conducted at the CCAP synod Secretariat. It is mainly seen that salaries for health workers come from government ties in tighter circumstances as an opportunity for collaboration. The availability of a service level agreement on maternal health services and community health networks set to facilitate interventions such as the AIDS program in society, are said to be secondary. Other informants added monthly grants including training and stationing of health workers.

MATRIX 5-2: CCAP SYNOD PERSPECTIVES ON HEALTHCARE MANAGEMENT COLLABORATION

Collaboration	Interview responses from Malawi Synod
Salaries (4)	“Clinical officers, nurses, doctors are on the payroll of the government ...” M-SoL-SM, M-SoL-APD Government is in agreement with CCAP running 64 primary schools, 8 secondary schools, 1 university & 1 teacher’s college with staff salaries. M-SoL-GS, M-SoL-HD
SLA on Maternal Health (3)	“SLA in place, so all maternity patients are not charged because government pays so its free service... the situation is close to 45% budget liability” M-SoL-APD, M-SoL-YD, M-SoL-HD
Community-based health networks (2)	“...the Uchembele Network deals with maternity issues...staff working are not just from our church but different churches surrounding our hospitals” M-SoL-SM Our CCAP AIDS in society program... Mission helps to prepare proposals which government passes to Parliament. M-SoL-GS
Drugs (1)	“... They are also giving us some drugs...” M-SoL-HD
Training/Deployment (1)	“Training of HR and deployment...” M-SoL-YD

Source: Researcher’s fieldwork based on interview responses on opportunities for collaboration (2014)

The literature in Chapter Three, according to Sanders (2014: 1), argues that equitable partnerships can form and help to transform communities. While this can be true that establishing networks can bring about formation and transformation in communities, most data categories show that there is a stronger link between government and mission hospitals than community health networks such as Uchembele and LISAP and government. To add, the meta-conceptual framework driving the study promises findings that reflect community stakeholders for strong collaboration based on equitable partnership.

In so far as the relationship between the system of congregational governance and stakeholder approach to FBO management is concerned, congregation governance alone can be a contentious issue as they exclude stakeholder consideration and so it is a necessary move to bring it up as part of the meta-theoretical framework driving the study.

The stakeholder-congregation concept seeks to bring together views of stakeholders such as community members including health workers as well as the presiding church leadership given the implications that come with the user and its abolition policy implemented in total by the government of Malawi and in part (gradually) by the government of Zambia, at the time of data collection.

In the above matrix 5-2, data suggests that a salary paid to the health workers is a means for collaboration with government than with community-based health networks. It is clear that salaries are paid to health workers because human resource is seen as a vital resource to service delivery and yet little attention is paid to community-based volunteers. It may be that in Synod's view, the opportunity by government for dismantling the wage bill, in what is vital for enhancing collaboration. How much may go or come from the community does not seem vital. Further, the earlier matrix 5-1 paid attention to the aspect of community contribution in terms of user fees and the effect it has had on the financial standing of the mission hospitals after abolition. If before abolition, user fees meant well in the sustainability of the operational funding in part, and then it is possible that community-based networking intervention could form a significant part of collaboration.

MATRIX 5-3: CCAP SYNOD PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS

Improvements	Interview responses from Malawi Synod
Management and administrative systems (2)	<p>“...I would love to see our personnel managing the hospital improve by exposing them to training...” M-SoL-SM</p> <p>“...resources, small as they may be ... by being effective in allocating and using them. ... have got good management and administrative systems in place.” M-SoL-HD</p>
Fulfilment of SLA regulation (2)	<p>Government to honour the agreement in paying for services of medical services say by cash budget – to properly fulfil SLA. M-SoL-YD</p> <p>Government must stop politicizing their assistance to health sector while Mission should further contribute to CHAM to strengthen empowerment. M-SoL-GS</p>
Fund raising/IGAs (1)	<p>“They should have other ways and means to generate income. If one day government withdraws they continue what they are supposed to do.” M-SoL-APD</p>
Orientation to mission regulations (1)	<p>Staff orientation of ‘called staff’ with special calling to serve in a mission (in still). M-SoL-GS</p>
Recruitment Criteria (1)	<p>Centralise employment/recruitment... empower health coordinator (director) for such decisions as recruitment and posting. M-SoL-YD</p>

Source: Researcher’s fieldwork based on interview responses to improvements for healthcare (2014)

The matrix 5-3 shows that improvements for managing healthcare from interviews at the CCAP Synod Secretariat (Malawi) related to systems in the management and administration of healthcare provision as well as fulfilment of the promises in the SLA regulation. Fund-raising initiatives, orientation to mission regulations and revisiting recruitment criteria are also among the suggestions from synod voices.

Literature according to Kaldor (2010: 16) maintains that FBOs are said to be trusted entities and have demonstrated this through their sound ‘social capital’ which has contributed to the new level of enthusiasm for the work of NGOs.

There is a relationship between the management and administrative systems which monitor the implementation of the SLA agreement in the mission hospitals and social capital – being the people relations and trustworthiness of church. Government promises to pay for the maternal health services based on the renowned social capital embedded in the church as a faith-based organisation. If they do not pay, particularly on time, then the envisaged implementation of planned and budgeted-for activities will not translate into improvements in the management of healthcare service delivery.

5.4.2 Interviews for Ekwendeni Mission Station

This section presents matrices 5-4 to matrix 5-6 which show interview responses in the perspective of the informants who participated in the study from Mbereshi Mission station. The matrices reflect responses from interviews in the context of challenges, opportunities for collaboration and areas of improvements.

The Matrix 5-4 depicts the interactive responses from the informants who were part of the in-depth interviews from Ekwendeni Mission station. The matrix reflects responses from interviews in terms of challenges, opportunities for collaboration and ends with ways pointing to improvements.

MATRIX 5-4: EKWENDENI MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES

Challenges	Interview responses from Ekwendeni
Inadequate Finances (2)	“...we provide free maternity services per agreement...we are unable to generate funds to pay staff & service.” M-Ek-HCC, M-Ek-HA
Shortage of Medicines (2)	“...sometimes we run short of essential drugs... if we do, we cannot stock all the drugs” M-Ek-HM, M-Ek-HA
Shortage of Staff (2)	“...shortage of staff, especially clinical officers, medical assistants and nurses.” M-Ek-HM, M-Ek-HA
Mission regulations (1)	“Our regulations here are quite tough being a Christian organisation.” M-Ek-HCC
Staff Retention (1)	“We have a problem with retention of staff; it’s a problem to keep workers here because our salaries are not as high...” M-Ek-HCC
Unsettled User Fees (1)	“Patients who can't pay are discharged trusting will pay.” M-Ek-HA

Source: Researcher’s fieldwork based on interview responses to challenges of healthcare (2014)

The matrix 5-1 shows that challenges from interviews at Ekwendeni Mission station related to inadequate finances, medicines and staff retention as well as unpaid user fees. Mission regulations pertaining to Christian doctrine are said to be tough, which could have an effect on retention of staff who may not be believers.

Furthermore, literature according McParke *et al.* (2011:104), advances that quick action to remove user fees without prior preparation could lead to unintended effects such as deterioration of quality of care and excessive demands on health workers. We can see unintended effects in the matrix regarding how the problem of unsettled user fees may be seen to have a negligible but close relationship with inadequate funds, ultimately having an effect on staff shortfall possibly attributed to lack of a proper retention scheme, and shortage of drugs at the mission hospital. “Patients who can't pay the bill are discharged trusting they will come back and pay but don't... we don't follow them because we lose more money to follow up” (Informant **M-Ek-HA**, 2014).

This then takes us to another matrix interpolation, matrix 5-5, covering Ekwendeni Mission station interviewees’ feedback on healthcare management collaboration.

MATRIX 5-5: EKWENDENI MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT COLLABORATION

Collaboration	Interviewee responses from Ekwendeni
Drugs (2)	“...Some drugs we get from government are free of charge example, malaria, STIs, TB and other...” M-Ek-HM, M-Ek-HA
Salaries (2)	“...our salaries come from the government” M-Ek-HM, M-Ek-HA
SLA on Maternal Health (2)	“...a service level agreement signed for maternity to be free and then government refunds what we spend...” M-Ek-HM, M-Ek-HA
Government driven in-Service Training (1)	“We appreciate when the government has refresher courses they always include us though it’s only for the workshops.” M-Ek-HCC
Honouring fees on SLA Regulation (1)	“We had a focus discussion with the DHO and we even involved the secretariat at the SYNOD level.” M-Ek-HM

Source: Researcher’s fieldwork based on interview responses to opportunities/collaboration (2014)

The matrix 5-5 shows that main opportunities for collaboration at Ekwendeni Mission station related to governments support on drugs supply, dismantling health workers’ salaries and the SLA on maternal health coverage.

Other than in-service training, honouring fees outstanding on the SLA regulation continues to be relatively similar opportunities that signify collaboration between government and the mission hospital.

Literature backed by Duff and Buckingham (2015: 1792) maintains that strong education guidelines (such as faith-specific training guidelines) developed and tailored to faith-based groups, exist for core competence building to innovate and encourage leadership, as attested by Informant **M-Ek-HCC**: “We appreciate when the government has refresher courses they always include us though it’s only for the workshops.” The appreciation by faith-based health workers for refresher capacity-building through workshops goes to show how much more needs to be done in terms of formal and conventional training to further harness opportunities for collaboration.

Improvements based on interactive responses for interviews from Ekwendeni Mission station are next for discussion in matrix 5-6 below.

MATRIX 5-6: EKWENDENI MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS

Improvements	Interviewee responses from Ekwendeni
Accommodation (1)	“Right now we are losing out a lot of employees because of housing. We are looking at having appropriate houses for the cadres that we have.” M-Ek-HA
Fundraising/IGAs (1)	“As management, we are struggling to generate income. At least we must have something that will bring money ... the user fees.” M-Ek-SHA
Food (1)	“Providing food in the ward because some patients come from far... and so no food. So we will need to hire people and have a kitchen.” M-Ek-HA
In-service Training (1)	“Have some staff exchange with government clinicians . It could also facilitate knowledge exchange.” M-Ek-HCC
Service free of fees (1)	“...people prefer govt hospitals, there are no charges.” M-Ek-HCC
Studies (1)	“...if given opportunities for further studies...” M-Ek-HCC
Water Supply (1)	“Water...” M-Ek-HM

Source: Researcher’s fieldwork based on interview responses to improvements for health (2014)

The matrix 5-6 depicts peoples responses premised on improvements for managing healthcare at Ekwendeni Mission station. They are all weighted with single responses that are relatively similar to matrix 5-5 for synod feedback on improvements, except for resource mobilisation, which is ultimately for self-sustainability. To effect improvement measures that point development and sustainability in healthcare, Mutale *et al.* (2013: 13) maintain that strengthening a health system is a complex intervention and calls for comprehensive improvements for any health system to be strong.

The section that follows discusses data presentation and interpretation based on focus group discussion meetings conducted during the cross national data collection tour.

5.4.3 Focus Group Discussions for church and community members in Ekwendeni

The focus group discussions (FGDs) were conducted to cover Ekwendeni and Embangweni Mission stations respectively. Ekwendeni comes first followed by Embangweni. In each sub-area focus group participants were drawn from healthcare workers at the mission hospital on the one hand and from church and community members on the other hand. This was shown in Table 4-2 in Chapter 4 regarding sampling. At the time of recruitment for the study, participants were drawn from two difference stakeholder groups in keeping with the units of analysis – the community members from within Ekwendeni Mission station and people from outlying areas particularly the traditional authorities' group interview from the Ekwendeni chiefdom, eventually considered as FGD. There was strength in the holistic approach to tackle both members from the community within the mission station and outlying areas which formed part of stakeholder segment of service recipients – church and community members. Other stakeholder groupings discussed in prior sections 5.4.2 and 5.4.3 are officials from synod (perceived in this study as owners) and healthcare workers from Ekwendeni mission hospital (being service providers).

The matrices 5-7 to Matrix 5-9 in this section display interactive responses from participants who were in the group interview, which for the purposes of this study was considered as part of the focus group discussions from Ekwendeni Mission station community, which included a group of traditional leaders who desired to be interviewed individually, while the rest as one group were listening. The matrices under discussion reflect responses in terms of challenges, opportunities for collaboration and ways of improvements.

First of all, the Matrix 5-7 highlights focus group participants’ perspectives at Ekwendeni Mission station on healthcare management challenges related to lack of caring, purpose and compassion, as well as low levels of hygiene/cleanliness. The issues of no equipment, harsh health workers, long waiting periods and unaffordable service fees have been highlighted again.

MATRIX 5-7: EKWENDENI MISSION STATION FGD PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES

Challenges	Focus Groups’ responses from Ekwendeni
Caring, Purpose & Compassion (2)	“How they receive the patient, the reception is not good...not befitting a mission hospital, there is just no patient care” M-Ek-OC: R5, M-Ek-OC: R10
Hygiene/Cleanliness (2)	There is no hygiene and once you are admitted toilets are closed and dirty – a smell that is especially bad for asthma patients. Mosquito nets are not well placed, M-Ek-OC: R11, M-Ek-OC: R10
Equipment/Facilities (1)	“Also you have to fetch hot water because geysers are not working.” M-Ek-OC: R2
Harsh Health Workers (1)	“The employees, the nurses and doctors for some unknown reason sometimes they tend to be a bit rough and aggressive...” M-Ek-TA: R1
Long Waiting Periods (1)	“...time management e.g. if you went at 13hours you are only to be attended to at 14hours.” M-Ek-OC: R5
Shortage of Medicines (1)	“There is another problem of shortage of medicines...” M-Ek-TA: R2
User Fees/Service Charges (1)	“...the charges that are administered at the mission hospital, if you look at the status of the community around, most of them can’t afford the charges.” M-Ek-TA: R1

Source: Researcher’s fieldwork based on FGD responses to challenges of managing healthcare (2014)

According to Ascroft *et al.* (2011: 5), many faith-based and government-run facilities raise revenue through collection of user fees, and although they represent only a small portion of what goes into the cost of providing healthcare, they are quite common and an important source of operational funding. In contrast, McParke *et al.* (2011: 104) contend that the removal of fees has the capacity to increase healthcare coverage citing that user-free access can trigger demand side of healthcare provision. On the basis of literature and close examination of the challenges particularly the regularly occurring problems such as inadequate finances, it is possible to attribute that part of the causes of lack of funding in mission and public hospitals to abolition of certain income-support means such as user fees. Equally important, it is possible to adduce that when healthcare provision is absolutely free of charge, it gives space for community members who cannot afford to come to hospital thereby pushing demand up, leaving the hospital basically constrained financially, as perceived in Matrix 5-1.

While low levels of hygiene and cleanliness may be traced even in other mission hospitals, the problem of practising caring, purpose and compassion can be highlighted here. Horton and Summerskill (2015: 1709) advance that criticising the influence on the practice of dogma in FBOs can arise from an incomplete appreciation of the doctrine that frames different approaches to healthcare. Participants **M-Ek-OC: R5** and **M-Ek-OC: R10** in their responses demonstrate how that there is certainly an incomplete appreciation of doctrine: "...how they receive the patient, the reception is not good...not befitting a mission hospital, there is just no patient care" on the part of health workers providing service delivery. To this end, Participant **M-Ek-TA: R1** adds: "the employees, the nurses and doctors for some unknown reason sometimes they tend to be a bit rough and aggressive..."

It is evident from data and literature that the aggression by harsh health workers can detract from the much needed care, purpose and compassion befitting a faith-based healthcare provider.

Secondly, the Matrix 5-8 highlights focus group participants' perspectives at Ekwendeni mission station on healthcare management collaboration related to government driven in-service training, the existence of the SLA on maternal health and transport support services.

**MATRIX 5-8: EKWENDENI MISSION STATION FGD PERSPECTIVES ON
HEALTHCARE MANAGEMENT COLLABORATION**

Collaboration	Focus Groups’ responses from Ekwendeni
Government-driven in-Service Training (1)	“In fact, they are working with the government by sending people from the college of nursing to work in the government hospital for practical.” M-Ek-TA: R2
SLA on Maternal Health (1)	We hear the government pays few maternity fees for women, so they work together. M-Ek-OC: R7
Transport (1)	“Also, 3 or 4 years ago, the government gave Ekwendeni an Ambulance and a bus for the college of nursing.” M-Ek-TA: R2

Source: Researcher’s fieldwork based on FGD responses to opportunities for collaboration (2014)

The data categories regarding collaboration are relatively similar to what is obtaining under matrix 5-2 in interview perspectives of CCAP synod and matrix 5-8 under Ekwendeni Mission station, except for transport support. Although transport is the most physically feasible collaborative effort participants as service recipients can see in the light of deficits the facility could be experiencing, Lentz (2010: 298) recommends that “facility deficits could be improved if donors foster relationships with corporations to provide rural health clinics with equipment, medications and trained staff.” In setting the ball rolling, for instance, participant **M-Ek-TA: R2** submits that “...also, 3 or 4 years ago, the government gave Ekwendeni an Ambulance and a bus for the college of nursing.”

Third, the Matrix 5-9 depicts Ekwendeni mission focus group participants’ perspectives on healthcare management improvements related to the need for providing in-service training, more equipment and facilities, enhanced hygiene, sound management of client relations and most significantly, revisiting recruitment criteria.

MATRIX 5-9: EKWENDENI MISSION STATION FGD PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS

Improvements	Focus Groups' responses from Ekwendeni
In-service Training (4)	<p>Medical staff attending to us should go for training again to remind them on ways of treatment of disease. M-Ek-OC: R11</p> <p>They don't scan or check to do diagnosis of disease - you are given glasses instead of eye drops, you complain of stomach ache, they give magnesium sometimes for - yes - issues – they just ask you to choose glasses after trying in them. M-Ek-OC: R6, M-Ek-OC: R10, M-Ek-OC: R3</p>
Equipment/Facilities (3)	<p>Add beds in the wards – when loaded some sleep on the floor. M-Ek-OC: R11</p> <p>More equipment is needed in the hospital. M-Ek-OC: R2</p> <p>Equip the hospital – No dental, no eye clinic – we have to go to Mzuzu and it high costing. M-Ek-OC: R7</p>
Hygiene (3)	<p>Improve hygiene – especially toilets. M-Ek-OC: R8</p> <p>Clean the environment – they must kill the smell of the toilet. M-Ek-OC: R10</p> <p>Beddings must be changed regularly. M-Ek-OC: R7</p>
Management of client relations (1)	<p>“I think this has to start with management itself. They need to be taught how they can treat their clients. They need not be rough.” M-Ek-TA: R1</p>
Recruitment Criteria (1)	<p>“...in different departments you will never find a person from Ekwendeni employed in a high position. They always pick people from outside even if they are not qualified.” M-Ek-TA: R2</p>

Source: Researcher's fieldwork based on FGD responses to improvements for healthcare (2014)

Thinking about recruitment, Topp, Chipukuma and Hanefield (2014: 10) posit that effective mechanisms for administrative enforceability should enable health facility managers to invoke positive rewards for good performance outcome or sanctions for inappropriate performance. This can be true for health facility hiring enforceability to award the job to deserving qualified aspirants and not award the poorly performed candidates.

Conversely, participant **M-Ek-TA: R2** doubts recruitment criteria, saying that “...in different departments you will never find a person from Ekwendeni employed in a high position. They always pick people from outside even if they are not qualified”. It is clear from the data and available literature that revisiting criteria in relation to prioritising recruitment to the locals regardless of their qualifications, though helpful, can certainly pose a few enforceability problems.

5.5 Primary data presentation and interpretation for Embangweni Mission Station

In terms of context of the hospital and the sub-area population, Embangweni Hospital (2014: 1) indicates that Embangweni Mission Hospital is a 130-bed capacity hospital located in the southern part of Mzimba district in northern Malawi. The boundaries of the catchment area are the Zambian border on the west and south, the M-1 highway (main north-south road in Malawi) on the east. The Moses Chilenge and Emazwini villages are situated north of Embangweni. The hospital serves a population of about 100,000 people, with referral cases often coming from as far away as eastern Zambia. It operates 4 remote health centres located in Kalikumbi, Mabiri and Mpasazi.

Figure 5-4 below depicts the location of Embangweni town where the Embangweni Mission station is situated in the case of CCAP Synod of Livingstonia, Malawi.

FIGURE 5-5: LOCATION MAP OF EMBANGWENI IN MZIMBA DISTRICT, MALAWI



Source: Adapted from Google Maps (www.googlemapsmalawi.com), 2015

Travel throughout the Embangweni region can be difficult, especially during the rainy months, November to April. The only access to the M-1 highway, a distance of 30 km, is by either the Jenda or Perekezi forest gravel roads. Work to establish Embangweni mission station, also known as "Loudon", was started by missionaries of the Free Church of Scotland, the Reverend Donald Fraser and his wife, Dr. Agnes Fraser, in 1902. The Scottish missionaries came to Malawi following the death of David Livingstone. Clinical work started by Dr. Mrs Fraser was further expanded in 1926 under the direction of Dr. W. Turner to become a rural hospital. A maternity ward was added in 1966. During the 1970s, the hospital doubled its size from 38 to 77 beds.

In 1989 under the ministry of Dr. Kenneth and Mrs. Nancy McGill, the hospital expanded its facilities and services to include separate buildings for maternity, paediatrics, male and female general care, as well as an operating theatre for minor surgeries and caesarean-section deliveries. In the 1990s, the primary healthcare department further expanded in scope and size.

In view of the above, the programs in primary health care include malaria, medicine revolving funds, water and sanitation, mobile clinics, nutrition rehabilitation, tuberculosis control, antenatal and family planning activities, prevention of mother to child transmission (PMTCT) of the HIV project and the child survival program. Embangweni Mission Hospital and its three health centres' staff bring the total number of over 130 health workers. Given its remoteness as well as the many transport hardships encountered by Malawians in accessing services, the hospital remains busy with wards often near capacity most of the times. In addition to outreach services, essential primary health care at Embangweni Mission Hospital includes malaria, tuberculosis, and AIDS Control programs as well as the nutritional rehabilitation services. A demonstration garden, showing agricultural practices, provides the harvest to be used by the home craft workers for food and orienting mothers on nutrition, diet and food preparation (Annual Report, 2013).

As for presentation and analysis of data from all sub-areas, the presentation of data is in the form of matrices covered informants' interviews and focus group discussions with the respective interpretation. The order in which the matrices are presented starts with interviews segmented per mission hospital followed by focus group discussions.

5.5.1 Interviews for Embangweni Mission Station

In this section, the matrices 5-10 to 5-12 under discussion in this section show the interview responses from the Embangweni CCAP Synod of Livingstonia, Malawi, from the perspective of informants who participated about in the study about FBO management for strengthening church-led healthcare provision. The matrices reflect responses from interviews conducted in terms of challenges, opportunities for collaboration and ways of making improvements. The flow of the discussion starts with data presentation in matrices based on interviews at Embangweni Mission station, followed by both feedback and FGD responses. Matrix 5-10 indicates that Embangweni Mission station interview perspectives on healthcare management challenges, related to low staffing levels in health workers and staff housing units. There is also insufficient flow of funds, transport, medicines and equipment as well as poor facilities. Matters of debt burden and staff retention are problems, too.

Furthermore, Matrix 5-10 below depicts Embangweni Mission Station Interview Perspectives on Healthcare Management Challenges

MATRIX 5-10: EMBANGWENI MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES

Challenges	Interviewee responses from Embangweni
Shortage of Staff (4)	“Under developed infrastructure cause staff shortage” M-Em-PHC, M-Em-HR, M-Em-HoS, M-Em-HA
Shortage of Staff Housing (3)	“We have shortages of houses, we can’t retain staff because of housing.” M-Em-HR, M-Em-HoS, M-Em-DFM
Inadequate Finances (2)	“Financial resource are a problem...” M-Em-HR, M-Em-HA
Inadequate Transport (2)	“...we have transport but no fuel.” M-Em-PHC, M-Em-DFM
Debt Burden (1)	“What we get is little compared to what we spend that is why we have outstanding debts of unpaid bills...” M-Em-HA
Inadequate Equipment/Facilities (1)	“hospital facilities are quite old... because of no equipment we refer to Mzuzu Central Hospital.” M-Em-HoS
Shortage of Medicines (1)	“We have shortages of drugs...the shortage of drugs is a major problem here.” M-Em-DFM
Staff Retention (1)	“we don’t have enough incentives.” M-Em-HoS

Source: Researcher’s fieldwork based on interview responses to challenges of healthcare (2014)

From the matrix, Informant **M-Em-PHC** (2014) states that “...we need to have adequate transport but you find sometimes you have no fuel or the car is not there”. The problem of not having adequate transport could also be because of bad road network to Embangweni, as observed by the researcher during the data collection assignment. While data associates the problem of transport to lack of fuel and non-availability of vehicles, Malawi, HSSP (2011: 77) is explicit that common challenges especially in the health sector include poor infrastructure due to bad road networks.

In addition, other hindrances to proper management of healthcare in Malawi which the data equally highlights include inadequate health workers due to brain drain, and a weak monitoring and evaluation framework owing to poor data management and coordination resulting in inconsistent reporting and information sharing.

The next is matrix 5-11 which shows that Embangweni Mission station perspectives on healthcare management opportunities for collaboration from interviews, and these related to SLA on maternal health, salaries to supported health workers' wages monthly, supply of drugs, funding appeals based on the established community health intervention for networking and transport support.

MATRIX 5-11: EMBANGWENI MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT COLLABORATION

Collaboration	Interview responses from Embangweni
SLA on Maternal Health (4)	“...the service level agreement for free maternal services and charge government though is not faithful...government provides supplements to the malnourished” M-Em-HR, M-Em-HoS, M-Em-PHC “...a Service Level Agreement, so government is paying.” M-Em-HA
Salaries (2)	“...the payment of wages to the hospital employees by the government through the CHAM.” M-Em-HR, M-Em-HoS
Drugs (1)	“...they also take the centre role in providing drugs and other services for STIs...” M-Em-PHC
Funding appeals (1)	“There’s a certain initiative where SYNOD funds from the churches to add to the purchase of new ambulances in all hospitals.” M-Em-PHC
Community-based health networks (1)	“SYNOD established PHC to assist people from their homes to ensure they have clean water and good food, etc...” M-Em-HoS
Transport (1)	“A service level agreement with the government...has given us a motor cycle which is helping in the reporting system...” M-Em-PHC

Source: Researcher’s fieldwork based on interview responses to opportunities/collaboration (2014)

According to Zulu *et al.* (2014: 14), suggestions to put community health workers (CHWs) as an intervention for local healthcare would trigger motivation in the people who volunteer to work for their communities.

Notwithstanding this action, credibility and accountability in terms of inclination would be affected because some people tend to perceive some of the ministry of health programmes such as CHW as being more inclined to government for accountability than to community. Clarke and Ware (2015: 39) further state that religious teaching also contains precepts on how to live a righteous life, including responding to those that are materially poor”. It may well be that in view of data the “Synod established PHC to assist people from their homes to ensure they have clean water and good food, etc...” (Informant **M-Em-HoS**, 2014), to contribute to EHS needs necessary to a health centre, as far as attempting to address public health issues is concerned.

Moreover, Matrix 5-12 below highlights improvements for managing healthcare based on responses from interviews at Embangweni Mission station related to the need for consolidated reporting, coming up with fund-raising ventures and a boost to infrastructure development. Others included the issue of in-service training as a refresher intervention for staff and recruitment criteria as well as revisiting labour regulations and salary top-ups.

MATRIX 5-12: EMBANGWENI MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS

Improvements	Interview responses from Embangweni
Consolidated reporting (3)	“Have a central place for all reports...there’s no consolidation” M-Em-PHC, M-Em-HoS, M-Em-HA
Fundraising/IGAs (1)	“Have a private wing then charge high rates to generate money. Or building a house which can be rented out.” M-Em-HA
Infrastructure Development (1)	“...the road is very bad. Getting drugs here is a problem. So, if the government fixed the roads, it will be easy.” M-Em-HoS
In-service Training (1)	“sending hard-working clinic attendants to upgrade would help” M-Em-HoS
Recruitment Criteria (1)	“Have more professionals being hired.” M-Em-HR
Labour Regulations (1)	“...conditions of service are in conflict with the constitution and one can drag you to court.” M-Em-HR
Salary ‘top ups’ (1)	“Get top-up salary ...” M-Em-HA

Source: Researcher’s fieldwork based on interview responses to improve healthcare (2014)

Worth noting, data sets in matrix 5-12 show that “In relation to labour laws, conditions of service in the context of the church are okay but in conflict with the constitution and one can drag you to court” (Informant **M-Em-HR**, 2014). But literature according to Segal (2009: 4), maintains that religious belief is relevant to both social and private realms, and further maintains that in addition to the worship of deity, it also involves belief in “a revealed scripture, a divinely ordained code of laws and an assortment of institutions, and communal structures in which religion is observed.” This scenario in literature and the voice of data entails that the constitution of the church in Malawi needs to be revisited so that aspirations of the church are in harmony the labour relations Act. The labour Act must be matched with the conditions of service for health workers to pacify the differences in between the two documents (The Labour Act and The CCAP Synod of Livingstonia Constitution).

5.5.2 Focus Group Discussions in Embangweni Mission

The focus group discussions (FGDs) were conducted to cover the mission station in Embangweni Mission station, where the mission hospital provides healthcare to a catchment population of approximately 200 000 people. Ekwendeni FGDs have been tackled under section 5.4.3 and now followed by Embangweni.

In this section, matrix 5-13 to matrix 5-15 show responses from the participants who were part of the focus group discussions from Embangweni Mission station. The matrices in question reflect responses from focus group discussions in terms of challenges, opportunities for collaboration and ways of improvements.

Firstly, the Matrix 5-13 highlights focus group participants’ perspectives at Embangweni Mission station on healthcare management challenges are associated with short supply of medicines, insufficient equipment/facilities in terms of bed-spaces and the lack of adequate transport.

MATRIX 5-13: EMBANGWENI MISSION STATION FGD PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES

Challenges	Responses from Focus Groups in Embangweni
Shortage of Medicines (3)	R1: "...shortage of medicine (drugs). At most, we just dispense panado because that is all we have." M-Em-MC: R1 R2: "Personally, I think shortage of medicine – If there are no drugs then treatment will not be completed" M-Em-MC: R2 R3: "You can have rooms but without medicine it is nothing." M-Em-MC: R3
Equipment/Facilities (2)	"Congestion in rooms for admitting patients – in times of overflow, patients sleep on the floor. Rooms don't accommodate patients in proportion to population." M-Em-MC: R1 R3: "You can have medicine but if there are no rooms there is still a challenge. So there is need to maintain some rooms and supply of medicine." M-Em-MC: R3
Transport (1)	R1: "The first problem is transportation... We have few drivers and only one or two vehicles so as a result the transport is not enough." M-Em-MC: R1

Source: Researcher's fieldwork based on FGD responses to challenges of managing healthcare (2014)

The matrix shows that challenges from focus groups at Embangweni Mission station related to shortage of medicines (3), inadequate bed-space (2) and lack of adequate transport. The conspicuous "congestion in rooms for admitting patients – in times of overflow, patients sleep on the floor when rooms don't accommodate patients in proportion to population", according to FGD participants (like **M-Em-MC:R1**), clearly shows a mismatch in management theory and practice at the hospital facility.

Secondly, the Matrix 5-14 shows focus group participants' perspectives at Embangweni Mission station on healthcare management opportunities for collaboration are associated with government arrangements of paying salaries to health workers.

MATRIX 5-14: EMBANGWENI MISSION STATION FGD PERSPECTIVES ON HEALTHCARE MANAGEMENT OPPORTUNITIES FOR COLLABORATION

Collaboration	Responses from Focus Groups in Embangweni
Salaries (1)	“...some of the employees working here were employed by the Government and they are paid by the government...” M-Em-MC: R1

Source: Researcher’s fieldwork based on FGD responses to opportunities for collaboration (2014)

Thinking about salaries paid to health workers as an expression of the opportunities for collaboration with government cannot be over emphasised. In the data segregation and analysis, it is one of the categories of responses which reached a point of saturation, and government support is evident.

Third, the Matrix 5-15 shows focus group participants’ perspectives at Embangweni Mission station on healthcare management areas for improvements relate to the need for revisiting recruitment criteria.

MATRIX 5-15: EMBANGWENI MISSION STATION FGD PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS

Improvements	Responses from Focus Groups in Embangweni
Recruitment Criteria (1)	R2: “There should be an increase in health workers like nurses. I am not sure if there is a doctor but we used to go to Mzimba for a dentist because of service here.” M-Em-MC: R2

Source: Researcher’s fieldwork based on FGD responses to improvements for healthcare (2014)

In the matrix 5-15, data issue of revisiting recruitment criteria in the perspective of the community indicates the need to expand the horizons under which health workers like nurses are employed. Revisiting recruitment criteria to include giving priority to the locals in isolated cases such as classified employees could certainly make a difference for community members as they would feel embraced. That difference could point to one of the much desired contribution to envisaged improvements that transform healthcare delivery.

In this perspective, the application of how literature and data speak to each other on improvements’ perspectives is relatively similar to Matrix 5-9 in the prior section 5.4.3

5.6 Chapter Summary

This chapter has covered discussions in the context of the Church of Central Africa Presbyterian Synod of Livingstonia in Malawi. Data presentation and interpretation, documentary evidence and field observations for both the synod secretariat and the two mission hospitals, Ekwendeni Hospital and Embangweni Hospital located in the northern region of Malawi, through interviews and focus group discussions by different stakeholder segments. Among other findings, what emerged is that there is a negligible partnership of the hospital with society and opinion leaders from the community in the two study sites. The call for increased involvement of local people in the affairs of the mission hospital seems not emphasised. Also, criteria for recruiting workers are to some extent said to be at the exclusion of community members. It can be concluded that despite varying backgrounds, some of people the two study sites feel placed in the margins of society and so are not much involved in local health service delivery. Creating space in the employment criteria may come with its own enforcement difficulties. Further, engaging them through community networks of healthcare such as PHC to address public health concerns including safe motherhood action groups (SMAGS) for expectant mothers could be one step to make members of the community especially Ekwendeni largely feel that they are part and parcel of the local health system.

CHAPTER SIX: CASE OF THE UNITED CHURCH OF ZAMBIA

6.1 Introduction

This chapter focuses on the country context of Zambia's health scenario and documentary evidence for Zambia before getting to details of the case of the United Church of Zambia, data presentation and interpretation for both hospitals. It starts with the UCZ synod headquarters, then moves on to Mbereshi and Mwandu Missions in Zambia through interviews and focus group discussions by stakeholder segmentation.

As with this section in Chapter Five, the chapter further seeks to set the stage for analysis. Participants who served as stakeholders in the study were segmented according to interest, the responsibility that their title carries and roles they play to make healthcare provision better. The segments included interview participants at the level of synod – the synod of Livingstonia with the laity and clergy members of staff (who represent the church as owners); the focus group discussions at the mission stations with the health workers (who represent the service providers), and members of the community who access the healthcare provided (as service recipients).

6.2 The Country of Zambia

Located in the sub-region of southern Africa like Malawi, Zambia is a landlocked country covering an area of 752,614 square kilometres. It shares borders with Tanzania (in the North), Malawi (in the East), Mozambique (in the South-East), Zimbabwe (in the South), Botswana and Namibia (in the South-West), Angola (in the West) and the Democratic Republic of Congo in the North-west of the country as the eighth neighbouring state.

According to the World Bank (2015), Zambia has an estimated population of 15.72 million (2014), Growth Domestic Product (GDP) US\$27.07 billion (2014), and GDP growth 6.0 percent (2014), while inflation stands at 7.8 percent (2014). The country's annual population growth rate is estimated at 2.8 percent.

FIGURE 6-1: LOCATION MAP OF ZAMBIA IN THE SOUTHERN AFRICA SUB-REGION (SADC)



Source: Adapted from the Google Maps (www.googlemapszambia.com), 2014

The national health policy (Zambia NHP, 2013: 7) posits that continuous strides to improve the delivery of healthcare to the people represent a call for action by concerned stakeholders, government, non-government entities, civil society organisations, partners and communities, to support the realisation of a national vision on health.

6.2.1 Zambian National Healthcare

The policy on the provision of healthcare demands equity of access, espouses healthy life styles and would like to see productive communities in a sustainable manner.

6.2.1.1 Equity of access

Equity of access entails affording every member of a particular community an opportunity to seek healthcare services from the nearest facility. Government's responsibility in providing primary healthcare services is to take health care in an equitable manner as close to the family as possible (Zambia NHSP, 2011: 35).

In relation to health infrastructure, the Ministry of Health (MoH) is responsible for facilitating a national health system and provides information pertaining to the Zambian health sector. In Zambia, there are hospitals ranging from private to public throughout the country, some of which include: Levy Mwanawasa General Hospital, Chipata General Hospital, Kitwe Central Hospital, Konkola Mine Hospital, Lubwe Mission Hospital, Maacha Hospital, Mtendere Mission Hospital, Mukinge Mission Hospital, Mwandishi Mission Hospital, Nchanga North Hospital, Chikankata Salvation Army Hospital, and Kalene Mission Hospital.

However, the University Teaching Hospital serves as both a hospital and a training site for future health care providers and health workers. There are very few hospitals in rural or remote places in Zambia, where most communities rely on small government-run community health centres and rural health posts (Lentz, 2010: 283). It is against this understanding that while government provides health service delivery through its public facilities especially in urban and peri-urban areas, this study explored faith-based health facilities supported by CCAP in Malawi and UCZ in Zambia to strengthen healthcare provision by contributing to the attainment of the national health policy of the Zambian government (NHSP, 2011: 35); the goal of the latter is to bring healthcare close to the family as possible because most mission hospitals are strategically situated in remote but hard-to-reach areas.

6.2.1.2 Healthy lifestyle

Healthy lifestyle entails good health, but according to the WHO definition on health. Health is not about mere absence of disease, it is the total well-being of a person (WHO, 2010). If a person is not sick it does not mean that they are healthy. Health encompasses other attributes such as the ability to lead a lifestyle that is able to make one proactively participate in a country's productive activities.

6.2.1.3 Productive communities

Productive communities have members who are healthy and make proactive contributions to the productivity of the country. Productivity of the country points to those activities that enable a country to produce goods and services for its people. World Bank (2015) reporting has estimated that about 46 percent of Zambia's population of 15.72 million people represents an active and productive workforce averaging between 15 and 64 years of age.

6.2.2 Documentary evidence and observations in the field

As part of secondary evidence, the researcher reviewed documents availed by the UCZ in Zambia: the Summary Strategic Plan 2011-2015 and 2012 Operational Plan for the United Church of Zambia. As discussed in section 6.2.1, the document spells out strategic direction for the church. A close examination showed that the strategic plan firstly, was for a period of 5 years and its implementation was phased out annually with an operation plan for each year. In place was the operational plan for 2011 and 2012. The operational plan and 2013 was not available at the time of the data collection in the year 2014. Secondly, it was formulated based on two strategic objectives: (a) To reform and strengthen both institutional and organisational capacities of UCZ for effective and efficient service delivery, and (b) to mobilise, distribute and utilise resources prudently at all levels, including the poor and the marginalised.

Most significant, the researcher also reviewed a concomitant document to the strategic plan, the UCZ mid-term performance review (2014) report. The key issues identified which affected management of the church related to: constitutional aspects of the church that inhibit organisational effectiveness such as – poor working environment coupled with inadequate supplies and dilapidated infrastructure, unequal distribution and placement of existing skills and resources in urban as well rural areas including inadequate human resource and training systems. The other key issue was financial instability and inadequate funding for the Synod office, departments and institutions, exhibited by the weak financial resource management systems and internal income around 30-50%. Important for evaluation was non-utilisation of the available vast lands of UCZ which had become a liability instead of an asset, including the loss making UCZ commercial enterprises such as Mpongwe Bee Keeping.

Equally important, the performance review process covered all synod departments including two strategic congregations: Chifubu and Chimwemwe, two strategic presbyteries; Copperbelt and Lusaka, Church projects; Diakonia and Mpongwe Bee Keeping, UCZ University College, Chipembi College of Agriculture, Chipembi Girls Secondary School and Chipembi Rural Health Centre. This study observed that the UCZ mid-term performance review (2014: 8) emphasised improvements on social issues such as social injustices as well as paid more attention to the sample review of education institutions than health.

Only one rural health centre was reviewed to the exclusion of higher level health institutions such as Mbereshi and Mwandi.

Furthermore, church statistics on membership from the UCZ Synod (2014) show that the UCZ has 2 000 000 (two million) members but the strategic plan (2011-2015) based on the performance review of the technical committee from section 6.3 (Table 6-1) shows that in 2010, the church had 426 804 (Four hundred and twenty six thousand, eight hundred and four) members. It is not immediately clear if the difference between 426 804 (of 2010) and 2 000 000 (of 2014) entails Church statistical growth between 2010 and 2014 or the stated UCZ Synod (2014) bulletin figure is an estimate not based on head count.

In addition, the 2014 edition of revised UCZ Constitution, Rules and Regulations of the United Church of Zambia were also made available to the researcher. The UCZ Constitution serves as a grand norm of the United Church of Zambia implying that it is a supreme document ‘with a set of laws’ which govern the church. Other documents provided were the UCZ Guide for Catechumens and Church Members. The document spells out the life and work of a Christian particularly in UCZ, and is mostly used by community members to guide their involvement as congregants at a local church unit.

In Mbereshi, the researcher could not review any documents as these were not available from both the UCZ leadership in the presbytery office and management at Mbereshi Mission Hospital. The review of documentary evidence and observations are discussed in detail under the Mwandu Mission Hospital (section 6.5.2).

6.2.2.1 UCZ Summary Strategic Plan 2011-2015 and 2012 Operational Plan

According to the United Church of Zambia, (2012: 3), the Synod Executive appointed a technical committee in the year 2008 to address some of challenges facing the Church especially; education, health and community development departments of the synod headquarters.

However, the technical committee realised that there was need to work on and have in place a strategic plan. It was the technical committee’s view that the strategic plan would best be used to address the challenges confronting UCZ in order to improve the overall management of the church. To develop the strategic plan, the appointed technical committee worked in consultation with various stakeholders of the United Church of Zambia. The strategic plan is a UCZ document (with the operational plan for only the year 2012) that examines the scale of challenges and how these challenges affect the management of UCZ and the delivery of spiritual and social services in Zambia for a period of 5 years, covering the period 2011-2015.

Overall, the key issues that were identified as affecting the management of the church included constitutional aspects inhibiting organisational effectiveness which have led to a poor working environment, such as inadequate supplies ranging from medical to non-medical and dilapidated infrastructure, unequal distribution and placement of existing skills and resources, in urban/rural areas. Others are inadequate human resources and training systems in place. For the purposes of this study, the strategic plan was used to focus on some of the challenges facing the departments, especially those of health in the provision of healthcare by CHIs owned by the United Church of Zambia.

6.2.2.2 Mid-term Review and Performance Improvement Plan 2014-15

In order to review progress made against its long term plan, the United Church of Zambia, (2014: 8) emphasises the need and carried a mid-term performance review of the Strategic Plan 2011-2015. Gaps were highlighted using a prescribed tool in an evaluation matrix for the first two-and-a-half years while remaining relevant to a Performance Improvement Plan 2014-2015, which was put in place pending the final end of term evaluation covering the remaining period. The performance improvement plan was devised to highlight gaps which for the purposes of this study focused on social issues such as health, community development and what could be done by reflecting on areas of improvement.

In order to determine performance in the life and work of the church, the mid-term review was conducted on the basis of two strategic objectives: Firstly, to reform and strengthen both institutional and organisational capacities of the UCZ for effective and efficient service delivery. Secondly, to mobilise, distribute and utilise resources prudently at all levels, including the poor and marginalised.

The mid-term review recommended firstly, the need to deepen existing Missional Congregations including promotion of church decentralisation (resources, authority, accountability and participatory bottom-up approach). Secondly, it showed the need to mobilise, distribute and utilise resources prudently at all levels, including the poor and the marginalised populations. The mid-term review further recommended the need to strengthen governance, financial management and audit function, enhance the quality of social services such as healthcare provision, educate while devising a mechanism of addressing social injustices by making strides on research that cover social challenges and opportunities, as well as engage with members of parliament (MPs).

6.2.2.3 Memorandum of Understanding in Zambia

The Memorandum of Understanding (MoU) is an agreement between GRZ-MoH and CHAZ that seeks to promote and develop co-operation in the field of health on the basis of equality and mutual benefit through the provision of health services to the people of Zambia. The MoU for CHAZ and MoH in Zambia places emphasis on obligations and implementations for planning and budgeting, management of human resources, healthcare financing, medical equipment, medicines and supplies as well as monitoring, evaluation and quality of service provision. In line with the CHAZ MoU, the proposed draft Ethos and Ethics for staff in CHI emphasises the promotion of Christian values in all its member health facilities.

At the time of data collection, the proposed draft ethos and ethics document had not yet been ratified with the government of the republic of Zambia. It has come to light at the time of writing up this research that in the subsequent review of the successive UCZ strategic plan (2017-2021), the draft Ethos and Ethics document has been upheld, paving way for the department of health of UCZ to revise the organisation's structure at Mwandu and Mbereshi respectively.

6.3 The United Church of Zambia in Context

The United Church of Zambia Synod (2014) describes the church foundation, affirming that on the 16th of January 1965, the United Church of Zambia was formed.

Four mainline separate missions came into union representing different Christian traditions, namely, the Paris Evangelical Missionary Society (PEMS) under the leadership of Francois Coillard, a French Calvinist missionary who arrived in 1884 and the London Missionary Society (LMS), in the northern part of Zambia came next (after the death of David Livingstone and just before colonization). The London Missionary Society was under the leadership of Mr Stevenson, who established the first mission station at Niamukolo in 1885. After the LMS, came the Primitive Methodists who were later on joined by the Wesleyan Methodists in 1885.

The United Church of Zambia is an organisation that has membership across the country. The Church membership constitutes 2,000,000 Christians. Out of this membership, 60% are women and the rest are men and youth (UCZ Synod, 2014 based on Church statistics, 2009).

The United Church of Zambia has, since her birth on 16th January 1965 (following the merger of the United Church of Central Africa in Rhodesia, the Methodist Missionary Society, and the Paris Evangelical Missionary Society of Barotseland), been a peculiarly ambivalent body.

At the time of the union in 1965, Zambia's population stood at 4 million and it was estimated that a quarter of the population or 200,000 people were members of the UCZ. The Church has now grown from four (4) presbyteries [Northern, Copperbelt, Lusaka and Western] to ten Presbyteries [Central, Copperbelt, Eastern, Luapula, Lusaka, Muchinga, Northern, North-Western, Southern and Western], and the total membership now stands about 2 million with over 1060 congregations (UCZ Synod, 2014).

Further, the strategic plan 2011-2015 (2012: 3) states that UCZ has laid down a functional structure comprising four courts: synod, presbyteries, consistories, congregations and sections. The church owns various infrastructure including church buildings, schools, hospitals, theological college (now a University). UCZ also owns large plots of land across the country. It has a moderate human resource base – trained clergy (said to be ministers of the word and sacraments) and many lay persons (well skilled, semi-skilled and unskilled). UCZ posits itself as a democratic church with participation from men, women and youth. It is also a growing church and the largest protestant church in Zambia. In the year 2010, the statistical situation stood as detailed in the table below.

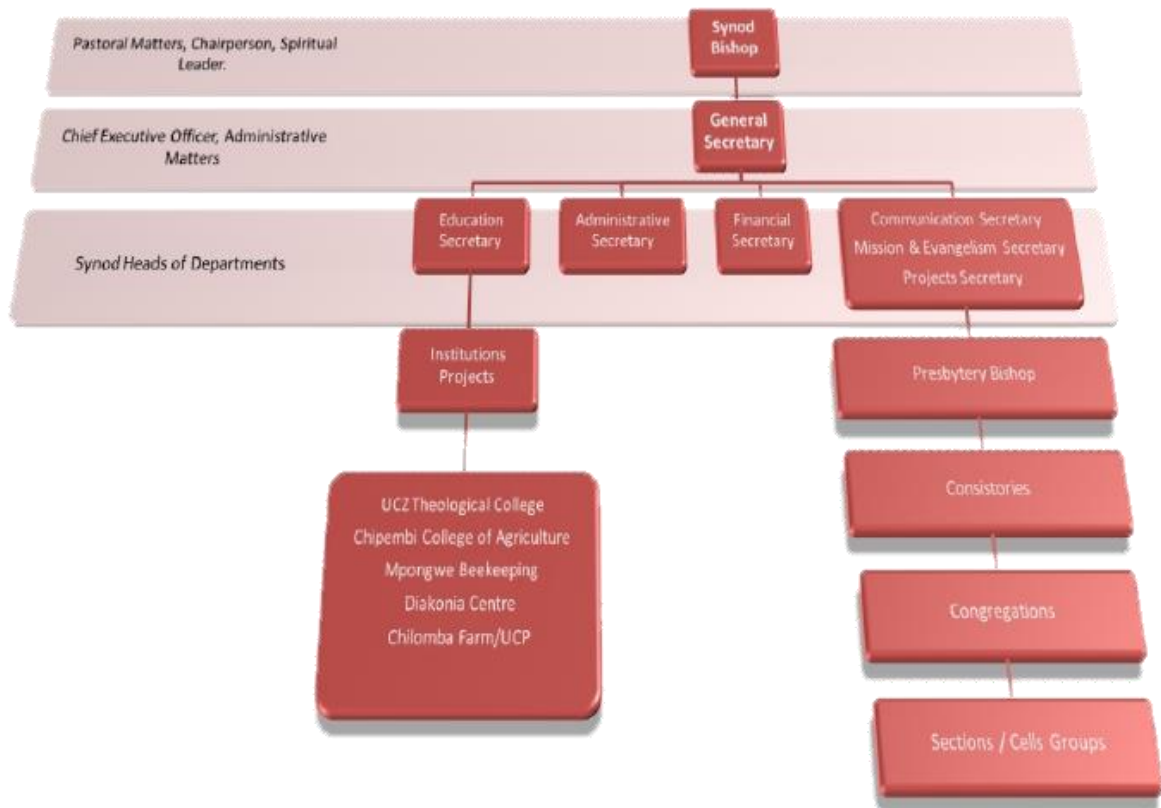
TABLE 6-1: THE UCZ STATISTICS FOR ZAMBIA AS AT DECEMBER, 2010

PRESBYTERY	TOTAL NO OF MEMBERS	CLERGY	RETIRED CLERGY	NON CLERGY	TOTAL
Central Presbytery	63,451	16			
Copperbelt Presbytery	96,139	47	5	10	
Eastern Presbytery	11,638	8	1	8	
Luapula Presbytery	70,832	13	2	4	
Lusaka Presbytery	55,672	31	6	7	
Northern Presbytery	42,762	12	4	10	
N/Eastern Presbytery	49,613	15	6	11	
Western Presbytery	19,650	14	4	1	
Southern Presbytery	12,872	17	4	20	
N/Western Presbytery	4,175	7		2	
Total	426,804	225			276

Source: Adapted from the Strategic Plan 2011-2015 (2012)

To emphasise, the United Church of Zambia Synod headquarters has departments that run as programmes; administration, communication, community development, education, finance, health, mission and evangelism, church projects, Chipembi farm college and the UCZ theological (later university) college (UCZ Synod, 2014).

FIGURE 6-2: THE CURRENT UCZ ORGANISATIONAL STRUCTURE



Source: United Church of Zambia Synod Monthly Bulletin-Jan (www.uczsynod.org), 2015

Figure 6-2 illustrates the functions of the United Church of Zambia through its organisational structure (or the organogram). Assuming a descending hierarchical order, first is the Synod Bishop (terminology commonly used even in churches which have not fully adopted Episcopal governance systems), who is the chairperson charged with the responsibility to preside over all *Synodous* gatherings (Zeze, 2012: 46) and serves as the spiritual leader in overseeing all pastoral matters of the United Church of Zambia. Synod Bishop is sometimes referred to as national overseer of UCZ. Second in the order, comes the General Secretary (GS) who serves as chief executive officer with vested authority over all administrative functional matters of the Church.

In addition, the GS is accountable for Heads of Departments (HoDs) charged with responsibility to manage functional departments which run as programmes namely projects Secretary, Mission and Evangelism Secretary, Communications Secretary, Financial Secretary, Administrative Secretary and Education Secretary.

Others reporting to the GS are heads of institutions and church projects, namely, the UCZ University College, Chipembi Farm College of Agriculture, Mpongwe Bee-keeping Project, Diakonia Centre and Chilomba Farm as well as the United Church Publications (UCP).

The UCZ Synod (2014) departmental information has more functional programmes such as community development and health. It is not immediately clear on the above organogram where both community development and health departments fit. It may be that they are in the same level with other stated departments or an omission. Moreover, the Revised UCZ Constitution (2014) does not seem to have clearly defined the position role and programme functions of the Health Secretary. It may have been an omission in the version presented for review under documentary evidence (section 6.2.2). Thirdly on the organogram, it is illustrated that immediately below the HoDs are the Presbytery Bishops which seems unusual in terms of reporting hierarchy. Presbytery Bishops act as heads providing leadership at presbytery level which may be equated to a department reporting to the GS and/or Synod Bishop. Further, Presbytery Bishops are charged with responsibility to oversee the work of consistories that supervise congregations. At a congregation, a clergy serves as a minister-in-charge specially called and commissioned by God to perform among other 18 duties, provide oversight, and watch over the life and work a congregation through Sections which are the local units led through elected elders (UCZ Constitution, 2014: 7).

In Zambia, the researcher visited the Synod Headquarters of the United Church of Zambia in Lusaka for a courtesy call before proceeding to Mbereshi Mission station in Luapula Presbytery and Mwandi Mission station in Western Presbytery respectively. At Synod HQ, in-depth interviews with selected informants were held followed by documentary evidence with related observations in the field as discussed in the next section.

6.4 Primary data presentation and interpretation for UCZ Synod and Mbereshi Mission Station

In terms of the context of the sub-area, Mbereshi (also spelled and pronounced as *Mbeleshi*) is a village in the Luapula province of Zambia, named after the Mbereshi River on its north side. It was the site of a large mission station founded in 1900 by the London Missionary Society. In 1915, the mission established the first Girls' school in the territory, as well as a boys' school and a large hospital. Mbereshi Mission station has a number of mission buildings including a large church which is now part of the United Church of Zambia.

Spatially, Mbereshi Mission Hospital is situated on the main tarred highway of the Luapula river valley running from Mansa district to Nchelenge, a district which is 10 kilometres north-east of Mwata Kazembe's town of Mwanabombwe (Chuba, 2005: 46).

FIGURE 6-3: LOCATION OF MBERESHI IN MWANSABOMBWE DISTRICT, LUAPULA PROVINCE (AMONG OTHER UCZ PRESBYTERIES)



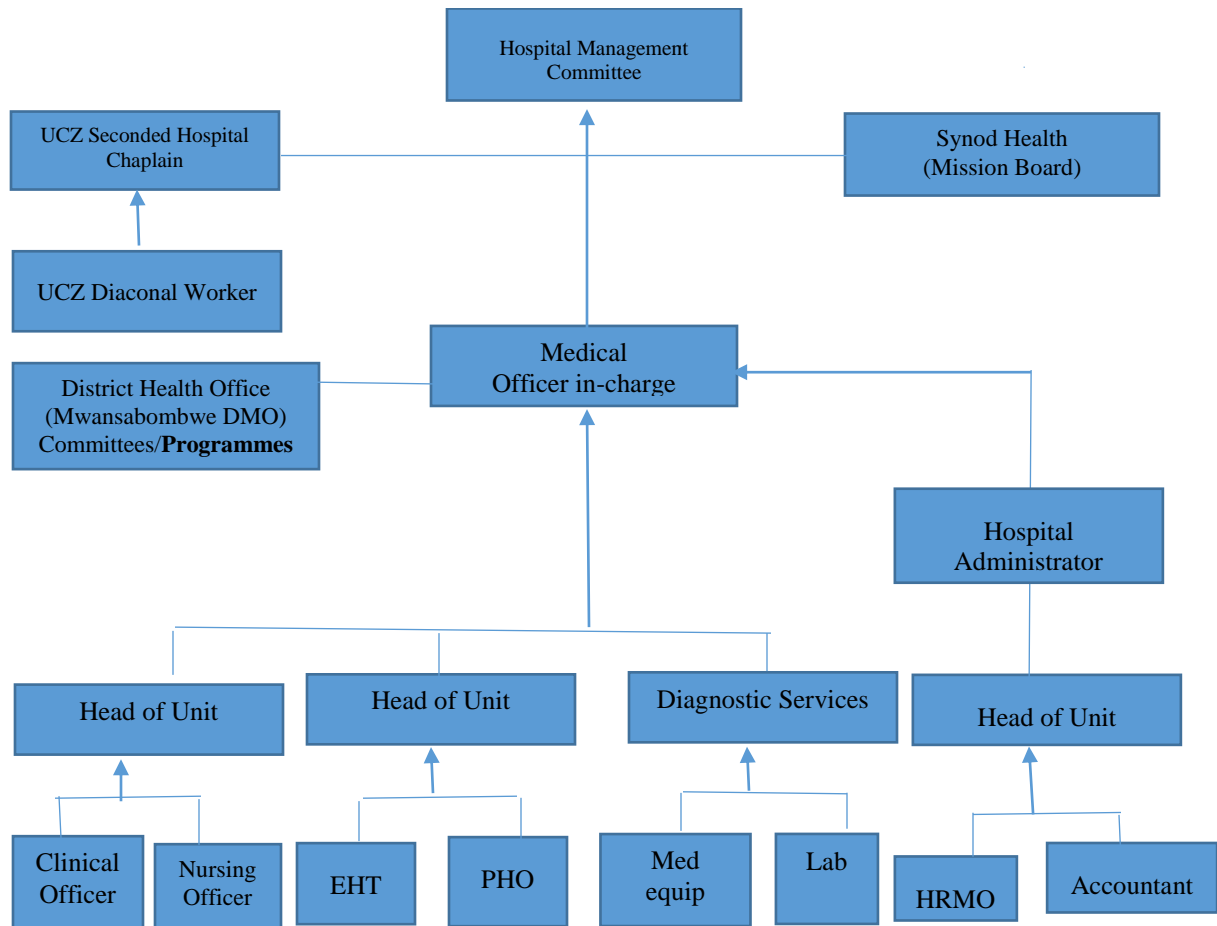
Source: Adapted from Google Maps (www.Googlemapszambia.com), 2015

In emphasising, the hospital offers among other services primary health care which includes; malaria, HIV/AIDS, water and sanitation, outreach clinics, nutrition, tuberculosis (TB) control, antenatal and family planning, prevention of mother to child transmission (PMTCT) of the HIV project, maternal and child health.

In Mbereshi, the researcher and team could not make a courtesy call on the day of arrival as the head of station at Mbereshi Mission station was reportedly unavailable despite prior arrangements by phone and in person through known congregation members. However, in-depth interviews and focus group discussions were held at the Mission Hospital, Mbereshi Mission Hospital-affiliated health centre, mission station community and outlying community at Fishiki rural health post.

Figure 6-4 below depicts the organogram which was obtained for Mbereshi Mission Hospital at the time of the researcher's fieldwork.

FIGURE 6-4: CURRENT ORGANISATION STRUCTURE AT MBERESHI MISSION HOSPITAL



Source: Researcher's fieldwork based on Informants Interview Data (2014)

The organisation structure for Mbereshi Mission Hospital is relatively similar to what is discussed under Mwandu Mission Hospital (section 6.5.2) with two exceptions. The first is that the hospital in Mbereshi has no mission partners' board to provide a platform for greater engagement with partners abroad. Second, the head of institution is the medical officer in charge, based on feedback from a good number of informants who participated in the study. The figure illustrates how the mission hospital at Mbereshi functions through its organisational structure. By the same token, a proposed code of ethos and ethics for Zambia for member churches which seeks to promote Christian values for staff, especially their conduct in CHI under CHAZ, could not be accessed as a separate document for Malawi, although the SLA touches on this.

In a similar way to section 5.4.1 involving the case of Malawi, data was presented and interpreted in form of matrices covering interview and focus group discussions. The order of presentation starts with interviews segmented according to the Church's synod headquarters and related mission hospitals, followed by focus group discussions whose responses are categorised according to key research questions. The matrices depict UCZ Synod interview perspectives on healthcare management in the wake of challenges, opportunities for collaboration and improvements. The data sets are discussed in line with literature reviewed in Chapters Two and Three, including documentary evidence and field observations.

As in section 4.9.1 of Chapter 4, the interviews constituted all in-depth interactions between the researcher and informants with responses. These formed excerpts contained in matrix tables, which in the process helped to establish categories that later became a special feature for processing preliminary themes pertinent to the UCZ synod headquarters in the context of Zambia.

Logically, data presentation is displayed in form of matrix tables covering informants' interviews and focus group discussions with respective interpretation. This is presented by having responses to interviews first, segmented according to the Church's synod headquarters and related mission hospitals, followed by focus group discussions.

6.4.1 Interviews for UCZ Synod Headquarters officials in Zambia

The perspectives in the matrices reflect interview responses in terms of challenges, opportunities for collaboration and ways to effect improvements. The matrices show the interactive responses from the informants who were part of the in-depth interviews for UCZ synod headquarters (or simply the secretariat) and Mbereshi Mission station, followed by Mwandu Mission station. Quite similar to the case of CCAP Synod of Livingstonia in Malawi in the prior chapter, there is a relationship between the synod of UCZ and the mission stations. According to the UCZ Constitution (2014: 6), the Synod being the supreme council of the Church which carries out its administrative mandate through the established Secretariat (or Headquarters headed by the GS as CEO), it therefore owns the mission stations where Mbereshi Mission Hospital and Mwandu Mission Hospital are located.

In this section therefore, the presentation flow starts with transcribed data highlighted in the form of matrices based on interview responses from officials of UCZ Synod Headquarters, followed by both interview and FGD meetings' responses for Mbereshi Mission and subsequently Mwandu Mission station.

Notably, there were no FDG meetings with health workers in Mbereshi and Mwandu because they could not make it due to various reasons; most feared disruption of work due to the critical staff shortage in these mission hospitals. The matrix 6-1 in this section shows the interview responses from the informants in the UCZ Secretariat at the Synod Headquarters and these related to a financial crisis as a result of inadequate health financing, lack of sound administrative structures and community integration. Dilapidated infrastructure said to have outlived its helpfulness, reliance on donor support, inadequate equipment /facilities and shortage of medicines were noted. Other challenges are the lack of commitment on the part of human resources, a meaningful staff retention intervention and shortage of staff.

MATRIX 6-1: UCZ SYNOD PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES

Challenges	Interviewee responses from Zambia Synod
Finances (4)	Health financing with sustainability struggle. Z-SHQ-GS, Z-LT-PSB, Z-SHQ-FS, Z-SHQ-HS
Administrative Structures (2)	The challenge is the administrative structures...with conflict of ethos between govt and church ... Z-SHQ-SB, Z-SHQ-GS
Integration (1)	“Lack of networking of hospitals with communities” Z-LT-PSB
Dilapidated infrastructure (1)	Infrastructure is old & have outlived the helpfulness Z-SHQ-GS
Donor Dependency (1)	Donor dependency to fund projects Z-SHQ-FS
Equipment/Facilities (1)	Inadequate supply of equipment, x-ray films, reagents for e. G. CD4 count. Z-SHQ-HS
Human Resource Commitment (1)	Human resource – has no grip on carrying out vision/mission Z-SHQ-GS, Z-SHQ-HS
Shortage of Medicines (1)	Inadequate supply of drugs... Z-SHQ-HS
Staff Retention (1)	Retention of staff. Z-SHQ-GS
Shortage of Staff (1)	“Lack of human resource esp. doctors/nurses...” Z-LT-PSB

Source: Researcher’s fieldwork based on interview responses to challenges of healthcare (2014)

The perspectives established in matrix 6-1 depict regularly occurring challenges such as inadequate financial support and current structures lacking sound administrative systems followed by inherent lean integration with other stakeholders such as “lack of local networking by these mission hospitals with the communities in which they are situated...” Informant **Z-LT-PSB** (2014). In contrast, Kondra and Hurst (2009: 38) posit that as organisations grow in size they tend to develop their own collective meaning structures, in certain circumstances, through intentional shaping of the culture they have. Hall (2009: 37) maintains that by the first half of the nineteenth century, while voluntary entities were assuming a recognised place in public life, the majority of the work such as care giving, healing, educating and even worshipping took place in primary institutions of family and community, rather than in associational or corporate settings.

However, there is a gap between established formal structures and primary institutions of family and community as well as how these two relate to local healthcare. This demonstrates evidence of one of the biggest challenges and opportunities investigated.

Other challenges brought out include old infrastructure in place, over-reliance on donor support, health facilities with inadequate medical equipment, commitment by staff is below expectation, medicines in short supply, inability to retain available health workers and generally, a shortage of person-power.

In the wake of their collective meaning of structures as regularly occurring issues they face, including inadequate financial resources, the UCZ Synod can be seen to perceive its hospitals facilities in Zambia as having shaped their own culture in managing healthcare and this is in light of what they have said are their challenges: there is a structural problem. It maybe that lack of sound administration which tolerates networking with other stakeholders is one of the major deterrents to optimum healthcare service provision.

MATRIX 6-2: UCZ SYNOD PERSPECTIVES ON HEALTHCARE MANAGEMENT COLLABORATION

Collaboration	Interview responses from Zambia Synod
Grants (4)	“Though delayed, grant is coming from government...” Z-LT-PSB, Z-SHQ-GS, Z-SHQ-FS, Z-SHQ-HS
Salaries (4)	“...and the government also pays the workers.” Z-LT-PS, Z-SHQ-GS, Z-SHQ-FS, Z-SHQ-HS
MoU on Admin (2)	Governance –arrangement, Z-SHQ-FS, Z-SHQ-SB
Drugs (1)	Drugs – the supply of essential drugs is by government. Z-SHQ-HS
Mission Partners (1)	...Mission partners collaborate through material & staff Z-SHQ-GS
Governance (1)	Overall, Hospitals are governed by the board in collaboration with govt. Z-SHQ-SB

Source: Researcher’s fieldwork based on interview responses to collaboration (2014)

The matrix shows that opportunities for collaboration from interviews at the UCZ Synod headquarters (Zambia) related to government grants (4), health workers salaries (2), memorandum of understanding on administration (2), and supply of drugs, mission partners and governance.

According to the above data set, while existing collaborative engagements in government grants support, health workers salaries provision and the memorandum of understanding on administration demonstrate a degree of strength, opportunities that lie ahead for fostering collaboration include drugs, mission partnerships and governance. The categorical responses on collaboration are apparently similar as they all point to government support rendered to the mission hospitals. The last category coined governance in the above matrix attests with a much more inclusive response in the excerpt below, the role of specifically other stakeholders like traditional authorities and mission partners: “Hospitals are governed by the board in collaboration with government, church members and other stakeholders such as traditional leaders and mission partners” (Informant **Z-SHQ-SB**).

In situating governance practice that is contextual to church-led healthcare, there is a relationship between data and literature. Literature in section 2.3.3 about organizational practices and religious identity, according to Sinha (2012: 569), shows that organisations vary in governance style, size, complexity, funding mix and other characteristics.

Significant to this, the funding mix and other characteristics are supported by some participants' own understanding that "Mission partners abroad demonstrate collaboration through support in form of materials and human resource" (Informant **Z-SHQ-GS**).

MATRIX 6-3: UCZ SYNOD PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS

Improvements	Interview responses from Zambia Synod
MoU/mission regulation (2)	Create close collaboration with ecumenical bodies and government (in form of consultations). Z-SHQ-FS, Z-SHQ-HS
Partnership,& management (2)	"...harness relationship with Senior Chief Inyambo Yeta who attempts to lure partnership ... Z-SHQ-SB "Sound management... " SHQ-GS
In-service Training (1)	"...the government should help train our clinical officers into medical licentiates and become medical doctors." Z-LT-PSB
Recruitment Criteria (1)	Improve management and recruit right people in order to overcome unfaithfulness. Z-SHQ-HS
Strategic planning (1)	"One thing is to encourage strategic planning because I am not sure if it's being encouraged." Z-LT-PSB

Source: Researcher's fieldwork based on interview responses to improvements for health (2014)

The matrix shows that improvements for managing healthcare from interviews at the UCZ Synod headquarters (Zambia) related to enforcement of the memorandum of understanding/orientation to mission regulations (2), partnership solicitation, management and ownership (2), in-service training, revisiting recruitment criteria and strategic planning.

Moreover, the above data set exhibits that whilst existing improvement areas lie in memorandum of understanding/orientation to mission regulations, solicitation for partnership as well as sound management processes and ownership, more needs to be done about in-service training in at the hospital, revisiting recruitment of staff criteria and strategic planning. Literature in section 2.3.3, according to Kondra and Hurst (2009: 38), maintains that FBOs with doctrinal orientations of especially the governance systems of the church which sponsor them, and emphasise the resource of human dignity as pivotal to the development of given communities.

The dignity inherent in human capital is thus being advocated for through the enforcement of MoUs and orientation of staff at its CHIs to mission regulations as well as partner solicitation, management and ownership being part of the anchor to development.

Uniquely, some of the excerpts related to literature about healthcare improvements that are vital to sustainable development pertinent to building amicable relationships with communities:

“There is need to harness the relationship with traditional leaders...the senior Chief Inyambo Yeta of Mwandu who is a Board member and a lawyer by profession, is fully involved in the work at Mwandu Mission. During Kuomboka traditional ceremony, he attempts to lure partnership especially from tourists who come for Kuomboka to support Mwandu mission hospital” (Informant **Z-SHQ-SB**).

The scenario obtaining in the sub-case of Mwandu Mission station as per above informant’s voice may bring out different viewpoints from Mbereshi Mission.

6.4.2 Interviews for Mbereshi Mission Station Health workers

In this section, the matrices 6-4 to matrix 6-6 show the interview responses in the perspective of the informants who participated in the study from Mbereshi Mission station. The said matrices reflect responses from interviews in terms of challenges, opportunities for collaboration and areas of improvements.

Thus, Matrix 6-4 presents interview perspectives on healthcare management challenges at Mbereshi Mission station and they related to inadequate equipment/facilities, poor management systems, shortage of staff and inappropriate supply of medicines. Collaboration, debt burden, dilapidated infrastructure, lack of finances, caring, purpose and compassion are some of the challenges facing the institution. Others are shortage of medicines, housing for shortage and transport.

MATRIX 6-4: MBERESHI MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES

Challenges	Interviews’ responses from Mbereshi
Equipment/Facilities (4)	Water and sewerage, poor equipment Z-Mb-MSD,Z-Mb-HCC, Z-Mb-MoI, Z-Mb-HM
Management Systems (2)	Managers are not UCZ and therefore they do not carry church policy focus. Z-Mb-MSD, Z-Mb-MHP
Shortage of Staff (2)	Staffing is inadequate. Z-Mb-HA, Z-Mb-MoI
Inappropriate Supply of Medicines (2)	Drugs – medical store not supplying according to requests. Z-Mb-HCC, Z-Mb-MoI
Collaboration (1)	Support from the church is very minimal. Z-Mb-HA
Debt Burden (1)	The hospital is in debt. Z-Mb-MoI
Dilapidated Infrastructure (1)	Infrastructure is old, Z-Mb-HA
Finance (1)	“Finance – serious financial problems...” Z-Mb-MoI
Caring, Purpose & Compassion (1)	Negative attention (attitude towards clients especially girls) Z-Mb-MSD
Shortage of Medicines (1)	Drugs supply is inadequate... Z-Mb-HA
Shortage of Staff Housing (1)	Staff houses are in bad conditions and some staff do not have houses, others are in guest houses. Z-Mb-MHP
Transport (1)	Transportation there’s only a motor bike... Z-Mb-HA

Source: Researcher’s fieldwork based on interview responses to challenges of healthcare (2014)

Duff and Buckingham (2015: 1787) posit that “sharpening focus on global health and the growing recognition of the capacities and scope of faith-based groups for improving community health outcomes suggest an intentional and systematic approach to forging strong, sustained partnerships between public sector agencies and faith-based organisations.” The data category on old infrastructure is a challenge and suggests to the contrary, that plastered un-burnt brick walls are now crumbling down, signifying lack of support from existing collaborative arrangements between government, partners and church, especially in the area of building infrastructure development.

Evidently, “Infrastructure is old – unburned bricks were used then plastered, so buildings are crumbling down” (Informant **Z-Mb-HA**).

To add, Section 6.3.3.1 the UCZ Synod maintains “infrastructure – is old and all buildings have outlived their helpfulness...it is the role of government to provide health care and yet does not come on board to improve infrastructure. For example, infrastructure improvements in Mwandu, it’s only mission partners who are doing it – no government help. The other example is Mbereshi infrastructure that has cracks which should just face new ones” (Informant **Z-SHQ-GS**).

As a result, data sets show how that Church-led healthcare management is technically challenged with issues of sustainability of mission hospitals with little or no support particularly infrastructure, yet the literature suggests the existence of strong collaborative support from the public sector. The study observed that there is a gap between what is obtaining in the field and what literature so far reviewed, is saying. People on the ground are complaining there is little or no maintenance to their colonial architecture in mission stations, while evidence adduced from literature shows that there is an existing strong connection between mission hospitals and government with mission partners abroad.

Second, matrix 6-5 presents interview perspectives on healthcare management collaboration at Mbereshi Mission station and these related to the supply of drugs, monthly grants, health workers salaries and the existence of a memorandum of understanding on mission school students treatment.

MATRIX 6-5: MBERESHI MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT COLLABORATION

Collaboration	Interview responses from Mbereshi
Drugs (1)	Supply of drug kits is another. Z-Mb-MSD
Grants (1)	Grants come from government though erratic. Z-Mb-MSD
Salaries (1)	The relationship is perfect with the government for example nurses are paid by government, Z-Mb-MHP .
MoU on Mission School Student Treatment (1)	Collaboration with CHAZ, many girls are supported.. Z-Mb-MSD

Source: Researcher’s fieldwork based on interview responses to collaboration (2014)

In the above matrix 6-5, the category on MoU on student treatment highlights opportunities for collaboration from interviews between government and Mbereshi Mission Hospital, whereby “...CHAZ pays Mable Shaw identified girl’s 100% of treatment bills.” (Informant **Z-Mb-MSD**). In this cross-national study, the government-funded CHAZ and CHAM belong to a continental grouping of associations for Africa that promote Churches health in supporting local communities, as in the case of the nearby Marble Shaw Girls Secondary School which is a mission station community that accesses healthcare from Mbereshi Mission. According to Anheier (2005: 105), “providing opportunities for involvement builds civil society and social capital, while giving voice is one of the key roles non-profit organisations are expected to play in society”. The civic engagement of CHAZ in covering community members such as Marble Shaw girls’ healthcare bills brings the facility closer to the people and this can be an avenue in which involvement can be harnessed.

Third, matrix 6-6 depicts interview perspectives on healthcare management improvements at Mbereshi Mission station which related to strengthening communication that will promote the hospital to the ministry of health and the world over, empowering Classified employees to handle certain clinic tasks, the need for ‘cold-chain’ equipment/facilities, classified employee in-service training, revisiting the memorandum of understanding on mission regulations and orientation of new staff to mission rules.

MATRIX 6-6: MBERESHI MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS

Improvements	Interview responses from Mbereshi
Communication (1)	Church to communicate with the ministry of health, Z-Mb-MHP
Empowerment (1)	Empowering helper in the running of the clinic. Z-Mb-HA
Equipment/Facilities (1)	A fridge for vaccines is needed. Z-Mb-HA
In-service Training (1)	Empowerment of CEs by sending them for training. Z-Mb-HA
MoU/mission regulation (1)	Increased partnership via CHAZ.. Z-Mb-MSD
Orientation to Mission Rules (1)	“Church to be felt, orient new staff on code of ethics. Z-Mb-MSD ”

Source: Researcher’s fieldwork based on interview responses to improvements for health (2014)

Central to this, Matrix 6-6 depicting envisaged improvements is the aspect of empowerment in relation to classified employee in-service training. Informant **Z-Mb-HA** advances for the need for “empowering helpers (teach classified employees-CEs) to help in the running of the clinic”. This may be in the wake of either staff shortage or poor distribution of workers as discussed in section 3.5 of Chapter Three. Topp, Chipukuma and Hanefeld (2014: 8) pointed out that weak continuum of care common to most health facilities are partly as a result of sub-standard clinical and administrative practice exacerbated by inadequate staff and unregulated task-shifting. Mutale *et al.* (2013: 3) maintain that the shortage of qualified health workers, bad attitudes exhibited by already lean staff, and poor work relations between community and health facility workers with long waiting times to be attended to at the facility, are some of the barriers hindering access to healthcare. While literature according to Mutale *et al.* (2013: 3) supported by Topp, Chipukuma and Hanefeld (2014: 8) point to characteristics that are detrimental to better healthcare services, there is encouragement in the data by health facility staff who further underline that the “quality of care is compromised, empowerment of CEs can be done by sending them to college for clinical training” (**Informant Z-Mb-HA**). In light of both literature and data, it may well be that this evidence of what workforce and community members are in dire need of, involvement in the running of the clinic, may regulate task shifting in their own healthcare system at micro-level.

6.4.3 Focus Group Discussions for church and community members in Mbereshi

Focus group discussions were conducted through meetings at mission community within the mission station and the outlying community located out of the station. These were scheduled through and by the mission station under the supervision of Mbereshi consistory of Luapula Presbytery.

During study recruitment, participants were drawn from two difference stakeholder segments in keeping with the units of analysis – the community within Mbereshi Mission station and people from outlying areas of Mbereshi, particularly Fishiki Health Post. Tackling both the Mission community and outlying areas ensured the stakeholder segment of service recipients, church and community members, was holistic. Other stakeholder groupings discussed in prior sections 6.4.2 and 6.4.3 are officials from synod (perceived as owners) and health workers from mission hospital (being service providers).

This therefore, follows that Matrices 6-7 to 6-9 in this section show the perspectives of the people who participated in the study from Mbereshi Mission station, incorporating the outlying community.

The matrices reflect responses from focus group discussions in terms of challenges, opportunities for collaboration and areas of improvements.

First, the Matrix 6-7 highlights Mbereshi mission focus group participants’ perspectives on healthcare management challenges related to short supply of medicines, lack of equipment/facilities, shortfalls in food supply for patients as well staff establishment and transport services.

MATRIX 6-7: MBERESHI MISSION STATION FGD PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES

Challenges	Focus Groups’ responses from Mbereshi
Shortage of Medicines (2)	Inadequate medicine. Z-Mb-MC Medicine supply is inadequate... Z-Mb-OC
Equipment/Facilities (1)	Mother’s shelter is dark – people taking care of patients sleep in dark shelters...Some people take 3-4 months taking care of the patients at mother’s shelter. Z-Mb-MC
Shortage of Food (1)	Food shortage in the hospital is the major problem...Porridge with ordinary Mealie Meal no HEPS (Soya-based food supplement for malnourished children)...Help is given according to the weight of the body. Z-Mb-MC
Shortage of Staff (1)	Lack of staff. Z-Mb-MC
Transport (1)	...but transport is the biggest challenge. Z-Mb-OC

Source: Researcher’s fieldwork based on FGD responses to challenges of healthcare (2014)

The category on lack of equipment/facilities stresses a gap in the much needed integration of work relations between hospital-based care and community-based healthcare. For instance, “mother’s shelter is dark – people taking care of patients sleep in dark shelters...Some people take 3-4 months taking care of the patients at mother’s shelter” (Informant **Z-Mb-MC**). Literature according to Kaplan *et al* (2009: 1120) maintain that community engagement by any institution with people takes time to build, develop trust and encourage meaningful participation. At Mbereshi Mission station, people have been civically involved with the work of the mission hospitals, especially men and women who accompany pregnant women for institutional deliveries from far areas like Fishiki.

Further, this includes attention for other non-communicable diseases associated with insanity. It is seen from evidence adduced in the literature and peoples’ perceptions in the community about mother’s shelter which has no power supply for several months. The community members want improvements in their own healthcare. While there is a certain level of enthusiasm from community, the hospital management seems to have priorities that technically focus more on internal patient care than those seen in the external category of equipment/facilities, like the concern about lighting of the mother’s shelter.

Second, the Matrix 6-8 highlights Mbereshi Mission focus group participants’ perspectives on healthcare management collaboration that demonstrated integration between Mbereshi Mission Hospital and government related to supply of medicines.

MATRIX 6-8: MBERESHI MISSION STATION FGD PERSPECTIVES ON HEALTHCARE MANAGEMENT COLLABORATION

Collaboration	Focus Groups’ responses from Mbereshi
Drugs (1)	“Sometimes we see ministry of health vehicles bring medicines here which means the mission hospital still working with government.” Z-Mb-MC

Source: Researcher’s fieldwork based on FGD responses to opportunities for collaboration (2014)

Data presented in the matrix shows how that opportunities for collaboration in the perspectives of focus group discussions at Mbereshi Mission station are demonstrated through supply of medicines. The matrix 6-8 on drugs as one of the opportunities for collaboration has been exhausted with literature searches such as Lentz (2010: 298), who recommends that “facility deficits could be improved if donors foster relationships with corporations to provide rural health clinics with equipment, medications and trained staff.” and may have reached a point of saturation.

Third, the Matrix 6-9 depicts Mbereshi Mission focus group participants’ perspectives on healthcare management improvements related to providing more equipment/facilities, food for patients and infrastructure development.

MATRIX 6-9: MBERESHI MISSION STATION FGD PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS

Improvements	Focus Groups' responses from Mbereshi
Equipment/Facilities (1)	Renovate the hospital buildings especially mothers shelter. Z-Mb-MC
Food (1)	"...Because of lack of food in the hospital, HEPS should be provided to help our children who are admitted from hunger." Z-Mb-MC
Infrastructure Development (1)	Suggestion is that the health post should be transformed into a rural health centre. Community service like making bricks can be the contribution towards building a health centre in Fishiki Community. Z-Mb-OC

Source: Researcher's fieldwork based on focus group responses to healthcare improvements (2014)

At the heart of this matrix 6-9 are the emotions, feelings and envisaged improvements to healthcare management in the perspectives of the community in far outlying areas of Mbereshi Mission station. In the area of infrastructure development, "...community service like making bricks can be the contribution towards building a health centre in Fishiki Community." In order to transform Fishiki Health Post into a health centre (Informant **Z-Mb-OC**). Sanders (2014: 13) maintains that equitable faith-based cross-sector partnerships can form and help transform communities, and participants at Fishiki are asking for just that in order to contribute to their own development for infrastructure improvements. In view of all these suggested improvements owing to long distances to and from Mbereshi Mission station such as the un-noticed local development initiatives by Fishiki community to build their own facility, CHAZ, which is supported by government and other donors in the SADC region have not come to their aid. This is despite the literature search positing that regional organisations are not just supporting local development on their own geographical turf but with the help of government and donor support (Ruffin, 2010: 44).

In the meantime, it may well be that regional organisation interventions prioritise their resources based on needs in collaboration with local governance arrangement (quite adverse in Zambia, where decentralisation seems be struggling to take effect) and this exacerbates the rate of development in far rural communities like Fishiki – a pertinent stakeholder in the much needed healthcare.

Central government's effort through national health policy (Zambia NHP, 2013: 29) advances that the over-arching objective is targeted at reducing the burden of disease, maternal and infant mortality, and increase life expectancy through the provision of continuum health care as close to the family as possible in a clean, competent and caring manner.

Similar to the CCAP Synod of Livingstonia in Malawi (in section 5.4.5), stakeholders in Zambia who participated in the study were segmented according to interest, the position of responsibility and roles they play in the United Church of Zambia to make the delivery of better healthcare services in mission hospitals possible. The segments included interview informants at the church's synod – the Synod Headquarters of the United Church of Zambia with the laity and clergy (who represent the church as owners), the focus group discussions at the mission stations in Mbereshi and Mwandu with the health workers (who represent the service providers), and members of the community who access healthcare services (as service recipients).

6.5 Primary data presentation and interpretation for Mwandu Mission Station

To set the context underlying the sub-area, according to the Mwandu Mission Hospital Board (2014), the Mwandu Mission began rendering service to the people of western province with a focus on delivering spiritual and health care in the establishment of a church and hospital. In the plains of the Zambezi, west of the country, the Paris Mission, with the active participation of people from Lesotho, had started work in 1885. The first group of missionaries, under the leadership of François Coillard, was arrested and mistreated. In 1964, under the name Evangelical Church of Barotseland, the church became independent and in 1965 the United Church of Zambia was inaugurated.

Consequently, the Mwandu Mission Hospital is an 80-bed capacity hospital with wards for men, women, children, tuberculosis (TB) patients and other patients with infectious diseases (primarily children). In addition to the wards, the hospital has an outpatient clinic, a mother-child health clinic and an Anti-retroviral Clinic.

The map below in Figure 6-5 depicts the location of Mwandi as one the study sites in Zambia.

FIGURE 6-5: LOCATION OF MWANDI STUDY SITE IN ZAMBIA



Source: Adapted from Google Maps (www.googlemapszambia.com), 2015

The UCZ Mwandi Mission Hospital is located in the village of Mwandi, midway between the city of Livingstone and Sesheke district, in the southwest part of Zambia. The environmental conditions are harsh in Mwandi, as it is situated on the edge of the Kalahari Desert. The Lozi people, who are the primary inhabitants of Zambia's western province, have to deal with regular, severe drought and severe flooding. Most people dwelling in Mwandi are fishermen and depend on subsistence farming by growing maize as their primary cash crop.

Of significance, Mwandi Mission Hospital board (2014) reports that other people of Mwandi community rear cattle, goats, pigs, and chickens. Most of the approximately 8,000 Mwandi dwellers live in one-room thatched-roof, mud houses with no electricity or plumbed water. The means of transport to travel from one place to another is by walking, riding bikes and sometimes by oxcart. Other outlying communities to Mwandi are scattered in the catchment area of the hospital with approximately 25,000 people. Even by vehicle, it can take 4-5 hours to drive along sandy, bumpy roads to reach the furthest Rural Health Centre.

A newly paved highway from Livingstone passing Mwandu to Sesheke recently improved transport and has seen many taxis and buses into the community. Similarly, a mobile phone mast has propelled better communication. While technological and transportation advancements have brought interconnectedness and development, they have also exacerbated the spread of HIV/AIDS.

In addition, the prevalence of HIV/AIDS and its secondary infections, tropical diseases such as malaria which are usually treated at Mwandu Mission Hospital, have had an enormous social and economic impact on the people of Mwandu.

Incidentally, at Mwandu Mission station there is a UCZ mission congregation, an Orphan & Vulnerable Children (OVC) Centre, mission-supported primary and secondary schools, a farm, a shelter for the homeless and a pre-school. Besides all the activities that make Mwandu what it is, Figure 6-6 below shows that the essential character of Mwandu lies in the historical mission work carried out under the health arm of the United Church of Zambia.

FIGURE 6-6: HISTORICAL BILL BOARD THAT DEPICT THE CHARACTER OF MWANDU (ALONG LIVINGSTONE SESHEKE ROAD)



Source: Adapted from Mwandu Mission Board, 2015

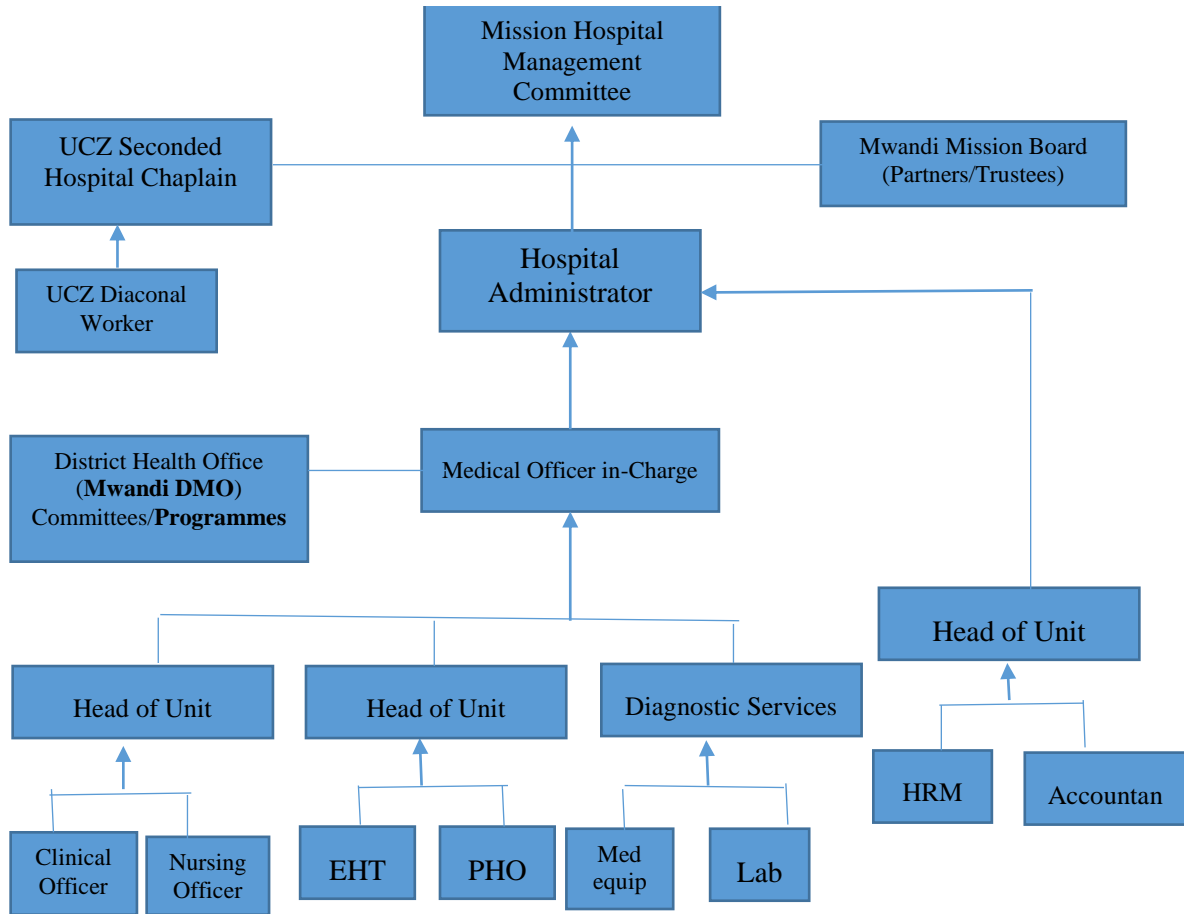
In Mwandu, the researcher and team visited Mwandu Mission station office in order to make a courtesy call on the Clergy who is the Head of Station and later held in-depth interviews with selected informants and focus group discussions with participants at the Mission Hospital, Mwandu Mission community and Mabumbu congregation outlying community.

In the same way as the review process of documents in Malawi, the researcher reviewed documents available by the UCZ in Zambia. This is explained in section 6.2.2. The review related to documents such as the Memorandum of Understanding (MoU) between the Republic of Zambia (GRZ) through the Ministry of Health (MoH) and UCZ through the Churches Health Association of Zambia (CHAZ) and the Draft Code of Ethos and Ethics for staff in the Church Health Institutions (CHI) under the CHAZ.

Of significance, while the researcher reviewed the panoramic status document providing a bird's view of the work in progress in the CCAP synod of Livingstonia, he could not access a similar document which shows life and work of the church as a whole in the United Church of Zambia. The UCZ provided slightly different documents for review. Some of the documents reviewed included the Strategic Plan for the period 2011-2015 with its respective mid-term performance review report for 2011-2013, operational plan 2012 and the revised (version 2014) UCZ constitution which the CCAP Synod of Livingstonia in Malawi could not make available. As earlier stated, the review of documentary evidence has been discussed to detail in section 6.2.2 but this section seeks to emphasize the difference in the various pockets of documents presented to the researcher in a bid to adduce evidence from field work, particularly for Mwandu Mission station in the case of the United Church of Zambia.

Figure 6-7 depicts the organisational structure obtained for Mwandu Mission Hospital at the time of the researcher's field work.

FIGURE 6-7: CURRENT ORGANISATIONAL STRUCTURE OF MWANDI MISSION HOSPITAL



Source: Researcher’s fieldwork based on Informants Interview (2014)

In terms of naturalistic observations, during the familiarisation tour of Mwand vicinity, the researcher and team found a well-constituted building construction team of partners and some locals working on a new multi-faceted block of wards nearing completion which is intended to expand the hospital bed capacity from the existing 80 bed spaces. We saw placards on the construction site, showing that the work was being undertaken with the support of the Presbyterian Church, USA. Most significantly, the research team noted with particular attention how people within the mission station and outside the mission relate to the royal establishment in Mwand and how they pay due allegiance to the tradition under the leadership of his royal highness, the Senior Chief Inyambo Yeta of the Lozi speaking people.

Meanwhile, Lentz (2010: 282) maintains that many of the pre-independence established hospitals in Zambia were supported by foreign religious organisations which later turned them over to indigenous church denominations and partners such as Mwand Christian Hospital.

Moreover, this was established in 1930 but is currently owned by the United Church of Zambia and has the Presbyterian Church of the United States of America as its international donor. Observations made in the wake of eminent construction works at the Mwandu Mission Hospital said to be carried by the partner church from the United States, the seemingly cordial relationship of the people with the traditional leadership and literature, suggest an historical partnership of the church and indigenous communities. The next section on data presentation and interpretation seeks to ascertain views of the people in addition to documentary evidence made available for review in the study.

6.5.1 Interviews for healthcare workers in Mwandu Mission

Segmented according to mission hospitals, data was presented in form of matrices covering in-depth interview and focus group discussions with respective interpretation. The order of presentation is such that interviews come first, followed by focus group discussions, while integrating all responses by stakeholder segments.

In a similar fashion as before in section 6.4 for Mbereshi Mission station, the matrices 6-10 to 6-12 in this section show the interactive responses from the informants who were part of the in-depth interviews from Mwandu Mission station. Thus, these matrices reflect responses from interviews in terms of challenges, opportunities for collaboration and possible improvements.

In follow up, the Matrix 6-10 displays healthcare challenges in the interview perspectives at Mwandu Mission station and these related to the inappropriate caring, purpose and compassion in line with attributes of a mission hospital and reporting structures. The lack of harmonised relations in ensuring collaboration/integration work among stakeholders because of inadequate inflow of finances was exacerbated by the existing debt burden. Shortage of staff characterised by low levels of human resource commitment and equipment/facilities are also some of the challenges faced. There are gaps in the memorandum of understanding/mission regulations in light of some health workers said to be harsh while the shortage of housing and transport was evident.

MATRIX 6-10: MWANDI MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES

Challenges	Responses from Interviews in Mwandini
Caring, Purpose & Compassion (4)	“We’re not giving full holistic service...not caring spiritually” Z-Mw-MHP, Z-Mw-HA, Z-Mw-HML, Z-Mw-HoS
Reporting Structure (3)	“...under the CHAZ memorandum...we are taking on the structures ...” Z-Mw-MHP, Z-Mw-HML, Z-Mw-HoS
Coordination (Integration) (2)	“The other thing is little harmonisation of relations...” Z-Mw-HA, Z-Mw-TA
Finances (2)	“The first challenge is the funding...” Z-Mw-HAc, Z-Mw-TA
Shortage of Staff (2)	“There is shortage of staff...” Z-Mw-CwS, Z-Mw-HoS
Debt Burden (1)	“...we have a debt with Zesco” Z-Mw-HAc
Equipment/Facilities (1)	“Another issue is we have no X-ray..” Z-Mw-HAc
Harsh Health Workers (1)	“Complain about the harshness from the nurses” Z-Mw-CwS
HR Commitment (1)	“The other issue is to do with human resource” Z-Mw-HA
Mission Regulations (1)	Government seconded staff’s failure to support mission and slowly encroaching in character of mission. Z-Mw-TA
Shortage of Staff Housing (1)	“The accommodation for workers is inadequate” Z-Mw-CwS
Transport (1)	“We also have no ambulance.” Z-Mw-HAc

Source: Researcher’s fieldwork based on interview responses to challenges of healthcare (2014)

According to Zulu *et al.* (2014: 14) suggestions for put community health worker (CHW) intervention would trigger motivation, credibility and accountability issues, as connectedness would be affected: some people would perceive the CHW programme as being too connected to government than community. The scenario where a health worker pays more allegiance to government than community because that is where the salary comes from may be true to what obtained in some interview responses.

To note, data shows that “...under the CHAZ memorandum of understanding, we are taking on the structures of the ministry of health, the medical officer, the administrator is answerable to them...we are not in charge of our own institution” (Informant **Z-Mw-MHP**).

Thus, it may be that the church through its seconded workers is realising the need to stand up and assume the role of ownership as government deploys senior management staff, like the medical officer in-charge in a mission hospital. In contrast, it is seen from literature and data that the issue of more connectedness to ‘who sponsors’ than ‘who owns’ has an impact on certain participants experiencing a marginal feeling of being side-lined and their community denied inclusivity, as the case in the above scenario.

Next, the discussion focuses on matrix 6-11 concerning interview perspectives on healthcare management collaboration in Mwandu, some of which relate to support in form of government grants, and the existing memorandum of understanding on administration. Government commitment on drugs supply, health workers salaries, technical support which basically comes after routine performance assessment and transport in form of vehicles from government, are some of the responses constituting collaboration.

MATRIX 6-11: MWANDU MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT COLLABORATION

Collaboration	Responses from Interviews in Mwandu
Grants (2)	“We only receive funding for the running cost of the hospital through government grant.” Z-Mw-Hac, Z-Mw-MHP
MoU on Administration (2)	“Administration be taken up by people from UCZ and CHAZ doc be signed so staff signs to abide” Z-Mw-HML, Z-Mw-HoS
Drugs (1)	“Also the government is supplying drugs.” Z-Mw-HML
Salaries (1)	“The government still continues to fund the hospital... They also provide us with staff and salaries.” Z-Mw-HML
Technical Support (1)	“Government fixed mortuary and can fix houses.” Z-Mw-CwS
Transport (1)	“We have a government vehicle as well.” Z-Mw-HML

Source: Researcher’s fieldwork based on interview responses to collaboration (2014).

The matrix 6-11 depicts opportunities for collaboration from interviews at Mwandu Mission station related to government grants (2), memorandum of understanding on administration (2), drugs supply, health workers' salaries, technical support and transport. Under technical support, Informant **Z-Mw-CwS** suggests that “recently, the government helped us to fix the mortuary and I think in the same way we can have them fix the houses” to increase the number of staff in decent dwelling. Chee *et al.* (2014: 8) maintains that supporting a health system is doing what increases outcomes by increasing inputs such as physical infrastructure, trained staff, technology systems, medicines, funding and managers.

MATRIX 6-12: MWANDI MISSION STATION INTERVIEW PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS

Improvements	Responses from Interviews in Mwandu
MoU/mission regulation (4)	“...SYNOD should come in strongly... by way of regular monitoring of programs... hospital administrator should take an active role... if possible seek partnership help... Chaplaincy – to be strong within hospital ministry (need for full time)” Z-Mw-Hac, Z-Mw-HA, Z-Mw-HML, Z-Mw-TA
Accommodation (1)	“Accommodation, if we could build more houses ” Z-Mw-HML
Clean Environment (1)	“I think the only thing the hospital needs to improve upon is cleanliness especially the surrounding.” Z-Mw-CwS
Equipment/Facilities (1)	“Portable x-ray machines are slightly cheaper than the mounted ones, so if they can switch to that alternative.” Z-Mw-HML
In-service Training (1)	“...Empower the local churches within the communities to take part in imparting these services through leadership.” Z-Mw-HA
Staffing (1)	“Any seconded staff to come under Church, not Govt” Z-Mw-TA
Strategic planning (1)	“We also lack a proper strategic plan. We have government’s strategic plan but we should have our own” Z-Mw-MHP
Supervision (1)	“The workers just need to be supervised.” Z-Mw-CwS

Source: Researcher’s fieldwork based on interview responses to improvements for health (2014)

The matrix shows that improvements for managing healthcare from interviews at Mwandu Mission station related to enforcing the memorandum of understanding/mission regulation (4), ensuring availability of staff accommodation, clean environment, equipment/facilities, in-service training, staffing, strategic planning and supervision. With regard to training as one of the interventions to create improvements in the management of healthcare in Mwandu, Informant **Z-Mw-HA** proposes that “We are saying if there was a way to empower the local churches within the communities to take part in imparting these services through leadership, trying to ensure that services are effectively done and that the church takes a leading role.” This study seeks to contribute to ways of making FBO healthcare stronger and not just supporting healthcare, as discussed in this section 3.7.1 and under matrix 6-11. Making a system stronger is attainable because strengthening a health system is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organisational structures and relationships to motivate behavioural change and effective use of human and financial resources (Chee *et al.* (2014: 86).

6.5.2 Focus Group Discussions for church and community members at Mwandu Mission Station

FDGs were conducted in Mwandu at both the mission station with the congregants and also the outlying community as part of the civil society pertinent to service provision at Mwandu Mission Hospital. The matrix 6-13 shows the focus group discussion perspectives on healthcare management challenges according to Mwandu Mission station. The matrices reflect responses from focus groups in terms of challenges, opportunities for collaboration and ways to improve.

MATRIX 6-13: MWANDU MISSION STATION FGD PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES

Challenges	Responses from Focus Groups in Mwandu
Shortage of Staff (3)	One nurse will run 2 wards... Z-Mw-MC: R7
	Shortage of staff compromises quality of care because observations are done quickly in order to see as many people as possible. Z-Mw-MC: R6
	One Doctor runs the entire hospital... Z-Mw-MC: R7
Long waiting period (1)	It takes time to be attended to – you wait a long time at OPD. Z-Mw-MC: R1

Source: Researcher’s fieldwork based on FGD responses to challenges of healthcare (2014)

Matrix 6-13 highlights challenges from focus groups at Mwandu Mission station and these related to shortage of health workers which may have contributed to one of the causes of long waiting periods to be attended to at the hospital.

To emphasise, Mutale *et al.* (2013: 3) maintain that staff shortage and long waiting time among others have been identified as some of the barriers to community health access. Community client (Z-Mw-MC: R6) confirms the “shortage of staff compromises quality of care because observations are done quickly in order to see as many people as possible.” Furthermore, “it takes time to be attended to – you wait a long time at OPD” according (participant Z-Mw-MC: R1), who advances contrary views on the period it take to be attended to is concerned.

MATRIX 6-14: MWANDI MISSION STATION FGD PERSPECTIVES ON HEALTHCARE MANAGEMENT COLLABORATION

Collaboration	Responses from Focus Groups in Mwandu
Salaries (1)	“There are no programs that we know that are from the government except the employees that come from the government.” Z-Mw-MC: R2

Source: Researcher’s fieldwork based on FGD responses to opportunities for collaboration (2014)

The matrix 6-14 shows that opportunities for collaboration from focus group discussions at Mwandu Mission station related to government health workers’ salaries. This falls in line with prior discussion under matrix 6-8 on opportunities for collaboration.

MATRIX 6-15: MWANDI MISSION STATION FGD PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS

Improvements	Responses from Focus Groups in Mwand
Accommodation (2)	“What they need to work on is now the accommodation. We can’t have four families sharing one house.” Z-Mw-MC: R6
Clean Built Environment (1)	“The renovations at the hospital that are currently taking place are very good and we are happy about that.” Z-Mw-MC: R3
MoU/mission regulation (1)	“If these people attended the Chapel, they would hear the voice of God. The word of God would build staff look at patients in love. Encourage them to attend Chapel, it would help” Z-Mw-MC: R7
Strategic planning (1)	“There’s been an improvement in treatment because we now receive a lot of referrals from other catchment areas like Kazungula and even Namibia.” Z-Mw-MC: R4

Source: Researcher’s fieldwork based on FGD responses to improvements for healthcare (2014)

The matrix 6-15 shows that improvements for managing healthcare from focus group discussions at Mwand Mission station related to providing adequate staff accommodation (2), ensuring a clean environment of built infrastructure, memorandum of understanding/mission regulations and strategic planning. Lentz (2010: 298) posits that “facility deficits could be improved if donors foster relationships with corporations to provide rural health clinics with equipment, medications and trained staff.”

However, the opportunities for collaboration as well as overall improvement for Zambia the study seeks to emphasise resonates with Kondra and Hurst (2009: 38) who maintain that envisaged synergies in ecumenical partnership with faith communities they originate from provide a base for local development.

Further, data sets show that the Church in Zambia commend Mission partners like Council for World Mission (CWM) and Community of Churches in Mission (CEVAA) for their global resource sharing locally and focus on empowerment in especially development of women societies respectively (Informant **Z-SHQ-SB, Z-SHQ-GS**).

6.6 Chapter Summary

This chapter focused on the Church's contribution to the country's national health outcomes and development in terms of healthcare provision, particularly through Mbereshi and Mwandu Mission Hospitals as part of mission and also civil society's responsibility in Zambia. The chapter covered discussions in the context of the United Church of Zambia based on data presentation and interpretation, documentary evidence and researcher's naturalistic observations in the field to arrive at findings for the Synod secretariat and both Mbereshi mission as well as Mwandu mission hospital in Zambia. Descriptive data on the case obtained through interviews, focus group discussions and document analysis was integrated to highlight different stakeholder perspectives. The integration in an intra-cross case manner using stakeholder segments of the chapter revealed that there are challenges in administrative structures causing friction between government's seconded and mission station health workers, prompting the two hospitals to shape their own work culture. Certainly, there are structural problems of sound administration which has become a deterrent to the provision of optimum healthcare.

CHAPTER SEVEN: COMPARATIVE FINDINGS, INTRA-COUNTRY AND CROSS-NATIONAL

7.1 Introduction

Chapter Seven offers a comparative analysis of intra-country findings across hospitals. The intra-country cross-case comparative analysis of findings covered Malawi's Ekwendeni Mission Hospital and Embangweni Mission Hospital. The other comparative analysis of findings covers Zambia's Mbereshi and Mwandi Mission Hospitals. The intra-country cross-case comparative analysis is then followed up with the help of relevant tables of matrices. Cross-country comparative analysis is finally interrogated between Malawi and Zambia with five themes emerging.

7.2 Cross-case comparative analysis of intra-country findings for Malawi

The over-arching goal of data analysis in most studies is the interpretation of sets of data that have been gathered during the data collection phase. Interpretation of data entails that the researcher had to make sense from the large sets of data from the field in a way that meaning is not varied and missed during the process. Creswell (2009: 183) posits that it is an iterative process: it involved back and forth reflection while making sense out of text and image data. This is so because the process of analysing data was not straightforward and did not always occur in an orderly, linear fashion, but required that the researcher re-arranged and immersed himself in the data to make meaning from the voices of participants across the study.

7.2.1 Intra-country Cross-case Comparative Analysis in Malawi

This parameter engages in an intra-country comparison that highlights the salient findings from within Malawi by relating the case of Ekwendeni with that of Embangweni Mission stations owned by the CCAP Synod of Livingstonia, in which the said hospitals are locally based.

7.2.2 Ekwendeni Mission Hospital and Embangweni Mission Hospital

This parameter contrasted responses categorised from the number of 14 in-depth interviews and 5 focus group discussions with 55 participants on the basis of key research questions from Ekwendeni and Embangweni, including that of the superintending arm of the CCAP Synod of Livingstonia head office, which is based at the Church's secretariat.

7.2.2.1 Documentary evidence and observations in the field

In the two cases of Ekwendeni and Embangweni covered for Malawi, two key documents which were reviewed in the study among others were the Revised Service Level Agreement (SLA) Guidelines 2012-2015 between the Ministry of Health and CCAP through the Christian Health Association of Malawi (CHAM), and the Summary of the Panoramic Status of the CCAP Synod of Livingstonia.

The physical environment and location covered in the two cases for Malawi were such that the CCAP Synod of Livingstonia secretariat has established itself as head office in the city of Mzuzu. The researcher observed that the secretariat has allocated office accommodation to key positions, such as the Synod Moderator, Moderator-elect, General Secretary, Deputy General Secretary, the Treasurer (head of finance) and some heads of departments (HoDs), including the Health Director as well as the Education Director who reports to the General Secretary. Mzuzu is the central business district and provincial capital for Malawi's northern region. Ekwendeni and Embangweni are located on the outskirts which were managed by a head of station for each mission station. Other heads of department directly responsible to the general secretary were not based at head office due to limited office accommodation space but at Ekwendeni Mission station. These HoDs included the LISAP Director, Lay Training Centre Director and the Youth Director. Except for the Director of Youth Work who was engaged by SKYPE interview, all other HoDs were interviewed through in-depth discussions in their respective offices at the Ekwendeni Mission station.

7.2.2.2 Interviews

MATRIX 7-1: ALIGNING CATEGORIES TO KEY INFORMANT QUESTIONS WITH EMERGING THEMES

Key Question	Ekwendeni	Embangweni	CCAP Synod HQ	Emerging Themes
Challenges – based on the regularly occurring	Inadequate funds (2), Drugs shortage (2), staff shortage, mission regulations, staff retention & user fees unsettled.	Staff shortage (4), housing shortage (3), inadequate funds (2), Inadequate trans (2), debt, Inadequate equip, drugs & staff shortage	Inadequate funds (3), autonomy, inadequate equip & facilities, management and admin, drugs shortage, staff shortage & unqualified staff.	Theme One Mission hospitals have limited capacity to offer essential healthcare
Collaboration – based on the regularly occurring	Drugs supply (2), Health workers salaries (2), SLA on maternal (2), Govt in-service training & honour SLA fees	SLA on maternal health (4), Health workers salaries (2), drugs supply, funding appeals, IGAs & transport	Workers’ salaries (5), SLA on maternal (2), community health networks (2) Drugs, grants, training & deployment.	Theme Two Mission hospitals have a heavy reliance on government and donor support to offer continued healthcare
Improvements – based on the regularly occurring	Staff accommodation, fund raising, providing food for patients, in-service training, service-free of user-fees, further studies & water.	Consolidated reporting (2), fund raising, infrastructure develop, in-service training, recruitment, HR regulations and salary top-ups.	Management and admin systems (2), fulfilment of SLA (2), fundraising, orientation to mission regulations & recruitment.	Theme Three Mission hospitals lack an integrated systems strengthening approach to provide better healthcare

Source: Researcher conceptualised based on transcribed/analysed data (2014)

From the above matrix table, the illustration depicts three themes that emerged in areas related to: limited capacity to offer essential healthcare, heavy reliance on government as well as donor support to offer continued healthcare, and apparent lack of an integrated systems strengthening approach to provide better healthcare.

While categorical responses speak volumes, this is supported by the documents. The SLA was reviewed in line with maternal health, the summary of the panoramic status and with observable changes in the field, to identify themes. Firstly, the interaction of views expressed from the category responses show that there is generally a not enough staff, supply of essential drugs, transport as well as housing for workers including inadequate finances. Increased interrogation of all responses related to challenges facing the institutions covered in the intra-case gave rise to theme one – mission hospitals having limited capacity to offer essential healthcare.

Secondly, responses highlighting government’s responsibility to supply medicine, remunerations of workers in the mission hospitals covered in the study including the agreement on provision of maternal health reflected opportunities that exist for collaboration gave rise to theme two stating that there is a heavy reliance on government as well as donor support to offer continued healthcare.

Thirdly, consolidated reporting, clear management and administrative systems and fulfilment of SLA regulation on maternal health highlighting pressing need for improvements, pointed to the third theme reflecting lack of integrated approaches that can make systems stronger if better healthcare is to be realised.

7.2.2.3 Focus Group Discussions

MATRIX 7-2: ALIGNING CATEGORIES TO KEY FGD QUESTIONS WITH EMERGING THEMES

Key Question	Ekwendeni	Embangweni	Emerging Themes
Challenges – based on the regularly occurring	Lack of caring, purpose & compassion (2), low hygiene/cleanliness (2), no equipment, harsh health workers, long waiting periods and unaffordable fees.	Shortage of medicines (3), inadequate bed-space (2) and lack of adequate transport.	Theme Four Healthcare services have a diminishing mission character
Collaboration – based on the regularly occurring	Government driven in-service training, SLA on maternal health and transport support.	Government salaries paid to Health workers.	Theme Two Mission hospitals have a heavy reliance on government and donor support to offer continued healthcare
Improvements – based on the regularly occurring	In-service training (4), more equipment and facilities (3), enhanced hygiene (3), manage client relations and recruitment criteria.	Revisiting recruitment criteria.	Theme Three Mission hospitals lack an integrated systems strengthening approach to provide better healthcare

Source: Researcher conceptualised based on transcribed/analysed data (2014)

Matrix 7-2 above depicts three themes that emerged in areas related to; first, the demonstration of a diminishing mission character in the delivery of healthcare, which comes out as a fourth theme in addition to the three themes established in matrix 7-1 which covered interviews. Second, a heavy reliance on government and donor support for continued healthcare and mission hospitals lacking an approach that integrates systems strengthening to provide better healthcare provision. Again, as in the prior section, the category of FGD responses are supported by the review of documents with a number of naturalistic observations made in the field assisted identifying the themes.

Aggregated categories of in-depth interview and FGD responses on the basis of key research questions about challenges, opportunities for collaboration and improvements gave rise to four thematic areas as part of the intra-Malawi findings covering Ekwendeni and Embangweni study sites. First, that there is limited capacity to offer essential healthcare; second, that too much donor dependency is eminent; third, apparent lack of an integrated health systems strengthening mechanism that can bring about better ways of delivering healthcare. And fourth, characteristics of mission reviewed in the literature chapter as trusted entities with a legacy of caring and hub of spiritual refuge are gradually fading.

7.3 Cross-case Comparative Analysis of Intra-country Findings for Zambia

As in section 7.3, this section evolves from the interpretation of sets of data that have been gathered during the data collection exercise. Interpretation of data enabled the researcher to make sense of the large data sets obtained from the field in such a way that meaning is not altered or lost in the process. As stated earlier, the process of data interpretation is not linear, nor does it always occur in order; it requires the researcher to re-arrange and immerse himself in the data to make meaning from the voices of participants across cases, to enable findings to emerge clearly in the study.

7.3.1 Intra-country Cross-case Comparative Analysis in Zambia

This parameter engages in an intra-country comparison that highlights the salient findings from within Zambia by relating the case of Mbereshi Mission station with that of Mwandu Mission station. The parameter contrasted outcome of responses from 24 in-depth interviews and 8 focus group discussions from Mbereshi and Mwandu, including that of the superintending as well as overview arm of Synod Headquarters of the United Church of Zambia.

7.3.2 Mbereshi Mission Hospital and Mwandu Mission Hospital

As in section 7.2.2 for the case in Malawi, this parameter contrasted responses categorised from the 24 in-depth interviews and 8 focus group discussions with 89 participants on the basis of key research questions from Mbereshi and Mwandu, including that of the superintending arm of the UCZ Synod Headquarters.

7.3.2.1 Documentary Evidence and Observations in the Field

In contrast to the two cases of Ekwendeni and Embangweni covered for Malawi in section 7.2.2.1, key documents which were reviewed in the study for Mbereshi and Mwandu in Zambia included the UCZ Strategic Plan 2011-2015 and 2012 Operational Plan.

Additionally, the Mid-term Review and Performance Improvement Plan 2014-2015; the 2014 edition of revised UCZ Constitution; Rules and Regulations of the United Church of Zambia, and the GRZ MoH/CHAZ Memorandum of Understanding with the draft Ethos and Ethics for staff which when reviewed, showed that it emphasises the promotion of Christian values in all its member health facilities. The Zambia side of the study provided more documents for review than Malawi.

Meanwhile, the implication of receiving less documents from Malawi (as in Section 7.2.2.1) than Zambia for review is that whilst selecting units of analysis was balanced as two study sites from each country, the study could not provide a balanced documentary analysis for the FBOs covered in the countries investigated. This scenario meant that the researcher went further to reflect on some commonalities based on the assumption that providing a UCZ constitution on the Zambian side did not mean that the CCAP of Malawi does not have a constitution at all. In actual fact, member checks during triangulation process reviewed that the constitution for CCAP was available but that access via electronic avenues proved difficult.

Evidently, the physical environment under which the study was conducted covering the two cases in Zambia were such that the UCZ Synod Headquarters has based its head office in the city of Lusaka. Despite the visibly limited office accommodation, the UCZ synod secretariat has lateral office space for its key positions, such as the Synod Bishop and General Secretary with executive officers (HoDs) directly responsible to the office of the Chief Executive Officer (CEO – the GS). In this study, they are considered as heads in-charge of programmes and these are the Financial Secretary, Administrative Secretary, Health Secretary, Education Secretary, Community Development (and Social Justice) Secretary, Communications Secretary as well as Projects Secretary. The only head of department who was said to operate from outside Zambia's capital city of Lusaka is the Mission and Evangelism Secretary (MES). The position was reported to have been based in the city of Ndola located on the Copperbelt province, Zambia's copper mining region from the time the MES office was established several years ago.

Meanwhile, Mbereshi and Mwandi Missions are in the outskirts of Zambia located in remote areas in Luapula (north-north west of the country) and Southern Presbytery respectively. Each mission station is overseen by the respective Head of Consistory. The Head of Consistory who is normally a clergyman and is referred to Consistory Chairman is responsible to the Presbytery Bishop in the province where the mission hospitals are based.

Thus, In-depth interviews were conveniently conducted with target HoDs because they were all based at the synod headquarters in Lusaka, with a few informants such as the former General Secretary in Luapula Presbytery; the immediate past Synod Bishop was part of synod stakeholder segment in the study as well as contributors to the format fitness test of interview instruments.

7.3.2.2 Interviews

MATRIX 7-3: ALIGNING CATEGORIES TO KEY INFORMANT QUESTIONS WITH EMERGING THEMES

Key Question	Mbereshi	Mwandi	UCZ Synod HQ	Emerging Themes
Challenges – based on the regularly occurring	Inadequate equip/facil (4), management (2), staff shortage (2), wrong medicines, collaboration, debt, old structur, funds, caring/ purpose & comp, drug/staff/houses & transp short	Caring, purpose & compassion (4), reporting (2), collaboration (2), funds (2), staff shortage, debt, equip, harsh workers, HR commitment, MoU/regs, staff, house & transp.	Inadequate funding (4), lack of sound admin (2), integration, dilapidated infrastructure, dependency, equip /facil, Commitment, medicines, staff retain/shortage.	Theme Five Reporting relationships render a dwindling grip on ownership of mission healthcare
Collaboration – based on the regularly occurring	Drugs supply, grants, Health workers salaries & MoU on student treatment	Government grants (2), MoU on Admin (2), drugs supply, Health workers’ salaries, technical support & transp.	Government grants (4), Health workers’ salaries (2), MoU on Admin (2),drugs, mission partners and governance.	Theme Two Mission hospitals have a heavy reliance on government and donor support to offer continued healthcare
Improvements – based on the regularly occurring	Drugs supply, grants, Workers’ salaries and MoU on student treatment	MoU on mission regulations (4), staff housing, clean setting, equip/facilities, training, staffing, strategy planning & supervision	MoU on mission regulations (2), training, partner solicitation, management and ownership, recruitment & strategy planning	Theme Three Mission hospitals lack an integrated systems strengthening approach to provide better healthcare

Source: Researcher conceptualised based on transcribed/analysed data (2014)

From the above Matrix 7-3, three themes emerged in areas related to reporting relationships rendering a dwindling grip on church ownership of mission healthcare, heavy government and donor dependency for continued quality of care with lack of an integrated systems strengthening approach for better health outcomes.

While responses based on categories speak volumes, they are supported by the documentary review conducted such as the existing UCZ Strategic Plan plus the 2012 Operational Plan; Mid-term Review and Performance Improvement Plan; the revised UCZ Constitution 2014 with Rules and Regulations and the MoU with draft Ethos and Ethics for staff, which were all reviewed in line with observations made in the field to come up with themes. The interaction of views expressed from the responses were deemed instrumental to the rise of theme five (as new theme in addition to those found in matrix 7-1 and 7-2), citing reporting relationships that render a loss of grip on church-led healthcare. Category responses which characterised theme two on heavy reliance on church-led healthcare on government and donors were monthly grants, health workers with their salaries and the memorandum of understanding on administration. The last theme which clearly depicts lack of integrated health systems strengthening was a special feature for enforcement of the MoU and orientation to mission regulations coupled with in-service training for human resource.

7.3.2.3 Focus Group Discussions

MATRIX 7-4: ALIGNING CATEGORICAL RESPONSES TO KEY FGD QUESTIONS WITH EMERGING THEMES

Key Question	Mbereshi	Mwandi	Emerging Themes
Challenges – based on the regularly occurring	Shortage of medicines (2), inadequate equipment/facilities, shortage of food for patients, shortage of staff and transport.	Shortage of staff (3) and long waiting periods to be attended to at the hospital.	Theme One Mission hospitals have limited capacity to offer essential healthcare
Collaboration – based on the regularly occurring	Government supply of medicines.	Government health workers' salaries.	Theme Two Mission hospitals have a heavy reliance on government and donor support to offer continued healthcare
Improvements – based on the regularly occurring	Providing more equipment/facilities, food for patients and infrastructure development.	Adequate staff houses (2), clean environment, MoU on mission regulations and strategic planning.	Theme Three Mission hospitals lack an integrated systems strengthening approach to provide better healthcare

Source: Researcher conceptualised based on transcribed/analysed data (2014)

Matrix table 7-4 depict three themes emerged in areas related to features similar to what has been identified and discussed in figure 7-1

The only exception is that views are supported by the review of documents conducted on the current UCZ strategic plan with the 2012 work plan; the mid-term review and performance improvement plan; the UCZ Constitution 2014 with rules and regulations and the MoU, in line with a number of observations made in the field, to identify themes.

Similar to the cross-case comparison of Malawi in matrix 7-1 and matrix 7-2 (covered in sections 7.2.2.2 and 7.2.2.3 respectively), aggregated categories of in-depth interview and FGD responses on the basis of key research questions in conformity with challenges, opportunities for collaboration and improvements, all gave rise to four thematic areas in the intra-Zambia findings covering Mbereshi and Mwandi study sites. The first, second and third themes are the same as that of Malawi, except the fourth and last theme five for Zambia, which adds that the reporting relationships render a dwindling grip on ownership of mission healthcare on the part of the church.

7.4 Emerging Themes from the Study

Interaction between and among aggregated categories of in-depth interview and FGD responses to key research questions in line with study objectives based upon challenges, opportunities for collaboration and improvements covering the four cases covered in the two countries and helped to identify themes. Using available, reviewed documentary evidence and naturalistic observations from the field in the wake of Multi-grounded theory (MGT) to interrogate informants and FGD data, five minor themes in the intra-country cross-case comparisons emerged, namely:

7.4.1 Theme One – Mission hospitals have limited capacity to offer essential healthcare

Having limited capacity to offer essential healthcare by mission hospitals means that the church-led healthcare falls short of enough health workers, medicines, funding and related resources that guarantee expected provision of primary health services as close to the people as possible.

7.4.2 Theme Two – Mission hospitals have a heavy reliance on government and donor support to offer continued healthcare

Having a heavy reliance on government and donor support means that established institutions church-led healthcare mostly depend on health workers with their salaries, medical supplies, grants and other related funding mechanisms from government, and donor organisations at home and abroad.

7.4.3 Theme Three – Mission hospitals lack an integrated systems strengthening approach to provide better healthcare

Requiring an integrated approach to the provision of improved healthcare means that church-led healthcare lacks a joint approach to issues related to various health systems. Particularly, there is a governance weakness in the embedded-ness (meaning integration) between health institutions (hospitals) and communities (members of the church and society in the localities) covered in the study.

The system issues include health thrusts such as the quality of care, improvements through training and those insisted on in the WHO's six building blocks – service delivery, health workforce, information, medical products, vaccines and technology, financing and leadership and governance. Theme Four – The offered limited capacity healthcare services have diminishing mission character

The already limited capacity healthcare services have a diminishing mission character, which means that church-led healthcare is slowly losing its historical legacy of being a trusted entity through a caring partnership due to lack of caring, purpose and compassion exhibited by traces of harsh health workers in some of its CHIs. The mission character emphasises doctrine of the church through special teachings and prayer. This character seems to be diminishing by the lack of mission station prayer time and many other facets that places emphasis on daily personal and group devotions as well as other mission regulations.

7.4.4 Theme Five – Reporting relationships render a dwindling grip on ownership of mission healthcare

The existing reporting relationships render a dwindling grip on ownership of mission health care which means that church-led healthcare is experiencing negligible human resource commitment, non-adherence to memorandum of understanding/mission regulations in the light of the lack of sound administrative structures, all indicating it is slowly losing ownership of its CHIs.

Overall, the use of category responses led to the generation of themes (in this study based on foundational factors) and ultimately appeared as part of major findings resulting in headings/sections in the study. With the use of an integrated MGT approach, the interconnection of emerging minor themes resulted in key thematic areas (section 8.3) that formed a story for developing a new meta-conceptual model.

The next section seeks to demonstrate through the use of a composite matrix, that there is a relationship between the meta-conceptual framework and the advocacy-participatory worldview that brings the voices of marginalised groups (including community members and hospital staff) to the forefront of the study, through involvement in their own health care management.

7.5 Meta-conceptual Framework and Transformative Worldview

This section seeks the alignment of the meta-conceptual framework driving the study and some of the vital rudiments of the advocacy-participatory worldview, as advanced by Creswell (2009: 9): the reform agenda, averting oppression and inequality, reversing marginalisation and alienation, and raising consciousness and empowerment.

Figure 3-3 is hereby re-cast as **Figure 7-1** to help in the demonstration of how the meta-conceptual framework worked collaboratively with the participatory worldview to consolidate the findings of the study.

FIGURE 7-1: INTEGRATING META-CONCEPTUAL FRAMEWORK IN VIEW OF CHALLENGES AND OPPORTUNITIES COLLABORATION



Source: Adapted from Sinha (2012), Eller (2014) and Zambia NHP (2013)

The literature survey in Chapter 3 notes Sinha's (2012: 569) organisation's systems theory and Eller's (2014: 147) organisation's theoretical concepts, which showed that the stakeholder-congregational meta-conceptual framework can work as a model for the study. The use of the framework has shown the ability to transform identified challenges into opportunities that can culminate in improved healthcare using an integrated (joint) approach to attain an atmosphere that contribute to equitable and affordable access for all people, translating into healthy lifestyles for the people and, as a result, a productive society (The Zambia NHP, 2013: 9).

To further clarify, there are significant relationships between providing equal access to healthcare and affordability for people to live healthily so that they contribute to a country's productivity, thus interpreting said health policy with various stakeholder voices offering empirical data.

In tandem with the philosophical worldview of the study, Matrix 7-5 below shows that oppression and inequality as well as consciousness-raising and empowerment were non-responsive, but the reform agenda and marginalisation with alienation reflected responses in line with the themes highlighted, to depict the alignment between the meta-conceptual framework and four rudiments that form the worldview that is advocacy-participatory.

The link between the framework and the worldview assisted the researcher to illustrate the alignment between two vital rudimentary features which were responsive in the study: instituting the reform agenda and rolling back marginalisation as well as alienation, which helped to yield in the different stakeholder groupings – health workers in light of internal stakeholders and church with community members in light of external stakeholders perspectives respectively. Synod officials have been treated differently as principals in the place of owners whose ideals are at the core of enforcing transformation within the confines of the organisation.

MATRIX 7-5: ALIGNING META-CONCEPTUAL FRAMEWORK IN RUDIMENTS OF TRANSFORMATIVE WORLDVIEW IN LIGHT OF EMERGING THEMES

Stakeholder-congregational conceptual framework	Health workers(as internal stakeholders; they perceive themselves as minimised)	Community members (as external stakeholders; they perceive themselves as marginalised)	Synod Officials (as owners; they perceive themselves as custodians of congregational governance)	Desired end state
Transformative worldview: Reform Agenda	Theme Five Reporting relationships render a dwindling grip on ownership of mission healthcare	Theme One, Theme Two & Theme Three	Theme One, Theme Two & Theme Three	Involvement – healthcare management
Oppression and Inequality	Non-responsive	Non-responsive	Non-responsive	Non-responsive
Marginalisation and Alienation	Theme One, Theme Two & Theme three	Theme Four The offered limited capacity healthcare services have diminishing mission character	Theme One, Theme Two & Theme three	Inclusivity – own healthcare management
Consciousness-raising and Empowerment	Non-responsive	Non-responsive	Non-responsive	Non-responsive

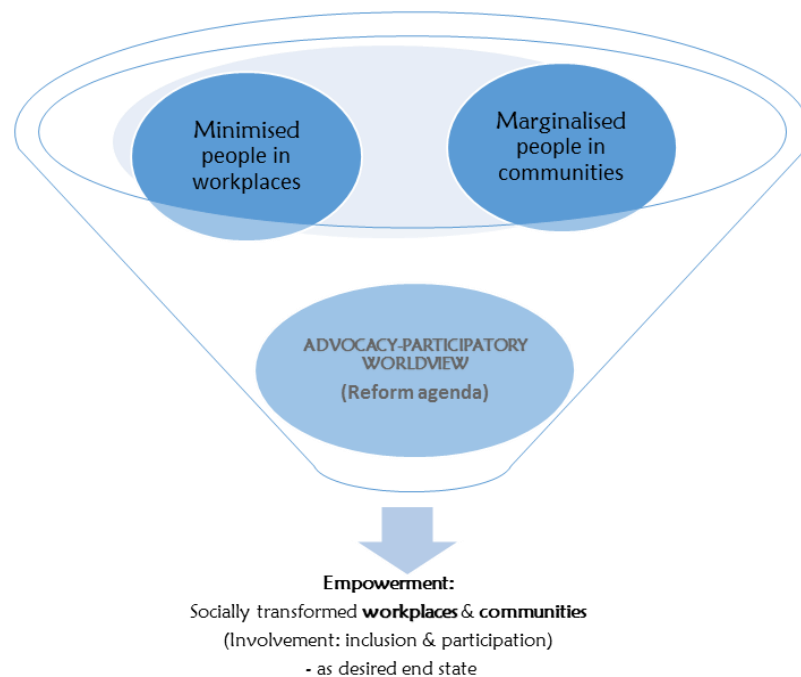
Source: Researcher conceptualised (2016)

In this study, the theoretical framework is drawn on the basis of a meta-theory of stakeholder-congregational conceptual framework adapted from Eller (2014) and Sinha (2012) discussed in section 3.7 (as detailed in figure 7-1 above and) of Chapter 3.

Matrix 7-5 depicts how a meta-conceptual framework highlighting the stakeholder segments underlying the advocacy-participatory worldview facilitated the emergence of two key themes and their embedded-ness in health worker voices, perceived in minimisation and church as well as community members pointing to marginalisation. Firstly, minimisation is characterised by theme five stating that reporting relationships render a dwindling grip on ownership of mission healthcare and secondly, marginalisation is underlined by theme four claiming that the offered limited capacity healthcare services have diminishing mission character. The meta-conceptual framework acts as a vehicle for driving the study and for helping in the attainment of the research objectives to ultimately answer key research questions.

Generally, most empirical studies do carry an underlying philosophical worldview, as yielded in this investigation despite the scenario not always being the case in most research undertakings. The advocacy-participatory philosophical worldview adopted for this study complements the meta-conceptual framework at the core of investigation. This is because it evolves around addressing concerns of different stakeholder groups, especially the minimised people in workplaces; it also addresses the issues by seeking to add a voice to marginalised as well as alienated people – such as community members from all the four multiple cases across the two countries.

FIGURE 7-2: TRANSFORMATIVE WORLDVIEW REFORM AGENDA AND VOICES OF STAKEHOLDERS



Source: Researcher’s work adapted from Creswell (2009); Informants and FGD data (2014)

The above illustration shows the relationship between the transformative (labelled and said to be advocacy-participatory) worldview reform agenda with minimised people in workplaces such as in the four mission hospitals and marginalised groups of people in the four communities who access healthcare provision in this study, pointing to empowerment as a desired end state for a socially transformed society particularly in Malawi, Zambia and other Southern Africa countries in the region. Transformation of any given society is about change. The pathway to reform a FBO management setting such as the four multiple cases has a relationship with transforming the three stakeholder segments discussed in section 7.5.1 about health workplaces, section 7.5.2 about communities and section 7.5.3 about principal ownership covered in the study.

Further, the illustration pertaining to the use of advocacy/participatory worldview reform agenda seeks to bring the voices of marginalised groups and minimised people in workplaces (including community members and hospital staff) to the forefront of the study, through involvement in their own health care management at local level.

Additionally, the responses which were segmented in a manner that enabled grouping of views expressed by different stakeholders covered in the study point to the desired end state of the meta-conceptual framework for involvement as well as inclusion. The grouping of informants and FGD participants in the study constituted various people with differing stakes in the healthcare service delivery, namely, health workers, community members and church synod officials of the CCAP of Malawi and UCZ in Zambia.

To contrast, the literature in Chapters 2 and 3 related to public governance and non-governmental organisation in particular, spelled out attempts to bring out change in the way service provision is rendered. While change is inevitable and welcome to some people, those who are anti-change tend to be gripped with anxiety and are overtaken by a sense of fear and uncertainty. To some extent, the anti-change people even devise means of frustrating proponents of change, as Hughes (2012: 8) maintains: “it is remarkable how far that public management has moved away from public administration”. Hugh further posits that public governance seeks to bring about transforming inside and outside aspects of service delivery to the people in underserved people. This is further supported by another proponent of social change, Anheier (2014: 416), who maintains that people in communities have the ability to influence policy decisions and direction as well as to enact them to regulate public life in a given socio-economic environment for developmental purposes.

Additionally, the approach to transform society seeks to reverse the way of thinking in public administration of ‘muddling through’ advanced by Lindblom (1959: 88), who maintains that service providers have a disposition of keeping the traditional avenues they use to in performing their functions, which have detrimental effects to change, completely blocking it so it is not attained. This may be seen to occur in the reform agenda of the advocacy-participatory which in this study, seeks to drive the outcome of a desired socially transformed end state embedded in involvement and inclusiveness.

7.5.1 Health workers – as service providers

The segment of health workers was created to provide space for views expressed by the church health institution (CHI) workers, who provide service across the four mission hospitals covered in the study. The composite matrix table above shows that as stakeholders who are inside the CHI, they perceive themselves as minimised. The literature in section 3.7 of Chapter 3 emphasises health workers as stakeholders who are inherent to the system of healthcare. Explication of contents in the matrix demonstrates this scenario of service provision as part of the internal stake they hold in the congregational governance style eminent in CHIs covered in the study – as internal stakeholders.

7.5.2 Church and community members – as service recipients

The segment of community members was created to provide space for views expressed by the members of civil society who receive healthcare services provided across the four mission hospitals covered in the study. The similar scenario seems to be the case of church and community members. Members of the church as well as those from the surrounding communities are a segment of stakeholders who are basically outside the operations of any CHI. In the composite matrix table above, they perceive themselves as marginalised. The literature in section 3.7 of Chapter 3 emphasises community members as stakeholders who are not intrinsically inherent but coherent to the system of healthcare. Explication of contents in the aforesaid matrix demonstrates this scenario of service provision as part of the external stake they hold in the governance system which characterises congregational settings in CHIs covered in the study – as external stakeholders.

7.5.3 Church synod officials – as principals (representing owners)

The segment of church synod officials was created to provide space for views expressed by synod secretariat who act on behalf wider ownership of the four mission hospitals in Malawi and Zambia covered in the study. The literature in section 3.7 of Chapter 3 has placed emphasis on synod officials as stakeholders who form part of ownership of church-led healthcare.

In emphasising, the composite matrix table above shows that as stakeholders who represent owners of the CHIs, they perceive themselves as custodians.

Further, explication of contents in the aforesaid matrix demonstrates this scenario of exclusive rights to ownership as part of the stake they hold in streamlining congregational governance eminent in CHIs covered in the study – as presiding principals.

To distinguish, having related all the three stakeholder segments through the use of advocacy/participatory worldview (as illustrated in Figure 7.5-1), the only variation lies in synod officials as presiding principals to stimulate organisational action by way of the reform agenda that seeks to bring the voices of marginalised and alienated groups (including community members and health workers) to the forefront of the study, through inclusion and involvement in their own health care management.

7.6 Cross-national Comparative Analysis in Malawi and Zambia

This section makes a cross-national comparison by highlighting the salient findings from Malawi in the case of Ekwendeni as well as Embangweni Mission stations and Zambia, in the case of Mbereshi and Mwandu Mission stations. The parameter then contrasted the outcome of responses segregated by stakeholders' segmentation approach from the two countries of study, Malawi and Zambia. CCAP Healthcare Mission in Malawi

7.6.1 Central Africa Presbyterian in Malawi

This section seeks to bring out comparative findings owing to established categories in responding to challenges, collaboration and improvements, by aligning them with stakeholder segments and themes that emerged.

MATRIX 7-6: ALIGNING MALAWIAN STAKEHOLDER PERSPECTIVES IN RESPECTIVE CATEGORIES WITH EMERGING THEMES

Emerging Themes	Health workers		Church & community members		CCAP Synod
	Ekwendeni	Embangweni	Ekwendeni	Embangweni	HO – Malawi
Theme One Mission hospitals have limited capacity to offer essential healthcare	Inadequate funds (2), Medicine shortage(2)	Staff (4) and housing shortage(3), lack funds(2) /transport(2)	Non-responsive	Non-responsive	Inadequate finances (3)
Theme Two Mission hospitals have a heavy reliance on government and donor support to offer continued healthcare	Drugs (2), Workers’ salaries (2), SLA on maternity (2)	SLA on maternal health (4), Health workers salaries (2)	Gov’t training, SLA on maternity and transport.	Government salaries paid to Health workers.	Workers’ salaries (5), SLA on maternity (2), community-networks (2)
Theme Three Mission hospitals lack an integrated systems strengthening approach to provide better healthcare	Housing, fund raise, food, training, free service, studies and water	Consolidated reporting (2)	Training (4), more equip and facilities (3), enhanced hygiene (3)	Revisiting recruitment criteria.	Management and administrative systems (2), fulfilment of SLA regulation (2)
Theme Four The offered limited capacity healthcare services have diminishing mission character.	Non-responsive	Non-responsive	Lack of caring, purpose & compassion (2), low hygiene / cleanliness(2)	Shortage of medicines (3), inadequate bed-space (2)	Non-responsive

Source: Researcher conceptualised (2016)

The matrix 7-6 constitutes comparative category responses aligned with stakeholder segments and emerging themes interrogated as in the sub-sections below:

The first theme brings out how that mission hospitals have limited capacity to offer essential healthcare; the second, that mission hospitals have a heavy reliance on government and donor support to offer continued healthcare; the third that Mission hospitals lack an integrated systems strengthening approach to provide better healthcare and the fourth, that the currently offered limited capacity of healthcare services have diminishing mission character. In matrix 7-6, theme four shows an over-riding difference between the two countries. Here, the limited capacity healthcare provision offered display a diminishing character in the real meaning of mission insofar as the people of Malawi in Ekwendeni and Embangweni communities are concerned. The theme is characterised by lack of sense of caring, purpose and compassion, in the wake of low levels hygiene/cleanliness, while exacerbated by shortage of medicines in a physical environment that has inadequate bed-space.

7.6.1.1 Health workers – as Service providers

Themes one, two and three are based on category responses from health workers – as service providers. Among the three, the only theme that differed from others in relation to stakeholder segments is the category responses that constitute theme number one. The theme states how mission hospitals have limited capacity to offer essential healthcare as substantiated by the views of the health workers who render healthcare services, because the provision is hampered by lack of needed human and financial resources.

In section 2.3 of the literature survey in Chapter 2, Putnam and Feldstein, (2009: 4) maintain that building social capital is not free of conflict and controversy. Some people build social capital because it can empower disadvantaged groups in their struggle for greater influence. This segment is merely being augmented as it was initially discussed in section 7.4.1 about key issues emerging from the findings of the study.

7.6.1.2 Community members – as Service recipients

Themes two, three and four are based on categorical responses from community members – as service recipients. Among the three, the only theme different from others based on stakeholder segments is theme four.

Ironically, the theme states that limited capacity healthcare services offered currently have diminishing mission character as substantiated by the views of the community who receive healthcare services, because the provision is gradually depleting of the initial aspect of caring, purpose and compassion for the underserved people. This segment is also discussed in the prior section 7.4.2.

Most importantly, empirical studies from literature such as Godlonton and Okeke (2016: 112) found decreased use of informal (traditional) health providers (such as TBAs) over a period of time in most communities in Malawi, following the ban by government, and some countries have taken gradual steps to transition from informal to the formal sector insofar as health seeking behaviours are concerned. While the explicated categories in two cases of Ekwendeni and Embangweni suggest the emerging theme that limited capacity healthcare services currently offered CCAP healthcare in the nation of Malawi have a diminishing character of mission because the provision is gradually losing the initial vocation of caring, purpose and compassion for the underserved people. It may not be clear if the ban of TBAs could have had in a way an adverse effect on the much-desired care, character of purpose and compassion for the poor in promoting community healthcare.

7.6.1.3 Church synod officials – as Principals (representing owners)

Themes one, two and three are based on category responses from church synod officials – as principals who own the CHIs. Themes against category responses across stakeholder segments are reflected in section 7.4 and further augmented in the stakeholder segment detailed in section 7.5.2.3 under UCZ healthcare mission in Zambia, which follows.

7.6.2 UCZ Healthcare Mission in Zambia

This section attempts to establish summarised findings in their respective categories as responding to challenges, collaboration and improvements, by aligning them with stakeholder segments and emerging themes.

MATRIX 7-7: ALIGNING ZAMBIAN STAKEHOLDER PERSPECTIVES IN RESPECTIVE CATEGORIES WITH EMERGING THEMES

Key Themes	Health workers		Church & community members		UCZ Synod HQ
	Mbereshi	Mwandi	Mbereshi	Mwandi	HO - Zambia
Theme Five Reporting relationships render a dwindling grip on ownership of mission healthcare	Inadequate equipment/facilities (4), lack of management systems (2), staff shortage(2)	Caring, purpose & compassion (4), reporting(2) integrate(2) in adequate finances (2)	Non-responsive	Non-responsive	Inadequate finances (4), lack of sound admin structures (2)
Theme Two Mission hospitals have a heavy reliance on government and donor support to offer continued healthcare	Drugs, grants, Workers' salaries and MoU on student treatment	Grants (2), MoU on Admin (2)	Supply of medicines	Gov't health workers salaries	Grants (4), Workers' salaries (2), MoU on Admin (2)
Theme Three Mission hospitals lack an integrated systems strengthening approach to provide better healthcare	Drugs, grants, Workers' salaries, MoU on student treatment	MoU on mission regulations (4)	Equipment/facilities, food and infrastructure development.	Providing adequate staff accommodation (2)	Enforcement of the MoU on mission regulations (2)
Theme One Mission hospitals have limited capacity to offer essential healthcare	Non-responsive	Non-responsive	Shortage of medicines (2)	Shortage of staff (3)	Non-responsive

Source: Researcher conceptualised (2016)

The matrix 7-7 attempts to unpack three sub-sections of stakeholder segments against emerging themes. Theme five indicates that reporting relationships have a dwindling grip on ownership of mission healthcare; second, that mission hospitals have a heavy reliance on government and donor support to offer continued healthcare, and third, that mission hospitals lack an integrated systems strengthening approach to provide better healthcare.

Theme one states that mission hospitals have limited capacity to offer essential healthcare.

In stressing this, Ascroft *et al.* (2011: 5) posit that medical and drug supplies for both government and church facilities are financed centrally, further posing reporting challenges. The church as owners of mission hospitals, further grapple with dual reporting in which they have to account for human, material and financial resources to government as well as donors. While this may be the case, what they may account for to government is not what they report to donors. Government has seen reluctance in disclosure of support by the church in terms of what they receive as donations as these go into the mission hospitals directly. The section that follows discusses health workers in the context of service provision.

7.6.2.1 Health workers – as Service providers

Using the bottom-up view, themes two, three and five are based on category responses from health workers – as service providers. Among the three, the only theme that differs from others in relation to stakeholder segments discussed under mission healthcare in Malawi, are the category responses that constitute theme number five. The theme shows how reporting relationships render a dwindling grip on ownership of mission healthcare on the part of the church, as substantiated by the views of the health workers who provide services because there is lack of human and financial resources for systems strengthening.

However, the cross-national comparison engaged in the literature, particularly Rasheed and Karpf (2010: 10), who maintain that in some church health organisations recruitment and promotion of staff are restricted by religious affiliation. This creates difficulties for the government sector-wide planning of human resources. Transcribed data promises stimulation and a particular degree of commitment to an organisational action on the part of health workers as service providers, with the intent to reverse minimisation within the church health institutions but promote inclusion in their own management of healthcare.

7.6.2.2 Community members – as Service recipients

Similar to section 7.4.2 taking the bottom-up view, themes one, three and two are based on category responses from church and community members – as service recipients. Among the three, the only theme that differs from others in relation to stakeholder segments discussed under mission healthcare in Malawi is the category response that constitutes theme number one. The theme states that mission hospitals have limited capacity to offer essential healthcare while the other two stakeholders as providers and owners remain silent.

Consequentially, empirical studies from literature such as the Singal (2013: 4) qualitative case study on the importance of TBAs in reducing the difficulties between home and formal health systems further emphasised the skills complement that can be used collaboratively to deliver healthcare (PMTCT, elaborated in section 3 of Chapter 2. While the explicated categories in the two cases of Mbereshi and Mwandi suggest the emerging theme that Zambian mission hospitals in question have limited capacity to offer essential healthcare attributed to a lack of consistent supply of medicines and health staff shortages, it may not be immediately clear if the involvement of TBA could have had the accelerating effect of promoting community-based healthcare.

Kong (2010: 4) maintains the need to “assess how institutions can be designed so that actors are motivated, for public-regarding reasons, to provide opportunities for public involvement and monitoring, and to facilitate explicit deliberation about these reasons and about evolving institutional practices”. Engagement of literature with data transcripts here made possible a cross-case national comparison which exhibited behaviour that divides an organisation’s alienation practices. Creswell’s (2009: 9) advocacy-participatory worldview reform agenda also promises stimulation and a commitment to organisational action on the part of healthcare service recipients as community members to avert marginalisation and divisive behaviour with yet another intent to promote participation in local delivery of healthcare services within the CHI structures.

7.6.2.3 Church synod officials – as Principals (representing owners)

Again similar to section 7.4.2.2 taking the bottom-up view, themes three, two and five are based on category responses from church headquarters represented by synod officials – as principals. Among the three, the theme that differs from others in relation to stakeholder segments discussed under mission healthcare in Malawi is the category response that constitutes theme number five. The theme states that reporting relationships have resulted in a dwindling grip on ownership of mission healthcare in relation to other stakeholders, service providers and recipients who have chosen to remain silent.

According to literature reviewed in Chapter Three with regard to management of mission hospitals, existing governance and historical background of certain churches is what shapes management of faith-based healthcare provision in CHIs.

Further, this is reinforced by the perspective of Eller's (2014: 147) stakeholder theory and Sinha's (2012: 566) congregational system (which is in tandem with Zeze, 2012: 46), whose enforcement advanced the development of a complementary conceptual framework. Here this is referred to as a meta-conceptual model (the Stakeholder-congregational theoretical model in Figure 3-2 in section 3.7), which is central to driving the study related to the case of Malawi's CCAP Synod of Livingstonia and Zambia's UCZ Synod Headquarters.

On the whole, section 7.3.2.1 observes that the geographical location under which the study was undertaken for the two cases in Zambia showed that the UCZ Synod Headquarters has its head office in Lusaka, the capital city of Zambia. The scenario under section 7.2.2.1 for field observations in Malawi is the opposite, where the geographical location under which the study was undertaken for the two cases in Malawi showed that the CCAP Synod of Livingstonia secretariat has its head office historically in Mzuzu town, which is the provincial capital city of Northern region and not Lilongwe, the administrative capital of Malawi. This means that there is administrative convenience for UCZ headquarters being based in Lusaka because of proximity with central government. Proximity of the UCZ secretariat with the central government of Zambia may have provided greater potential benefits and opportunities for smooth collaboration as compared to CCAP Synod of Livingstonia, which is geographically quite a distance apart from central government of Malawi administrative offices and does not make for smooth and efficient coordination.

7.7 Demonstrating Meta-conceptual Model with Research Questions and Objectives

The purpose of this section is two-fold. First, it shows how the meta-conceptual model relates to the answering the research questions and achieving the research objectives. Second, it uses matrices to show variance of responses from multiple sources of data as these relate to challenges, collaboration and improvements in terms of structural, clinical and doctrinal factors.

Literature reviewed in section 2.2.3 of Chapter Two demonstrates how Bankauskaite and Novinsky (2010: 388) maintain that the approach to using stewardship theory in a health system shows progress in generating intelligence as well as formulating a strategic policy framework, but

lacks appropriate authority to efficiently coordinate a sound healthcare system and to ensure that autonomous communities implement policy in line with overall national health system objectives. The scenario is complemented by Eller's (2014: 141) assumption on stewardship theory that the person is engaged as a steward and provides required services to clients with a view to maximise the principal's interests in terms of motivation and controls.

Interestingly, there is very little on exercise of power by the steward who is said to be a caretaker on behalf of the principal being the owner of the establishment, be it a health system or a given organisation. Given that we are dealing with FBOs which are Christian organisations and hints of doctrine have come out, stewardship in Christian circles follows the belief that human beings were created by the same Almighty God who made the entire universe and everything that exist in it. This follows that to look after the earth's creation and thus God's dominion, is the responsibility of the Christian steward.

While there is a balance in personal goals of the steward and that of the organisation, it is evident from the literature particularly in section 3.6 of Chapter 3 such that authority is exercised to a minimal level if applied to this study in isolation. Hence adapting the stakeholder assumption in a 'congregationalised' governance orientation which is said to be committee or people-centred became pertinent.

Most importantly, at the core (centre) of the meta-theoretical framework of the study, is the stakeholder theory and how it is embedded in the congregational form of governance that in this study is said to exist in the Church of Central Africa Presbyterian and the United Church of Zambia as major protestant churches in Malawi and Zambia and the four sites of research. The Church in Malawi and Zambia is a faith-based organisation that owns and is responsible for the management of its mission hospitals in the provision of improved healthcare services in Malawi and Zambia respectively. The church, as an organisation – here the CCAP and UCZ - are covered in this study and shown to be governed using the top-down approach.

However, using the proposed meta-theoretical conceptual model as a vehicle to drive the study, the section elaborated a three-pronged approach that demonstrates stakeholder theory in an environment that has a congregational type of governance, based on research objectives embedded in key research questions.

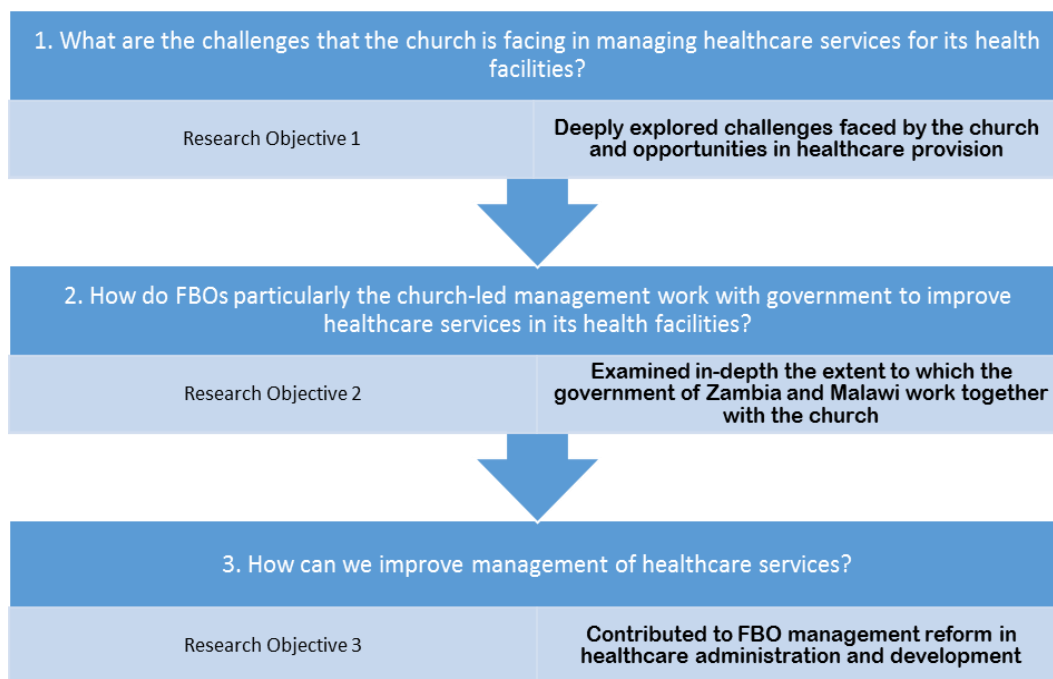
Summing up, the theory espouses three ideal situations in the case of FBO management of mission hospitals in Malawi and Zambia: eminent challenges, opportunities for collaboration and

improvements thereof. CCAP and UCZ have strong connections with communities they work with through their long standing historical membership. According to both the CCAP panorama and revised UCZ constitution, noted in the literature chapters, the church is strongly founded on the priesthood of all believers which gives space for expression of faith in God among the clergy and the laity to foster a collaborative effort. There is much recognition of working through stakeholder committees and respect for opinion at grassroots in the overall governance of the Church. Both the CCAP and UCZ organograms attest to the understanding that sections (or sessions) as grassroots units of the Church, report to courts above them.

Arguably, in seeking to reverse the tide of the top-down approach and promote a bottom-up one, the meta-conceptual model brings Sinha’s (2012) organisational systems in Faith-based organisations and Eller’s (2014) theory on corporate governance in a non-profit organisation, together. This joint move underscored the study.

Figure 7-2 below depicts how the outcome of the meta-conceptual model which gave rise to the embedded-ness in research objectives, could be demonstrated with key research questions.

FIGURE 7-3: RECASTING RESEARCH OBJECTIVES EMBEDDED WITH THE KEY RESEARCH QUESTIONS



Source: Researcher’s framework based on study objectives and questions (2014)

Sections 7.7.1 to 7.7.3 show whether responses converge or diverge as a form of triangulation of data sources.

7.7.1 Challenges

The issue of addressing the key question on challenges raises situations that hinder proper management of faith-based organisations in the provision of healthcare. The section seeks to respond to the key research question 1 on what challenges the church faces in managing healthcare services for its health facilities. The embedded research objective one was met as the study deeply explored challenges faced by the church and opportunities now as well as those that lie ahead in healthcare provision.

MATRIX 7-8: ALIGNING STAKEHOLDER PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES WITH EMERGING STRUCTURAL FACTORS

Cross-country Analysis						
(a) Structural Factors from Challenges	Malawi			Zambia		
	Principals (Synod)	Health-workers	Community	Principals (Synod)	Health-workers	Community
1. Shortage of staff (17) & no Staff retention (4)	“Staff shortage and staff retention” M-Em-HoS, M-SoL-APD, M-Ek-HA, M-Em-HA, M-Em-HoS	“Not enough staff & few overwork” M-Ek-HM, M-Em-HR, M-Em-PHC, M-Ek-HCC	Non-responsive	“Few staff overwork and opt to leave” Z-Mw-HoS, Z-CM-PSB, Z-SHQ-HS, Z-SHQ-GS	“Staffing is inadequate ... “ Z-Mb-HA, Z-Mb-Mol, Z-Mw-HA	“Staff shortage compromises care ... “ Z-Mw-MC: R6, Z-Mw-MOC: R7, Z-Mb-MC, Z-Mb-MOC: R5
2. Finances (14) and Debt Burden	“Sustainability is hard – due to inadequate funds” M-SoL-GS, M-	“...finance problems, grant reduction critical” M-Ek-HCC,	Non-responsive	“Financing is inadequate...so critical ...” Z-	“... church has debt & no funds, staff leave for greener pastures” Z-	“Inadequate financing – l...here and also Mbereshi Mission Hospital” Z-

	SoL-SM, M-SoL-HD	M-Ek-HA, M-Em-HR, M-Em-HA, M-Em-HA		SHQ-HS, Z-CM-PSB, Z-SHQ-FS	Mw-HAc, Z-Mb-Mol, Z-Mw-HAc, Z-Mb-Mol	Mw-MOC: R9, Z-Mw-TA
3. Inadequate equipment/facilities (12)	“We don’t have adequate equipment.” M-Em-HoS, M-SoL-SM	Non-responsive	“Congestion, overflow, faulty geysers” M-Em-MC, M-Ek-OC, M-Ek-TA	Inadequate equip, x-ray films, reagents Z-SHQ-HS	“No equip, air-con, Gen-set” Z-Mw-HAc, Z-Mb-HCC, Z-Mb-Mol, Z-Mb-HM	“Pilferage & no theatre air-con, no male ward toilet” Z-Mb-MC, Z-Mb-MSD, Z-Mb-MOC
4. Transport (6)	Non-responsive	“...inadequate transport ...at times no fuel.” M-Em-PHC, M-Em-DFM	“transportation ... we have few drivers...not enough.” M-Em-MC: R1	Non-responsive	“No ambulance, transport – staff sacrifice vehicles” Z-Mb-HA, Z-Mw-HAc,	“... but transport is the biggest challenge.” Z-Mb-OC
5. Collaboration (5)	“Autonomy of hospital, employees not transferable negatively affects, limits initiative” M-SoL-YD	Non-responsive	Non-responsive	“Lack of local networking with communities leaves a gap ...” Z-CM-PSB	“Collaboration ... little harmony... holistic service to community.” Z-Mw-HA, Z-Mb-HA	“Disjointed missionary partnership (due to Church conflicting priorities, values.)” Z-Mw-TA
6. Housing shortage &	“...not enough	“Shortages of houses,	“No hygiene –	Infrastructure	Housing – crumbling	“Accommodation is

dilapidated infrastructure/ Hygiene (4)	housing, can't retain staff due to housing shortage." M-Em-HoS	can't keep qualified staff " M-Em-HR , M-Em-DFM	toilets, dirty & smell. M-Ek-OC: R11, M-Ek-OC: R10	outlived, yet gov't does not come on Z-SHQ-GS	& no house others are in guest houses. Z-Mb-MHP, Z-Mb-HA	inadequate ...hospital hasn't got enough workers." Z-Mw-CwS
7. Management systems and Reporting structure	" systems in place..." M-SoL-HD	Non-responsive	Non-responsive	"No ownership, feel its govt." Z-Mw-HoS	No policy, Board mtgs. Z-MbMHP, Z-Mb-MSD, Z-Mw-MHP, Z-Mw-HML	Non-responsive
8. Harsh health workers & HR commitment (3)	Non-responsive	Non-responsive	Employees; nurses and doctors for some unknown reason tend to be a bit rough & aggressive ..." M-Ek-TA: R1	HR – not carrying out mission, no compliance to mission regulations, sidelining partners by gov't workers. Z-SHQ-GS	Non-responsive	"Others complain about harshness from nurses and other personnel... may be overworked, tired and start mistreating people." Z-Mw-CwS

Source: Researcher's work based on MGT (2016)

In the second instance, Matrix 7-8 above illustrates that the 12 categories of responses mainly characterised by shortage of staff, inadequate finances and equipment/facilities, were basically structural and evolve around challenges pointing to limited human and financial thematic area.

MATRIX 7-9: ALIGNING STAKEHOLDER PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES WITH EMERGING CLINICAL FACTORS

Cross-country Analysis						
(b) Clinical Factors from Challenges	Malawi			Zambia		
	Principals (Synod)	Health-workers	Community	Principals (Synod)	Health-workers	Community
1. Shortage of medicines (12) and inadequate food	“No required drugs” M-SoL-APD	“No drugs” M-Ek-HM, M-Ek-HA, M-Em-DFM,	“No medicines” M-Em-MC, M-Em-MC	“In-adequate supply of drugs...” Z-SHQ-HS	“Drugs inadequate” Z-Mb-MC, Z-Mb-HA	“Medicine & food inadequate” Z-Mw-OC, Z-Mb-OC, Z-Mb-MC
2. Inappropriate medicines supply & unqualified Staff (2)	“No qualified staff to diagnose diseases.” M-SoL-SM	Non-responsive	Non-responsive	Non-responsive	“Drugs not as requested” Z-Mb-Mol, Z-Mb-HCC	Non-responsive
3. Long waiting periods (2)	Non-responsive	“time management” M-Ek-	Non-responsive	Non-responsive	“You wait a long time at OPD.” Z-	Non-responsive

		OC			Mw-MC: R1	
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Source: Researcher’s work based MGT (2016)

Second, Matrix 7-9 above illustrates that the 4 categories of responses mainly characterised by shortage of medicines, inadequate supply of medicines and unqualified staff as well as long waiting periods at the out-patient department (OPD), were basically clinical, and similar to structural factors (as depicted in Matrix 7-8) that evolve around challenges pointing to limited human and financial thematic area.

MATRIX 7-10: ALIGNING STAKEHOLDER PERSPECTIVES ON HEALTHCARE MANAGEMENT CHALLENGES WITH EMERGING DOCTRINAL FACTORS

c) Doctrinal Factors from Challenges	Malawi	Zambia			
	Principals (Synod)	Health-workers	Community	Health-workers	Community
1. Caring, Purpose & Compassion (7)	“You find one person is working and the other isn’t. Apart from them being few, not doing their work has also contributed to the mission station being dirty.” Z-Mw-HoS	Non-responsive	“There is just no patient care ... reception is not good” M-Ek-OC: R5, M-Ek-OC: R10	“We are not giving holistic service... have lost spiritual aspect of service.” Z-Mw-MHP, Z-Mw-HA, Z-Mw-HML	“Negative attention by management of Mbereshi mission.” Z-Mb-MSD
2. Mission Regulations (2)	Non-responsive	“Our regulations are quite tough	Non-responsive	Non-responsive	“Holistic approach is degenerating (i.e. not being part of chapel)

		being a Christian organisation.” M-Ek-HCC			and this is slowly encroaching in character of mission.’ Z-Mw-TA
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Source: Researcher’s work based MGT (2016)

Third and last, Matrix 7-10 above illustrates that the 2 categories of responses mainly characterised by caring, purpose and compassion, were basically doctrinal and also evolve around challenges pointing to constrained human and financial resource areas.

Collectively, the three matrix sets being Matrix 7-8, 7-9 and 7-10 show the categories of responses on challenges displayed as; structural, clinical and doctrinal characteristics which related to shortage of staff (17), finances (14), equipment and facilities, medicines in short supply, lack of caring-compassion and purpose, transport shortage, collaborative engagements, staff housing shortage, debt burden, administration and management issues, staff retention, dilapidated infrastructure, harsh health workers, human resource commitment, hygiene/cleanliness, inappropriate supply of medicines, long waiting periods at out-patient department, mission regulations, patient user fees, donor dependency, patients food shortage and unqualified staff.

In particular, the shortage of staff and finances categories outweighed other responses to challenges, from which a key thematic area on limitation in financial and human resources emerged. The key emergent thematic area on limited financial and human resources is mainly substantiated by one informant: “...the fact is that the church does not seem to have enough financial resources to manage health institutions. If one looks at the budget of Synod, it’s difficult to see any allocation that is given to health institution because the Synod has been struggling with financial sustainability...” (Informant **Z-CM-PSB**). Literature suggests that the removal of user fees could have exacerbated the problem of finances for mission hospitals. Over time, many church and government facilities raise revenue through user fees and although they represent only a small portion of the total cost that goes into the provision of healthcare, they are quite common and an important source of operational funding (Ascroft *et al.* 2011: 5). Further, Mutale *et al.* (2013: 291) maintain that strengthening a health system through the six WHO building blocks can be a complex intervention, the shortage of skilled health workers continue to affect healthcare service delivery. Health centre level of care and surrounding communities are the hardest hit. In charting ways of

improving service delivery at community level, the data category on skills empowerment of classified employees suggests empowerment in clinical skills for providing continued healthcare by: “...empowering helpers (by teaching/building capacity of classified employees-CEs) to help in the running of the clinic...” (Informant **Z-Mb-HA**).

However, interrogating transcribed data and the literature above, research objective one was used to deeply explore challenges faced by the church and opportunities in healthcare provision which, based on MGT factors of structure (16), clinical (5) and doctrine (2), related to limited human and financial resources.

7.7.2 Collaboration

The second issue of addressing opportunities available for cooperative engagement with government, partners and other stakeholders is unpacked in the next matrix related to collaboration. The section seeks to respond to the key research question 2 on how FBOs, particularly the church-led management, work with government to improve healthcare services in its health facilities. The embedded second research objective with key research question 2 was met as the study examined in depth ways and the extent to which the government of Zambia and Malawi work together with the church to provide service delivery in health care.

Matrices 7-11, 7-12 and 7-13 below depict the alignment of perspectives based on stakeholder groupings for managing healthcare in terms of opportunities for collaboration.

MATRIX 7-11: ALIGNING STAKEHOLDER PERSPECTIVES ON HEALTHCARE MANAGEMENT COLLABORATION WITH EMERGING STRUCTURAL FACTORS

Cross-country Analysis						
(a) Structural Factors from Collaboration	Malawi			Zambia		
	Principals (Synod)	Health-workers	Community	Principals (Synod)	Health-workers	Community
1. Salaries (17) and government-driven training/deployment (4)	“... gov’t pays salaries for staff “ M-SoL-APD, M-Em-HoS, M-SoL-YD, M-SoL-GS, M-SoL-HD, M-Em-HoS, M-SoL-YD	“Salaries and wages come from gov’t with refresher courses...” M-Ek-HA, M-Ek-HM, M-Em-HR, M-Ek-HCC	“...some of the employees working are trained and paid by the government ...” M-Em-MC: R1, M-Ek-TA: R2	“Gov’t pays seconded staff” Z-SHQ-HS, Z-CM-PSB, Z-SHQ-GS, Z-SHQ-FS	“Relations with gov’t perfect... nurses and other staff paid by gov’t” Z-Mb-MHP, Z-Mw-HML	“Gov’t pays sch girls treatment, employees are gov’t” Z-Mw-MC, Z-Mb-MSD
2. Grants (8)	“...currently 45% budget comes from gov’t...” M-SoL-HD	Non-responsive	Non-responsive	“Grants come from government” Z-SHQ-GS, Z-SHQ-FS, Z-SHQ-HS, Z-CM-PSB	“Reliant on gov’t grant” Z-Mw-MHP, Z-Mb-MSD, Z-Mw-Hac	Non-responsive
3. Trans	Non-	“SLA with	“Years ago,	Non-	“We have	Non-

port (3)	responsive	gov't ... gave motor cycle, reporting” M-Em-PHC	gov't gave Ekwendeni Ambulance & Bus.” M-Ek-TA,	responsive	a gov't vehicle as well.” Z-Mw-HML	responsive
4. Church & Government MoU/ Administrators (2)	Non-responsive	Non-responsive	Non-responsive	“UCZ employs Admin, gov't medics” Z-SHQ-FS	“UCZ can take Admin” Z-Mw-HML,	Non-responsive
5. Funding appeals/Income generating initiatives (2)	“Synod PHC in communities for water, food...” M-Em-HoS	“...Synod raise funds for new ambulances .” M-Em-PHC	Non-responsive	Non-responsive	Non-responsive	Non-responsive
6. Partnership and LISAP (HIV/AIDS program) (2) and technical support	“LISAP agreed gov't ... Mission writes proposal & gov't takes to Parliament. M-SoL-GS	Non-responsive	Non-responsive	“Mission partners collaborate in form of materials and human resource” Z-SHQ-GS	Non-responsive	Gov't helped fix mortuar, in same way, can fixhouses.” Z-Mw-CwS

Source: Researcher's work based on MGT (2016)

Firstly, Matrix 7-9 above illustrates that the 8 aggregated categories of responses mainly characterised by salaries and government-driven training/deployment, grants, transport, Church and government MoU, funding appeals and partnerships, were basically structural. These perspectives evolve around collaboration pointing to two emerging themes: policy on salaries, drugs and grants support as well as regulations on certain health services by stakeholder segmentation covering both countries.

MATRIX 7-12: ALIGNING STAKEHOLDER PERSPECTIVES ON HEALTHCARE MANAGEMENT COLLABORATION WITH EMERGING CLINICAL FACTORS

Cross-country Analysis						
(b) Clinical Factors from Collaboration	Malawi			Zambia		
	Principals (Synod)	Health-workers	Community	Principals (Synod)	Health-workers	Community
1. SLA on maternal health (9)	“The SLA... government has offered to pay...for free service...” M-Sol-APD, M-Sol-SM, M-Sol-YD	“SLA with gov’t that maternity be free then gov’t refunds ...” M-Ek-HM, M-Ek-HA, M-Em-HR, M-Em-PHC, M-Em-HA,	“We hear government pays maternity fees for women” M-Ek-OC: R7	Non-responsive	Non-responsive	Non-responsive
2. Drugs supply (8)	“They are also giving us some drugs...” M-Sol-HD	“Gov’t drugs for STIs, TB & ARVs...” M-Ek-HM, M-	Non-responsive	“Drugs – the supply of essential drugs is done by government	“Also the government is supplying drugs.” Z-	“Sometimes medicines/drug kits are brought by MoH vehicles” Z-

		Ek-HA, M-Em- PHC		" Z-SHQ-HS	Mw-HML	Mb-MC, Z- Mb-MSD
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Source: Researcher’s work based on MGT (2016)

Secondly, matrix 7-12 above shows that the 2 categories of responses mainly characterised by SLA on maternal health and drugs supply, were basically clinical and evolve around collaboration pointing to two emerging themes: policy on salaries, drugs and grants support as well as regulations on certain health services by stakeholder segmentation.

MATRIX 7-13: ALIGNING STAKEHOLDER PERSPECTIVES ON HEALTHCARE MANAGEMENT COLLABORATION WITH EMERGING DOCTRINAL FACTORS

Cross-country Analysis						
(c) Doctrinal Factors from Collaboration	Malawi			Zambia		
	Principals (Synod)	Health-workers	Community	Principals (Synod)	Health-workers	Community
1. Mission Regulations via CHAM/CHAZ (3)	...Staff are not just from our church but different churches M-SoL-SM	“MoU focus discussion with DHO involving Synod.” M-Ek-HM	Non-responsive	“CHAZ document for staff coming to CHI signs but is not yet approved by MoH.” Z-Mw-HoS	Non-responsive	Non-responsive
2. Mission partnership	Non-responsive	Non-responsive	Non-responsive	“mission partners abroad support in materials & HR” Z-SHQ-GS	Non-responsive	Non-responsive

Source: Researcher’s work based on MGT (2016)

Last, Matrix 7-13 above indicates that the 2 categories of responses mainly characterised by mission regulations through CHAM/CHAZ and partnership, were basically doctrinal and evolve around collaboration that points to two emerging themes: policy on salaries, drugs and grants support as well as regulations on selected healthcare services by stakeholder grouping.

The above matrices (Matrix 7-11, 7-12 and 7-13) depict that the perspectives on opportunities for collaboration similarly displayed structural, clinical and doctrinal characteristics which essentially emanated from salaries (17), service level agreement on maternal health (9), mission regulations and various other leading categories. Here, we see how that the salaries (with 17 overwhelming informant responses) and service level agreement on maternal health (9 informant responses) categories outweighed all other categories to opportunities for collaboration. On the same note, DeGroof (2009: 4) maintains that reflecting the broader relationships that exist between government and its political, administrative and social environment where within a public governance framework, government work is done through interdependent networks rather than the traditional hierarchy alone. In light of the literature while engaging relevant data in the matrices above, a key thematic area on policy and regulations related to salaries, drugs as well as grants support. The emerging theme pointing to the policy measure of government for continued support of mission hospitals is mainly testified by informants:

“...the people that we would employ as a church would be the care takers, hospital attendants, watchmen, messengers etc., those would be paid directly by us the church. But clinical officers, nurses, doctors are always on the payroll of the government...” (Informant **M-SoL-SM**).

Similarly, interrogating literature with related transcribed data, research objective two was used to examine in depth the extent to which the government of Zambia and Malawi work together with the church in healthcare provision which is based on established MGT factors.

Worth noting, these factors are of structure (11), doctrine (3) and clinical (2) in nature, related to policy on salaries, drugs and grants support, and regulations on certain healthcare services offered such as maternal health substantiated through related Malawi data transcripts:

“...there’s also a service level agreement we have signed with the government that maternity services should be free of charge and the government should be paying...” (Informant **M-Ek-HM**).

7.7.3 Improvements

The third issue of addressing envisaged areas that require improvement, is unpacked in the matrix table below. This section seeks to tackle key research question 3 on how we can improve management of healthcare services. The embedded third research objective with key research question 3 was met, as the study contributed to FBO management reform in healthcare administration and development.

MATRIX 7-14: ALIGNING STAKEHOLDER PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS WITH EMERGING STRUCTURAL FACTORS

Cross-country Analysis						
(a) Structural Factors from Improvements	Malawi			Zambia		
	Principals (Synod)	Health-workers	Community	Principals (Synod)	Health-workers	Community
1. In-service/training (9), recruitment criteria (5) & salary 'top ups' with further studies (2)	"...send hard-working Clinic Attendants for refresher courses, recruitment and posting" M-Em-HoS, M-SoL-YD	"Staff exchange/gov't clinicians & hire c/w top-ups, further study." M-Ek-HCC, M-Em-HR, M-Em-HA, M-Ek-HCC	"Staff training on ways of treatment." M-Ek-OC: R11, M-Ek-OC: R3, M-Ek-OC: R10, M-Ek-OC: R6 M-Ek-TA: R2, M-Em-MC: R2	"HR dev to improve management ... train clinical officers and develop into medical licentiates & doctors." Z-CM-PSB, Z-SHQ-HS	"Empower CEs with clinical training... so communities own while church leads." Z-Mb-HA, Z-Mw-HA	Non-responsive
2. Hygiene/cleanliness & appearance (5)	Non-responsive	Non-responsive	"improved hygiene/toilets, beddings." M-Ek-OC: R8,R10, R7	Non-responsive	Non-responsive	"improve cleanliness, renovations will change appearance" Z-Mw-CwS, Z-Mw-MC: R6
3. Management/HR-client relations (5)	"Ensure good management & administrative	"Conditions of service in conflict	"...management needs to be taught how they	"Sound organization to uphold mission	Non-responsive	Non-responsive

	ve systems ... also train personnel ...” M-Sol-SM, M-Sol-HD	with labour laws.” M-Em-HR	treat clients ... need not be rough” M-Ek-TA: R1	values... everyone to treat hospitals as their own” Z-SHQ-GS		
4. Consolidated reporting and supervision (4)	“Sensitize community to participate to improve services.” M-Em-HoS	“Central reporting, consolidate” M-Ek-HA, M-Em-PHC	Non-responsive	Non-responsive	Non-responsive	“We’ve workers. just need to be supervised.” Z-Mw-CwS
5. Infrastructure development (4) & Staff accommodation (3)	“...the road is very bad...getting drugs is a problem...if only gov’t fixed roads...” M-Em-HoS	“Water reticulation & appropriate houses for the cadres we have” M-Ek-HM, M-Ek-HA	Non-responsive	Non-responsive	“Church to communicate with MoH, use brochures advertise hosp to the world for housing support.” Z-Mb-MHP, Z-Mw-HML	“...community contribution like making bricks towards building RHC & hse at Fishiki healthpost” Z-Mb-OC, Z-Mw-MC: R6
6. Strategic planning (3) and removal of service fees (1)	Non-responsive	“...if church can run hospital for free maybe, we can keep it busy.” M-Ek-HCC	Non-responsive	“encourage strategic planning...f or infrastructure, staff and institution development” Z-CM-PSB	“have our own strategic plan were we want to see mission in five years’ time” Z-Mw-MHP	“...plan improvement in treatment because of referrals from Kazungula and even Namibia.” Z-Mw-MC: R4
7. Finances / Income Generating Activities (3)	“There should be means to generate own income in case one day government withdraws”	“apart from fees, high cost wing or house for rent” M-Ek-HA, M-	Non-responsive	Non-responsive	Non-responsive	Non-responsive

	M-SoL-APD	Em-HA				
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Source: Researcher’s work based on MGT (2016)

First of all, Matrix 7-14 above illustrates 7 categories of responses mainly characterised by: in-service training, recruitment criteria, hygiene/cleanliness/appearance, management of HR/client relations, consolidated reporting, infrastructure with staff accommodation, strategic planning and IGAs were structural in outlook.

To add, they basically evolve around improvements pointing to two emerging themes. These are a re-model of structures and reporting relationships, by stakeholder segmentation involving both Malawi and Zambia.

MATRIX 7-15: ALIGNING STAKEHOLDER PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS WITH EMERGING CLINICAL FACTORS

Cross-country Analysis						
(b) Clinical Factors from Improvements	Malawi			Zambia		
	Principals (Synod)	Health-workers	Community	Principals (Synod)	Health-workers	Community
1. Medical equipment/facilities (6)	Non-responsive	Non-responsive	“More equipment; for dental, eye clinic & also beds in wards” M-Ek-OC: R11, M-Ek-OC: R2, M-Ek-OC: R7	Non-responsive	“Portable x-ray machines cheaper, use as alternative...& fridge for vaccines” Z-Mw-HML, Z-Mb-HA	“Renovate the hospital buildings especially mothers shelter” Z-Mb-MC
2. Food for in-patients (2)	Non-responsive	“... providing food in that ward ...” M-Ek-HA	Non-responsive	Non-responsive	Non-responsive	“...HEPS should be provided for children admitted of hunger.” Z-Mb-MC
3. Empowerment in community clinical skills(1)	Non-responsive	Non-responsive	Non-responsive	Non-responsive	“Empowering helpers (teach	Non-responsive

					CEs) to help in running clinic.” Z-Mb-HA	
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Source: Adapted from transcribed data (2016)

Secondly, Matrix 7-15 above illustrates that the 3 categories of responses mainly characterised by medical equipment/facilities and patients’ food were basically clinical.

Notably, the category of responses evolve around improvements pointing to two emerging themes: re-model structures and reporting relationships by stakeholder segmentation.

MATRIX 7-16: ALIGNING STAKEHOLDER PERSPECTIVES ON HEALTHCARE MANAGEMENT IMPROVEMENTS WITH EMERGING DOCTRINAL FACTORS

Cross-country Analysis						
(c) Doctrinal Factors from Improvements	Malawi			Zambia		
	Principals (Synod)	Health-workers	Community	Principals (Synod)	Health-workers	Community
1. (MoU)/mission regulations (10) & staff orientation (3)	“orient staff with special calling to serve in mission...gov’t to stop politicising assistance & pay by cash budget to fulfil SLA” M-SoL-YD, M-SoL-GS	Non-responsive	Non-responsive	“Refurbishing infrastructure ... collaborate more with ecumenical bodies & gov’t, find space for consultative talks at parliamentary sessions” Z-SHQ-HS, Z-SHQ-FS	“...perhaps Synod to do regular visits...church/gov’t-admin conflicts” Z-Mw-HAc, Z-Mw-HA, Z-Mw-HML	“Need for fulltime chaplaincy...the word of God can build staff to look after patients with love... Orient new staff on the code of ethics” Z-Mw-TA, Z-Mw-MC: R7, Z-Mb-MSD,

Source: Researcher's work based on MGT/transcribed data (2016)

Lastly, matrix 7-16 above illustrates that a category of responses mainly characterised by memorandum of understanding (MoU)/mission regulations and staff orientation was basically of doctrinal orientation.

Essentially, the evolution of what informants said comes from improvements pointing to two emerging themes; re-model structures and reporting relationships by stakeholder segmentation involving the two countries.

However, the above sets of matrices (Matrix 7-14, 7-15 and 7-16) show that the category of areas for improvements which similarly displayed structural, doctrinal and clinical characteristics, related to the following: what the memorandum of understanding/mission regulations (10) say, in-service training (9), equipment & facilities and other leading categories such as recruitment criteria, human resource management/client relations, accommodation, finances & income generating activities, hygiene, strategic planning, clean built environment, consolidated reporting, patients food, infrastructure development, staff orientation, skills empowerment, further studies, service free of fees, staffing, salary top-ups and supervision.

Purposefully, the memorandum of understanding/mission regulations and in-service training categories weighed more than other category of responses to challenges out of which a key thematic area on remodelling structures and reporting relationships emerged. The emerging theme is substantiated by Chee *et al.* (2012: 86), who maintain that strengthening a healthcare system “is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organisational structures and relationships across the health system to motivate changes in behaviour and allow more effective use of resources” in order to improve multiple healthcare services. Allowing for more effective use of resources is further sounded by emphasis on empowerment through training:

“Quality of care is compromised; empowerment of classified employees (CEs) can be done by sending them to college for clinical training” (Informant **Z-Mb-HA**).

In addition, “...the government should help in the human resource development if we partner well, we could come up with our training needs or staff development...if, for example, UCZ fought for

that and saying that on this programme each year government can be training one or two of our clinical officers and develop them into medical licentiates and some can go further and become medical doctors” (Informant **Z-CM-PSB**).

There is a relationship between significant changes in performance drivers that permit organisational structure and relationships across healthcare systems, to motivated changes in behaviour from literature and the emerging theme on remodelling structures and reporting relationships.

In essence, if healthcare such as malaria control, tuberculosis, HIV/AIDS, maternal and child health as well as other primary healthcare services in mission hospitals have to see significant improvements, then this has to be geared up by performance drivers embedded in the re-designing organisation’s structures and existing relationships for reporting emerging from the study.

Nevertheless, interrogating literature with transcribed data above, research objective three was used to demonstrate contribution by the study to FBO management reform in healthcare administration and development for improved healthcare provision, which based on MGT factors of a structural (19), doctrinal (2) and clinical (3) nature related to tenets that re-model organisation structures and reporting relationships.

7.8 Chapter summary

Chapter Seven considered a cross-case comparative analysis of intra-country findings. The intra-country cross-case comparative analysis of findings covered Malawi’s Ekwendeni and Embangweni Mission Hospitals. The other set of a comparative analysis of findings covered Mbereshi and Mwandu Mission Hospitals in Zambia. The intra-country cross-case comparative analysis was defined with the help of relevant tables of matrices. Cross-country comparative analysis was then interrogated between Malawi and Zambia, while demonstrating the meta-conceptual framework underpinning the study by stakeholder segments.

In this chapter, summarised comparative findings for the study arising from interrogation of matrices in light of literature reviewed, was presented. This included the voice of participants and the researcher’s observations, and related to: firstly,

- The use of human and financial resources (in addressing RQ & RO on challenges)

This was about challenges, opportunities for collaboration and improvements which have been ascertained with the application of multi-grounded theoretical factors founded on structural, clinical and doctrinal perspectives that considerably affect health systems; secondly,

- Church-led policy and regulations on health systems (in responding to RQ & RO as opportunities for collaboration)

The meta-conceptual model of stakeholder-congregational governance point to principals who are the church's synods (represented by officials) with a mandate from the large constituency for effective use of available human and financial capital;

Thirdly and lastly,

- Structures and reporting relationships for organizational action (pointing to RQ & RO on improvements)

Policy and regulations characterised by the need to re-model structures and reporting relationships that motivate organisational action for a desired end state.

To sum up, if findings from the study compare well, the informants and focus group participants who were the service recipients from the community and mission health workers being service providers substantially contributed to the conclusions drawn. Further, recommendation made with policy implications would help chart the way forward and these are discussed in the final and last chapter which now follows.

CHAPTER EIGHT: CONCLUSIONS, RECOMMENDATIONS, POLICY AND KNOWLEDGE PRODUCTION

8.1 Introduction

Chapter Eight is the final chapter and outlines how research objectives and questions are recapitulated. The conclusions drawn are pertinent to chapter summaries while recommendations made related policy implications and finally, the new knowledge produced in this study.

8.2 Recapitulation of Research Questions and Objectives

The focus of the study was based on answering research questions and achieving objectives as laid out in the outcome Table 8-1 below:

TABLE 8-1: RESEARCH QUESTIONS AND OBJECTIVES

Research Questions	Research Objectives
1. What are the challenges that Faith-based Organisations face in managing church-led healthcare services for its health facilities?	1. Deeply explore challenges and opportunities for church-led healthcare management and administration services.
2. How do Faith-based Organisations particularly the church-led management work with government to improve healthcare provision in its health facilities?	2. Examine in-depth the ways in which church-led management work with government to improve healthcare provision in its health facilities
3. How can church-led healthcare management and administration services be improved?	3. Determine strategies for faith-based organisational strategies for healthcare management and administration reform.

Source: Researcher's work based on literature, transcribed data and findings (2017)

Table 8-1 depicts how the research questions and research objectives have been integral part of attaining consistence in pursuit to findings of the study. Embedding research questions with related objectives has played a pivotal role towards explication of relevant themes that led to the development of new knowledge from analysed data sets in view of literature and key study findings.

8.3 Summary of Chapters

The summary of chapters seeks to bring out pertinent issues from each of the chapters covered in the study and these are discussed chapter by chapter, after which conclusions are made. This has been done by further addressing how each chapter contributed to addressing the research problem in answering which key research questions based on established objectives.

8.3.1 Chapter One – Introduction and study overview

Chapter one considered, among other issues, why the study was conducted, its ontological and epistemological perspectives, background to FBO work particularly the church, and its philanthropic mandate. The issue of how new knowledge generated from the research will contribute to the development of countries explored in this study, particularly Malawi and Zambia but also including those of the Southern African sub-region. The knowledge gap existing in the reviewed literature indicates that theory and practice in the management of healthcare service is provided by the Church of Central Africa Presbyterian in Malawi and the United Church of Zambia, but their key role is that of pastoral work. The research questions and objectives around the research problem were explored. The navigation involves addressing the matter of making a proactive contribution for strengthening church-led healthcare provision in Malawi, Zambia and other countries in Southern Africa, as the significance of the study.

8.3.2 Chapter Two – Public Governance and Non-governmental Organisations

The review of literature for the study had a purpose in providing a contextual framework for investigating how best to resolve the key research questions, based on the study's key objectives. This chapter discussed public governance and NGOs in a contemporary national and cross-national context. There was a deeper reflection made in the disciplines of public administration, public management and governance, which were done in light of community-based healthcare.

The discussion on NGOs heightened awareness of corporate governance in non-profit entities and thereafter engaged on how the theory relates to Faith-based organisations (FBOs), particularly church-led governance systems insofar as healthcare provision counts. This created a base for discussing the management of mission hospitals and the quest for improved Church-led healthcare provision in the next chapter.

8.3.3 Chapter Three – Management of Mission Hospitals for Improved Healthcare

Chapter Three generally covered the management of mission hospitals and the impending need for improved healthcare service provision. The chapter paid particular attention to the background of churches and their vocational roles in philanthropic causes. To add, emerging challenges evolved around donor dependency, dual responsibility and user fees, while opportunities took a reflection on FBOs as being trusted entities, which have a historical legacy of a caring partnership and spiritual refuge. Collaborative engagements between churches and government were further explored, with the need for improved healthcare and lastly, the development of a meta-conceptual framework that is aimed at driving the study. This was discussed in tandem with Multi-grounded theory.

8.3.4 Chapter Four – Research Design and Methods

Chapter Four detailed the research design in view of the main research problem, key questions and the study objectives. The philosophical worldview underlying the study was based on an advocacy-participatory worldview, together with research strategies identified for the study. The case study strategy incorporated multiple cases that worked in combination with a multi-grounded theory as an approach to undertake and ascertain outcomes of the study. Further, the selections based on case, site and respondent were included to data collection techniques employed, such as semi-structured interviews, focus groups and documentary evidence as well as naturalistic observations. Data analysis was conducted in line with content, matrix and established thematic areas. Also, while ethical considerations and limitations evoked the scenario in which the investigation was done, the qualitative study specifically pursued data quality assurance standards in terms of credibility (as in trustworthiness), dependability (i.e. consistency), transferability and confirmability, including authenticity, to respond to key research questions. A rationale for all choices in research design was offered.

8.3.5 Chapter Five – Case of the Church of Central Africa Presbyterian in Malawi

Chapter Five discussed the context of the Church of Central Africa Presbyterian Synod of Livingstonia in Malawi. Data presentation and interpretation, documentary evidence and field observations for both the Synod of Livingstonia CCAP Secretariat and the two mission hospitals, namely, Ekwendeni Hospital and Embangweni Hospital in northern Malawi were gained through interviews and focus group discussions segregated by stakeholder segments being principal owners, service providers and service recipients.

8.3.6 Chapter Six – Case of the United Church of Zambia

Chapter Six focused on the Church's philanthropic contribution to the country's national health outcomes and development in terms of service provision particularly through hospitals in Mbereshi and Mwandi Mission stations as part of civil society's responsibility in Zambia. The chapter discussed the context of the United Church of Zambia, data presentation and interpretation for Synod secretariat and Mbereshi Mission Hospital as well as Mwandi Mission Hospital through interviews and focus group discussions, while highlighting different stakeholders – synod as owners, health workers as service providers and church as well as community members being service recipients.

8.3.7 Chapter Seven – Comparative Findings; Intra-country and Cross-national Analysis

Chapter Seven showed how the four multiple cases have been bound by highlighting crucial findings and the manner in which they match with key questions and objectives from the study. In this chapter, summarised comparative findings for the study arising from interrogation of matrices were presented, while engaging with the literature reviewed chapters, the voices of participants and the researcher's observations, in relation to the outcome of the study.

However, the study sought to illustrate the need for the strengthening of Church-led healthcare provision by case study strategy using multiplicity of cases, concomitant to MGT factors that affect the management of mission hospitals in Malawi and Zambia. It focussed too on its mother body's policy and regulations, structures as well as the relationships that motivate changes in behaviour of organisations for effective use of available human and financial capital.

8.3.8 Chapter Eight – Conclusions, Recommendations, Policy and New Knowledge

Chapter Eight is the final chapter and outlines the embedded-ness of key research questions within objectives and summary of chapters. Conclusions drawn are pertinent to chapter summaries, while recommendations are made with its policy implications. Finally, the new knowledge produced in the study of this magnitude is outlined.

The summary of chapters then leads us into the next section of findings and conclusions drawn from the study about FBO management pertinent to strengthening church-led healthcare provision.

8.4 Findings and Conclusions

8.4.1 Challenges of Church-led healthcare management and administration

Some of the challenges of Church-led healthcare management and administration emerged from study findings and conclusions as depicted in Table 8-2 below.

TABLE 8-2: CHALLENGES OF CHURCH-LED HEALTHCARE MANAGEMENT AND ADMINISTRATION

Findings	Conclusions
1. There are issues with administrative systems posing some degree of friction between mission hospital ownership and government partnership	1. There is a structural problem as sound administration has become a deterrent to optimum care for clients/service recipients
2. Mission hospitals have opted to shape their own work culture which may be a disposition of the science of ‘muddling through’ to manage hospital institutions and provide healthcare	2. There are traces of ‘what works and what doesn’t’ in the management and administration of church-led healthcare

Source: Researcher’s work based on literature, transcribed data and findings (2017)

Table 8-2 depicts some of the challenges associated with the extent of administrative friction between principals and seconded health workers resulting in a disposition of a particular work culture. What works and what doesn’t in the management and administration of healthcare to recipients with a view to promote FBO and government collaboration as discussed in the next subsection.

8.4.2 Faith-based organisations and government collaboration

Collaboration of FBOs and government that emerged from findings with conclusions made, are depicted in Table 8-3 below.

TABLE 8-3: FAITH-BASED ORGANISATIONS AND GOVERNMENT COLLABORATION

Findings	Conclusions
1. There is an overwhelming partnership between mission hospitals and government despite few enforcement difficulties on certain contractual obligations such as the SLA for Malawi and workers’ MoU for Zambia	1. The church and government area of collaboration seems to be working while the mission hospital and community collaboration does not seem to be working to the optimum care of service recipients

2. There is perceived strong presence of donor partnership between mission hospitals and external partner churches based on historical connections, especially Mwandu study site of Zambia	2. The non-disclosure of financial and material information makes it difficult to ascertain the value in the benefits derived from the relationship with mission partners abroad pointing to management healthcare.
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Source: Researcher’s work based on literature, transcribed data and findings (2017)

The above Table 8-3 depicts ways and the extent to which the presence of agreements and other obligations as well as church partner connections demonstrate collaboration between FBOs and governments in countries covered in the study. Community integration needs to be further strengthened.

8.4.3 Faith-based organisational management reform for healthcare management and administration

FBO management reforms for healthcare management and administration emerged as central to strengthening church-led healthcare provision, where management reform entails employing turning around strategies in FBO health management and administration for meaningful development as well as sustainability at both local and national level.

TABLE 8-4: FBO MANAGEMENT REFORMS FOR HEALTHCARE MANAGEMENT AND ADMINISTRATION

Findings	Conclusions
1. There is a negligible partnership of the hospital with society especially opinion leaders from the community in three out of four study sites; Mbereshi, Ekwendeni and Embangweni. The call for increased involvement of local people in the affairs of mission hospitals service provision seems not emphasised.	1. Despite diverse backgrounds, some people felt placed in the margins of society and so are not much involved in the affairs of local health service delivery. Increased integration of programmes between hospitals with Church and community members can make a difference in the involvement of their own healthcare.

Source: Researcher’s work based on literature, transcribed data and findings (2017)

Table 8-4 depicts how that the societal call for members of the community to be more involved in the provision of healthcare should not be ignored if meaningful integrated systems strengthening

has to be sustained. Programmes that show integration between community and hospitals would surely demonstrate emancipation the local people from their perception of marginalised life.

Nevertheless, the summation of the study indicates it has fulfilled objectives and responded to research questions in a threefold-way: firstly, it has explored to a deeper extent challenges faced by the church and opportunities for collaboration now and ahead in performing management and administration functions that improve healthcare services. Secondly, the study has also provided an in-depth examination of the extent to which the government of Malawi and Zambia work together with the church in the two countries respectively, for improved healthcare service delivery. Thirdly, the study has identified various issues such as clinical, doctrinal and structural factors that contribute to FBO management reform in healthcare administration and development, particularly for the CCAP of Malawi and UCZ of Zambia.

As a result, the study is proud to have contributed to the reform of technical work in FBO management and development for improved healthcare provision in Church-led facilities. A significant evolution in the approach to the study has been to shift the focus from national health systems said to be mainly on government-based facilities, to strengthening health systems incorporating faith-based facilities, too. With a new scenario, emphasis could thereafter be placed on strengthening systems by increasing the ability of countries such as Malawi and Zambia and other Southern African countries, to enhance capacity of faith-based facilities that integrate community participation for improved healthcare provision. Country ownership for strengthening healthcare through the seemingly neglected Faith-based health facilities will be a crucial step in achieving sustainability and in the end, gain what was previously MDG (now SDGs – Sustainable Development Goals) coverage for regional, continental and global healthcare service delivery.

Of significance, is what the study has since added to our knowledge, and this is a new meta-conceptual model. This contribution to the body of knowledge with its applicability embedded in the due process of recommendations made to stimulate policy development could be valuable.

8.5 Recommendations and Policy Implications

If the precepts characterised by major findings of this study are to be subjected to implementation, then an understanding of it is that it promises intellectual stimulation (interaction) in policy formulation and regulation for strengthening healthcare provided by Faith-based facilities owned by CCAP and UCZ including other similarly placed FBOs.

8.5.1 Recommendations

The recommendations are as follows:

8.5.1.1 The use of human and financial resources

Challenges, opportunities for collaboration and improvements are established on the basis of multi-grounded (foundational) factors and in order address them, there is need to consider segregating them under structural, clinical and doctrinal perspectives for specialised attention;

8.5.1.2 Church-led policy and regulations on healthcare systems

The church principals for both CCAP and UCZ who own respective mission hospitals represented by synod officials with an governance mandate from the large constituency need to consider the use appropriate church-led policy and regulations for maximised use of available people, be it hospital workers or community members, and prudence in money resources for vibrant healthcare;

8.5.1.3 Structures and reporting relationships for church action

The church should consider using the new meta-conceptual model of stakeholder-congregational approach to re-model structures and reporting relationships and see if that can motivate organisational action to a desired end state.

The next section discusses policy implications in sections 8.5.2.1, 8.5.2.2 and 8.5.2.3 below with a view to localise suggestions that came from recommendations for action.

8.5.2 Policy Implications

This section examines implications of the study for future policy developments premised on the voice of church and community members, as well as health workers from all four cases in terms of policy implication.

Putting it differently, how can these stakeholder segments that are often marginalised and minimised, contribute to policy implications based on what they have said during the interview and focus group interactions? This process of interrogation ultimately gave rise to major thematic areas related to the use of human and financial resources, and policy and regulations including pursuing prospects that motivate organisational action. In literature chapters, Anheier (2014: 416) stressed the significance of governance as part of organisational actions that demonstrate “the process whereby elements in society wield power and authority, and influence and enact policies and

decisions concerning public life, and economic and social development”. The implication of this is such that working on prospects that promise organisational action entails seeking new management ethos such as a radical re-design of governance structures and having a people culture remodelled for inclusivity and increased participation in their own healthcare management, as follows:

8.5.2.1 The Use of human and financial resources to address challenges

The prudent utilisation of human and finances points to effective use of available skills inherent in the clergy and laity that are in key leadership positions, as well as members of a senior management team including those who have volunteered to be stakeholders such as traditional authorities, civil society and other non-government actors. The challenges which related to effective use of available skills inherent to financial and human resources of FBOs in managing healthcare service provided by mission hospitals emanated from literature reviewed in line with analysed data thoroughly engaged by the researcher in this study. Better utilisation of available skills-sets, supporting them with necessary policy, is therefore pertinent.

8.5.2.2 Church-led policy and regulations on health systems as opportunities for integration

The policy on health by the church as principal owners of mission hospitals needs to be revisited through constant review of regulations on healthcare that will ensure faith-based organisations keep pace with national health system trends. Health system trends that tend towards a realistic regionally integrated and global change in MDGs especially the goal on universal health are needed.

Most importantly, this may compel a stronger approach to doctrinal review of healthcare provided by revising regulation on the Church-government relationship through CHAM and CHAZ, including establishing efficiency and effectiveness of available regional level relationships as well as any global body coordination on church-led healthcare.

Approaches to FBO management, especially church-led policy and regulations on health, if revisited by mission hospitals, could be a grounded basis of vital opportunities for improved integration.

8.5.2.3 Structures and reporting relationships for organizational action pointing to improvements

Relationships for reporting within the existing structures require reform to pave way for action that will point to and effect organisational turn around. Current structures in both countries seem top-heavy and so the need for re-modelling reporting relationships is pertinent. The running of mission healthcare system needs to be more decentralised. This calls for better governance that will influence sound and stronger FBO management systems.

However, the implication of policy in this study is such that the FBOs in the two churches covered in the study can develop policy guidelines. Policy guidelines can initiate stimulation and a commitment to organisational action on the part of the health work force and services recipients who are community members, with the intention to promote inclusivity in and among the church health institutions (CHIs).

Management of church-led healthcare provision in CHIs should then focus on foundational factors established in this study which are clinical, doctrinal and structural, and that positively affect its principal owners, with effective use of available human and financial resources, policy and regulations as well as re-modelling structures and reporting relationships to motivate organisational action. An organisation can demonstrate action through relevant policy particularly in society, and social policy is seen as fundamental to development.

8.6 New Knowledge Produced in this Study

The cross-country comparison utilised Multi-grounded theory by a synthesis based on theoretical, empirical and the internal grounding processes. Key thematic areas through the three MGT processes emerged as foundational factors for the development a theory. The MGT foundational factors manifested various clinical, doctrinal and structural characteristics.

Table 8-5 below illustrates the use of multi-grounded theory and the inter-relation of established foundational factors with emergent themes thereof, resulting in new knowledge: The ‘stakeholder-congregational’ model for stimulating organisational action in strengthening Faith-based local healthcare management.

TABLE 8-5: NEW KNOWLEDGE PRODUCED IN THE STUDY

Category		MGT/ factors	Key thematic areas	Overarching theory (as in theoretical propositions)
1.	Challenges	Doctrinal	Human and financial capital	In this study, Faith-based healthcare (being doctrinal & clinical) provision under a ‘Stakeholder-congregational’ model can motivate organisational action (via a given structural framework) that points to management capacity for inclusivity
2.	Collaboration	Clinical	Policy and regulations	
3.	Improvements	Structural	Re-model structures and reporting relationships	

Summary Findings:

Through in-depth interrogation of literature with analysed data, the study established that financial and human capital challenges are mainly inherent in church doctrine, while opportunities for collaboration based on government-driven policy and subsidiary regulations are essentially clinical, and that improvements essentially structural, require re-modelling of current structure and reporting relationships.

Source: Researcher’s work based on literature, transcribed data and findings (2017)

Consequentially, the study has contributed to the science of management as applied in the broad discipline of administration that ascribes to empirical processes both in explaining and providing direction on how we can improve organisational aspects of FBOs particularly management capacity and inclusivity that may have been ignored in past research.

8.6.1 Meta-conceptual Model for Strengthening Church-led Healthcare

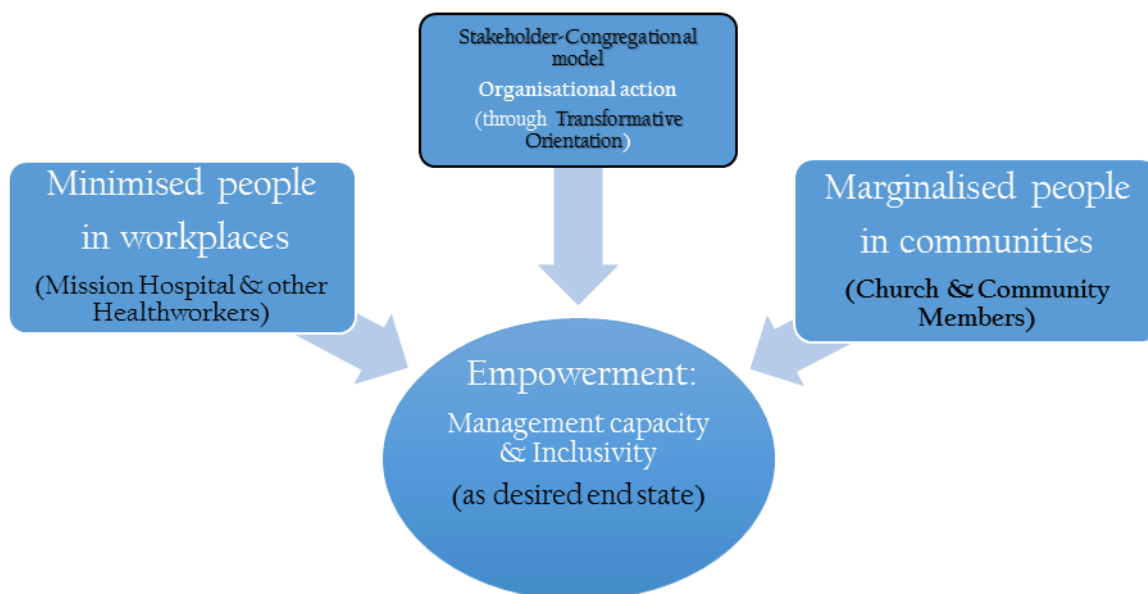
Scoping from the transformative philosophical worldview and using a case study strategy with multiple cases through an integrated MGT approach, the interconnection of established key thematic areas resulted in a story for developing a new theoretical proposition.

To this end, the study contributes the meta-conceptual model for strengthening church-led healthcare provision to the body of knowledge. The model asserts that re-visiting collaborative arrangements between church, mission partners and government with stakeholder inclusivity of health workers in mission hospitals and considering community opinion-led voices, could help reconstruct the grassroots meaning of managing Faith-based ‘community-participatory’ healthcare.

Ordinarily, the use of the new conceptual model (as in Figure 8-1 below) to reform formal mission hospital management while stressing increased participation of members from the church and communities covered in the four study sites, are considered as key findings and conclusions that can move the study beyond the stakeholder-congregational model used as the meta-conceptual framework in tandem with the philosophy of transformative worldview.

Figure 8-1 depicts the new stakeholder-congregational model for strengthening management of church-led healthcare provision in Malawi, Zambia and beyond.

FIGURE 8-1: NEW STAKEHOLDER-CONGREGATIONAL MODEL FOR STRENGTHENING MANAGEMENT OF CHURCH-LED HEALTHCARE



Source: Researcher’s model based on Sinha (2012), Eller (2014) and interview/FGD data (2014)

In an integrated fashion, the new stakeholder-congregational model in tandem with the transformative worldview narrows down minimisation and marginalisation to empowerment. The model can be used for organisational action to get to the desired end state, empowerment for management capacity and inclusivity.

Logically, empowerment entails socially transformed workplaces and communities calling for involvement which brings about inclusion and increased participation of minimised people working in mission hospitals, including marginalised community members in their own healthcare management.

Significant of all, a desired management capacity and empowerment in skills with stakeholder inclusivity would foster their own improved church-led healthcare provision. Other faith-based healthcare institutions (besides mission hospitals) which could benefit include theological schools, colleges and universities, where the clergy and laity are nurtured for pastoral care and service. Also, church-led nursing schools where most healthcare workers placed in mission hospitals are trained would clearly benefit. Certainly, mission hospitals with their affiliate facilities (including rural health centres) owned by the churches could consider adopting governance a stakeholder-congregational meta-conceptual style. This would require the participation of national faith-based healthcare coordinating bodies; church-health associations such as the Christian Health Association of Malawi (CHAM); Churches Health Association of Zambia (CHAZ) and other ecumenical umbrella organisations in the global south as well as southern Africa countries.

Equally important, the meta-conceptual model contributed to the body of knowledge wraps up with the next but conclusive section charts the way forward for the study.

8.6.2 Way forward for Future Research

The study undertaken envisions further research. This means that the outcome of this study could provide a basis for further research ingenuity on organisational aspects of management for improved Faith-based healthcare in Malawi and Zambia as well as other southern African countries like South Africa. Raising and intensifying the research agenda at regional and global level would be a great asset. Enhanced research can establish how Faith-based healthcare provision is contributing to the attainment of global objectives on health, especially those which were embedded in the MGDs, and most recently enshrined in the 17 goals on sustainable development (SDGs), whose first six priority goals include health particularly good health and well-being.

8.7 Concluding Statement

Chapter Eight as the final chapter has outlined how the whole study created an integral match (embedded-ness) of research objectives with questions, with main findings highlighted in the summary of chapters. Further, pertinent conclusions have been drawn while recommendations and policy implications are brought to the fore. Finally, the contribution of a meta-conceptual model for making church-led healthcare systems stronger whereas new knowledge is foregrounded assures that research questions were adequately answered and objectives of the study met as appropriate.

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APPENDICES

APPENDIX A – SEMI-STRUCTURED INTERVIEW GUIDE (MALAWI)

Country of Study: **Malawi** Name of Church: **CCAP**

Name of Hospital/Court: **Ekwendeni/Embangweni Mission**

Objective: To strengthen FBO management in mission hospitals for improved healthcare provision

Key Research Questions	Actual Informant Questions
1. Engagement Phase	
What are the challenges that the church is facing in managing healthcare services for its health facilities;	<p>A. If you had to name 3 situations that really bother you about health care delivery at Ekwendeni / Embangweni Mission Hospital, what would those things be?</p> <p>B. Thinking about those problems, tell me why you think at least one problem or situation seems to happen on a regular basis?</p> <p>C. What do you consider to be one of the causes of the problem or situation you mentioned?</p> <p>D. If you could change that situation or solve that problem, what would you do?</p> <p>E. If you think the hospital is the only one who can change or improve that situation, what should they do & who should do that?</p> <p>F. How can we address these challenges so that they do not occur in the future?</p>
2. Exploration Phase	
How do FBOs particularly the church-led management work with government to improve healthcare services in its health facilities;	<p>A. If you had to name 3 opportunities (or situations) where you see hospital management work (in collaboration) with government in providing health care delivery at Ekwendeni / Embangweni Mission Hospital, what would those situations be?</p> <p>B. Thinking about those situations you see, tell me why you think at least one opportunity or situation seems to happen on a regular basis?</p> <p>C. What do you consider to be one of the areas of collaboration with government, partners or stakeholders in the situation you mentioned?</p> <p>D. If you could get involved in that situation to improve collaboration, what would you do?</p> <p>E. If you think government and other stakeholders can</p>

	<p>help improve that situation, what should they do & who should do that?</p> <p>F. Is there anything else we can do to strengthen the way the hospital collaborates with government in providing improved healthcare?</p>
3. Exit Phase	
<p>How can we improve management of healthcare services;</p>	<p>A. If you had to name 3 opportunities (situations) where you see hospital management work with the Church synod (in improving) health care delivery at Ekwendeni / Embangweni Mission Hospital, what would those situations be?</p> <p>B. Thinking about those situations you see, tell me why you think at least one opportunity or situation seems to happen on a regular basis?</p> <p>C. What do you consider to be one of the areas of collaboration with the Synod of the Church in the situation you mentioned?</p> <p>D. If you could get involved in that situation to improve collaboration, what would you do?</p> <p>E. If you think the Church Synod and Partners can help improve that situation, what should they do & who should do that?</p> <p>F. Is there anything else you would recommend to the Hospital management and Synod of the Church to improve administration and development of healthcare?</p>

Key Research Questions	Actual Informant Questions
<p>1. Engagement Phase</p> <p>What are the challenges that the church is facing in managing healthcare services for its health facilities;</p>	<p>A. If you had to name 3 situations that really bother you about health care delivery at Mbereshi / Mwandi Mission Hospital, what would those things be?</p> <p>B. Thinking about those problems, tell me why you think at least one problem or situation seems to happen on a regular basis?</p> <p>C. What do you consider to be one of the causes of the problem or situation you mentioned?</p> <p>D. If you could change that situation or solve that problem, what would you do?</p> <p>E. If you think the hospital is the only one who can change or improve that situation, what should they do & who should do that?</p> <p>F. How can we address these challenges so that they do</p>

	not occur in the future?
2. Exploration Phase	
How do FBOs particularly the church-led management work with government to improve healthcare services in its health facilities;	<p>A. If you had to name 3 opportunities (or situations) where you see hospital management work (in collaboration) with government in providing health care delivery at Mbereshi / Mwandi Mission Hospital, what would those situations be?</p> <p>B. Thinking about those situations you see, tell me why you think at least one opportunity or situation seems to happen on a regular basis?</p> <p>C. What do you consider to be one of the areas of collaboration with government, partners or stakeholders in the situation you mentioned?</p> <p>D. If you could get involved in that situation to improve collaboration, what would you do?</p> <p>E. If you think government and other stakeholders can help improve that situation, what should they do & who should do that?</p> <p>F. Is there anything else we can do to strengthen the way the hospital collaborates with government in providing improved healthcare?</p>
3. Exit Phase	
How can we improve management of healthcare services;	<p>A. If you had to name 3 opportunities (situations) where you see hospital management work with the Church synod in (improving) health care delivery at Mbereshi / Mwandi Mission Hospital, what would those situations be?</p> <p>B. Thinking about those situations you see, tell me why you think at least one opportunity or situation seems to happen on a regular basis?</p> <p>C. What do you consider to be one of the areas of collaboration with the Synod of the Church in the situation you mentioned?</p> <p>D. If you could get involved in that situation to improve collaboration, what would you do?</p> <p>E. If you think the Church Synod and Partners can help improve that situation, what should they do & who should do that?</p> <p>F. Is there anything else you would recommend to the Hospital management and Synod of the Church to improve administration and development of healthcare?</p>

APPENDIX B – SEMI-STRUCTURED INTERVIEW GUIDE (ZAMBIA)

Country of Study: **Zambia** Name of Church: **UCZ**

Name of Hospital/Church Court: **Mbereshi / Mwandi Mission**

Objective: To strengthen FBO management in mission hospitals for improved healthcare provision

Key Research Questions	Actual Informant Questions
1. Engagement Phase	
What are the challenges that the church is facing in managing healthcare services for its health facilities;	<p>A. If you had to name 3 situations that really bother you about health care delivery at Mbereshi / Mwandi Mission Hospital, what would those things be?</p> <p>B. Thinking about those problems, tell me why you think at least one problem or situation seems to happen on a regular basis?</p> <p>C. What do you consider to be one of the causes of the problem or situation you mentioned?</p> <p>D. If you could change that situation or solve that problem, what would you do?</p> <p>E. If you think the hospital is the only one who can change or improve that situation, what should they do & who should do that?</p> <p>F. How can we address these challenges so that they do not occur in the future?</p>
2. Exploration Phase	
How do FBOs particularly the church-led management work with government to improve healthcare services in its health facilities;	<p>A. If you had to name 3 opportunities (or situations) where you see hospital management work (in collaboration) with government in providing health care delivery at Mbereshi / Mwandi Mission Hospital, what would those situations be?</p> <p>B. Thinking about those situations you see, tell me why you think at least one opportunity or situation seems to happen on a regular basis?</p> <p>C. What do you consider to be one of the areas of collaboration with government, partners or stakeholders in the situation you mentioned?</p> <p>D. If you could get involved in that situation to improve collaboration, what would you do?</p> <p>E. If you think government and other stakeholders can help improve that situation, what should they do & who should do that?</p> <p>F. Is there anything else we can do to strengthen the way the hospital collaborates with government in providing improved healthcare?</p>
3. Exit Phase	
How can we improve management of healthcare services;	<p>A. If you had to name 3 opportunities (situations) where you see hospital management work with the Church synod in (improving) health care delivery at Mbereshi / Mwandi Mission Hospital, what would</p>

	<p>those situations be?</p> <ul style="list-style-type: none">B. Thinking about those situations you see, tell me why you think at least one opportunity or situation seems to happen on a regular basis?C. What do you consider to be one of the areas of collaboration with the Synod of the Church in the situation you mentioned?D. If you could get involved in that situation to improve collaboration, what would you do?E. If you think the Church Synod and Partners can help improve that situation, what should they do & who should do that?F. Is there anything else you would recommend to the Hospital management and Synod of the Church to improve administration and development of healthcare?
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APPENDIX C – STUDY RECRUITMENT | INFORMANT’S CONSENT



UNIVERSITY OF KWAZULU-NATAL

School of Management, IT and Governance (MIG)

College of Law and Management Studies

Programme: Doctor of Administration
Researcher: Edward Nondo (+26 0975 824 292)
Supervisor: Prof. Fayth A Ruffin (+27 768 119 595)
Research Office: Ms P Ximba +27 312 603 587

Dear Informant,

I, Edward Nondo am a Doctoral student with the School of Management, IT and Governance (MIG) in the College of Law and Management Studies at the University of KwaZulu-Natal invite you to participate in a doctoral research project on;

‘Faith-Based Organisational Management: Strengthening Church-led Healthcare Provision in Zambia and Malawi’

The research seeks:

1. To deeply explore challenges faced by the church and opportunities that lie ahead in performing management functions that improve healthcare delivery
2. To examine in-depth the ways in which church-led management work with government to improve healthcare provision in its health facilities
3. To contribute to FBO management reform in healthcare administration and development, particularly the UCZ of Zambia and CCAP of Malawi

Please note that your participation in this project is voluntary and follows your organization's prior authorization for me to conduct the research through interviews. You are however free to decline participating in the interview and may stop the interview at any time with no consequence on your part or organization.

There will be no monetary or material reward for your participation in this interview. The Researcher and the University of KwaZulu-Natal will ensure strict confidentiality and anonymity of your responses and records were demanded or required.

If you have any questions or concerns about the interview, please ask before undergoing the interview.

The interview may (with your consent) be recorded and should take approximately 40 (forty) minutes to complete.

I hope you can make time to participate in this noble research.

Sincerely,

Researcher's Signature:



Date _____

Duplicate of this page – retained by participant



UNIVERSITY OF KWAZULU-NATAL

School of Management, IT and Governance (MIG)

College of Law and Management Studies

Programme: Doctor of Administration

Researcher: Edward Nondo (+26 0975 824 292)

Supervisor: Prof. Fayth A Ruffin (+27 768 119 595)

Research Office: Ms P Ximba (+27 312 603 587)

INFORMANT'S CONSENT

I _____ (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and voluntarily consent to participating in the research project through an in-depth interview.

I also understand that I am at liberty to withdraw from the research project at any time, should I so desire.

Further, I hereby consent ___ / do not consent ___ to have this interview recorded.

Signature of Participant

Date

APPENDIX D – FOCUS GROUP DISCUSSION GUIDE
(Per Stakeholder with Actual Questions)



UNIVERSITY OF KWAZULU-NATAL

School Of Management, IT and Governance (MIG)

Researcher: Edward Nondo (+26 0975 824292)

Supervisor: Prof. Fayth A Ruffin (+27 76 8 11 9595)

Research Office: Ms P Ximba +27 312 603 587

Focus Group: Introductory Guide & Actual Questions

1. Welcome

Thank you for agreeing to be part of the focus group.

2. Introduction

The Researcher (as above) moderated discussion whilst the Assistant took notes and simultaneously recorded deliberations as well as ensure participant's **Consent** is authenticated

3. Purpose

With prior authorization from the Church's synod headquarters, the study seeks;

- To deeply explore challenges faced by the church and opportunities that lie ahead in performing management functions that improve healthcare
- To examine in-depth the ways in which church-led management work with government to improve healthcare provision in its health facilities
- To contribute to FBO management reform in healthcare administration and development, particularly the UCZ of Zambia and CCAP of Malawi

4. Ground Rules

- Participation – We would like YOU to do the talking
- Assurance – There is no right or wrong answer
- Recording – We would like to record the discussion / what is said remains here
- Confidentiality – All answers including sensitive issues that may arise will not be personally identifiable and shall be for academic purposes only.

5. Discussion

Researcher used attached Actual **Focus Group Questions** (attached - A & B) to ignite discussion. Encouraged participants to talk and fully explain answers with probes like;

- “Could you please talk a bit more about that”
- “Help me understand what you mean by that”
- “Can you give an example”

6. Closure - Researcher thanked participants for their time and valued participation

ACTUAL FOCUS GROUP QUESTIONS

(a) Health-workers

Key – Engagement Questions

1. What are the challenges that the church is facing in managing healthcare services for its health facilities;

- If you had to name 3 situations that really bother you about health care delivery at hospital, what would those things be?
- Thinking about those problems, tell me why you think at least one problem or situation seems to happen on a regular basis?
- What do you consider to be one of the causes of the problem or situation you mentioned?
- If you could change that situation or solve that problem, what would you do?
- If you think the hospital is the only one who can change or improve that situation, what should they do & who should do that?
- How can we address these challenges so that they do not occur in the future?

Key – Exploration Questions

2. How do FBOs particularly the church-led management work with government to improve healthcare services in its health facilities;

- If you had to name 3 opportunities (or situations) where you see hospital management work (in collaboration) with government in providing health care delivery at hospital, what would those situations be?
- Thinking about those situations you see, tell me why you think at least one opportunity or situation seems to happen on a regular basis?
- What do you consider to be one of the areas of collaboration with government, partners or stakeholders in the situation you mentioned?
- If you could get involved in that situation to improve collaboration, what would you do?

- If you think government and other stakeholders can help improve that situation, what should they do & who should do that?
- Is there anything else we can do to strengthen the way the hospital collaborates with government in providing improved healthcare?

Key – Exit Questions

3. How can we improve management of healthcare services;
- If you had to name 3 opportunities (situations) where you see hospital management work with the Health-workers (in improving) health care delivery at Hospital, what would those situations be?
 - Thinking about those situations you see, tell me why you think at least one opportunity or situation seems to happen on a regular basis?
 - What do you consider to be one of the areas of collaboration with the health-workers as members of staff in the situation you mentioned?
 - If you could get involved in that situation to improve collaboration, what would you do?
 - If you think the local community and other stakeholders can help improve that situation, what should they do & who should do that?
 - Is there anything else you would recommend to the Hospital management and Synod of the Church to improve administration and development of healthcare?

ACTUAL FOCUS GROUP QUESTIONS

(b) Church and Community Members

Key – Engagement Questions

4. What are the challenges that the church is facing in managing healthcare services for its health facilities;
 - If you had to name 3 situations that really bother you about health care delivery at hospital, what would those things be?
 - Thinking about those problems, tell me why you think at least one problem or situation seems to happen on a regular basis?
 - What do you consider to be one of the causes of the problem or situation you mentioned?
 - If you could change that situation or solve that problem, what would you do?
 - If you think the hospital is the only one who can change or improve that situation, what should they do & who should do that?
 - How can we address these challenges so that they do not occur in the future?

Key – Exploration Questions

5. How do FBOs particularly the church-led management work with government to improve healthcare services in its health facilities;
 - If you had to name 3 opportunities (situations) where you see hospital management work (in collaboration) with government in providing health care delivery at hospital, what would those situations be?
 - Thinking about those situations you see, tell me why you think at least one opportunity or situation seems to happen on a regular basis?
 - What do you consider to be one of the areas of collaboration with government, partners or stakeholders in the situation you mentioned?

- If you could get involved in that situation to improve collaboration, what would you do?
- If you think the government and other stakeholders can help improve that situation, what should they do & who should do that?
- Is there anything else we can do to strengthen the way the hospital collaborates with government in providing improved healthcare?

Key – Exit Questions

6. How can we improve management of healthcare services;

- If you had to name 3 opportunities (situations) where you see hospital management work with the church and community members (in improving) health care delivery at hospital, what would those situations be?
- Thinking about those situations you see, tell me why you think at least one opportunity or situation seems to happen on a regular basis?
- What do you consider to be one of the areas of collaboration with local community members in the situation you mentioned?
- If you could get involved in that situation to improve collaboration, what would you do?
- If you think the local community and other stakeholders can help improve that situation, what should they do & who should do that?
- Is there anything else you would recommend to the Hospital management and Synod of the Church to improve administration and development of healthcare?

.....

**APPENDIX E – STUDY RECRUITMENT | FOCUS GROUP PARTICIPANT’S
CONSENT**



UNIVERSITY OF KWAZULU-NATAL

School of Management, IT and Governance (MIG)

College of Law and Management Studies

Programme: Doctor of Administration
Researcher: Edward Nondo (+26 0975 824 292)
Supervisor: Prof. Fayth A Ruffin (+27 768 119 595)
Research Office: Ms P Ximba +27 312 603 587

Dear Participant,

I, Edward Nondo am a Doctoral student with the School of Management, IT and Governance (MIG) in the College of Law and Management Studies at the University of KwaZulu-Natal invite you to participate in a doctoral research project on;

*'Faith-Based Organisational Management: Strengthening Church-led Healthcare
Provision in Zambia and Malawi'*

The research seeks:

1. To deeply explore challenges faced by the church and opportunities that lie ahead in performing management functions that improve healthcare delivery
2. To examine in-depth the ways in which church-led management work with government to improve healthcare provision in its health facilities

3. To contribute to FBO management reform in healthcare administration and development, particularly the UCZ of Zambia and CCAP of Malawi

Please note that your participation in this project is voluntary and follows your organization's prior authorization for me to conduct the research through focus group discussions. You are however free to decline participating in the focus group and may stop the discussion at any time with no consequence on your part or organization.

There will be no monetary or material reward for your participation in this focus group discussion. The Researcher and the University of KwaZulu-Natal will ensure strict confidentiality and anonymity of your responses and records were demanded or required.

If you have any questions or concerns about the focus group, please ask before undergoing the group discussion.

The focus group discussion may (with your consent) be recorded and should take approximately 40 (forty) minutes to complete.

I hope you can make time to participate in this noble research.

Sincerely,

Researcher's Signature:



Date _____

Duplicate of this page – retained by participant



UNIVERSITY OF KWAZULU-NATAL

School of Management, IT and Governance (MIG)

College of Law and Management Studies

Programme: Doctor of Administration

Researcher: Edward Nondo (+26 0975 824 292)

Supervisor: Prof. Fayth A Ruffin (+27 768 119 595)

Research Office: Ms P Ximba (+27 312 603 587)

DECLARATION OF CONSENT

I _____ (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and voluntarily consent to participating in the research project through a focus group discussion.

I also understand that I am at liberty to withdraw from the research project at any time, should I so desire.

Further, I hereby consent ___/ do not consent ___ to have this interview recorded.

Signature of Participant

Date

APPENDIX F – ALIGNMENT OF CHALLENGES WITH EMERGING FACTORS / THEMES

Responses – Challenges	Category	MGT1/ factors	Key thematic areas
<p>1.</p>	<p>“...shortage of staff, especially clinical officers and medical assistants and nurses.” M-Ek-HM</p> <p>“We end up having shortage of staff. We have many staff establishments that we are not able to fill because we cannot get the right people for those posts. Our staff end up working overtime...” M-Ek-HA</p> <p>“...the shortage of medical personnel...” M-Em-HR</p> <p>“The second one is staffing...Some other times the staff we have maybe off duty and in those cases it becomes hard to get those staff to work in the field because even the clinical staff available are few.” M-Em-PHC</p> <p>“...we do not have enough workers at the hospitals in terms of doctors and nurses. We have these shortages here because the area is rural and that poses a challenge to recently graduated health personnel.” M-Em-HoS</p> <p>“This is a rural area and people normally wouldn’t want to work here because the schools and infrastructure is underdeveloped. Because of that we have movement of staff from here to towns and other developed places. This causes shortage of staff... Not having enough staff is a challenge. Here we have very few nurses and our staff overwork.” M-Em-HA</p>	<p>Shortage of Staff (17)</p> <p>Structural</p>	<p>Limited human resources</p>

“The other thing is that in some departments there is shortage of staff...So there were few people looking after a lot of patients. I think they were overworked.” **Z-Mw-CwS**

“...the issue of the dirty environment...because of the shortage of staff so some people were given responsibilities other than what they were employed for.” **Z-Mw-HoS**

One nurse will run 2 wards e.g. Maternity and children’s ward at the same time. **Z-Mw-MC: R7**

Shortage of staff compromises quality of care because observation are done quickly in order to see as many people as possible. **Z-Mw-MC: R6**

One Doctor runs the entire hospital and when that Doctor leaves for another station there is no one. We are forced to go to other towns like Livingstone and Sesheke... **Z-Mw-MC: R7**

“...then sometimes they don’t have specialised doctors.” **M-SoL-APD**

“...lack of human resource to manage the institution...especially in area of medical doctors and nurses, so we are struggling because we may have a doctor who is seconded by the government who may, after serving for few months, leave and you will have to struggle again to look for another doctor...in Mwandu, Mbereshi we don’t have capacity to pay...they would be paid by the government but the allowances we fail to pay them in full to motivate them so they opt to leave.” **Z-CM-PSB**

	<p>Staffing is inadequate... Z-Mb-HA</p> <p>Staff is inadequate – only 30%, not enough doctors, clinical officers, nurses especially middle wives. Sometimes there is only two nurses in the whole hospital... Z-Mb-MoI</p> <p>Lack of staff... Z-Mb-MC</p> <p>Human Resource shortage... Z-SHQ-HS</p>			
<p>2.</p>	<p>“...we are supposed to provide free maternity services and the government is supposed to pay us but currently we are having problems with this agreement...” M-Ek-HCC</p> <p>“...salaries and allowances for staff. The hospital is not able to generate funds to pay its staff members and support other services and activities of the hospital... In summary, funding is a big challenge affecting the running of our hospital in many ways like acquiring drugs...” M-Ek-HCC</p> <p>“Financial resources. We have a problem maintaining our vehicles...it’s difficult for us to raise funds to maintain them... Even resources for buying drugs are unavailable.” M-Ek-HA</p> <p>“...we have big financial problems. This is a mission hospital and we are financially challenged, we cannot run the hospital from fees paid by patients... we need money for fuel, drugs, wages, top-ups, equipment and many other things... Finance is a very critical problem.” M-Em-HR</p>	<p>Finances (14)</p>	<p>Structural</p>	<p>Limited financial resources</p>

“The first challenge is the funding for the running cost of the hospital. We only receive funding for the running cost of the hospital through the government which comes as a grant and very infrequently.” **M-Em-HA**

“Here we look at the salaries or wages. This has had a negative impact because many staff leaves the hospital in search for greener pasture.” **Z-Mw-HAc**

“...the fact is that the church does not seem to have enough financial resources to manage health institutions. If one looks at the budget of SYNOD, it’s difficult to see any allocation that is giving to health institution because the SYNOD has been struggling with financial sustainability...” **Z-CM-PSB**

Finance – serious financial problems, reduction in the grant due to creation of new district. The grant has dropped by three (3) times. Patients have to eat three meals per day. **M-SoL-SM**

Inflow of finance not as before (inadequate) for operations of the hospital. There is a hand-to-mouth situation. **Z-Mb-MoI**

Sustainability of the hospitals – due to inadequate funds. For example Nurses can protest any day for salaries not being paid on time. CCAP before was self-reliant. From 1956 we became autonomous. With the birth of CHAM, we agreed with government that salaries will be paid by government. **M-SoL-GS**

	<p>Health financing – which is inadequate at the moment leads to insufficient medicines and equipment. Mwandishi mission hospital needs specialized services but lacks funds for this. Also Mbereshi mission hospital. Z-Mw-TA</p> <p>Critical financial situation – due to low income assistance from CHAZ. For example we have a staggering debt with NAPSA. We have an agreement to pay K5, 000 per month to service the debt. Partners help and contribute directly. Z-SHQ-FS</p> <p>Healthcare financing – is inadequate to support medical supplies. Z-SHQ-HS</p> <p>“...the first one is to do with funding of hospital itself.” M-SoL-HD</p>			
<p>3.</p>	<p>“Another bother as far as this hospital is concerned is also the facilities we have at the hospital. Some are quite old and we need new ones. There are some illnesses that we could treat here but we do not because we do not have the equipment so we refer them to Muzuzu Central Hospital. We don’t have adequate equipment.” M-Em-HoS</p> <p>R1: “...rooms for admitting patients. There is usually congestion. And when there is an overflow we can even make patients sleep on the floor. The available rooms don’t accommodate enough patients in proportion to the population we serve at this centre.” M-Em-MC: R1</p>	<p>Equipment/Facilities (12)</p>	<p>Structural</p>	<p>Limited financial resources</p>

R3: “You can have medicine but if there are no rooms there is still a challenge. So there is need to maintain some rooms and supply of medicine.” **M-Em-MC: R3**

“Another issue is we have no X-ray. It has been down for almost a year now and we have to refer patients to Sesheke and it becomes a challenge.”

Z-Mw-HAc

“The hospital facility bothers me in the sense that our hospital receives a lot of patients...and then the doctor will tell them we don’t have the facilities to do this...” **M-SoL-SM**

Pilferage of materials especially mattresses at the mission hospital because most workers are not UCZ – they pilfer items and do not care.

Z-Mb-MSD

Water and Sewerage – the hospital has poor leaking pipes and water pumps still being paid for...Electricity – poor supply of electricity (hospital relies on gen sets which are sometimes down, too). **Z-Mb-HCC**

Equipment – pharmacy air conditioner is down, drugs are in danger. Operating theatre has got no air conditioner... no toilet in male ward ablution block. **Z-Mb-MC**

Kitchen is in bad shape and laundry, too. **Z-Mb-MoI**

Mother’s shelter is dark – people taking care of patients sleep in dark

<p>shelters...Some people take 3-4 months taking care of the patients at mother's shelter. Z-Mb-HM</p> <p>Inadequate supply of equipment, x-ray films, reagents for e. g CD4 count. Z-SHQ-HS</p> <p>Also you have to fetch hot water because the geysers are not working. M-Ek-OC: R2</p>			
<p>"There is another problem of shortage of medicines..." M-Ek-TA: R2</p> <p>"...issue is resources that can assist the patients. For example, sometimes we run short of essential drugs which can assist the patients..." M-Ek-HM</p> <p>"...because we are not able to generate enough funds, that affects even our drugs. We cannot stock all the drugs we need especially now that the prices of drugs are going up." M-Ek-HA</p> <p>"We have shortages of drugs...the shortage of drugs is a major problem here." M-Em-DFM</p> <p>"...shortage of medicine (drugs). At most we just dispense panado because that is all we have." M-Em-MC: R1</p> <p>"Personally I think shortage of medicine is a bigger challenge. Patients may afford to walk to the hospital but if there are no drugs then treatment will not be completed... the nearest pharmacy costs 1,500 which is a lot of money. And people from deep rural areas may not afford that." M-Em-</p>	<p>Shortage of Medicines (12)</p>	<p>Clinical</p>	<p>Limited financial resources</p>

	<p>MC: R2</p> <p>“You can have rooms but without medicine it is nothing.” M-Em-MC: R3</p> <p>“...they don’t have all the drugs that they require so they would send or refer people to central hospital for some other drugs. That’s a challenge. Sometimes they would prescribe drugs that they don’t have...” M-SoL-APD</p> <p>Drugs supply is inadequate. Also, drugs requested for from medical stores are brought but at all times drugs not requested are the ones supplied. They give us what they have not what we need. Z-Mb-HA</p> <p>Inadequate medicine. Z-Mb-MC</p> <p>Medicine supply is inadequate... Z-Mb-OC</p> <p>Inadequate supply of drugs... Z-SHQ-HS</p>			
<p>5.</p>	<p>“We are not giving full holistic service to our patients...we are not caring for them spiritually...we seem to have lost the ability to go the extra mile for our patients...There’s not the serenity, not the friendliness and we have lost that.” Z-Mw-MHP</p> <p>“...just the link between the church and the hospital...just how to incorporate the spiritual aspect of service delivery...” Z-Mw-HA</p> <p>“The other thing is the working culture has gone down. People do whatever they want. They report for work at what time they want and knock off</p>	<p>Caring, Purpose & Compassion (7)</p>	<p>Doctrinal</p>	<p>Limited human resources</p>

	<p>whenever they want.” Z-Mw-HML</p> <p>“You find one person is working and the other isn’t. Apart from them being few, not doing their work has also contributed to the mission being dirty.”</p> <p>Z-Mw-HoS</p> <p>Negative attention by the management of Mbereshi mission (ie. attitude towards clients especially girl students). Negative attitude stands out. Nurses on duty sometimes exhibit this and patients are not well attended to.</p> <p>Z-Mb-MSD</p> <p>R5: How they receive the patient, the reception is not good. M-Ek-OC: R5</p> <p>R10: There is just no patient care... M-Ek-OC: R10</p>			
<p>6.</p>	<p>“...we need to have adequate transport but you find sometimes you have no fuel or the car is not there.” M-Em-PHC</p> <p>“We also don’t have adequate transportation.” M-Em-DFM</p> <p>“The first problem is transportation... We have few drivers and only one or two vehicles so as a result the transport is not enough.” M-Em-MC: R1</p> <p>“We also have no ambulance and we are running on the land cruiser which is a utility vehicle which does everything. It does everything as well as being an ambulance. You find it’s out buying supplies, cater to emergencies and so on. It’s very difficult.” Z-Mw-HAc</p> <p>Transportation there’s only a motor bike. Fuel supply is not good – not</p>	<p>Transport (6)</p>	<p>Structural</p>	<p>Limited financial resources</p>

	<p>enough, sometimes staff only sacrifice their vehicles. Z-Mb-HA</p> <p>... but transport is the biggest challenge. Z-Mb-OC</p>			
7.	<p>“The other thing is the church, donor and government collaboration. I believe this kind of collaboration seems to have certain challenges in the sense that there’s very little harmonisation of relations and also recognising the important role that each one of these play in ensuring holistic service delivery to the community.” Z-Mw-HA</p> <p>“...there is a lack of local networking by these mission hospitals with the communities in which they are situated, there may be presbyteries, consistories and better still congregation...I think it leaves a gap in the management though...” Z-CM-PSB</p> <p>Support from the church is very minimal or if not nil. Z-Mb-HA</p> <p>Disjointed missionary partnership (due to Church conflicting priorities, values.) Z-Mw-TA</p> <p>Independence of the mission hospitals (i.e. the autonomy of Embangweni/Ekwendeni/Donald Gordon hospitals)... Hospitals do their own things – they work one for themselves... Employees are not transferable from one hospital to another. The main problem is employees not being transferable. This situation negatively affects service delivery – it limits initiative/new ideas from employees’ where improvements are</p>	Collaboration (5)	Structural	Limited human resources

	concerned... M-SoL-YD			
8.	<p>“We have shortages of houses. As you know this is a rural area and if we asked someone to go out of the hospital compound to find accommodation to rent, chances are there is no electricity and there’s no water. You can’t keep someone highly qualified in such an area.” M-Em-HR</p> <p>“The other reason is that we do not have enough housing here. So when we have staff sent here, we can’t retain them because of housing.” M-Em-HoS</p> <p>“Another thing is the doctors. We don’t have professional doctors because of the facilities such as housing that is not okay.” M-Em-DFM</p> <p>“The accommodation for the workers is inadequate...hospital hasn’t got enough workers because there is no accommodation for them.” Z-Mw-CwS</p> <p>Staff Accommodation – houses are in bad conditions and some staff do not have houses, others are in guest houses. Z-Mb-MHP</p>	Shortage of Staff Housing (5)	Structural	Limited financial resources
9.	<p>“What we get is little compared to what we spend that is why we have outstanding debts of unpaid bills...” M-Em-HA</p> <p>“...we have a debt with Zesco, more than 180 000. Before the prepaid meters were installed, all the staff houses, the hospital and other stakeholders like the farm and everyone around the mission were connected to one meter...the bill still stands and Zesco is expecting their payment.”</p>	Debt Burden(3)	Structural	Limited financial resources

	<p>Z-Mw-HAc</p> <p>The hospital is in debt. Z-Mb-MoI</p>			
10.	<p>Managers are not UCZ and therefore they do not carry church policy focus. Z-Mb-MSD</p> <p>The Board meetings where hospital management presents its problems for solutions are not regular. Z-Mb-MHP</p> <p>“...something to do with the management administrative and accounting systems that we have in place so these are the major ones.” M-SoL-HD</p>	<p>Management Systems (3)</p>	<p>Structural</p>	<p>Limited human resources</p>
11.	<p>“Now as we have discovered under the CHAZ memorandum of understanding, we are also taking on the structures of the ministry of health; the medical officer, the administrator is answerable to them...we are not in charge of our own institution. We have no say.” Z-Mw-MHP</p> <p>“...the administration of the hospital...taking someone from the government who will try to bring his or her own things to the mission hospital and in the process distorting the whole picture of it being a mission.” Z-Mw-HML</p> <p>“The aspect of ownership has not been accepted so much so. If we understand that this is our property, there should be a way in which we contribute...we have not accepted the ownership as UCZ and even other churches. We all feel it’s the role of the government.” Z-Mw-HoS</p>	<p>Reporting Structure (3)</p>	<p>Structural</p>	<p>Limited human resources</p>

12.	<p>“We have a problem with retention of staff, it’s a problem to keep workers here because our salaries are not as high...” M-Ek-HCC</p> <p>“Further, mission hospitals don’t have enough incentives to retain health workers in general...we always hear of someone resigning and this is largely because we do not have enough incentives to retain our workers.” M-Em-HoS</p> <p>Retention of staff – at remote institutions and there HR is generally inadequate at both mission hospitals and rural health centres e. g Doctors, nurses and other health workers – we have no ‘top ups’ such as money, a car and so on ...so health workers in our facilities cannot stay. Z-SHQ-GS</p>	Staff Retention (3)	Structural	Limited financial resources
13.	<p>The infrastructure is old – when building infrastructure, unburned bricks were used then plastered so buildings are crumbling down. Z-Mb-HA</p> <p>Infrastructure – is old and all structures have outlined their helpfulness... It is the role of government to provide health care and yet does not come on board to improve infrastructure. For example, infrastructure improvements in Mwandu it’s only mission partners who are doing it – no government’s help. The other example is Mbereshi infrastructure that has cracks which should just facelift with new ones. Z-SHQ-GS</p>	Dilapidated infrastructure (2)	Structural	Limited financial resources
14.	<p>“The employees, the nurses and doctors for some unknown reason sometimes they tend to be a bit rough and aggressive...” M-Ek-TA: R1</p>	Harsh Health Workers (2)	Structural	Limited human resources

	<p>“Others complain about the harshness from the nurses and other personnel...sometimes you may be overworked and tired and start mistreating people. Some people in the maternity ward have complained about this this.” Z-Mw-CwS</p>			
15.	<p>Human resource – has no grip on carrying out the vision/mission of the church, non-compliance to the mission regulations such as worship, conflict of ethos between government and the church, for instance sidelining of mission partners by government seconded workers. Z-SHQ-GS</p> <p>“The other issue is to do with human resource. Human resource in the sense that I would connect to the aspect of sustainability...if we don’t address that then it will affect even the quality of human resource that we attract to this place...” Z-Mw-HA</p>	Human Resource Commitment (2)	Structural	Limited human resources
16.	<p>In the environment there, there is no hygiene once you are admitted. M-Ek-OC: R11</p> <p>The toilets are closed and dirty – there is a certain smell that comes from there especially that it is bad for asthma patients. The mosquito nets are not well placed. M-Ek-OC: R10</p>	Hygiene/Cleanliness (2)	Structural	Limited human resources
17.	<p>Drugs – medical stores does not supply according to requests. Z-Mb-MoI</p> <p>Medical stores supplies wrong drugs... Z-Mb-HCC</p>	Inappropriate Supply of Medicines (2)	Clinical	Limited financial resources

18.	<p>It takes time to be attended to – you wait a long time at OPD. Z-Mw-MC: R1</p> <p>Time management e.g. if you went at 13hours you are only to be attended to at 14hours. M-Ek-OC: R5</p>	Long Waiting Periods (2)	Clinical	Limited human resources
19.	<p>“Our regulations here are quite tough being a Christian organisation.” M-Ek-HCC</p> <p>The holistic approach at the mission station is degenerating - spiritual and Health wise... government seconded staff’s failure to support mission values (not being part of chapel... with Christ loving spirit) and this is slowly encroaching in character of mission. Z-Mw-TA</p>	Mission Regulations (2)	Doctrinal	Limited human resources
20.	<p>“...the charges that are administered at the mission hospital, if you look at the status of the community around, most of them can’t afford the charges.” M-Ek-TA: R1</p> <p>“The patient may tell us that they can't afford the bill and then we are left with nothing to do. We discharge them with trust that when they get the money they will come back and pay but they don't come back. Regardless of us having contact details, we don't follow them up because we actually lose more money trying to follow them up.” M-Ek-HA</p>	User Fees/Service Charges (2)	Structural	Limited financial resources
21.	Donor dependency to fund projects – the Church’s funding reliance is now	Donor Dependency	Structural	Limited

	mainly on Sunday offering (due to unreliability of partner support). Z-SHQ-FS	(1)		financial resources
22.	Food shortage in the hospital is the major problem...Porridge with ordinary mealie meal no HEPS (the Soya-based food supplement for malnourished children)...Help is given according to the weight of the body. Z-Mb-MC	Shortage of Food (1)	Clinical	Limited financial resources
23.	"...personnel in the sense that we don't have the personnel that are fully qualified. We have some personnel that fail to diagnose some diseases." M-SoL-SM	Unqualified Staff (1)	Clinical	Limited human resources

APPENDIX G – ALIGNMENT OF OPPORTUNITIES FOR COLLABORATION WITH FACTORS / THEMES

Responses – Opportunities for Collaboration	Category	MGT2/ factors	Key thematic areas
<p>1. “We get the salaries from the government...” M-Ek-HM</p> <p>“...our salaries come from the government that is why we are still existing otherwise most of the hospitals cannot afford to pay even a few officers...” M-Ek-HA</p> <p>“...the payment of wages to the hospital employees by the government through the CHAM.” M-Em-HR</p> <p>“Other than the salaries...” M-Em-HoS</p> <p>R1: “...some of the employees working here were employed by the Government and they are paid by the government...” M-Em-MC: R1</p> <p>“The government still continues to fund the hospital... They also provide us with staff.” Z-Mw-HML</p> <p>“There are no programs that we know that are from the government except the employees that come from the government.” Z-Mw-MC: R2</p> <p>“The people that we would employ as a church would be the care takers, hospital attendants, watchmen, messengers etc, those would be paid directly by us the church. But clinical officers, nurses, doctors are always on the payroll of the government.” M-SoL-SM</p>	Salaries (17)	Structural	Policy on salaries, drugs and grants support

	<p>“...the government pays all the salaries for all the staff working in the hospital...” M-SoL-APD</p> <p>“...and the government also pays the workers.” Z-CM-PSB</p> <p>The relationship is perfect with the government for example nurses are paid by government. Z-Mb-MHP</p> <p>Government is in agreement with the church and CCAP is running 64 primary schools, 8 secondary schools, 1 university and 1 teacher training college. Government assists with staff salaries. M-SoL-GS</p> <p>Salaries come from government through CHAM... M-SoL-YD</p> <p>Secondment staff from government (Doctors, nurses and other medical staff). Z-SHQ-GS</p> <p>Secondment of staff – these are paid by government. Z-SHQ-FS</p> <p>Government pays all seconded staff working in mission hospitals. Z-SHQ-HS</p> <p>“And the government is paying for these salaries as well for the staff that we have at least the medical staff...” M-SoL-HD</p>			
2.	<p>“...there’s also a service level agreement we have signed with the government that maternity services should be free of charge and the government should be paying...” M-Ek-HM</p> <p>“...we have another area that we call Service Level Agreement... we provide</p>	SLA on maternal health (9)	Clinical	Regulations on certain healthcare services

maternity services and the government refunds the money that we spend.” **M-Ek-HA**

“Second area is in the service level agreement to provide free services in the maternity section.” **M-Em-HR**

“The government provides the supplements to the malnourished... so we provide the service for free.” **M-Em-PHC**

“In HIV for instance, the government has service agreements which are free, meaning we do the service and charge the government though they are not being faithful.” **M-Em-HoS**

“...there is an agreement a Service Level Agreement. That one came as a result of maternal deaths... so the government said all pregnant mothers should attend hospitals when they have delivered the government pays. So the government is paying.” **M-Em-HA**

“...the service level agreement were all maternity patients that come to the hospital are not charged because the government has offered to pay that charge so they receive free service...” **M-SoL-APD**

The existence of SLA – Mission Hospital render service free of charge but the government will settle depending on agreement. **M-SoL-YD**

R7: We hear the government pays few maternity fees for women, so they work together. **M-Ek-OC: R7**

<p>3.</p>	<p>“...there are some drugs that we get from the government that are free of charge example, malaria drugs, drugs for STIs...” M-Ek-HM</p> <p>“The government also is always coming here to support us with supervision and other services like drugs for STIs, TB and ARVs. So we work hand in hand with the government...” M-Ek-HA</p> <p>“...they also take the centre role in providing drugs and other services for STIs...” M-Em-PHC</p> <p>“Also the government is supplying drugs.” Z-Mw-HML</p> <p>Supply of drug kits is another. Z-Mb-MSD</p> <p>“Sometimes we see ministry of health vehicles bring medicines here which means the mission hospital still working with government.” Z-Mb-MC</p> <p>Drugs – the supply of essential drugs is done by government. Z-SHQ-HS</p> <p>“...they are also giving us some drugs...” M-SoL-HD</p>	<p>Drugs (8)</p>	<p>Clinical</p>	<p>Policy on salaries, drugs and grants support</p>
<p>4.</p>	<p>“We only receive funding for the running cost of the hospital through the government.” Z-Mw-Hac</p> <p>“We are very much reliant on the government grant.” Z-Mw-MHP</p> <p>“In the area of partnership with the government, I think the government has done a lot...may be 90 percent is coming from the government...” Z-CM-PSB</p>	<p>Grants (8)</p>	<p>Structural</p>	<p>Policy on salaries, drugs and grants support</p>

	<p>Grants come from government though erratic. Z-Mb-MSD</p> <p>Government grants (even when this is done government argues it's the responsibility of the church)... Z-SHQ-GS</p> <p>Grants which otherwise come late, come from government (ie MOH – ministry of health). Each mission hospital receives a government grant per month. Two weeks ago we received K19, 000 (January grant for Mwandu...several months late). Over the period of 2013, in 2013 the highest grant was K 22, 000 – Mwandu whilst in 2013 the highest grant was at K6, 000 – Mbereshi (which resulted in Subletting of Bed Space – PHO 18/sub-unit)... Z-SHQ-FS</p> <p>Grants – on a monthly basis though sometimes delayed. Z-SHQ-HS</p> <p>“...currently the situation is at close to 45% budget that we use in the hospital comes from the government...” M-SoL-HD</p>			
<p>5.</p>	<p>“Also, 3 or 4 years ago, the government gave Ekwendeni an Ambulance and a bus for the college of nursing.” M-Ek-TA: R2</p> <p>“We have signed a service level agreement with the government...The reporting system...the government has given us a motor cycle which is helping in the reporting system...” M-Em-PHC</p> <p>“We have a government vehicle as well.” Z-Mw-HML</p>	<p>Transport (3)</p>	<p>Structural</p>	<p>Policy on salaries, drugs and grants support</p>
<p>6.</p>	<p>“We appreciate when the government has refresher courses they always include</p>	<p>Government-driven in-service training</p>	<p>Structural</p>	<p>Policy on salaries, drugs and grants</p>

	<p>us though it's only for the workshops.” M-Ek-HCC</p> <p>“In fact, they are working with the government by sending people from the college of nursing to work in the government hospital for practicals.” M-Ek-TA: R2</p>	(2)		support
7.	<p>“We had a focus discussion with the DHO and we even involved the secretariat at the SYNOD level. They promised they would give us but we are still waiting.” M-Ek-HM</p> <p>“What we have used in this hospital was a CHAZ document that needed to be approved so that whoever is coming to the Church Health Institution (CHI) has to sign and abide by that but it wasn't approved by the ministry of health.” Z-Mw-HoS</p>	Mission regulations (2)	Doctrinal	Regulations on certain healthcare services
8.	<p>Training of HR and deployment... M-SoL-YD</p> <p>Most notable is collaboration with CHAZ (transparency is seen) many girls are supported of their medical attention at the hospital by CHAZ for user fees and other personal requests in school. CHAZ pays Mable Shaw Mission School identified girls 100% of treatment bills. Z-Mb-MSD</p>	Training/deployment (2)	Structural	Regulations on certain healthcare services
9.	<p>“...we do meetings together with the government officials for example the Uchembele Network which deals with maternity issues...We also have the CHAM where we have hospital staff supported by the government. The CHAM is a linking body to the government...even the staff working in our hospitals are</p>	Christian health association – CHAM (1)	Doctrinal	Policy on salaries, drugs and grants support

	not just from our church but from different churches but are funded by the government through CHAM.” M-SoL-SM			
10.	“...being a mission hospital run by UCZ...administration aspects can be taken up by people from UCZ because they know how our UCZ is run and what is needed...” Z-Mw-HML	Church & Govt memorandum of understanding (1)	Structural	Regulations on certain healthcare services
11.	“There’s a certain initiative which is happening within the SYNOD hospitals where we have SYNOD funds from the churches and the purpose of that fund is to add to the purchase of new ambulances in all the hospitals.” M-Em-PHC	Funding appeals (1)	Structural	Policy on salaries, drugs and grants support
12.	“The SYNOD established PHC because they feel that communities can start to assist the people from their homes to ensure that they have clean water and good food, etc...” M-Em-HoS	Income Generating Initiative (1)	Structural	Policy on salaries, drugs and grants support
13.	Our CCAP AIDS in society program, we have agreed with government that they will help mission with vehicles except staff. Mission helps by preparing proposals which government passes to Parliament. M-SoL-GS	HIV/AIDS program - LISAP (1)	Structural	Regulations on certain healthcare services
14.	Mission partners abroad (demonstrate collaboration through support in form of materials and human resource). Z-SHQ-GS	Mission partnership (1)	Doctrinal	Policy on salaries, drugs and grants support
15.	Governance –arrangement is such that UCZ employs Hospital Administrators	MoU on	Structural	Regulations on certain healthcare

	whilst government seconds a medical officer and other staff. Z-SHQ-FS	Administrators (1)		services
16.	“Recently, the government helped us to fix the mortuary and I think in the same way we can have them fix the houses.” Z-Mw-CwS	Technical Support (1)	Structural	Regulations on certain healthcare services

APPENDIX H – ALIGNMENT OF IMPROVEMENTS WITH FACTORS / THEMES

Responses – Improvements	Category	MGT3/ factors	Key thematic areas
<p>1.</p>	<p>“...I think our mother body SYNOD should really come in strongly because sometimes we get to feel paralysed...It’s like running two institutions within one institution.” Z-Mw-HAc</p> <p>“...perhaps it would be an appeal that SYNOD need to take a more active role in demonstrating interest in what is going on by way of regular monitoring of programs...” Z-Mw-HA</p> <p>“I think the hospital administrator should take an active role to communicate with SYNOD and SYNOD can come and talk over these issues and then tell the people what is supposed to be done at a mission hospital like this one.” Z-Mw-HML</p> <p>There should be increased partnership via CHAZ by its presence in supporting vulnerable children. CHAZ could be used to employ UCZ members including first member churches, CHAZ could be the conduit..... policy direction of the Church should be re-emphasised at the institution. Z-Mb-MSD</p> <p>Find Funds to support HA - strengthen clinical care, have workshops of authority in hospitals, if possible seek partnership help...</p>	<p>MoU/mission regulations (10)</p> <p>Doctrinal</p>	<p>Re-model reporting relationships</p>

Chaplaincy – to be strong within hospital ministry (need for full time) even doctors and nurses can have time with Christ. **Z-Mw-TA**

Government to honour the agreement in paying for services of medical services say by cash budget – to properly fulfil SLA. **M-SoL-YD**

Government must stop politicizing their assistance they give to health sector. Mission should further contribute to CHAM as member to strengthen empowerment. **M-SoL-GS**

Create close collaboration with other economical bodies and government (in form of consultations). Government at times sees a threat in us and so General Secretary can write and consultations can start from there. If possible, find space at parliament for a consultative talk during parliamentary business sessions. **Z-SHQ-FS**

Refurbishing infrastructure – with partners help from outside although partners are now fatigued with their own problems as a result of global recession issues. **Z-SHQ-HS**

“If these people attended the Chapel, they would hear the voice of God but very few attend. The word of God would build the staff and help them look at patients in love. If there’s a way to encourage people to attend services at the Chapel, it would be helpful.” **Z-Mw-MC: R7**

2.	<p>“If we could also have some staff exchange when we have some on leave with government clinicians so that we do not feel the shortage of staff. It could also facilitate knowledge exchange.” M-Ek-HCC</p> <p>“...if the hospital could have the idea of sending already existing workers to upgrade, it would be better for them and it would encourage them. The clinic attendants for example are very hard-working...they have forgotten what they were taught to do, therefore, refresher courses would be helpful.” M-Em-HoS</p> <p>“We are saying if there was a way to empower the local churches within the communities to take part in imparting these services through leadership, trying to ensure that services are effectively done and that the church takes a leading role.” Z-Mw-HA</p> <p>“...the government should help in the human resource development if we partner well we could come up with our training need or staff development...if for example UCZ fought for that and saying that on this programme each year government can be training one or two of our clinical officers and develop them into medical licentiates and some can go further and become medical doctors.” Z-CM-PSB</p> <p>Quality of care is compromised, empowerment of classified employees (CEs) can be done by sending them to college for clinical training. Z-Mb-HA</p>	In-service training (9)	Structural	Train to re-model structures
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	<p>Diagnosis of disease is an issue which should improve...Medical staff attending to us should go for training again to remind them on ways of treatment of disease. M-Ek-OC: R11</p> <p>They don't check when you are being given glasses and its better they give you eye drops. M-Ek-OC: R3</p> <p>They don't scan – complain of stomach ache, they give magnesium. M-Ek-OC: R10</p> <p>Eyes issues – they just ask you to choose after trying in them. M-Ek-OC: R6</p>			
<p>3.</p>	<p>“I hear there are some portable x-ray machines that are slightly cheaper than the mounted ones, so I don't know if they can switch to that alternative.” Z-Mw-HML</p> <p>A fridge for vaccines is needed. Z-Mb-HA</p> <p>Renovate the hospital buildings especially mothers shelter. Z-Mb-MC</p> <p>Add beds in the wards – when loaded some sleep on the floor. M-Ek-OC: R11</p> <p>More equipment is needed in the hospital. M-Ek-OC: R2</p> <p>Equip the hospital – No dental, no eye clinic – we have to go to</p>	<p>Medical equipment/facilities (6)</p>	<p>Clinical</p>	<p>Re-model structures</p>

	Mzuzu and it high costing. M-Ek-OC: R7			
4.	<p>“Another thing is in their different departments you will never find a person from Ekwendeni employed in a high position. They always pick people from outside even if they are not qualified.” M-Ek-TA: R2</p> <p>“There were challenges of hiring professionals because focus was on church members and relatives...we have more professionals being hired.” M-Em-HR</p> <p>“There should be an increase in the number of health workers like nurses. I am not sure if there is a doctor but we also would like to have some. I remember there was a time we used to go to Mzimba for a dentist because the service is not available here.” M-Em-MC: R2</p> <p>Centralise employment/recruitment... empower health coordinator (director) for such decisions as recruitment and posting. M-SoL-YD</p> <p>Improve management and recruit right people in order to overcome unfaithfulness. Z-SHQ-HS</p>	Recruitment Criteria (5)	Structural	Re-model reporting relationships
5.	<p>“I think this has to start with management itself. They need to be taught how they can treat their clients. They need not be rough.” M-Ek-TA: R1</p>	Management / Human Resource / Client Relations (4)	Structural	Re-model structures

	<p>“...I would love to see our hospital improving in the personnel, how they handle the patients that come. The facility can only be improved if the personnel’s day to day service also improves. This can also be done by exposing them to training...” M-SoL-SM</p> <p>There is need for sound organisational management. HR in administration to uphold the values and mission of the church</p> <p>Ownership is critical. Everyone needs to treat mission hospitals as our/their own. Z-SHQ-GS</p> <p>“You know there are instances where you know maybe you have resources, small as they may be but we must be effective in terms of allocating these resources and using them. So one of the reasons is to ensure that we have got good management and administrative systems out there in place.” M-SoL-HD</p>			
<p>6.</p>	<p>“One thing that I am working on with my colleagues right now is the housing because we are losing out on a lot of employees. We are looking at having appropriate houses for the cadres that we have.” M-Ek-HA</p> <p>“I think on the aspect of accommodation, if the mission would build a few houses or even one or two houses every two years that would help because we have a lot of staff that are coming and they are</p>	<p>Accommodation (3)</p>	<p>Structural</p>	<p>Re-model structures</p>

	<p>going back because there is no accommodation.” Z-Mw-HML</p> <p>“What they need to work on is now the accommodation. We can’t have four families sharing one house.” Z-Mw-MC: R6</p>			
7.	<p>“Another area that we are struggling as well as management is that of generating income. At least we must have something that will bring money apart from the user fees.” M-Ek-HA</p> <p>“I feel that if there was something that could bring in money so that we can run the hospital better. I have in mind the idea of having a private wing that we can charge high rates...that can generate some money. Or building a house which can be rented out and the money can help in the administration of the hospital.” M-Em-HA</p> <p>“They should have other ways and means to generate their own income. If one day the government withdraws they should have a backup so they are able to continue whatever they are supposed to do.” M-SoL-APD</p>	Finances/IGAs (3)	Structural	Re-model structures
8.	<p>Improve hygiene – especially toilets. M-Ek-OC: R8</p> <p>Clean the environment – they must kill the smell of the toilet. M-Ek-OC: R10</p> <p>Beddings must be changed regularly. M-Ek-OC: R7</p>	Hygiene (3)	Structural	Re-model reporting relationships

9.	<p>“We also lack a proper strategic plan. We have the government’s strategic plan but we should have our own strategic plan were we want to see the mission in five years’ time as a mission.” Z-Mw-MHP</p> <p>“There’s been an improvement in treatment because we now receive a lot of referrals from other catchment areas like Kazungula and even Namibia.” Z-Mw-MC: R4</p> <p>“One thing is to encourage strategic planning because I am not sure if it’s being encouraged. We need that so that the issue of infrastructure, the issue of just growth of a health institution and also the development of staff is addressed.” Z-CM-PSB</p>	Strategic planning (3)	Structural	Re-model reporting relationships
10.	<p>“I think the only thing the hospital needs to improve upon is cleanliness especially the surrounding. The hospital is really looking dirty. The hospital needs to be improved upon. The grass is over grown.” Z-Mw-CwS</p> <p>“The renovations at the hospital that are currently taking place are very good and we are happy about that.” Z-Mw-MC: R6</p>	Cleanliness/Appearance (2)	Structural	Re-model reporting relationships
11.	<p>“We would like to have a central place were all reports from different departments should be at a certain period of a month and from there go to the relevant authorities...there’s no consolidation.” M-Em-</p>	Consolidated reporting (2)	Structural	Re-model reporting relationships

	<p>PHC</p> <p>“The community itself must be sensitized on the importance of working together and participating in improving the services they receive.” M-Em-HoS</p>			
12.	<p>“One of the thing that management is working on is providing food in that ward because some of our patients come from far and cannot have visitors frequently enough to bring them food. So we will need to hire people and have a kitchen.” M-Ek-HA</p> <p>“....Because of lack of food in the hospital, HEPS should be provided to help our children who are admitted from hunger.” Z-Mb-MC</p>	Food for patients (2)	Clinical	Re-model reporting relationships
13.	<p>“...the road is very bad. Even when drugs are available in town, getting them here is a problem. So, if the government fixed the roads, it will be easy to access the drugs.” M-Em-HoS</p> <p>Suggestion is that the health post should be transformed into a rural health centre. Community service like making bricks can be the contribution towards building a health centre in Fishiki Community. Z-Mb-OC</p>	Infrastructure Development (2)	Structural	Re-model structures
14.	<p>There is need for the Church to be felt at the institution... orient new staff on the code of ethics at the mission which should be signed at</p>	Orientation for staff (2)	Doctrinal	Re-model reporting

	mission station before in-coming staff can engage in the MoU that may exist between government and churches. Z-Mb-MSD Staff orientation of ‘called staff’ with special calling to serve in a mission (in-situ). M-SoL-GS			relationships
15.	Church to communicate with the ministry of health, use brochures to advertise the hospital to the outside world for support. Z-Mb-MHP	Communication (1)	Structural	Re-model reporting relationships
16.	Empowering helpers (teach classified employees-CEs) to help in the running of the clinic. Z-Mb-HA	Empowerment in clinical skills(1)	Clinical	Re-model structures
17.	“...we would appreciate it if we were given opportunities for further studies like government workers because currently we meet our own study bills.” M-Ek-HCC	Further studies (1)	Structural	Re-model structures
18.	“Another is in relation to labour laws. We have conditions of service. In the context of the church they are okay, but are in conflict with the constitution and someone can drag you into court.” M-Em-HR	Labour regulations (1)	Structural	Re-model structures
19.	“...we are a paying hospital and people prefer to go to the government hospitals where there is no service charge, so maybe if the church can get to a place where we can sufficiently run the hospital for free maybe, we can keep it busy.” M-Ek-HCC	Removal of service fees (1)	Structural	Re-model structures

20.	“...the issue of reporting itself because this hospital depends on funding from other stakeholders...so the reporting in all departments should improve.” M-Em-PHC	Departmental reporting (1)	Structural	Re-model reporting relationships
21.	“I think our staff should get top-up salary as an incentive or rural allowance to make them happy because they say things are expensive in the rural areas.” M-Em-HA	Salary ‘top ups’ (1)	Structural	Re-model structures
22.	Any staff coming from government (by secondment) must come under Church and not government straight to hospital. Take a survey – we only have one administration. Under administration values and ideals of the Church mission are promoted but I think this is not what is happening. Z-Mw-TA	Staffing (1)	Structural	Re-model reporting relationships
23.	“I think we have workers. The workers just need to be supervised.” Z-Mw-CwS	Supervision (1)	Structural	Re-model reporting relationships
24.	“Water. Right now we have no water even in the toilets there is no water right now. We use an engine powered by fuel and right now the other one isn’t working so we don’t have enough water being pumped around to cater to the size of the clinic. So if the water issue was addressed, we would run the hospital better.” M-Ek-HM	Water supply (1)	Structural	Re-model structures

APPENDIX I – ETHICAL CLEARANCE APPROVAL



(University of KwaZulu-Natal, South Africa)

03 January 2014

Mr Edward Nondo (212561364)
School of Management, IT & Governance
Westville Campus

Protocol reference number: HSS/1141/013D
Project title: Faith-based Organisational Management: Strengthening Church-led Healthcare Provision in Zambia and Malawi

Dear Mr Nondo,

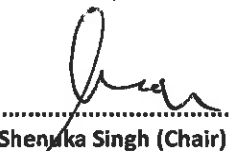
In response to your application dated 25 June 2013, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **Expedited Approval** FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully


.....
Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Dr Fayth A Ruffin
cc Academic Leader Research: Professor Brian
cc School Administrator: Ms Zarina Bullyraj

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: zn.ac.za/

Website: