
# Strategic Leadership and Change Management Imperatives in a Volatile Era: A Case Study of Prince Mshiyeni Memorial Hospital

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# DECLARATION

I, **Knowledge Lungisani Zungu**, declare that:

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# DEDICATION

This research project is dedicated to my late grandmother, Mrs Judith Siphiwe Sithole, who passed away in February 2021 while I was in the middle of my MBA studies. Thank you, Shenge, for raising me from childhood in the absentia of my parents. Your spirit will remain forever; I will continue living by the teachings, values, and principles you instilled in me. If it wasn't for you, I would not be where I am today. Rest in Power!

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# ABSTRACT

The South African public healthcare system plays a critical role in rendering care to the majority of the population. Public healthcare is one of the democratic government's key priorities, reflected in the constitutional commitment to providing accessible and quality healthcare efficiently and sustainably to all citizens. To realise this commitment, leadership and management of public healthcare facilities play a significant role as they can influence the success or failure of delivering quality and efficient healthcare services. Primarily because it is the responsibility of leaders to render healthcare sector demands efficiently and effectively. Strategic leadership is one of the effective tools for efficient management. Its effect on managing complexities, shocks, and various forms of turbulence and its efficiency is well documented in the literature. As a country heavily burdened by socio-economic development challenges such as the increasing poverty and unemployment rate, the number of people relying on public healthcare continually increases. With increasing healthcare demands and the burden of disease, public hospitals and clinics as institutions operate in challenging, complex and dynamic environments. Additional to an already turbulent environment prone to change and instability, public healthcare institutions in South Africa operate under the globally experienced volatile, uncertain, complex and ambiguous business environment. Therefore, the assessment of leadership styles, practices, and their impact is of performance in of great importance. Given such a state, the literature points to the importance of strategic leadership being a vital requirement for healthcare management and leadership. The wide range of strategic leadership competencies enables leaders to adapt continuously to change and the fast speed of innovation. This is because strategic leaders are visionary; they have the capacity to innovatively and creatively navigate organisations through volatility to improve performance. This study aimed to investigate the role of strategic leadership and change management at Prince Mshiyeni Memorial Hospital. Through a qualitative inquiry, an interview schedule of sixteen questions was administered to fifteen participants in leadership positions within the hospital. Questions probed to unearth the strategic activities and successfully captured experiences and viewpoints on the impact of strategic leadership in managing change and the hospital's performance in this era of unpredictable constant change. The findings of this study pointed out that Mshiyeni hospital operates in a complex and demanding environment with constrained human and financial resources. The hospital tackles extensive responsibilities of regional and district hospital services in an overly populated location dominated by socio-economically challenged communities. Results further showed that keeping the hospital operational at a satisfactory level has been achieved through strategic leadership approaches designed and actioned by the leaders at the hospital level. As access and delivery of quality healthcare is a constitutional mandate in SA, the commitment to deliver efficient and effective healthcare service is cited as one of the main priority objectives of the department of health. However, the financial provisions for public healthcare facilities seem not to match the service demands in a manner that can enable public hospitals to deliver their service sufficiently. It is recommended that future research probe into this matter at an executive level within the health department. This recommendation will aid in getting an idea of how the health department idealises its public institutions to execute its services in the context of the existing constrained resources state.

**Keywords:** Change management, efficient leadership, strategic leadership.

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# ACRONYMS

| | |
|---|---|
| 4IR | Fourth Industrial Revolution |
| ADKAR | Awareness, Desire, Knowledge, Ability and Reinforcement |
| AIDS | Acquired Immunodeficiency Syndrome |
| ARV | Antiretrovirals |
| CEO | Chief Executive Officer |
| CHC | Community Health Centres |
| COVID-19 | Coronavirus Disease of 2019 |
| DoH | Department of Health |
| DPSA | Department of Public Service and Administration |
| EC | Eastern Cape |
| ECG | Electrocardiogram |
| EHRP | Emergency Human Resource Programme |
| EPMDS | Employee Performance Management and Development System |
| ESG | Environmental, Social and Governance |
| FS | Free State |
| GP | Gauteng Province |
| HIV | Human Immunodeficiency Virus |
| HR | Human Resources |
| HRKM | Health Research and Knowledge Management |
| ICU | Intensive Care Unit |
| IoT | Internet of Things |
| KCD | King Cetshwayo District |
| KZN | KwaZulu-Natal |
| LP | Limpopo Province |
| MEC | Member of the Executive Council |
| MOPD | Medical Outpatient Department |
| MP | Mpumalanga Province |
| Mshiyeni Hospital | Prince Mshiyeni Memorial Hospital |
| MTCT | Mother-to-Child Transmission |
| MTT | Ministerial Task Team |
| NC | Northern Cape |
| NHI | National Health Insurance |
| NHS | National Health Service |
| NW | North West |
| OM | Operations Manager |
| OPD | Out Patient Department |
| PHC | Primary Health Care |
| PMDS | Performance Management and Development System |
| PSC | Public Service Commission |
| PSI | Patient Safety Incident |
| PwC | PricewaterhouseCoopers |
| RSA | Republic of South Africa |
| SA | South Africa |
| Stats SA | Statistics South Africa |
| TB | Tuberculosis |
| UK | United Kingdom |
| UKZN | University of KwaZulu-Natal |
| USA | United States of America |

| | |
|---|---|
| VUCA | Volatility, Uncertainty, Complexity, Ambiguity |
| WC | Western Cape |

# CHAPTER ONE: GENERAL INTRODUCTION

## 1.1 Introduction

Public healthcare in South Africa (SA) is one of the State's key priorities. From the dawn of democracy, post 27 April 1994, healthcare accessibility was made a constitutional provision promised by the South African Government to deliver to all citizens (Stuckler, et al., 2011, p. 165). The Department of Health (DoH) has committed to rendering quality and accessible healthcare services efficiently and sustainably. To realise this mandatory commitment, leadership and management play a crucial role in healthcare organisations, especially in today's complex and unpredictable world. Therefore, specific and ideal leadership behavioural attributes are a strategic imperative in determining the success or failure of public health organisations.

Hospitals are healthcare organisations that provide various health services, such as preventative, curative, palliative, or rehabilitative services (Sekhar, 2008, p. 48). Robbins and Judge (2013, p. 578) argued that not even a single company can claim to be operating in a stable environment today; even those that dominate the market are subject to change. Hospitals operate in the same constantly changing environment that other institutions and businesses operate in. Given this noticed increasing environmental dynamism, leadership needs strong strategic orientations to successfully navigate organisations throughout the complexities, uncertainties, and unpredictability's to success.

Additional to the operational management of organisations, modern leaders have to manage uncertainty. Effective leadership and the successful performance of an organisation's human capital are also the determinants of organisational success or failure (Robbins & Judge, 2013). Numerous studies and research attest as to how strategic leadership improves organisational readiness and adaptability to the increased uncertainty and volatility of the 21$^{st}$ century. This study aimed to investigate strategic leadership style and practices at the Prince Mshiyeni Memorial Hospital (Mshiyeni Hospital) to assess its extent, significance, and effect on the performance of rendering healthcare. This academic pursuit will be galvanised by the alignment of the peculiar scholastic literature review and methodical oriented empirical

research data collection and analysis while rounding it off with findings, conclusions, and recommendations.

## 1.2 Background to the Research

Mshiyeni hospital is a regional hospital located in Umlazi township in the South of Durban. This hospital began operating on 20 March 1987. Within these 35 years of service, the hospital has grown to a level 2 Specialist Hospital in the Durban Functional Region (KZN Department of Health, 2014). The hospital has 1 075 bedded facilities, 17 linked clinics, one of the gigantic mother-to-child transmission (MTCT) sites, and the colossal crisis centre that has been labelled as the Place of Comfort (KZN Department of Health, 2014).

Mshiyeni hospital offers a broad number of healthcare services to the regional and district community members, including communities from some parts of the Eastern Cape Province. Table 1.1 outlines the services available at Mshiyeni hospital. In delivering these public healthcare services, the hospital is driven by the vision of "providing optimal healthcare to all patients in the catchment area" (KZN Department of Health, 2014). This hospital is one of the most industrious and busiest public among its peers, as it services approximately 2 000 patients per day (Hlangu, 2022). The magnitude of work that Mshiyeni hospital undertakes daily is influenced by its location. Statistics indicate that Umlazi Township is the second most populated township in SA, consisting of 26 sections with more than half a million people (Statistics South Africa, 2012).

SA is an upper-middle-income country facing various socio-economic development challenges, primarily a high unemployment rate, poverty, and the highest inequality index in the world (World Bank, 2020). These challenges extend into the healthcare sector. Townships, popularly known as Locations areas, are ordinarily occupied by Black people, mainly affected by these socio-economic challenges. The 2011 census conducted by Statistics South Africa (2012) reported that Umlazi population was 404 811, of which demographically, 25.8% were young persons aged 0-14, 71.2% were working-age group aged between 15-64, and 3% of the elderly aged 56 years and above. Furthermore, 9.5% of the population from the age of 20 and above held higher education qualifications, and 40% with matric as the highest qualification (Statistics South Africa, 2012). Arguably, this statistical profile detrimentally affects the opportunities and the standard of living of the people of Umlazi township. The socio-economic profile of Umlazi township makes it suggestable that the majority of the population of this

township needs and relies on public healthcare. Hence the sizeable daily number of patients serviced by Mshiyeni hospital and its associated clinics.

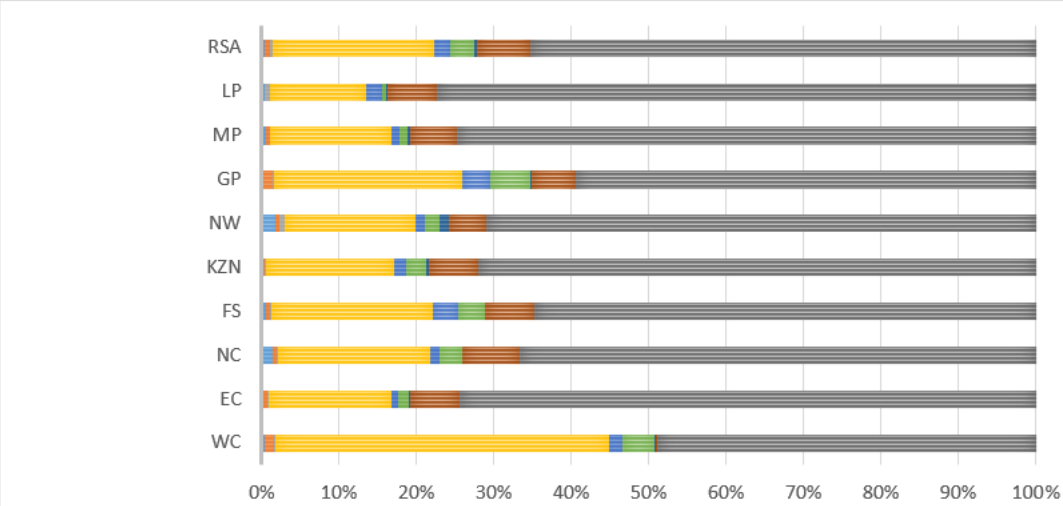
**Table 0.1: Services and Clinics available at Mshiyeni hospital**

| Services | | Clinics within the Hospital | |
|---|---|---|---|
| **District** | **Regional** | **Name** | **Service** |
| 24 hours Emergency Services | Anaesthesiology | Asthma clinic | **Paediatric Services** |
| Eye Care | Casualty/Emergency Services | Cardiac clinic | |
| Family Medicine | Gynaecology | Epilepsy clinic | |
| HIV/AIDS Management | ICU/High Care | Genetic clinic | |
| Mortuary Services | Internal Medicine | PHC clinic | |
| Mental Health | Obstetrics | Special need clinic | |
| Obstetrics | Operating theatres | Thokomala clinic (HIV & ARVs) | |
| | | | |
| Paediatrics | Ophthalmology | Cardiac clinic | **Medical Out-patients** |
| Pharmacy | Orthopaedic Surgery | Chronic clinic dealing with: cardiac, epilepsy, hypertension, plastic surgery, wound care, and asthma on designated days. | |
| Primary Health Care | Psychiatry & Mental Health | ECG clinic | |
| Radiology | Radiology& diagnostic | Echo clinic | |
| Rehabilitation | Specialised OPD | ENT clinic | |
| Surgery | Surgery | Eye clinic | |
| | | Leprosy clinic | |
| | | Skin clinic | |
| | | Warfarin clinic | |

**Source:** (KZN Department of Health, 2014)

The socio-economic profile of Umlazi Township is not unique; other townships and rural areas share similar living standards and livelihoods. Figure 1.1 presents an outlook from a national survey that questioned the type of healthcare facility individuals use in cases of natural illness or injury and found out that most South Africans relied on public healthcare. Moreover, the 2019 mid-year household survey reported that out of the 58.8 million people of SA, only 10.1 million had medical aid coverage (Statistics South Africa, 2019, p. 25). Figure 1.2 depicts a racial breakdown of the people with medical aid schemes, of which most are in Metropolitan municipalities. Mshiyeni hospital primarily serves vulnerable and low-income communities. The surrounding community and taxi rank in the hospital's vicinity lack essential services such as water and sewerage, leading to reports of local community members accessing water in the hospital (News24, 2017).

**Figure 0.1: Preferred type of healthcare facility first consulted by household members during illness or incident**

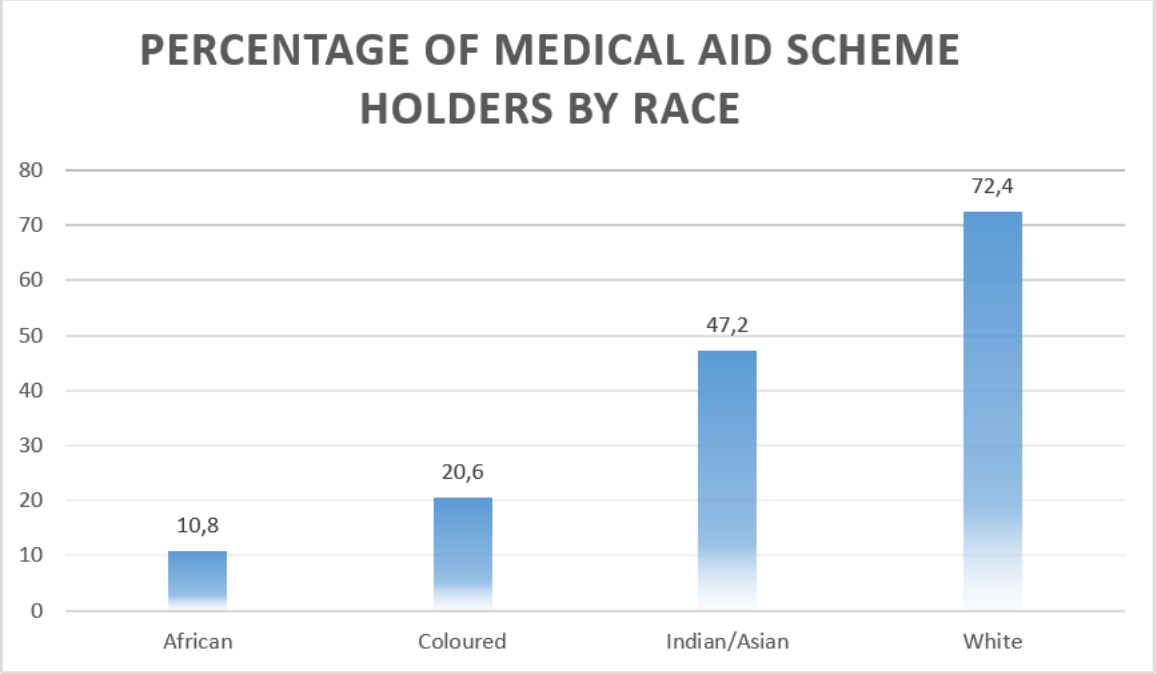



| | WC | EC | NC | FS | KZN | NW | GP | MP | LP | RSA |
|---|---|---|---|---|---|---|---|---|---|---|
| Other | 0,3 | 0,2 | 1,3 | 0,5 | 0,2 | 1,8 | 0,2 | 0,6 | 0,3 | 0,4 |
| Pharmacy | 1 | 0,5 | 0,6 | 0,5 | 0,1 | 0,4 | 1,2 | 0,4 | 0,1 | 0,6 |
| Traditional healer | 0,2 | 0,1 | 0,1 | 0,2 | 0,2 | 0,7 | 0,1 | 0,1 | 0,7 | 0,3 |
| Private doctor | 37,2 | 15,9 | 19,8 | 20,9 | 16,6 | 17 | 24,4 | 15,7 | 12,4 | 21 |
| Private cleaner | 1,5 | 0,9 | 1,2 | 3,2 | 1,5 | 1,2 | 3,6 | 0,9 | 2 | 2,1 |
| Private hospital | 3,7 | 1,4 | 2,9 | 3,6 | 2,7 | 1,8 | 5,2 | 1,2 | 0,6 | 3,1 |
| Other public institution | 0,1 | 0,2 | 0 | 0 | 0,3 | 1,2 | 0,2 | 0,2 | 0,1 | 0,2 |
| Public hospital | 13,70% | 6,3 | 7,4 | 6,3 | 6,4 | 4,9 | 5,7 | 6,1 | 6,5 | 6,9 |
| Public clinic | 42,3 | 74,5 | 66,7 | 64,9 | 72 | 71,1 | 59,4 | 74,9 | 77,4 | 65,4 |

**Source:** Adapted from (Statistics South Africa, 2019, p. 24)

Additional to being resource-constrained, the public healthcare system in SA is overly burdened with communicable and non-communicable diseases (World Bank, 2020). Human immunodeficiency virus (HIV) is an example of one of the most prevalent diseases in the country. In 2021, 8.2 million people reportedly lived with HIV (Statistics South Africa, 2021). The KwaZulu-Natal (KZN) province was marked as the epicentre because it had the highest HIV prevalence in the country, especially among young women (Kharsany, et al., 2019). Umlazi Township has the highest HIV prevalence in the KZN province (Human Sciences Research Council, 2018). Most people living with HIV in KZN are on treatment (Ritshidze, 2021). Effective and efficient leadership is essential in this hospital; undoubtedly, strategic leadership in public hospital management is imperative.

**Figure 0.2: Race categorisation of people on medical aid schemes in SA- percentage distribution**




**Source:** (Statistics South Africa, 2019, p. 26)

In a cross-sectional study on risky sexual behaviours among women of reproductive age in this highly burdened township, Hlongwa et al. (2020, p. 2) asserted that Umlazi has 10 public clinics. These clinics serve more than 50 000 patients each month, and the Township has only one public hospital. The health access operating system requires patients to first visit clinics, especially those closer to their homes, before going to the hospital. Figure 1.1 also reiterates findings on the type of healthcare facility people visit first when they get ill or have accidents (Statistics South Africa, 2019, p. 24). These findings indicate that public clinics are the leading health institutions that communities consult in cases of illness or accidents across all the provinces of SA.

The 17 clinics at Mshiyeni hospital are the busiest in Umlazi Township. This hospital's public healthcare system is overwhelmed and overly burdened by the expected service. The hospital plays a considerable role, and direct or out-of-pocket costs for healthcare services would disadvantage many in its absence. Despite the importance of public healthcare services in the country, overwhelming evidence suggests that SA public healthcare is compromised by various constraints and challenges that disrupt the delivery of quality healthcare (Maphumulo & Bhengu, 2019).

The complex issues challenging public hospitals, accompanied by the significantly sizable population and prevalence of diseases such as HIV, TB, diabetes and poverty in communities, indicate that leaders and managers have a demanding responsibility. A strategic leadership style and consideration of change management are essential to effect and strengthen the hospital healthcare system. Edwards and Saltman (2017) argued that public hospitals are known to be difficult to implement improvement reforms. Leadership, specifically from a strategic perspective in public health institutions, is undeniably an instrumental element of a robust healthcare system. Therefore, leaders who can deliver their management strategically in complex environments and maintain efficiency in delivering quality health in a rights-based health system are necessary (Gilson & Daire, 2011). This study assessed whether there is an association between strategic leadership and positive hospital performance. This was done through probing into the role, influence, or effect of strategic leadership and the importance of change management on the hospital's leadership within the context of a fast-paced turbulent.

### 1.3 Problem Statement

In SA, public healthcare service is a constitutionally stipulated human right. The Constitution of the Republic of South Africa (1996, p. 11) stipulated that everyone has a right to access healthcare services, including reproductive health. The Constitution further emphasises the right to equality, affordability, and quality in the provision of public healthcare (Department of Health, 2020b, p. 4). The DoH is responsible for administering the public healthcare system in the country. Through policies, frameworks and strategies such as the National Health Act (Act No. 61 of 2003) or the White Paper for the transformation of the health system, the DoH understand its responsibility, and it has committed to render efficient service in respect of the people's right to healthcare (Department of Health, 2009).

The efficient delivery of quality healthcare services is of utmost priority for public healthcare facilities. Therefore, public hospitals are tasked with offering healthcare services successfully and productively. Nationally, about 83% of the entire population of SA relies on public healthcare. In addition to servicing the masses, public healthcare faces several challenges: lack of resources, shortage of medical professionals, ageing infrastructure, and unemployment (Ngobeni, et al., 2020; Lencoasa, et al., 2022). There is a growing concern about the state of public healthcare capacity, efficiency, and capability of sustainable service delivery as SA demonstrates poor health outcomes worse than any low-income country, yet SA is a middle-income country (Coovadia, et al., 2009; Mayosi & Benatar, 2014; Ngobeni, et al., 2020). Given

the high level of obligation and demand, the DoH gets a significant budget allocation from the National Treasury. In the 2022/23 financial year, the expenditure budget allocated for health is R259 billion, of which R115.7 billion is allocated to the district health services and R11.1 billion for maintenance and facilities management (National Treasury, 2022, p. 62).

Despite the constitutional mandate, healthcare policies, frameworks, significant budget allocation and expenditure, public hospitals and clinics remain overly burdened, pressured by high reports of inefficiency, poor outcomes, unsatisfactory performance, and bad public reputation (The Presidency, 2018; Public Service Commission, 2018; Competition Commission, 2019; Ngobeni, et al., 2020). This warrants a qualitative enquiry into the role of strategic leadership within the ever-changing context of the public health system and its institutions. It is the responsibility of leaders to optimally render health sector demands and ensure that the realisation of healthcare service outcomes in public hospitals is achieved. Strategic leadership is one of the effective tools for efficient management, and its effect on managing complexities, shocks and various forms of turbulence and its efficiency is well documented in the literature. However, there are limited studies on strategic leadership in public hospital management, specifically in emerging economies, both locally and internationally. Thus, it results in a lack of evidence-based and peer-reviewed literature on strategic leadership context-specific to public hospitals.

In 2016, Mshiyeni hospital was one of the four KZN public hospitals included in a Ministerial Task Team (MTT) enquiry commissioned by the former Mister of Health, Dr P.A. Motsoaledi. The MTT assessment report raised issues of hospital neglect, poor infrastructure, ward overcrowding, and poor location (News24, 2017). Furthermore, Mshiyeni hospital was also one of the KZN public hospitals assessed during the Service Delivery Inspections by the Public Service Commission (PSC). The PSC reported challenges such as slow patient flow leading to extended waiting times, especially in the pharmacies, poor infrastructure, and lack of professional ethics in some employees, supply chain, procurement, and shortage of staff in laundry service as the main challenges affecting public hospitals in KZN (Public Service Commission, 2021).

Authors such as Hao and Yazdanifard (2015) argued that “leadership is one of the main factors in bringing positive change to the organisation; if there is no leadership in the organisation, they will not be able to change in the direction they desire and could experience negative

change instead" (p. 1). An analysis of strategic leadership and change management based on experience and practice must be made to pinpoint and signpost their effect on public hospital management, enact recommendations, and add to the existing body of literature. Without research into strategic leadership in public hospital management, it will be challenging to determine whether strategic leadership can be considered key in managing, maintaining, and reaching hospital objectives and outcomes in this ever–evolving volatile era.

## 1.4 Aim of the Research

This study aimed to investigate the role of strategic leadership and the importance of change management at Mshiyeni hospital. In doing so, to determine the impact of strategic leadership and change management on hospital management and performance in this era of unpredictable constant change.

## 1.5 Research Objectives

The objectives of this study were:

i. To assess the existential strategic leadership style at Prince Mshiyeni Memorial Hospital.
ii. To determine the impact of strategic leadership style on organisational performance.
iii. To investigate the perceptions of leaders on change management in public hospital management.
iv. To examine how the hospital can improve the strategic leadership and management style in this rapidly changing era for effective and efficient performance.

## 1.6 Main Research Questions

Below are the research questions of this study, and there are sub-questions under each question as per the Interview Schedule (Appendix 1).

i. What are the existing strategic leadership styles at Mshiyeni hospital?
ii. What is the impact of the existing strategic leadership on performance and service delivery?
iii. Considering the volatile nature of the modern era, what changes has the hospital management experienced?
iv. What are the systems or strategies used by leaders to address change or disruptions?

## 1.7 Justification for the Study

Studies show that leadership is essential and can dictate organisational performance (Robbins & Judge, 2013). Literature also posits that effective leadership strategies can lead to successful organisational performance. In the past two decades, researchers started to pay attention to strategic leadership, which many have viewed as an important factor of organisational success (Daft & Lane, 2005). Despite having an undeniable significance to effect positive organisational outcomes, there is a shortage of literature on leadership strategies and their effectiveness in the hospital environment - particularly strategic leadership in public hospitals in developing countries and that gap in literature will be attempted to be systematically and methodologically addressed by this study.

Time and again, local studies on public healthcare institutions have revealed that most SA public healthcare institutions are challenged in management and leadership astuteness and resource-constrained. They face various setbacks that halt the delivery of the promised quality and efficient healthcare service. Authors such as Maphumulo and Bhengu (2019) have argued that improvement in quality healthcare in the national healthcare system refers to limitation of errors, decrease in care delivery delays, and efficiency. However, studies have not focused on the public hospital environment, strategic leadership behaviours, styles, and activities.

Leaders are responsible for navigating through complexities and developing strategies that will allow their organisations to succeed regardless of whether they are for-profit or non-profit (Slawinski, 2007, p. 297). Therefore, public hospitals' leaders and managers can play a crucial role in improving their organisations' desirable performance. Given that public hospitals operate in an increasingly opaque, complex and ambiguous environment on top of the other challenges affecting public hospitals in general, this study responds to the lack of evidence-based literature on strategic leadership context-specific to public hospitals. This study is significant because it can test the perceived association between strategic leadership, change management and hospital performance. The final output of this study will address the gaps in the literature on strategic leadership in public hospitals and contribute to the existing body of knowledge on strategic leadership within the agile, adaptive and changing context.

## 1.8 Overview of Research Methodology

The research methodology describes the data collection and analysis method. Creswell (2014) explains that a research method describes how the research is done, how the information is collected, and how the collected data will be analysed. Two commonly used research methodologies are qualitative and quantitative data collection and analysis approaches as well as mixed methods which is a complementary approach of the two methods. This study employed the qualitative method. Qualitative research takes an interpretive and inductive-oriented approach; it uses words and images instead of numbers that will seek to generate meaning and theory construction, whilst quantitative research employs statistical or numerical hypothesis testing of data collection and analysis (Berg & Lune, 2011; Creswell, 2014).

Qualitative research has become common in various disciplines, such as business management and organisational research, which were previously founded upon objectivity, numbers, and quantification (Cassell, et al., 2019, p. 3). Berg and Lune argued that "qualitative research properly seeks answers to questions by examining various social settings and the individuals who inhabit these settings" (2011, p. 8). Given that this study aimed to understand strategic leadership and change management as experienced by participants, fifteen middle and senior managers from Mshiyeni hospital were used as a sample.

Qualitative research uses various data collection techniques, including observations, interviews, focus groups, and questionnaires (Creswell, 2007; Creswell, 2014; Eshun-Wilson, et al., 2019). This study employed purposive sampling to select key middle and senior hospital management participants and collected data through semi-structured interviews. Arnold and Lane (2011, p. 690) defined semi-structured as open-ended uncontrived questions or topics that can allow the responses to broaden into relevant unanticipated areas. Semi-structured interviews do not follow a sequential list of pre-decided questions.

According to Flick (2018), qualitative research allows researchers to address complex questions and answer them in different ways without dealing with variables, treatment, or hypothesis testing. Furthermore, qualitative research studies things in their natural setting and makes sense or interpretations based on the meanings and worldviews of the participants (Given, 2012). Most importantly, data analysis from well-established patterns and themes, the research output of a qualitative methodology should present the participants' voices, the reflexivity of the researcher and a thorough analysis interpretation of the problem and extend

the literature or call for action (Creswell, 2007, p. 37). The study employed a thematic data analysis method. The nature of the research topic in this research enquiry positioned this study within the interpretivist paradigm. Epistemologically, ontologically, and axiology interpretivism position is the belief that reality is relative and multiple (Hudson & Ozanne, 1988).

Moreover, Angen (2000) argued that the interpretivist paradigm posits reality based on the social and experiential construct developed through meanings and understanding drawn from reality. Observation and personal experience can be argued to inform a person's understanding and knowledge. This study applied an inductive approach drawing from relevant leadership theories. Inclined to the hypothesis that the volatile modern era challenges are tremendous, strategic leadership and management are even more remarkable.

## 1.9 Scope of Study

The SA Constitution and the Bill of Rights stipulate that all citizens have a right to basic healthcare services (South Africa, 1996). Approximately 84% of the South African population relies on the public healthcare system (Chu, et al., 2020; Statistics South Africa, 2021). In fulfilling this constitutional provision, public healthcare services are offered to all citizens regardless of their social, racial, or economic status in public hospitals and clinics. The SA public healthcare service is categorised into a level system, with the first level being the primary health care clinics (PHC), community health centres (CHC) and district hospitals (Chu, et al., 2020). The second level consists of regional hospitals, and the third level is provincial tertiary hospitals and central or specialised hospitals that provide higher levels of care (Chu, et al., 2020; KZN Department of Health, 2021).

Given the significant role of the public healthcare sector, researchers need to focus on leadership and its contribution to public hospitals' operation, service, and performance. This study was conducted in one of the regional hospitals in KZN; therefore, the study outcomes should not be generalised to all public hospitals in KZN. In this study, leadership and management are viewed as equally relevant and interrelated concepts based on the roles and responsibilities of the participants in this study. This viewpoint is drawn from Ayeleke et al. who argued that "in the health care sector, the term *leadership* is closely associated, and often used interchangeably, with *management* because both management and leadership are seen as being relevant to health care services" (Ayeleke, et al., 2018, p. 84).

Hospitals are generally complex organisations to change, and public hospitals are even more so because internal operations are controlled externally in various countries, especially financial circumstances (Edwards & Saltman, 2017, p. 2). External circumstances include political and intra-institutional, as public hospital leadership is policy-driven, not autonomous at the hospital level (ibid.). For instance, hospital-level leadership is informed by national and central government and policies in SA. Despite these external driving forces, it can be argued that day-to-day operations or performance is dependent on the hospital-level managerial or leadership behaviours and approach.

The delivery of quality service efficiently and effectively can hardly be subjected to the political, central policy or administration or departmental bureaucracy rigidness as operations' work ethic and culture can be shaped at the hospital level. In the context of this study, the author agrees with Gilson and Daire, who argued that "leadership is a necessary element of strong health systems, and so it is vital that SA nurtures and sustains leaders who can work strategically within their complex environments to develop a rights-based health system that promotes health equity" (Gilson & Daire, 2011, p. 69).

### 1.10 Outline of the Dissertation

**Chapter 1 - General Introduction:** This chapter introduces the study and presents a detailed research background. The problem statement, the study objectives, questions, the methodological approach, and a breakdown of the organisation of the study are outlined in this chapter.

**Chapter 2 - Literature Review:** This chapter presents literature from secondary sources of data such as academic journals, books, reports, and online news articles on the subject matter of this study.

**Chapter 3 - Research Methodology**: This chapter discusses the research methodology, research design, sampling and the data collection method employed in this study. Discussions on validity and ethical considerations are covered in this section.

**Chapter 4 - Presentation and Discussion of Findings**: This chapter unpacks a detailed analysis of the research findings. It interprets the collected data contextualised with the study's objectives and questions.

**Chapter 5 - Recommendations, Conclusions, Managerial Implications and Future studies**: This chapter summarises the study findings and concludes whether the study objectives were met. It further provides recommendations and suggestions for further research.

## 1.11 Chapter Summary

This chapter presented a background of the Mshiyeni hospital and a brief profile of the national and local states of the public healthcare system. The background and problem statement acknowledged that public healthcare provision is a constitutional right for all citizens. Due to socio-economic development challenges, most of the population relies on public healthcare. This chapter briefly highlighted the role of public hospital leaders in navigating these challenged and resource-constrained institutions towards successfully rendering health sector demands effectively and efficiently. The chapter also outlined the objectives, research questions, research methodology, significance of this study, and the study scope.

# CHAPTER TWO: LITERATURE REVIEW

## 2.1 Introduction

The literature review is an important and fundamental section of a dissertation; it provides a presentation, analysis, and summary of the body of knowledge within the topic of the study (Arshed & Danson, 2015). A comprehensive literature review provides a robust background on the subject, includes existing literature, and identifies gaps or inconsistencies in the chosen research interest. The authors further argued that the literature review aims "to educate oneself in the topic area to understand the literature before shaping an argument or justification" (Arshed & Danson, 2015, p. 31). This chapter analyses and summarises the literature on strategic leadership and change management to determine their effectiveness in hospital leadership with cognate identification of the gap in the relevant scholastic literature. The researcher consulted peer-reviewed academic journals, academic books, online newspaper articles, and official government reports to draw understanding, interpretations, theoretical framework, and conceptualisation to respond to this study's problem statement, objectives and questions.

## 2.2 Definition of Key Concepts

### 2.2.1 Strategy

Literature in strategy has a long tradition, and it stems from various disciplines and contexts, including business, management, and the military (Simeone, 2020, p. 516). For instance, in the military, strategy refers to a general attack or defence planned and arranged in advance (Nickols, 2011). In the context of business, strategy refers to the arranging and deployment of resources and formulation of a general plan for action to achieve organisational goals and objectives (Nickols, 2011). Management and business studies scholars describe strategy as "a coherent, unifying, and integrative pattern of decisions" (Hax & Majluf, 1988, p. 102; Simeone, 2020, p. 516). Moreover, strategy can be defined as "the determination of an enterprise's basic long-term goals and objectives and the adoption of courses of action and the allocation of resources necessary for carrying out these goals" (Chandler, 1962, p. 13). The core of strategy work is centred on discovering the critical factors in a situation and designing a way of coordinating and focusing actions on dealing with those factors (Rumelt, 2011, p. 3; Simeone, 2020).

The concept of strategy is critical in organisational success because, in leadership, strategy is crucial as it can guide, shape and structure actions. As the 21st century presents a greater magnitude of change than ever globally, these changes directly impact businesses and organisations as changes take away certainty, control, and stability (Swayne, et al., 2006). Leaders set the direction, project and foresee what lies ahead, and visualise what can be achieved while also facilitating the provision of encouragement and inspiration (Bush, 2012, p. 1328). Therefore, employing strategy in thinking, planning, management, decision-making, problem-solving, coordination, and leadership enables leaders to achieve intent in a planned, easy-to-monitor and goal-oriented manner that is performance oriented or results-driven.

### 2.2.2 Leadership

Leadership as an act and a process is as old as civilisation, and it is one of the foundations of human progress because of its facilitation of people's capability to collaboratively work together toward civilisation (Bhattacharyya & Jha, 2018, p. 1). Leadership defines the process-oriented, non-specific practices of challenging the process, inspiring a shared vision, enabling others to act, modelling the way, and encouraging the heart (Klingborg, et al., 2006; Fry, 2003).

According to Daft (2018, p. 5), leadership can be defined as "an influence relationship among leaders and followers who intend to effect real changes and outcomes that reflect their shared purposes". It can be argued that the absence of singularity in Daft's definition points out that leadership is not unilaterally about one person controlling and telling a group of people how to operate. Instead, it is a two-way process between followers and leaders, both working towards accomplishing their organisational goals or targets. Concurring with the Draft's definition, Northouse posits leadership as a "process whereby an individual influence a group of individuals to achieve a common goal" (2016, p. 6). Furthermore, leadership is "the art of persuading a follower to want to do the things, activities, which the leader sets as goals. Therefore, the role of leaders is in the process of directing the individual's behaviour towards the desired goal" (Mihelič, et al., 2010, p. 32).

Bush stated that "leadership is a process by which one person influences thoughts, attitudes, and behaviours" (2012, p. 1328). In this manner, leadership is a shared responsibility whereby all staff, irrespective of role, function or authority level, demonstrate appropriate behaviours for the success of the organisation and service delivery (Siddiq & Zaman, 2016, p. 58). Studies show that leadership quality directly impacts the quality of service or organisational

performance (Klingborg, et al., 2006). As leadership involves leading and following, those who lead are expected to act and behave in a manner that will be positive for the organisation. This expectation is crucial as followers walk in the shoes of their leaders and follow the skills and knowledge application shared by leaders (Sharma & Jain, 2013).

Leadership has evolved over the years. Historically, leadership was characterised by position and was centred on a charismatic individual leader. However, today leadership can be described as a role one moves continuously into and out of, depending on the circumstance (Klingborg, et al., 2006). For instance, characteristics of modern leaders include team building, creative and strategic thinking, principles of honesty and integrity and the ability to motivate others to action. Ideally, "today, organisational goals are pursued by people who move rapidly between leading and following roles" (Klingborg, et al., 2006, p. 280). Leadership is no longer rigidly about commanding people to work harder or faster; instead, leadership is about unblocking the people's capacity to adapt, innovate and reinvent their organisation (Bush, 2012, p. 1328).

Ordinarily, leadership and management tend to be confused and used interchangeably; however, they vary in meaning. According to Sharma and Jain (2013, p. 309), as much as leadership and management are not the same things, they are linked and complementary and must go hand-in-hand. Leadership is about inspiring, motivating, vision creation and coping with change. On the other hand, management is focused on planning, controlling, organizing, coordinating, and implementing strategies and actions laid out by leaders whilst aligning with the vision created by leaders (Sharma & Jain, 2013; Robbins & Judge, 2013). Klingborg et al. (2006, p. 281) argued that leadership and management are complementary and interrelated, they have overlapping attributes, they are interdependent, and they are both essential for effective leadership. Robbins et al. (2003, p. 242) argued that it is commonly accepted in the literature that all managers have a collaborative leadership and managerial functions. Arguably, in practice, managers are responsible for leading organisations to efficiency.

According to Swayne et al. (2006), leadership is an inevitable and undeniable necessity to cope with constant changes in the healthcare sector; if hospitals want to succeed, they must have leaders who understand internal and external sources of change and build coping strategies. Today's environment demands more effective leadership throughout the healthcare system (Klingborg, et al., 2006). Moreover, the healthcare sector has been undergoing rapid and significant changes and operating in a challenging environment has called for advancement in a leadership capacity. Rust and de Jager (2011, p. 2278) argued that "leadership in hospitals,

in general, and particularly within provincial hospitals in South Africa, experiences challenges and difficulties. Actually, the entire public sector industry is searching for an appropriate and sensible model" (ibid.). Therefore, public healthcare organisations must ensure awareness and adopt leadership approaches that can enable the efficient provision of exceptional patient care despite the challenging and constantly changing environment (Siddiq & Zaman, 2016).

### 2.2.3 Effective Leadership

Defining effective leadership is not easy because this concept is complex, and it tries to capture myriad components such as various organisational contingencies and personal and interpersonal behaviours in their variety (Cooper & Nirenberg, 2004). Defining the concept, Cooper and Nirenberg (2004, p. 1) stated that leadership effectiveness is "the successful exercise of personal influence by one or more people that results in accomplishing shared objectives in a personally satisfying way to those involved." According to Hao and Yazdanifard (2015), effective leadership is one of the most critical parts of the overall method for organisations to sustain their business even in the face of challenges caused by rapid economic and environmental growth. Furthermore, Rust and de Jager (2011) posit that effective leadership is a common goal for all public hospitals. Therefore, it can be argued that if leadership strategies and style successfully yield positive outcomes for the organisation, it is characterised as effective leadership. Leadership that works and helps an organisation meet objectives, improve productivity, service delivery or performance and yield mandatory desired results defines leadership effectiveness.

Rust and de Jager (2011) argued that the critical component of effective leadership is selecting the best leadership style fitting the current circumstances of an organisation, which is challenging. The outcome is that "an effective leadership style will necessitate a successful partnership and teamwork between individuals, organisations, politicians, healthcare professionals and other stakeholders within the complex network of public health" (Rust & de Jager, 2011, p. 2279). Organisations comprise diverse people with various backgrounds, beliefs, cultures, idiosyncrasies and attitudes. These differences, coupled with other organisational demands and the constant global and economic changes, make leadership challenging and complex. Hence the need for suitable and effective leadership which considers that "leadership is a people-centric activity that occurs among people; rather than being something done to people" (Daft, 2018, p. 6).

According to Hrivnak Jr et al., “effective leadership is commonly believed to be an essential element of organisational success” (2009, p. 456). Therefore, effective leadership can lead organisations to success, while poor leadership sets organisations towards failure. Effective leadership leads and drive changes across all levels of the health system to actualise the objectives of healthcare organisations (Ayeleke, et al., 2018, p. 83). It should be noted that leadership is not a one size fits all process. Leadership styles differ considerably, and effective leadership can be achieved when an organisation has identified the leadership style, model, or approach that works for its people. The bottom line is that organisations need strong leadership and management for optimal effectiveness (Robbins & Judge, 2013, p. 368).

### 2.2.4 Strategic Leadership

Organisations need strategic leaders in this highly globalised world where complexity, unpredictability and uncertainty are the norms. Over the years, the definition and understanding of strategic leadership have evolved and moved with time and context. Originally, strategic leadership was considered to be a process or practice privileged to the highest management level in the organisations (Cyert & March, 1963). This viewpoint of strategic leadership resonated with the traditional thinking of leadership, which provided that top managers handle strategic matters, implying that middle and lower-level managers deal with operational matters only (Cyert & March, 1963; Crossan, et al., 2008). For instance, Hambrick and Mason (1984) characterised strategic leadership as characteristics or traits of top management team members. Hambrick and Mason (1984) drew influence from strategic management literature and implied that strategic leadership belonged to the dominant coalition.

Daft and Lane (2005) argued that the focus on top-level management in traditional leadership approaches and theories was because top-level managers hold the decision-making responsibilities that affect the whole course and performance of the organisation. Schendel (1989) postulated that there was sufficient evidence pointing to operating leadership differing from strategic leadership because of the variation of responsibility and scope held in the different leadership levels in organisations. Post the mid-1980s, the domination of strategic leadership and traditional macro-level leadership focus began to shift, and this concept’s conceptualisation became versatile. As the world became more competitive, studies began to move towards the idea that organisations need increased flexibility, innovation, adaptability, and strategic approaches to leadership that can effectively synch with today’s existential complex and constantly changing environment (Orchard, 1998). Researchers began to

investigate the strategic role and impact of leadership in organisations' successful performance (Judge & Piccolo, 2004; Keller, 2006).

Challenging the traditional approach to strategic leadership, some researchers emphasised that it is about influence; therefore, managers can exercise it across all hierarchical levels (Crossan, et al., 2008; Hitt, et al., 2010). These authors argued that the modern-day dynamic demands required strategic leadership at all organisational levels arguing that an open-minded approach or shared responsibility leadership was strategic (Crossan, et al., 2008). In this way, strategic leadership takes advantage of competitive opportunities that develop rapidly in the new competitive landscape. It provides organisations with enough flexibility and agility to strategically improve present efficiency whilst maintaining future competitiveness (Ireland & Hitt, 1999, p. 52).

In the contemporary context, strategic leadership refers to a leadership approach that continuously evolves with emerging economies. Whereby strategic leaders keep up with the business landscape context, which involves acknowledging market dynamics, technology, globalisation, cultural adaptability, regulatory frameworks, and innovation (Bhattacharyya & Jha, 2018). In this manner, strategic leaders use approaches that accepts the complexity of change and infuse it into the implementation agenda of sustained capacity and competency to operate in volatility without sustaining organisational inefficiency (Taylor-Bianco & Schermerhorn, 2006, p. 459). Moreover, strategic leadership define various types of strategic activity characterised by strategic alternatives performed by senior managers in organisations (Yardan & Aydin, 2018, p. 877). Fry (2003) adds that strategic leadership prioritises vision, motivation and control through values or adaptability behaviours in leadership.

Strategic orientation is one of the essential and fundamental factors in strategic leadership. According to Davies and Davies (2007, p. 30), strategic-oriented leaders can link the future or long vision with daily work. They understand the organisation's currently existing context, see a bigger picture, and develop a clear direction for the organisation. Moreover, strategic leadership is holistic; as it involves influencing organisational or internal elements and external ones as well (Rowe, 2001). Davies and Davies (2007, p. 30) presented nine factors associated with strategic leadership. These factors illustrated in Figure 2.1 are activities or behaviours that strategic leaders can do.

According to Rowe, "strategic leadership is the ability to influence others to voluntarily make day-to-day decisions that enhance the long-term viability of the organisation while at the same time maintaining its short-term financial stability" (2001, p. 81). Given the traditional and contemporary conceptualisation of strategic leadership, it is important to note that the researcher adopts the contemporary view of strategic leadership in this study. This study aligns with the characterisation of strategic leadership as the ability to invest in planning, visioning and exploiting available competencies and resources to maintain current efficiency while simultaneously considering long-term success despite turbulence and change (Levinthal & March, 1993; Rowe, 2001; Hitt, et al., 2010). The researcher believes that in the context and state of the public healthcare system in SA, which is affected by several impediments and challenges, the above-selected characterisation of strategic leadership is essential and fitting.

**Figure 0.1: Strategic leadership activities and behaviours**


**Source:** (Davies & Davies, 2007, p. 30)

### 2.2.5 The Concept of Change

Today, "there is no word that is so magical and mysterious except the word 'change'. It is even considered as something that is ubiquitous, indispensable and eternal in this world'' (Iskandar, 2019, p. 28). Iskandar's characterisation of change is justified because, currently, the world operates in a space of complexity, uncertainty, fast-growing change, and unpredictability. According to Oliver (1997), change refers to any form of transition from a known state or phase becoming different. Defining the change concept further, Oliver explained that change results

from either internal or external forces that create a need for change. Moreover, Stobierski (2020) stated that the concept of change within the organisational context refers to any alterations of major components of the organisation, such as the organisational culture, internal processes, or technologies.

Change in organisations ranges from small initiatives to large-scale or administrative transformations (Fernandez & Rainey, 2006; Doğru, 2016). For instance, during the outbreak of the COVID-19 virus, the pandemic was an external factor that forced most organisations to digitalise some operations, such as virtual meetings, working from home and on-line interactions. Change is the order of the day in today's organisations, the associated external environment, and the elements of change are substantial (Doğru, 2016). Commitment to continuous change is expected; it is ever-present as the goal (Taylor-Bianco & Schermerhorn, 2006, p. 458). As much as change can be overwhelming and uncertain, thus causing redirection or new processes, it must be accomplished without compromising organisational performance (Taylor-Bianco & Schermerhorn, 2006). An expert in the literature on change, Rosabeth Moss Kanter (1983), emphasised that organisations need to be continuously innovative if they want to succeed in this change-prone environment.

Health institutions are no different; they also suffer similar yet peculiar to their sector change effect. Health systems worldwide function in the constantly changing local and global ecosystems. Resulting from economic, demographic, governance, and technological changes, among others (Schneider, 2020, p. 1). In addition, public healthcare systems must balance the right to health with the substantial change elements. Çalişkan asserts that "the ability to change is the greatest competitive advantage for the future in organisations" (Çalişkan, 2018, p. 803). "Along with change, in today's fast-paced competition, today's organisations will be able to survive only if they adapt to their changing environment. This adaptation effort appears to be one of the most important problems health institutions face" (Çalişkan, 2018, p. 803).

It can be argued that the success or failure of organisations relies on the hands of leaders and managers, policy-makers, authorities, and technocrats, as they are responsible for accomplishing objectives and outcomes. This argument is supported by Çalişkan, who states that "in our time wherein rapid developments and changes occur, it is profoundly important and critical that healthcare institutions find leaders with a strong inner compass" (Çalişkan, 2018, p. 874). To that end, one can argue that managing change demands strategic leadership

and management. Çalişkan argues that "organisations and managers who can adapt to change on time can have the chance to survive, while those who cannot are lost in this cycle of change" (Çalişkan, 2018, p. 803). This argument reiterates the importance of strategic leadership and its interconnectedness to managing change strategically to avoid poor performance in organisations. Agreeing with this standpoint, Bayin (2014) argues that change brings variables and the mitigation of vagueness and ambiguity in organisations that demand quick adaptation and necessitates greater management style flexibility, which connotes strategic leadership.

### 2.2.6 Change Management

Change occurrence in organisations requires attention and a careful approach to avoid adverse effects or take advantage of the change. Change management in organisations defines the consideration and understanding of change to develop efficient resolutions. It is a process of taking advantage of change which ordinarily includes reparation, implementation, and follow-through (Stobierski, 2020). Moreover, these three phases relate to the three stages of change management outlined by the experts from the Jakarta Consulting Group, namely the planning, implementation and management of change results stage (Susanto, et al., 2007). Planning or preparation refers to recognising factors that can push the organisation towards change and create a sense of urgency for all employees. Iskandar (2019, p. 29) cautions that change preparation or planning should occur while the organisation is still in a good state rather than when changes have begun affecting the organisation.

Change management is also defined as the method of initiating transformation activities in a planned and strategic manner to ensure that the changes relate to the organisational strategy (Dominguez, et al., 2015). Furthermore, Dominguez et al. (2015, p. 414) argued that "the sceptical paradox of change is that firms need stability and change at the same time to survive in their environment". Higgins (2000) shares similar beliefs and argues that leaders are expected to manage change and stability simultaneously and successfully in the modern day. Therefore, managing change requires a strategic approach. Supporting this argument, Kasali (2007, p. 4) highlighted that change management is not a basic application of changes such as new structures or technology. However, it involves changing the people's behavioural intentions and motivations and an overall perception and way of thinking in the organisation. It can be argued that Kasali's argument complements strategic leadership in change management.

According to Sturdy and Grey (2003), change and continuity can be successfully managed as coexisting factors rather than being taken as alternative factors. Furthermore, these authors argued that "it is imperative that today's managers embrace stability and learn to manage continuity if they want to survive" (Sturdy & Grey, 2003, p. 651). These arguments on simultaneous management of change and stability resonate with factors and processes of strategic leadership. They resonate because strategic leadership goes beyond merely infusing change into the organisation's vision, including developing a sustainable capacity for change implementation (Taylor-Bianco & Schermerhorn, 2006, p. 459). Additionally, Ireland and Hitt's (1999) definition of strategic leadership reflected the relationship between change management and strategic leadership. These authors postulated that strategic leadership is the "ability to anticipate, envision, maintain flexibility, think strategically, and work with others to initiate changes that will create a viable future for the organisation" (Ireland & Hitt, 1999, p. 43).

### 2.2.7 Volatility, Uncertainty, Complexity, Ambiguity (V.U.C.A.)

The nature of the modern world necessitates innovation and adaptability to manage and cope with headwinds and turbulences in a changing context. The 21st century has presented a greater magnitude of change than ever; these changes directly impact market sentiments, businesses, and organisations, taking away certainty, control, and stability (Swayne, et al., 2006). Moreover, Swayne et al. (2018) asserted that the fast-growing speed rate of change globally is disruptive in nature, and it has become the norm and the new normal; more than ever, it calls for a greater magnitude of leadership. Elaborating further, Çalişkan (2018) argued that in today's world, organisations often face changes due to various sources such as new developments, geopolitical factors, technological advances, innovation, globalisation of the economy, and widespread information. Organisations today operate in an environment consisting of volatility or unpredictability, uncertainty or pessimism, complexity or intricacies, and ambiguity or disharmony.

The acronym V.U.C.A. stands for "volatility, uncertainty, complexity, and ambiguity", which defines significant and prevalent changes within the external environment of an organisation which directly or indirectly affect the organisation's operations or functions (Simkova & Hoffmannova, 2021). Moreover, V.U.C.A. describes fast and chaotic changes that push for transformation, competence or skills update as organisations or project plans or operations

constantly outdate with new developments or changes (Nowacka & Rzemieniak, 2022). Examples of digitalisation, technological advancements, automation, crypto-currencies, artificial intelligence, e-commerce and globalisation are some of the causatives of V.U.C.A., which can also be characterised as expected in this modern age of the fourth industrial revolution (4IR). The 4IR refers to the era of technological revolution characterised by advances such as artificial intelligence, 3D printing, the Internet of Things (IoT), Big Data, cloud computing, generic engineering, and many other technologies (Schwab, 2016). It can be argued that both V.U.C.A. and 4IR are the core impetus of the fast phase of change and unpredictability of today's world. Given the state of this era and its demands, organisational leadership, management, approaches, and operational procedures are affected. Hence the significance of strategic leadership and change management.

Organisations, including public institutions such as hospitals, operate in this V.U.C.A. environment, which affects decision-making and strategic planning and negatively influences institutional performance or service delivery. Swayne et al. (2006), the United Nations Development Programme (2019) and Wishnia et al. (2020) explained that changes and new developments are being experienced intensely in recent years, citing environmental, political and economic changes directly causing changes in the healthcare sector. Taking the argument further, the examples of technology and digitalisation in hospitals, advances in information technology and communication processes, widening global markets, declaration of the V.U.C.A. world and the constant shocks of disease outbreaks such as the recent Covid-19 Pandemic. Considering that strategic leaders can analyse situations to determine their effects on the vision and objectives of healthcare organisations and provide a suitable organisational strategy (Carter & Greer, 2013; Bayin, 2014).

### 2.2.8 Innovation

Innovation is a commonly used concept in today's world. According to the Oxford English Dictionary (2002), innovation describes an introduction of something new such as an idea, method, or product (Soanes, 2002, p. 428). Explaining further, O'Sullivan and Dooley (2008, p. 3) argued that innovation help organisations to grow, and the growth could be in the form of profit, knowledge, human experience, efficiency, or quality. Moreover, innovation can be incremental or radical, and it can occur across all levels of the organisation (ibid.).

### 2.2.9 Public Hospital

The foregoing discussions have demonstrated that strategic leadership and change management enable organisations with a strategic advantage in today's competitive process, which is an inevitable process that healthcare institutions and managers must understand. According to Sekhar (2008), hospitals are healthcare organisations that offer preventive, curative or ameliorative, healing, therapeutic, palliative, or rehabilitative services. Hospitals are characterised by their operations, including services for out-patients, in-patients, general wards, emergency, intensive care units (ICU), operation theatre, and support services such as pharmacy, radiology and imaging, blood bank and laboratory (Sekhar, 2008, p. 48). Moreover, hospitals also include teaching, training, and bio-social research facilities for doctors, nurses, and other healthcare professionals (World Health Organisation, 2021).

Hospitals are categorised as public and private in terms of ownership. Public hospitals refer to government-owned and administered hospitals, while individuals or shareholders own private hospitals. As mentioned earlier in this study, the public hospital environment has proved challenging to manage concerning change because of internal and external control complexities (Edwards & Saltman, 2017). According to Arsaria et al. (2022), there is a great distinction between public and private hospital management; however, the efficiency of management determines the success of organisations. On the contrary, private hospital leadership approaches are precise; managers have increased autonomy to be more entrepreneurial and maximise quality service and efficiency to remain competitive and profitable. On the other hand, public hospital management takes on administrative approaches centred on or occupied by bureaucratic burdens, authoritative scope and adhering to regulations (Asaria, et al., 2022, p. 80).

Now more than ever, change is endemic across all dimensions of healthcare systems, pushing for policymakers and practitioners to balance rising public expectations, fast-advancing science and technology, changes in the burden of disease, and the resulting imbalances between supply and demand (Preker & Harding, 2003). Despite complexities, public healthcare systems operate amid all these changes; they must realise the common government service commitment of realising equity, efficiency, and responsiveness (ibid.). The researcher took the arguments mentioned above from Preker and Harding (2003); and Asaria (2022) to call for open-source innovative, out-of-the-proverbial box thinking, tactics and strategic approaches to public hospital management to induce efficient service delivery and satisfactory hospital

performances. The absence of profits in public hospitals should not jeopardise the central goal of efficiently providing quality healthcare, especially to those at the Bottom of the Societal Pyramid. Therefore, public healthcare professionals' professionalism, skills, work ethic, and motivation require strategic leadership.

## 2.3 Theoretical Framework

Leadership has a variety of theories and approaches. Daft (2018) presented six group categories of leadership theories: great-man, trait, behavioural, contingency, influence and relational theories; Table 2.1 briefly defines these theories. This study dovetailed from these leadership inventories of theories and was based on transformational, transactional, and contingency theories due to their relevance in strategic leadership and the complex nature of this volatile era. The selected theories for the study will offer alignment and reflection of the phenomenon the literature is attempting to illuminate the scholastic gap on.

**Table 0.1: Categorisation of Leadership Theories**

| Leadership Theories - Description and examples |
|---|
| **Great Man Theories** |
| Daft **(2018, p. 18)** defined great man theories as the oldest approaches in leadership studies which believed that leaders were naturally born with heroic leadership traits. According to this theory, great leaders had to be powerful men with great influence such as Napoleon Bonaparte. |
| **Trait Theories** |
| Moving from the great man leadership, in the 1920s, studies began to research specific traits or characteristics of leaders, such as intelligence or energetic individuals believed to be capable of leading organisations to success **(Daft, 2018, p. 18)**. Explaining further, Robbins and Judge **(2013, p. 369)** gave examples of charismatic and courageous leaders such as President Nelson Mandela, Buddha and Steve Jobs, the co-founder of Apple. Moreover, the then research studies failed to produce a specific list of traits that would always ascertain leadership success in leadership characteristics **(Daft, 2018; Robbins & Judge, 2013)**. |
| **Behavioural Theories** |
| Failure of early trait studies resulted in the late 1940s up to the 1960s led researchers to look into whether effective leaders could be identified by how they behaved **(Robbins & Judge, 2013, p. 370)**. There was a significant shift from trait approaches that believed the right leaders could be pin-pointed and selected to behavioural theories that believed people could be trained into influential leaders. For instance, some studies attempted to compare and differentiate the behaviour of effective leaders versus ineffective ones **(Daft, 2018)**. |
| **Contingency Theories** |
| Research studies shifted and considered the contextual and situational variables that possibly influenced leaders to be efficient with the idea that leaders can assess their situation and apply appropriate or fitting behaviours to effect success **(Daft, 2018)**. This approach to leadership introduced flexibility in thinking as it acknowledged that leadership could not be understood in a vacuum separate from the environment, situation, or state in which organisations operate. |
| **Influence Theories** |
| Influence theories focus on the level of influence between leaders and followers, believing that effective leadership results from leaders with inspiring, visionary, and charismatic leaders whose followers idolise and |

| |
|---|
| draw inspiration from **(Daft, 2018)**. Robbins and Judge **(2013, p. 379)** further explained that influence leadership approaches could occur outside formal leadership positions and gave examples of Martin Luther King Jr and Bill Clinton as individuals who portrayed extraordinary leadership abilities that inspired many. |
| **Relational Theories** |
| Since the late 1970s, studies on leadership approaches or theories shifted towards the leader and follower relational aspects. Research started to look at the contributions of leaders' influence on followers by empowering, motivating, and encouraging followers to achieve a shared vision **(Daft, 2018)**. The most prominent examples of relational theories are servant leadership and transformational leadership. |

**Source:** Adapted from (Robbins & Judge, 2013; Daft, 2018)

### 2.3.1 Transformational and Transactional Leadership

Transformational leadership is one of the leadership approaches which is crucial in strategic leadership and cognate change management. According to Northouse, transformational leadership is "concerned with emotions, values, ethics, standards, and long-term goals that assess followers' motives, satisfy their needs, and treat them as full human beings" (2016, p. 161). Giving further description, Luthans et al. (2015) asserted that transformational leadership is an innovative approach because it can change or transform the behaviour of employees as it allows leaders to inform change and empower followers to be effective enough to achieve organisational objectives or goals. Based on the above definition, it can be argued that transformational leadership is about leaders informing change and empowering and motivating followers to reach the organisational goals anticipatively.

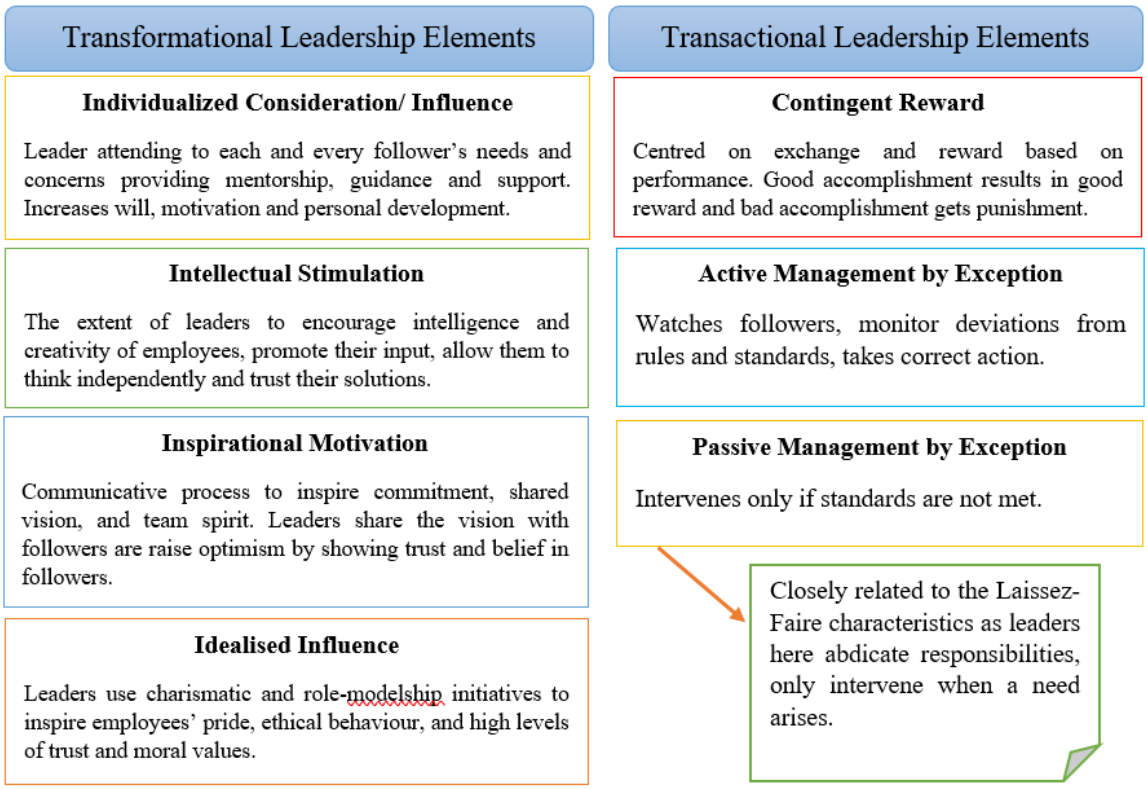
Luthans et al. (2015) stated that Burns introduced the concept of transforming leadership in 1987 and later expanded by Bass as a leadership style in 1978. Burns believed that a transformational approach to leadership entails a mutual relationship between leaders and followers who are motivated and driven enough to jointly advance the organisation to a higher level (Burns, 1978). This high commitment and devotion to performance is a transformed approach whereby leaders redesign employees' perceptions, values, and aspirations (Burns, 1978). Robbins and Judge (2013, p. 383) argued that transformational leadership is most effective when transformational behaviours are regularly used because followers perform exceptionally, resulting in higher productivity or work satisfaction.

Along with leadership transformation, Burns introduced transactional leadership and theorised that the transformational and transactional leadership approaches are mutually exclusive. Transactional leadership is a leadership approach centred on attaching rewards to the performance of followers (Goodwin, et al., 2001, p. 759). Meaning that employees are expected

to meet their contractual obligations and expectations and accomplish their duties to ensure the organisation meets its objectives. Moreover, Burns (1978) explained that transactional leadership does not ordinarily strive for cultural change; it uses the existing culture and focuses on the performance of employees. Figure 2.2 presents individual transformational and transactional leadership components outlined by Bass and Avolio (1994).

Bass (1985) expanded Burns work and changed the concept from transforming leadership to transformational leadership and added that transformational leadership could be measured by assessing the impacts of followers' motivation in performance. In this way, Bass theorised that transformational and transactional leadership should not be viewed as individually exclusive approaches but as a model that leaders can employ simultaneously (Bass, 1985). Argued that transformational and transactional leadership have a certain level of efficiency and engagement and proposed an inclusive model called the Full Range of Leadership Model made up of laissez-faire, transactional, and transformational leadership (ibid.), refer to Figure 2.3.

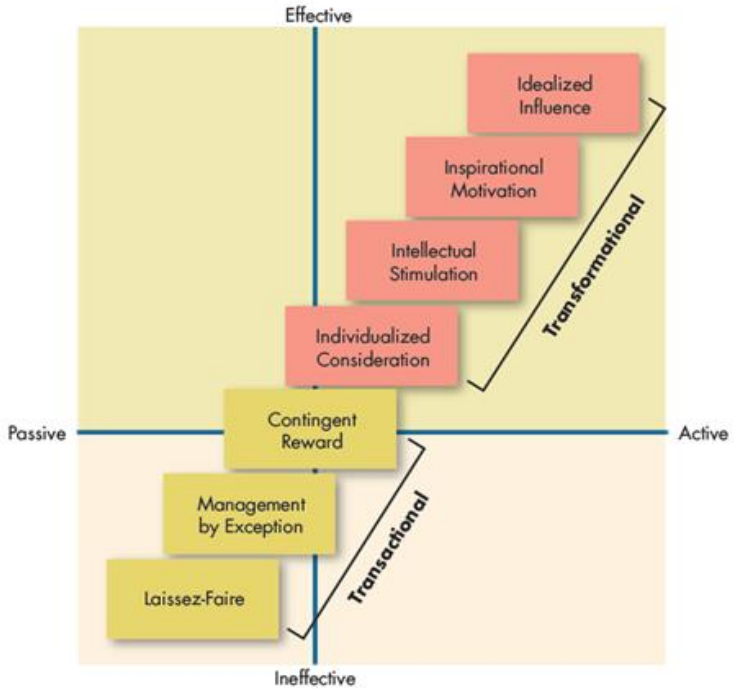
**Figure 0.2: Transformational and Transactional Leadership Components**




**Source:** Adapted from: (Burns, 1978; Bass & Avolio, 1994; Robbins & Judge, 2013; Luthans, et al., 2015)

Odumeru and Ifeanyi argued that when "transactional leadership is being applied to the lower-level needs and being more managerial in style, it is a foundation for transformational leadership hierarchically, which applies to higher-level needs" (2013, p. 358). Within this context, leaders with highly motivated, skilled, and committed employees can observe the situation and, from time to time, limit their involvement, avoid micro-managing employees and let them make decisions. For instance, Google's distributed leadership style demonstrates how highly motivated and skilled employees perform exceptionally, irrespective of the hands-off leadership approach (Manimala & Wasdani, 2013).

**Figure 0.3: Full Range of Leadership Model**




**Source:** (Robbins & Judge, 2013, p. 384)

According to Kendra (2021), laissez-faire leadership is a relaxed leadership style characterised by a hands-off approach where leaders minimally govern the decision-making and practices of their employees in an organisational situation. Meaning that employees are trusted to carry out their tasks without leaders constantly pushing them to be productive. Literature shows that laissez-faire leadership ordinarily result in the lowest performance or productivity from groups and individuals (ibid.). Undoubtedly, laissez-faire leadership demands a great deal of professional motivation, enthusiasm, and discipline at a personal level for employees to give their best performance with limited supervision.

The Full Range of Leadership Model shown in Figure 2.3 is a three-factor model made up of transformational, transactional and laissez-faire leadership approaches. The Full Range of Leadership Model is a comprehensive and holistic approach to leadership styles that characterise leaders' level of engagement and possible efficiency outcomes. According to Robbins and Judge (2013, p. 382), transactional and transformational leadership are complementary, not oppositional; effective leaders can draw specific qualities from both these approaches.

### 2.3.2 Contingency Theory

Considering the earlier discussions of the volatile state of today's world, characterised by change and unpredictability, the effects of these characteristics on leadership and performance bring different challenges and situations to organisations. Dunphy and Stace (1993) argued that different organisations face different situations; therefore, it is strategic for leaders to apply different strategies varying with specific changes or situations. Moreover, the authors asserted that "managers and consultants need a model of change that is essentially a "situational" or "contingency model", one that indicates how to vary change strategies to achieve "optimum fit" with the changing environment" (Dunphy & Stace, 1993, p. 905). This form of thinking is associated with the contingency approach to leadership, which believes that leadership is often not static; it is contingent on people and situations (Daft, 2018).

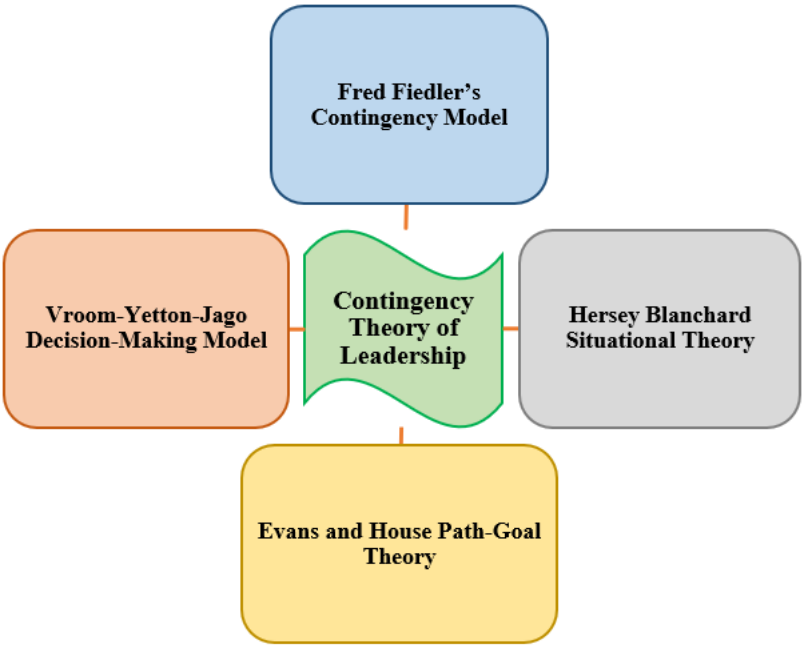
According to Daft, "contingency means that one thing depends on other things, and for a leader to be effective, there must be an appropriate fit between the leader's behaviour and style and the conditions in the situation. A leadership style that works in one situation might not work in another situation" (2018, p. 67). Leaders should assess each situation's nature and apply a suitable leadership style for the best outcomes. Burnes (2005) explained that the contingency theory originates from the need to provide managers with clear guidelines for choosing the most suitable or appropriate structure best fitting their organisations, which can affect the best performance.

Burnes (1996) further argued that the contingency theory has been studied and proved by managers and academics who viewed that structuring and running organisations is dependent on the situational variables faced. These variables can be the environment, technology, and organisational size. Researchers found that different situations and operations consequence in different outcomes. As a result, organisations that align their structures with specific

contingencies faced can lead organisations to success. Therefore, the one factor that affects what leadership approach will be most effective is the situation in which leadership activities occur (Daft, 2018, p. 65).

A leadership style that works in one situation might not work in another situation. There is no one best way of leadership. Contingency means ‘‘it depends.’’ Successful outcomes are highly likely if a leader can adequately diagnose a situation and muster the flexibility to behave according to the appropriate style. There are various models within the contingency theory, such as the Fiedler contingency model, which believes that effective group performance depends on the proper match between the leader’s style and the degree to which the situation gives the leader control (Robbins & Judge, 2013, p. 373). Additionally, there are various approaches under the contingency theory umbrella; Figure 2.4 outlines these models.

**Figure 0.4: List of models under the contingency theory of leadership**




**Source:** Adapted from: (Daft & Lane, 2005; Daft, 2018)

## 2.4 International Studies

### 2.4.1 Strategic Leadership in Healthcare: Global Understanding and Cases

Throughout the world, leadership is an essential factor in organisational performance. Leadership is the best way to get the best people to do their best work (Bush, 2012, p. 1328). Within the healthcare literature, several studies have highlighted the importance of effective and innovative leadership strategies to improve the safety of patients, quality of care, and patient satisfaction and reduce healthcare service delivery shortcomings (Kovach, et al., 2008; Kumar & Steinebach, 2008). Moreover, Porter-O'Grady et al. (2018, p. 108) stated that the increased use of the internet primarily drives the need for innovation in healthcare.

Internet and globalisation are some of the drivers of innovation and change. The internet-enabled information widespread that exposes fragmented services, ineffective processes, patient safety concerns, and consumer expectations which calls for change in the system. According to Siddiq and Zaman (2016, p. 54), global changes significantly influence local and conventional managerial practices in the industrial and services sector, particularly in education and healthcare systems. As organisations across other sectors operate in a complex and dynamic environment, hospitals are no different. The need and importance of effective leadership strategies are necessary for this environment of uncertainty. According to Ayeleke et al., "effective leadership has been recognised as crucial in shaping organisational culture and driving the implementation of reforms in the health care sector" (Ayeleke, et al., 2018, p. 84).

Furthermore, Ayeleke et al. (2018, p. 83) argued that the healthcare sector faces ongoing reforms targeting efficient delivery and provision of quality healthcare; effective leadership across all healthcare system levels is essential. Globally, healthcare systems follow governmental policies and market forces to maintain patient-centeredness (Siddiq & Zaman, 2016). Moreover, these authors argued that in this highly globalised age where changes affect socio-political, governance, socio-economic, and demographic trends, there is a strong need for innovative and strategic changes to improve healthcare systems. Porter-O'Grady et al. (2018) argued that professional government frameworks need to welcome, embrace, and support innovation. Operational or service departments can transform their operations and adapt to the changing environment and innovation development.

Authors have argued that healthcare delivery can be improved by leadership and management approaches that result in focused, developed, and efficient individuals and groups committed

to achieving healthcare goals effectively (Ellis & Kell, 2014; Edwards & Saltman, 2017; Asaria, et al., 2022). The needed leadership and management should be focused on "rethinking and recreating healthcare methods of care delivery that include diagnostic approaches, communication methods with those involved in providing healthcare, documentation of services, and billing and payment services" (Porter-O'Grady, et al., 2018, p. 108).

It is argued that today's healthcare environment requires managers and leaders to have a wide range of competencies to manage operations and continuously adapt to new evidence, new technologies or new processes created by innovation or change (Porter-O'Grady, et al., 2018, p. 106). These authors further argue that adapting to the current environment requires specific knowledge to forecast strategically, innovatively, and creatively. Advance and develop effective structures of operating amid complexity.

### 2.4.2 Leadership Structural Changes: Shift from Traditional to Alternative Models

The right to health is one of the globally recognised and prioritised human rights. The 1946 Constitution of the World Health Organisation defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity which should be enjoyed and attained in quality by all humans regardless of socioeconomic status, rage, gender, religion or political belief" (World Health Organization, 2008, p. 1; Ak, 2018). The Universal Declaration of Human Rights in 1948 raised healthcare as a right, and officially health was declared a human right in the 1966 International Covenant on Economic, Social and Cultural Rights, which led to most governments or states committing to the provision and protection of healthcare for all citizens (World Health Organization, 2008, p. 1).

Throughout the world, the healthcare system is policy regulated by governments. Despite the recognition and prioritisation of health, most government-led health systems and public hospitals, especially in developing countries, have failed to improve efficiency in quality care provision (Harding & Preker, 2000). The failure to improve performance and service, poor treatment of patients, ageing equipment, poor resources, and other technical efficiencies have led to the questioning of the viability of state-led policies leading to countries seeking alternative strategic approaches. Harding and Precker (2000) argued that improving public hospitals requires decentralisation, increased hospital autonomy, corporatisation or even privatisation of public hospitals services to improve performance and the reported challenges.

According to Harding and Preker (2000), it is not uncommon for public service delivery, including healthcare, to be poor. Some of the contributing factors include the external policy regime, governance structures, and bureaucratic systems that govern hospital management. Therefore, strategically opting for structural reforms such as decentralisation is one of the ways that some countries have opted to take, given that most private hospitals tend to be more efficient than public ones. Making it ideal that perhaps leadership and management structures and systems used in the private sector can improve efficiency in the public sector. For instance, the introduction of corporate hospitals in the Indian healthcare sector is one of the strategic changes that revolutionised this country's health system.

According to Sekhar (2008, p. 48), the growth of corporate hospitals in India was driven by the need to provide competitive, prompt, adequate, continuous, and satisfactory services to the patient community. The route of the corporation promised efficiency and productivity of healthcare facilities given that the leadership approach required balancing the provision of quality healthcare, productive employees, and increased profits (Sekhar, 2008). Similar practices have been observed in other countries; Table 2.2 shows examples of health policy reforms or decentralisation practices; the changes were accompanied by a restructuring of various parts of the health system in these countries (Harding & Preker, 2000). The following passage will further put more spotlight and signpost on the role of decentralisation within the public health sector fraternity.

#### 2.4.2.1 The Impact and Influence of Health Sector Decentralisation: Global Lenses

The whole idea behind decentralisation came from the need to better government policies that have failed to achieve program goals.

Saltman et al. (2011) conducted a study in Europe, looking at acute-care public seven hospitals under the European systems and one Israel structured health system. This study showed that rapid technological improvements in clinical and informational capacity in hospitals increased patient expectations regarding quality, safety, and responsiveness and pressured policymakers to think of new ways of hospital management approaches. As a result, public hospital governance had to be innovative and flexible in in-service delivery arrangements through models that increase institutional autonomy for improved efficiency and effectiveness.

**Table 0.2 Autonomation of Public Hospital Leadership**

| Country | Transformation |
|---|---|
| United Kingdom & New Zealand | The United Kingdom (UK) and New Zealand changed public hospitals from state ownership into public corporations making hospitals legally independent entities (Crown Health Enterprises). This structural change enabled decision-making rights, leadership and accountability mechanisms to be entirely operated and regulated at the hospital level. |
| Argentina | Argentina took an approach designed to entice the competitiveness of public hospitals. This was done by dismantling the national governance into individual hospital autonomy by making provinces hospital owners. This created flexibility, and leaders were motivated to implement strategies relevant to their individual hospital needs and surrounding environment. |
| Tunisia | Tunisia started by reforming 22 of its teaching hospitals in the 1990s. After observing improved efficiency resulting from increased hospital autonomy, this country widened corporatisation given its performance sustainability, patient satisfaction, and improved healthcare delivery. Tunisia focused on strategically balancing technical, managerial, and organisational changes simultaneously. |
| Hong Kong | After discovering the key drivers of public hospital inefficiencies being traced back to rigid and lack of management expertise, Hong Kong policymakers designed a new corporatisation Hospital Authority in 1991. Managers and leaders at the hospital level were granted significant autonomy and encouraged to approach their duties and functions like a corporation. |
| Singapore | This country was the first to explore the strategic shift of reforming hospital leadership by increasing autonomy. In 1985, Singapore hospital management approaches began to combine autonomy with market-based performance pressures. |
| Malaysia | There was a growth of corporatisation state-owned enterprises failed to deliver services in Malaysia. In 1992, the country introduced the corporatisation model into health, first witnessed in its then-new National Heart Institute. The driver for change was innovation and efficient service delivery. |
| Austria | Driven by the need to increase efficiency in public hospitals, the State of Victoria in Australia rationalised hospital reforms in 1995. This process decentralised government-driven rationalisation plans by integrated groups of metropolitan hospitals into several networks, which could then compete. |

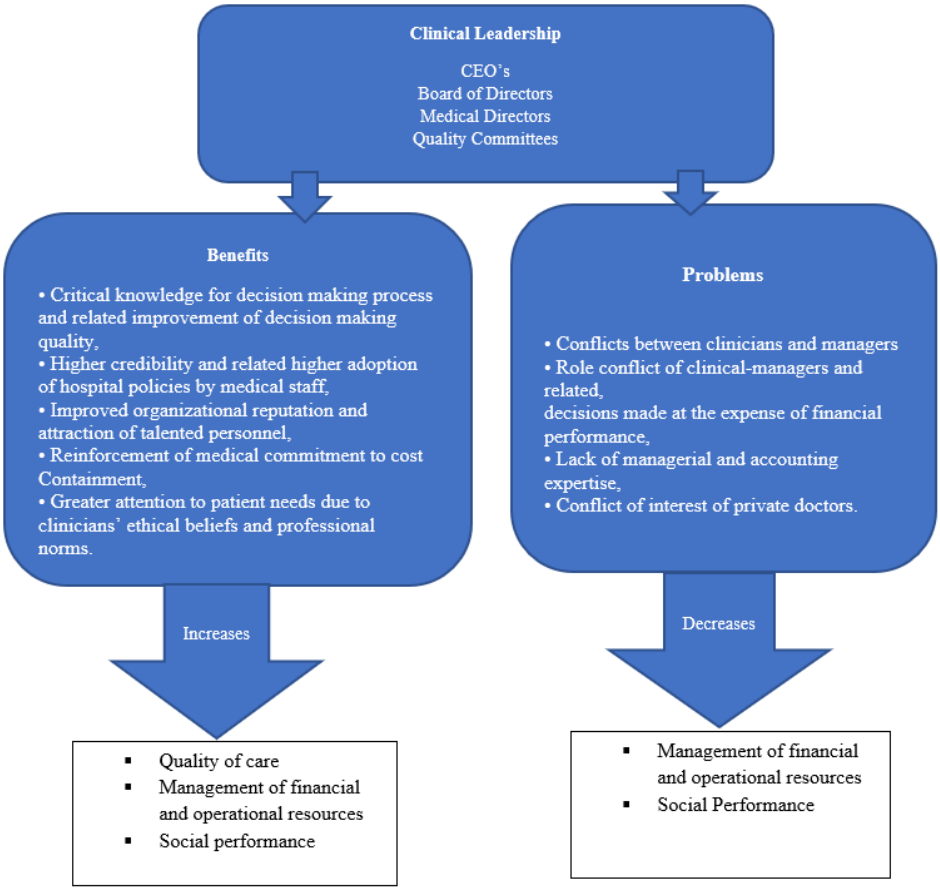
**Source:** (Harding & Preker, 2000, pp. 26-28)

Another observed alternative governance approach that other countries have employed to improve healthcare service and quality in public hospitals is clinical leadership, where clinicians such as doctors are involved in leadership positions, especially in top-level leadership such as Chief Executive Officer (CEO) level (Sarto & Veronesi, 2016). Furthermore, these authors stated that this strategic model approach is common in the UK, Italy, Germany, France, and some hospitals in the United States of America (USA) and presented a detailed analysis behind this approach, displayed in Figure 2.5 (Sarto & Veronesi, 2016). The next section will provide a discourse on the crucial role facilitated by global-oriented clinical leadership.

### 2.4.2.2 The Role of Clinical Leadership Re-imagined

The characterisation of the advantages that yield inherent benefits and problems disadvantages that incorporate the headwinds, as exhibited in Figure 2.5, depicts the significant contribution of viewing leadership from the strategic clinical perspective.

**Figure 0.5 Explanatory Model of Clinical Leadership in Hospitals**




**Source:** (Sarto & Veronesi, 2016, p. 94)

Citing similar practices in European public hospitals, Kirkpatrick et al. asserted that "since the early 1980s, all European countries have prioritised reforming the management of health services. A distinctive feature of these reforms has also been the drive to co-opt professionals into the management of services, taking on full-time or part-time (hybrid) management or leadership roles" (Kirkpatrick, et al., 2016, p. 7). Despite the absence of leadership and management competence in traditional undergraduate medical curricula, the increasing demands and challenges within healthcare worldwide call for the development of new competencies hence the increase in medical professionals taking leadership and management

positions (MacCarrick, 2014, p. 1). Moreover, Sarto and Veronesi (2016, p. 85) argued that the various attempts to restructure leadership models in healthcare institutions follow the fundamental underlying assumption that corporate governance has better governance mechanisms that lead to greater efficiency and effectiveness of organisations. Therefore, adopting these business-like governance arrangements has been seen as crucial for performance improvement.

### 2.4.3 Leadership Focus on Performance from the Global Viewpoint

It has been established that public hospital management contextualises the political and technical factors due to the national and district policy structure challenging hospital leadership. Adding to the challenging nature of leading public hospitals in the technology-driven environment creates new ways for top executives to formulate strategies and facilitate work and relationships to create value for stakeholders.

Countries such as Turkey introduced changes to public hospitals, focusing on increased performance management to improve the efficiency and performance of hospitals. This change in focus was done through the establishment of the Institution of Turkish Public Hospitals and General Secretariat, which was a law introducing the employment and work of managers in General Secretaries and hospitals performance, created public hospital unions and a Productivity Scorecard to measure performance (Tekin & Torun, 2017, p. 17; Uğurluoğlu, et al., 2010). This law came with health system developments that mandated strategic leadership as managers were required to identify different factors affecting the hospitals, prioritise learning, maintain stability and manage the complex environment effectively and efficiently (Tekin & Torun, 2017).

Turkey developed a Health Transformation Program, which is a strategic management model designed to ensure fiscal discipline in financial management and the distribution of resources according to strategic priorities (Uğurluoğlu, et al., 2010; Tekin & Torun, 2017). Systematically, this approach increased leader responsibility and accountability because managers were expected to succeed by ensuring their planning, implementation, and control were strategic to yield positive outcomes. This approach characterises flexibility, adaptability, creativity, and informal interactions, which Pascuci et al. (2017, p. 2) categorised as a hospital's critical strategic and innovative initiatives.

Similar to Turkey, some hospitals in Brazil changed their leadership methodologies from a welfare approach to professionalisation which entails public hospital leaders being responsible for financial performance, which can be achieved by transforming their strategies into effective, efficient, and meaningful outcomes (Meyer Jr, et al., 2012). As a result, "some Brazilian hospitals have overcome administrative difficulties by customising management practices to their specific needs. These organisations have learned how to reconcile the complexities inherent in hospitals with strategic management initiatives and practices, achieving positive results" (ibid., p. 25).

### 2.4.4 Leadership Capacity and Competencies

In a study assessing the strategic competitiveness of public hospitals in Pakistani, Siddiq and Zuman (2016, p. 59) explained that the public healthcare system in this country consists of inefficiencies, inadequacies and unproductivity, arguing that these poor conditions may be perpetuated by poverty, high illiteracy rate, malnutrition and unequal access to health facilities. Amid these challenges, Pakistan is said to have failed by the absence of strategic leadership frameworks that can guide leadership practices within the existing shortcomings (ibid.). Saddiq and Zuman's study found that top-level leaders in Pakistani public hospitals demonstrated detachment or lack of commitment to the environment they worked in; the absence of their personal qualities hinders them from being change agents in bringing survive management improvements shortcomings (2016, p. 66). Moreover, these authors concluded that a lack of strategic leadership capacity and attributes contributed to the following:

- The reported inefficiency of public hospitals in this country,
- Lack of motivation and change agency from top leaders, which affected internal and external factors of public hospitals,
- Lack of sensitivity to environmental factors led to poor decision-making and future planning.

The case study from Pakistan points to the significance of leadership capacity for organisational success. According to Siddiq and Zaman (2016, p. 66), effective strategic leadership in healthcare is achieved when leaders effectively plan, develop, and implement strategies that prioritise patient care and organisational efficiency whilst embracing communication and accountability. Moreover, the strategic planning and implementation should be aligned with the hospital culture, objectives and overall environment or context, arguing that failure to that

makes an ill alignment of strategy with healthcare system requirements (Siddiq & Zaman, 2016).

In a study examining the influence of transformational leadership and job satisfaction toward innovative behaviour among public hospital nurses conducted in nine general hospitals in Kelantan, Malaysia, the authors Afzan and Aziz (2020) emphasised the importance of leader influence in driving innovation. Moreover, Afzan and Aziz argued that leaders must figure out and understand appropriate measures and factors relevant enough to inform change and efficiency in the healthcare system for healthcare organisations to be innovative. In this way, the leaders can use their strategic capabilities to guide, direct and motivate healthcare employees and enhance their performance by encouraging innovation so that employees can cope with the complex and dynamic hospital environment. Central to strategic leadership is having the leadership competencies to enable innovative and strategic abilities; Table 2.3 lists some leadership skills, attitudes, and behaviours necessary for professional leadership (MacCarrick, 2014).

**Table 0.3: Professional Leadership Competencies**

| Competencies, skills, behaviours, attitude, and knowledge of a professional leader |
|---|
| Implementing ethically appropriate management decisions |
| Consistently acting with integrity and accountability |
| Demonstrating respect for professional, legal, and ethical codes of practice |
| Demonstrating maintenance of professional competence and lifelong learning, such as participating in peer review and audits |
| Demonstrating a willingness to accept constructive feedback |
| Demonstrating a balance between personal and professional priorities |
| Recognising other professionals in need and responding appropriately |
| Demonstrating emotionally intelligent leadership and reflective practice |
| Demonstrates knowledge of current leadership theory and reflects this in practice |

**Source:** (MacCarrick, 2014, p. 8)

The competencies listed in Table 2.3 are essential to what is described as the necessary ability to manage the relationship between employees, stakeholders, technology, coping with change, being transformational, and creating economic value. Furthermore, MacCarrick (2014) explained that effective leadership in modern healthcare demand leaders who are knowledgeable of current leadership frameworks and theories as they can apply these in

everyday practice. MacCarrick, gave examples of the Leadership Qualities Framework employed by the National Health Service (NHS) in the UK, which employs evidence-based and research-led strategies in hospital leadership. As well as the LEADS Framework of Canada which fosters strategic alignment between leadership competency frameworks, strategies, and the current needs of Canada's health sector (MacCarrick, 2014, p. 9). In a study assessing the factors affecting strategic management in this age of turmoil in public hospitals of Guilan province in Iran, authors found that leadership style in strategic turmoil management is essential in managing complex systematic changes. Furthermore, a leadership style that considers change management enables dynamic adaptation, and it points out that traditional leadership methods are likely to be less responsive in today's hospital environment (Dalafroz & Mirsidi, 2017).

## 2.5 Public Healthcare in Africa

African countries face numerous socio-economic and socio-political issues that affect growth and development. Most countries face challenges such as poverty, unemployment, high illiteracy rate and challenges in access to resources. Amid all these challenges, African countries commonly experience severe constraints on human resources for health and shortfalls that seriously limit access and provision of healthcare services (Western or allopathic health care) for their populations (van Rensburg, 2014, p. 2). The prevalence of poorly developed healthcare professionals and a dearth of tertiary training institutions to produce health professionals in sub-Saharan Africa is too great. Additionally, the reported lack of supplies and equipment, chronic staff shortages, low staff motivation and healthcare professionals opting for urban hospitals over rural ones characterises the context of African public healthcare (ibid.).

Malawi is one of the African countries that has been enormously burdened with disease, HIV and AIDS, tuberculosis, and malaria overly burdened the healthcare system and the traditional healthcare professions cadres could not tackle these diseases (Muula, 2019). Government policy-led reforms have been introduced to improve access and quality of public healthcare. For instance, in 2020, the country introduced the National Health Policy 2018-2022 to increase access to healthcare (ibid.). Furthermore, the country introduced the Emergency Human Resource Programme (EHRP), which increased the number of healthcare workers, provided various talent management strategies to entice staff performance and increased the motivation of healthcare employees for retention (Malawi Department of Health and Human Services, 2016). These strategies included overtime pay and free and postgraduate training to improve

hospital efficiency through strategic human resource management. Along with improving the healthcare system context, equal attention has been given to the improvement of hospital leaders. According to Bates et al. (2018, p. 134), “effective leadership is a key component of any health system. The opportunity for multidisciplinary leadership training for health practitioners is relatively new in Malawi”.

In Ghana, the Ministry of Health developed and implemented various policies to guide the running of healthcare services and human healthcare resources institutionally at the national, provincial and district level. However, the service performance of public hospitals kept deteriorating and operations were deemed inefficient, leading the country to realise that the overall institutional reforms required decentralisation (Ghana Statistical Service, et al., 2003, p. 15). Decentralisation meant that the decision-making role was shifting from having the Ministry of Health as the sole provider and guider coming closer to the hospital level to expanding autonomy (ibid.). It can be argued that many African countries' strategic frameworks and healthcare policies are sound and relevant; however, they fail to work or lead public hospitals into efficient institutions with quality service, a professional workforce, and happy patients. Perhaps the decentralisation of power could empower hospital leaders to have direct responsibility attached to accountability, pushing them to be strategic leaders to be efficient and effective in leading public hospitals to improve service delivery.

## 2.6 An Overview of the South African Health System

### 2.6.1 The State and Context of the South African Healthcare System

SA has a rights-based healthcare system, gazetted as a constitutional obligation belonging to the state to deliver quality healthcare service to all citizens (Stuckler, et al., 2011). This commitment to healthcare service is based on equality, accessibility, and quality principles, correcting racial policy provisions of the apartheid system regime that created significant inequalities. Under the apartheid system, quality access to healthcare was racially based, world-class care was reserved for White elites, including the first heart transplant in the world, and the majority of the population who were Black were denied access to the same quality healthcare (Stuckler, et al., 2011, p. 165). Moreover, the distribution and access to all services were unequal. For instance, spatial segregation meant urban areas reserved for White people had better infrastructure, education, and work opportunities, deepening living standards and

socio-economic inequalities. Therefore, the redress and restructuring process meant that those previously oppressed were given a chance to catch up.

Post-apartheid, SA transitioned to a constitutional democracy, and the democratic state focused on policy reforms for social development addressing all aspects of life discriminated against before 1994 (Mayosi & Benatar, 2014). Having inherited a highly privatised health service system with high inequalities distorted toward the hospital needs of urban Whites, the South African health care system must be understood in the context of its unique political, economic, and social history (Baker, 2010, p. 79). Health policy reform's focus on equality, inclusion and access is not enough, given the magnitude of inequality and other socioeconomic factors outside the healthcare sector, such as poverty, unemployment, and lack of education. These factors affect public hospitals and create great demands regarding capacity and service demands requiring strategic leadership to achieve efficient and quality public healthcare service. For instance, Ngobeni et al. (2020) presented that the 2016 Statistical survey estimated that 83% of the total population of 59 million people rely on public healthcare, making public hospitals and clinics overly burdened. Additional to the large population depending on public healthcare, SA battles the relentless burden of non-communicable and infectious diseases, persistent social disparities, inadequate human resources, poor health infrastructure and other socioeconomic challenges outside the health system (Baker, 2010; Mayosi & Benatar, 2014; Ngobeni, et al., 2020).

It has been 28 years into democracy, and as much as many restructuring and reform efforts have been made, the public healthcare sector in SA requires service delivery improvements. Literature and reports indicate that the current state of public hospitals remains a concern. For instance, the White Paper on the Transformation of the Public Service 1997 proclaimed that public service delivery should put people first by employing the Batho Pele (People first) framework, which is a set of principles designed to improve service delivery in the public sector (Department of Public Service and Administration, 1997). However, public hospitals' management remains fragmented despite the government's commitment to various health policy frameworks, policies, and strategies (ibid.).

The reported fragmentation is said to be contributing to the poor operations due to the management processes being dominated by hierarchy, poor attendance of patient needs and experiences, and poor communication and interaction (Fusheini, et al., 2017, p. 68). Coovadia

et al. (2009, p. 817) further explained that despite the transformation of the public health system from discriminatory into an integrated, comprehensive national service, failures in leadership and stewardship and mismanagement have led to inadequate implementation of what are often good policies. Table 2.4 presents various literature-related factors as critical contributors to inefficient management and incompetent leadership in South African public hospitals.

Coovadia et al. (2009), Mayosi and Benatar (2014) indicate that South Africa is in the middle-income economy category. Nevertheless, its health outcomes are worse than in many low-income countries. In the context of public hospitals, Ranchod et al. (2017, p. 101) explain that the public hospital sector caters to most people in the country; however, it faces significant challenges such as lower human-resourcing ratios, financial constraints and ageing infrastructure. Therefore, "leadership is a necessary element of strong health systems, so SA must nurture and sustain leaders who can work strategically within their complex environments to develop a rights-based health system that promotes health equity" (Gilson & Daire, 2011, p. 69).

**Table 0.4: Factors Affecting Hospital Leadership in SA**

| **Contributing factors** |
|---|
| The gap between relevant skills and managerial competencies of hospital managers,<br>***Resulting to:***<br>There is a lack of health management capacity to be efficient and effective and a lack of successful policy adoption and associated implementation. |
| Lack of interconnection between clinical and administrative leadership,<br>***Resulting to:***<br>Hospital leadership and management have limited familiarity with the interface between socio-political, socio-economic, technological, governance and the influence of other internal and external factors that impact the hospital environment. |
| Increasing healthcare delivery costs,<br>***Due to:***<br>The cost of providing medical care, salaries of medical practitioners, and service errors such as medical negligence litigation by patients or victims leading to the Department of Health paying large amounts of money are some challenges that leaders must work with within the constrained budget environment. |
| Infrastructure and resources shortage,<br>***Examples include:***<br>Poor waste management, poor cleaning services, ageing infrastructure, ageing equipment, poor equipment maintenance (affects diagnosis, treatment, or surgery), inadequate healthcare professionals and medication/treatment shortages. |

**Source:** Adapted from (Pillay, 2008; Baker, 2010; Health Systems Trust, 2016)

Hospitals are considered as one of the most complex types of organisations in modern society to manage (Etzioni, 1964). The factors given in Table 2.4 indicate that hospital leadership in SA goes beyond internal administrative and directive management. Instead, public hospital leaders are faced with myriad interconnected issues that directly and indirectly affect hospital management, operations and leadership. Hence, strategic leadership needs to effect change, improvement, and efficiency within the constraints. For instance, Coovadia et al. (2009) report that the health sector is negatively affected by weak political and management leadership to manage underperformance in the public health sector. The need for strategic leadership also draws from the interrelationship between strategy and organisational environment that Hambrick (1981, p. 253) explained as the necessary ability for leaders to cope with strategic contingencies or uncertainty facing the organisations they are political, structural, or administrative.

### 2.6.2 Challenges in South African Public Hospitals

Giving a national standpoint, Figure 2.6 presents key complaints about public hospital service experience during the 2018/19 financial year (Department of Health, 2020b, p. 22).

**Figure 0.6: 2018/19 Public Hospital Complaints**

| Category | South Africa | Eastern Cape | Free State | Gauteng | KwaZulu-Natal | Limpopo | Mpumalanga | North West | Northern Cape | Western Cape |
|---|---|---|---|---|---|---|---|---|---|---|
| Waiting times | 31% | 27% | 40% | 25% | **31%** | 8% | 37% | 32% | 24% | 32% |
| Patient care | 29% | 26% | 28% | 31% | **26%** | 40% | 24% | 23% | 30% | 38% |
| Staff attitude | 26% | 25% | 29% | 28% | **20%** | 20% | 25% | 31% | 46% | 31% |
| Other | 13% | 16% | 11% | 9% | **15%** | 30% | 15% | 13% | 13% | 10% |
| Access to information | 8% | 4% | 14% | 9% | **5%** | 13% | 6% | 7% | 3% | 10% |
| Safe and secure environment | 5% | 6% | 4% | 4% | **5%** | 0% | 7% | 3% | 9% | 4% |
| Waiting list | 4% | 3% | 2% | 7% | **2%** | 3% | 3% | 4% | 0% | 6% |
| Hygiene and cleanliness | 3% | 6% | 3% | 2% | **3%** | 0% | 5% | 4% | 2% | 3% |
| Availability of medicines | 3% | 3% | 3% | 2% | **3%** | 0% | 2% | 3% | 3% | 3% |
| Physical access | 3% | 2% | 2% | 5% | **3%** | 0% | 3% | 3% | 5% | 1% |

**Source:** (Department of Health, 2020b, p. 22)

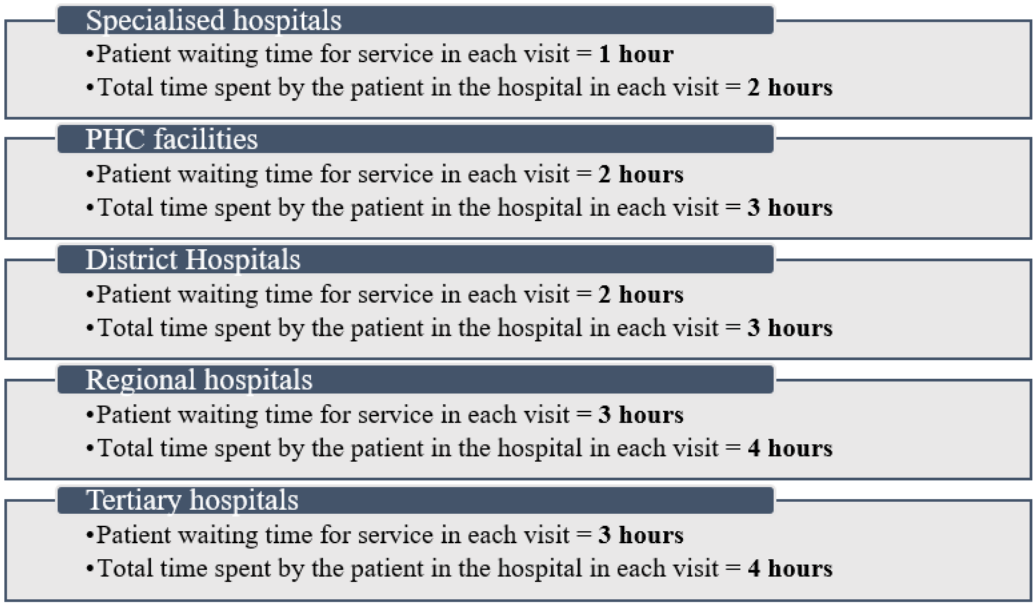
The above-reported challenges are experienced by patients who visit public hospitals across the country, and the different percentages indicate that situations vary according to the different hospital contexts.

### 2.6.3 Long Waiting Time

Prolonged patient waiting time before receiving hospital service has been one of the common challenges facing most SA public hospitals across the country due to these systemic sluggish turnaround times. The national policy on patient waiting time management explained that patient waiting time for services is characterised by daily long queues of out-patient or primary healthcare patients in hospitals. Most of these patients come very early in the morning before operating hours to receive public health services (Department of Health, 2015, p. 7). Besides the large population depending on public hospitals, literature shows that inadequacy in human resources is the main factor behind prolonged waiting time. According to Barron and Padarath (2017, p. 4), the noted shortage of healthcare professionals in the public sector in SA is worsened by the unequal distribution of health professionals between the private and public sectors.

Mayosi and Benatar (2014) also mentioned that physicians are reluctant to practice in far-flanged rural areas. Most medical doctors are employed in the well-remunerating and abundantly resourced private sector, which leads to shortages in the public sector. “In many health facilities, demands for services are greater than the capacity at hand. Where the demand exceeds capacity, appointments are postponed, and these postponements increase the queues. In instances where average capacity matches the demand, a mismatch between daily demand and daily capacity causes long queues” (Department of Health, 2015, p. 7). As a result, unfortunate situations such as patients ending up not receiving services or receiving partial service very late in the day in hospitals are outcomes of long patient queues. The DoH prescribed the expected patient waiting time for the various hospitals, as demonstrated in Figure 2.7. Hospital leaders must find strategic solutions to reduce the patient inconvenience of prolonged waiting time for health services.

**Figure 0.7: Policy Standardised Patient Waiting Period in Public Hospitals**




**Source:** (Department of Health, 2015, p. 8)

### 2.6.4 Public Health Infrastructure Shortage

Most public hospitals face infrastructure run down due to neglect, underfunding, mismanagement and dysfunction, which compromises health care quality (Mayosi & Benatar, 2014; Ngobeni, et al., 2020). Public facilities remain in a state of crisis; at the same time, they are expected to service the majority of the population, and the private sector has the appropriate infrastructure to offer world-class care. However, only a small proportion of the population can access private healthcare while resources are available in the private sector healthcare (News24, 2017). A 2018 study on health market enquiry by the Competition Commission reported that these vulnerable and poorly resourced public hospitals in SA serviced approximately 83% of the population who were not on medical aid, while private healthcare facilities serviced 17% of the population with healthcare insurance (Competition Commission, 2019).

Additional to poor infrastructure, public hospitals faced a critical shortage of resources, such as a shortage in bed allocation, including state-of-the-art cutting-edge technology and appropriately competent human resources (Marten, et al., 2014; The Presidency, 2018). On the challenge of human resources, there are reports of a healthcare professional deficit in the country mainly driven by migration and uneven distribution of qualified and skilled professionals who mostly join the private sector, which negatively impacts the ability to deliver

critical programmes in public healthcare facilities (Coovadia, et al., 2009; Ngobeni, et al., 2020).

The PSC conducted two years (2016/17 and 2017/18) of research into the KZN health sector following public complaints on social media and discovered the below challenges on infrastructure in Table 2.5.

**Table 0.5: Infrastructural Challenges Discovered by the Public Service Commission in KZN Hospitals**

| Infrastructure: |
|---|
| Congestion in specific areas such as Outpatient Departments, poor ventilation in waiting areas and consultation rooms, |
| Poor ventilation generally, which may pose infection risks. |
| Insufficient office space for personnel in administrative units: Some hospitals scrounge for administrative space and medication storage space. |
| No hospital in the study sample was found to have sufficient archival space. The archives issue seems to be a problem left for hospitals to contend with. |
| Inadequate bed capacity or bed spacing not meeting acceptable norms (some hospitals have visible challenges with bed capacity in certain units) |
| HR recruitment and retention of skills is not given an approach sensitive to the various context of facilities. |

**Source:** (Public Service Commission, 2018, p. 14)

### 2.6.5 The High Cost of Public Healthcare Provision

The Health Systems Trust reported that SA public health costs had rapidly increased in the past three decades. Topping the list of costs are high public sector salaries, high administration costs, duplication of services, and inefficiencies (Health Systems Trust, 2016; Ngobeni, et al., 2020). Moreover, the National Treasury (2021) reported that another factor that escalates costs is the contingent risks of medical-legal claims resulting from healthcare professionals' negligence, where provincial health departments end up paying billions per year. The Health Systems Trust suggested that public healthcare facilities require scientific methods to evaluate and compare public healthcare efficiency spending to reshape healthcare policy and decrease healthcare expenditure or costs (Health Systems Trust, 2016; Ngobeni, et al., 2020).

### 2.6.6 The High Burden of Disease

SA have demonstrated the vulnerability of diseases in their variety, from HIV and TB to non-communicable diseases such as hypertension, diabetes, cardiovascular disease, high maternal, neonatal, and child morbidity, and high levels of trauma and violence (Govender, et al., 2018; Harrichandparsad & Mahomed, 2021; Mattila, et al., 2022). In KZN alone, it was reported that

"94% of people living with HIV know their status, and 85% of those people are on HIV treatment" (Ritshidze, 2021, p. 5).

Social factors such as poverty and unemployment also contribute to the disease burden, and most South African population relies on public hospitals for diagnosis and treatment. The challenge of the high disease burden relates to patient overcrowding and long waiting queues in hospitals. Mokoele (2012, p. 56) stated that the most overly burdened hospitals are those found in urban areas due to the influx of people from rural areas into cities and an additional number of immigrants, which leads public hospitals to operate beyond capacity, which then cascades to resource constraints and cost constraints. These challenges necessitate the element of strong leadership qualities cited by Gilson and Daire (2011), as they require strategic leadership to deal with complex environments.

### 2.6.7 Lack of Professional Ethics of Employees

The PSC conducted service delivery inspections and reported a noticeable lack of professional ethics and ethical dilemmas among employees in most public hospitals (Public Service Commission, 2018; Public Service Commission, 2021). For instance, the Ritshidze (2021, p. 5) raised concerns that "*there is growing concern that poor staff attitude is doing serious damage to primary healthcare. Not only is it affecting the delivery of healthcare services to people, but it is indirectly putting people's lives at risk too. More and more people living with HIV are reporting that they have or are contemplating stopping treatment, and some have already stopped taking their medicines because they are fed up and can no longer stomach the abuse and dismissive attitude of nurses, security guards and cleaning staff working at the province's facilities".* This example demonstrates the extent of poor professional ethics from healthcare practitioners, which compromises what public health services stand for. Courtesy, respect, and prioritising human dignity are enshrined throughout state legislative frameworks and policies; therefore, it is critical that hospital leadership monitor employee attitudes and level of professionalism to minimise public distrust of state hospitals.

### 2.6.8 Leadership and Operational Management Capacity

In today's world, more than ever, effective leadership accompanied by good management is critical in health organisations (Galer, et al., 2008; Fana & Goudge, 2021). Public healthcare leadership capacity in Sub-Saharan Africa requires improvement and nutrition at all levels for solid health systems governance and improved outcomes, which demands strategic and

participatory leadership and orientation to develop leadership capacity (Agyepong, et al., 2018). According to Gilson and Daire (2011), SA has long established the need for improved health management because leadership is a significant element of a robust health system made up of leaders who can work strategically within their complex environments to develop a rights-based health system that promotes health equity. Leadership in South African public hospitals have been marked as dysfunctional, institutionally ineffective, and highly hierarchical, with management failures caused by a lack of managerial capacity (Fusheini, et al., 2017). Given the burden of disease and the state of public hospitals, managers need absorptive strategies, increased resilience, and increased communication in management (Fana & Goudge, 2021).

In a study examining leadership strategy to enhance healthcare service delivery in South African regional hospitals, Govender et al. (2018) explained that SA needs strong leaders who can simultaneously handle clinical and organisational management. This can be achieved by having key competencies and leadership approaches that enable flexibility and adaptability to change circumstances to effect efficient healthcare service delivery (Govender, et al., 2018). Moreover, Govender et al. (p. 158) stated that their study focused on examining leadership in the four regional hospitals in KZN. The study pointed to the critical need for the KZN-DoH to employ effective leadership principles for the future development of health care leaders.

Additionally, Patel (2015) reported that public hospital leaders have been failing to balance the burden of disease with patient loads, quality of care and supporting the growing population within available resources. This author cautions that today’s leaders must do things differently to avoid the system's collapse. Therefore, change management and transformational processes are essential drivers of innovation and improving quality healthcare service (ibid.). Table 2.6 presents examples of leadership competencies that Galer et al. (2008, p. 16) defined as the specific mindset, skills and knowledge that can aid managers in being effective leaders.

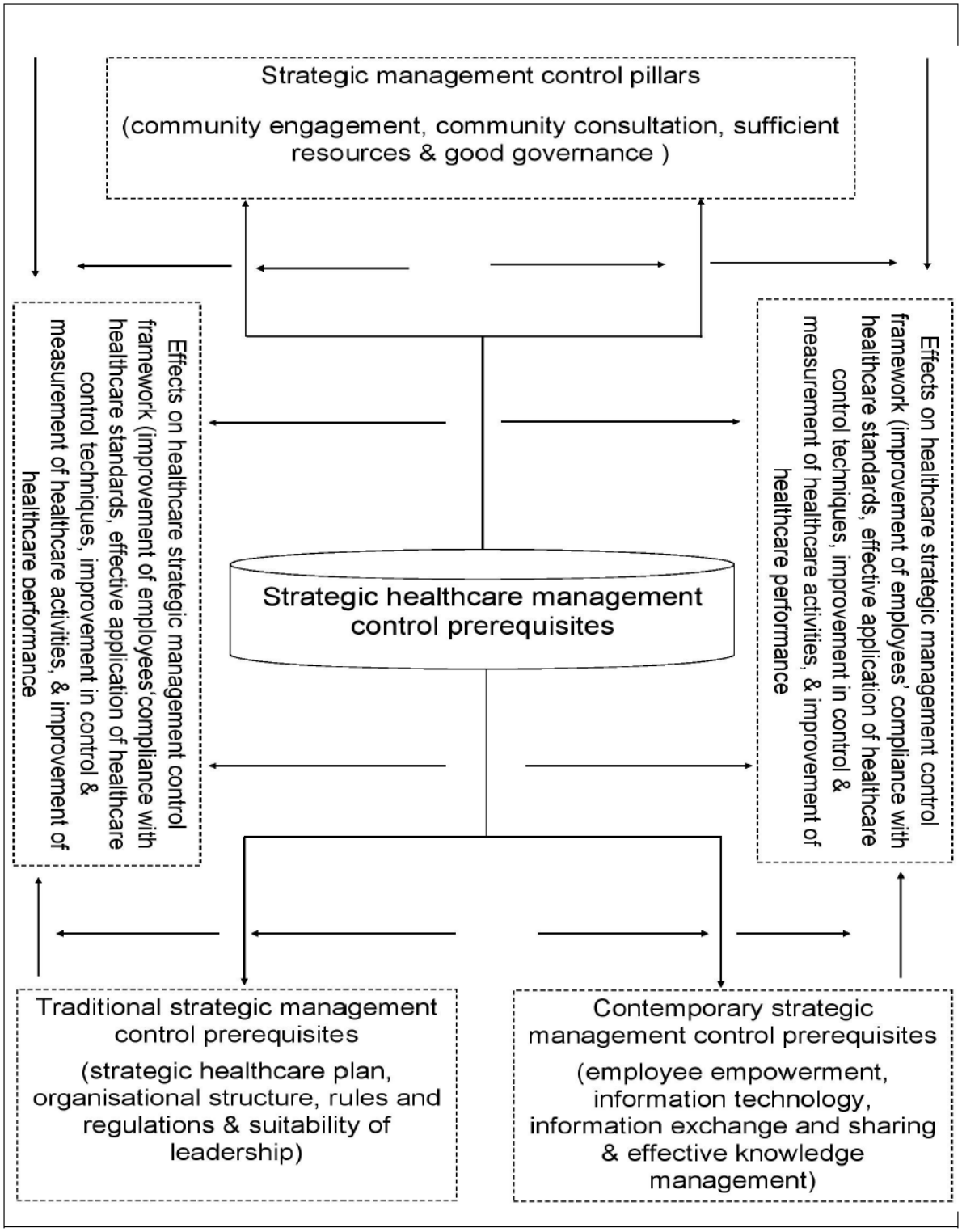
**Table 0.6: Effective Leadership Competencies**

| Competency | Application |
|---|---|
| Master yourself | Reflect on yourself and be aware of your impact on others, manage your emotions effectively, use your strengths, and work on your shortcomings |
| See the big picture | Look beyond a narrow focus to consider conditions outside your immediate area of work |
| Create a shared vision | Work with others to envision a better future and use this vision to focus all your efforts |
| Clarify purpose and priorities | Know your own values and what is most important to accomplish |
| Communicate effectively | Hold conversations focused on outcomes; balance advocacy with the inquiry; and clarify assumptions, beliefs, and feelings within yourself and others |
| Motivate committed teams | Create the clarity, trust, and recognition necessary to lead teams to high performance that can be sustained over time |
| Negotiate conflict | Reach agreements from which both sides can benefit |
| Lead change | Enable your workgroup to own challenges, enlist stakeholders, and navigate through unstable conditions |

**Source:** (Galer, et al., 2008, p. 16)

Against the context of the South African public healthcare environment and the various policy initiatives formulated by the DoH targeting the improvement of service delivery, Okanga and Drotskie (2015, p. 552) developed a framework for strategic healthcare management control presented in Figure 2.8. This illustration demonstrates strategic leadership approaches necessary in public health organisations.

**Figure 0.8: Okanga and Drotskie's Framework of the Strategic Healthcare Management Control**




**Source:** (Okanga & Drotskie, 2015, p. 552)

## 2.7 Chapter Summary

Twenty-eight years into democracy, SA remains one of the world's dual economies countries with the highest inequality rates (World Bank, 2020). SA inherited this persistent inequality state from the exclusionary apartheid policies in its socio-economic context. The democratic government has introduced reform and redressed strategic frameworks and policies to drive the equal delivery of services, including health care. These frameworks and policies aim to improve health status by preventing illness and disease, promoting healthy lifestyles, and consistently improving the health care delivery system by focusing on access, equity, efficiency, quality, and sustainability (Department of Health, 2020b). The various healthcare policies are implemented by managers and leaders in public hospitals, which are reported to be servicing the majority of the South African population who are profiled to be disadvantaged and faced with various socio-economic challenges such as poverty and unemployment.

Despite the existence of strategic frameworks and policies guiding the delivery, administration and management of healthcare services, public hospitals are reported to need improvement when it comes to efficient service delivery. The decline in quality health care has caused the public to lose trust in the healthcare system in South Africa (Department of Health, 2020b; Public Service Commission, 2021). Public hospitals are well known to be challenging to reform (Edwards & Saltman, 2017). Moreover, leaders are tasked with the complex responsibility of rendering "service delivery that is aligned with legislation, regulations, standards, policies and frameworks, and relevant medical training standards (MacCarrick, 2014, p. 21). The reported challenges facing public hospitals, coupled with the constantly changing environment driven by innovation and technology, requires strategic leadership and change approaches to effect service delivery improvements in public hospitals.

# CHAPTER THREE: RESEARCH METHODOLOGY

## 3.1 Introduction

Research methodology refers to the description and justification of the approaches employed by the researcher to systematically conduct the study and respond to the research problem and questions (Mishra & Alok, 2017). This chapter outlines how the study was undertaken to address the research objectives. It thoroughly describes the research design, sampling design, methods and techniques used to collect and analyse data. Moreover, this chapter includes challenges experienced during data collection as well as matters of ethics, validity and reliability of results.

## 3.2 Research Paradigm/Tradition

A research paradigm, sometimes called a worldview, refers to shared beliefs or understandings about research or assumptions on how things work in research (Brown & Dueñas, 2020). As philosophical assumptions, research paradigms are essential; they inform the study's design, methods or approaches, whether qualitative, quantitative or mixed-method research (Saunders, et al., 2019). Crewell (2018) emphasized that researchers must select the philosophical worldview before conducting a study because paradigms provide ground rules that will guide the data collection, analysis and presentation. According to Creswell (2018), there are four research paradigms commonly used in qualitative research: postpositivism, constructivism, transformative and pragmatism paradigm. Figure 3.2 characterises these four paradigms. Adapting from the work of Burrell and Morgan (1979), functionalism, interpretivism, radical humanism and radical structuralism are the four paradigms most specific to organisational analysis; Figure 3.3 presents a brief analysis of these paradigms. Irrespective of the field of study or branch of philosophy, all paradigms comprise four elements: axiology, epistemology, ontology, and methodology – Table 3.1, which are the primary building blocks that construct the philosophical assumptions of the paradigms (Brown & Dueñas, 2020). These elements are concerned with the following:

**Table 0.1: Characterisation of Axiology, Epistemology, Ontology, and Methodology**

| Axiology | Epistemology | Ontology | Methodology |
|---|---|---|---|
| The role of values | The view of knowledge | The nature of reality | The process of research or acquiring knowledge |

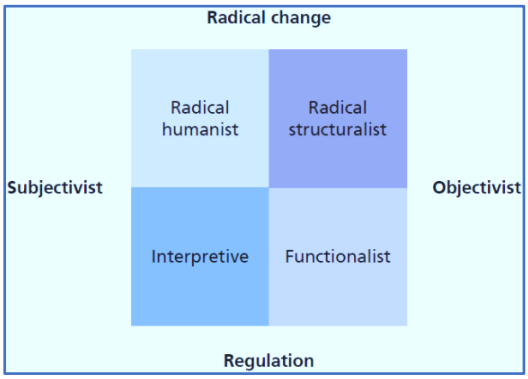
**Adapted from:** (Saunders, et al., 2019; Brown & Dueñas, 2020)

**Figure 0.1: The Four Worldviews**

| Postpositivism | Constructivism |
|---|---|
| • Determination<br>• Reductionism<br>• Empirical observation and measurement<br>• Theory verification | • Understanding<br>• Multiple participant meanings<br>• Social and historical construction<br>• Theory generation |
| **Transformative** | **Pragmatism** |
| • Political<br>• Power and justice oriented<br>• Collaborative<br>• Change-oriented | • Consequences of actions<br>• Problem-centered<br>• Pluralistic<br>• Real-world practice oriented |

**Source:** (Creswell & Creswell, 2018, p. 45)

**Figure 0.2: Four Paradigms of organisational analysis**




**Source:** (Saunders, et al., 2019, p. 140)

**Table 0.2: Definition of Research Paradigms**

| | |
|---|---|
| **Radical humanism** | The radical humanist paradigm holds a subjective view with an emphasis on change. This paradigm acknowledges that society is made up of structures which can result in domination or inequality. Therefore, radical humanist studies can share insights, experiences or views from a critical perspective that can change the status quo and be empowering, e.g., feminist theories. |
| **Radical structuralism** | The radical structuralist paradigm holds an objective view with an emphasis on change. The belief is that structural relationships, inequality, or conflict are part of reality and can be explained logically. Research within this paradigm uses scientific methods, and they acknowledge inequality or power dynamics as patterns that characterize the reality of the world and the nature of knowledge. They are committed to radical change to destabilise the status quo of inequalities. |
| **Interpretivism** | The interpretive paradigm believes in subjectively understanding the world as it exists. Researchers in this paradigm capture the participants' experiences and realities and understand that there are multiple realities in interpretation. The key emphasis is on understanding people's lived realities. |
| **Functionalism** | The functionalist paradigm is a positivist perspective which believes that reality can be objectively studied. It is rooted in the viewpoint of the traditional science on logical and measurement-based problem-oriented approach where research aims to provide practical solutions from rational explanations. |

**Adapted from:** (Taylor & Callahan, 2005, pp. 253-257)

Table 3.2 describes the research paradigms and Table 3.3 presents a philosophical account of the radical humanism, radical structuralism, interpretivism and functionalism paradigms.

**Table 0.3: Characterisation of Paradigm Elements**

| Philosophical Element | Radical humanism | Radical structuralism | Interpretivism | Functionalism |
|---|---|---|---|---|
| **Axiology**<br>Role of values | Value bound | Value-free in quantitative studies and can be value bound in mixed-method research | Value bound | Value-free, and the researcher is neutral or detached from what is being researched |
| **Epistemology**<br>View of knowledge | Knowledge has to be personally experienced, and science is historical | Knowledge has to be acquired, and science is class-specific | Knowledge has to be personally experienced, and science is value-laden | Knowledge has to be acquired, and science is value-free. |
| **Ontology**<br>Nature of reality | Phenomena are subjective and are a product of the individual's mind.<br>*Political or economic reality* | Reality is objective and external to the individual.<br>*Singular (quantitative) or multiple realities (mixed method)* | Reality is subjective and consists of the individual's lived experiences<br>*Multiple realities* | Reality is objective and measurable or quantifiable<br>*Single reality* |
| **Methodology**<br>Process of research | Inductive | Deductive | Inductive or participatory | Deductive |
| **Research Type** | Participatory action research, emancipatory action research or critical discourse analysis | Technical action research, experimental research, quasi-experimental research or mixed-method research | Case study, ethnography, phenomenological research, grounded theory, discourse analysis, narrative analysis, exploratory sequential research or mixed method research | Descriptive study, correlational research, survey research, mixed explanatory sequential design, mixed convergent parallel design or mixed multiphase design |

**Adapted from:** (Ardalan, 2010; Gunbayi & Sorm, 2018)

This study adopted interpretivism, with the connotations of social constructivism, with the semblance of a deductive approach. The interpretive paradigm was fit to guide the direction of this research because of the following characteristics:

- Interpretivism believes that understanding the world being studied requires the in-depth subjective experience of participants.
- Interpretivism argues that a qualitative approach captures context-bound human experiences and this paradigm values participants as part of the research.
- Investigates and describe the real-life context of a phenomenon being studied.

Creswell (2014) argued that people develop subjective meanings from the realities of the world they live and work in. The nature of the topic and the research objectives of this study warranted philosophical underpinnings that allow the capturing of participants' understanding and knowledge of the environment they work in and live in. Interpretivism was ideal for this study because the epistemology and ontology of this paradigm believe that reality is relative and multiple (Belk, et al., 2012).

Further to the above, the interpretivist paradigm posits that reality is based on the social and experiential construct developed through meanings and understanding drawn from reality (Angen, 2000). Therefore, through a qualitative study, following an inductive approach of

drawing meanings from applicable leadership theories and employing semi-structured interviews and a self-administered questionnaire, this study captured multiple views from individual managers who participated in it for analysis. Figure 3.4 presents a philosophical description of the interpretive paradigm from Saunders et al. (2019).

**Figure 0.3: Interpretivism**

| **Ontology** (nature of reality or being) | **Epistemology** (what constitutes acceptable knowledge) | **Axiology** (role of values) | **Typical methods** |
|---|---|---|---|
| | **Interpretivism** | | |
| Complex, rich<br>Socially constructed through culture and language<br>Multiple meanings, interpretations, realities<br>Flux of processes, experiences, practices | Theories and concepts too simplistic<br>Focus on narratives, stories, perceptions and interpretations<br>New understandings and worldviews as contribution | Value-bound research<br>Researchers are part of what is researched, subjective<br>Researcher interpretations key to contribution<br>Researcher reflexive | Typically inductive. Small samples, in-depth investigations, qualitative methods of analysis, but a range of data can be interpreted |

**Source:** (Saunders, et al., 2019, p. 145)

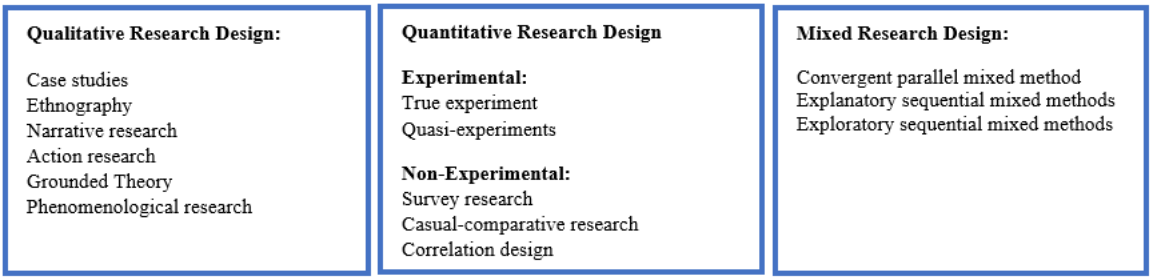
## 3.3 Research Design

A research design is a plan, procedure or strategy adopted by the researcher which informs the data collection, analysis and presentation of results (Creswell & Creswell, 2018). Elaborating further, Saunders et al. (2019) emphasised that selecting an appropriate research design should be informed by the research question so that the research project can adopt suitable techniques and methods. Concurring, Kerlinger (1986) argued that a research problem suggests the research design because and in return, the research design expresses the structure of the research problem and the appropriate plan of investigation to be used to attain empirical evidence on the research problem or questions.

According to Kerlinger (1986, p. 282), "research designs are invented to enable researchers to answer research questions as validly, objectively, accurately and economically as possible". Therefore, the association between the research question and design is fundamental to the overall research process because an inappropriate design can compromise the quality of the research (Cronin, et al., 2014). This study adopted Saunders et al, Cronin et al, and Kerlinger's prescriptions for choosing the appropriate research design. The researcher selected the research design with the best tools or approaches capable enough to respond to the question of the imperative of strategic leadership and change management in a volatile era.

Figure 3.1 presents some examples of the research designs under the three research approaches: qualitative, quantitative and mixed method three research designs.

**Figure 0.4: Research Design Types and Examples**




**Adapted from:** (Asenahabi, 2019, p. 78)

## 3.4 Research Approach

The research approach refers to the method employed when conducting research. Research can take a qualitative, quantitative or mixed method. These methods are defined and discussed below.

### 3.4.1 Qualitative Research

Qualitative research is an idealistic approach to research that captures participants' beliefs, experiences, attitudes and behaviours, seeking in-depth understanding through collecting and analysing data non-numerically (Pathak, et al., 2013). In an inquiry into understanding a social phenomenon, qualitative research is descriptive, exploratory, explanatory, humanistic, complex and sensitive to detail (Azungah, 2018). Additionally, qualitative research "studies, documents, analyses, and interprets how human beings construct and attach meanings to their experiences" (Patton, 2015, p. 13). Hence, it is less structured and more flexible in the nature of the approach, enabling participants to voice their opinions and share their interactive experience of social reality on the phenomenon of investigation (Azungah, 2018). Such flexible approaches can be accomplished through focus groups, interviews, questionnaires, case studies, and first-hand or participant observation when collecting data (Saunders, et al., 2019; Creswell, 2014). These data collection methods allow researchers to address complex questions and answer them in different ways without dealing with variables, treatment, or hypothesis testing (Flick, 2018).

This study used a qualitative approach to investigate the role, significance and impact of strategic leadership and change management at Mshiyeni hospital in this era of unpredictable

constant change. Qualitative research provided the appropriate tools for in-depth and descriptive contextualisation of the research questions from the lived experiences of hospital managers who participated in this study. For instance, the semi-structured interviews and a focus group session proved to be the best-fit instruments to capture the complex views, personal perspectives and narratives of each participant of this study.

### 3.4.2 Quantitative Research

Quantitative research systematically investigates social phenomena involving measurements or statistical data to analyse, calculate or verify relationships or trends (Watson, 2015). Additionally, quantitative research collects numerical data through mathematical-based methods to measure social reality or find quantities in the subject matter of investigation (Sukamolson, 2007). Examples of quantitative research types include correlational, experimental, survey, and causal-comparative research (Saunders, et al., 2019). According to Creswell (2014, p. 4), the research inquiry in quantitative research is typically based on deductively testing a theory or building protection against bias based on a specific assumption to draw conclusions or findings which can be generalised or replicated.

### 3.4.3 Mixed Method Research

A mixed method is an approach to research where both qualitative and quantitative approaches are combined in a study (Creswell & Creswell, 2018). According to Sukamolson (2007, p. 10), "mixed method research is a flexible approach where the research design is determined by what needs to be found rather than by any predetermined epistemological position. In mixed method research, qualitative or quantitative components can predominate, or both can have the equal status". A mixed method is an ideal solution in research enquiries where qualitative or quantitative research cannot sufficiently address the research problem when applied independently (Creswell, 2012).

## 3.5 Study Population and Sampling

This study targeted a minimum of fourteen participants who lead or manage the hospital's operational and service departments or units at Mshiyeni hospital. Having purposefully excluded departments that were not relevant to the study, there was a clear direction of whom to target through purposive sampling. Twenty-five invitations or requests for participating in the study were sent electronically through emails to the targeted population. The researcher made an initiative to make telephone calls and on-site visits to the hospital to those potential

participants who could not be accessed electronically. Table 3.4 presents the participants' profiles, it should be noted that for confidentiality purposes, all participants were allocated pseudonyms which are used in the discussion of the results, instead of using the participants' true names.

Fifteen participants welcomed the participation request and based on availability and convenience, data collection occurred in the following manner:

- Four participants utilised the Google Form questionnaire and responded electronically,
- One participant responded to the questionnaire and emailed the responses,
- Eight one-on-one semi-structured interviews were conducted with participants, and
- A focus group with two participants was conducted. *(It should be noted that the initial number of participants who had confirmed availability for the focus group was five. These leaders were approached in a meeting session where seven leaders who are in the same level/portfolio were present and welcomed the researchers request to participate in the study. A suitable date where five prospective participants availed themselves was agreed upon. Due to the demanding nature of their job, a suggestion to meet as a group was made. Unfortunately, on the date of the focus group, three of the leaders had to attend to emergencies, leaving availability of two participants. Given the busy schedule of the participants, the researcher continued with the two participants instead of holding one-on-one sessions as it may have resulted in rescheduling and possibly securing only one session due to availability constraints of the participants).*

**Table 0.4: Participants' Profile**

| Designation/Speciality | Section/Department | Quantity |
|---|---|---|
| CEO | General Management | 1 |
| Head Clinical Unit | Orthopaedic / Dermatology / Surgery | 3 |
| Clinical Manager | Anaesthetics / Internal Medicine | 2 |
| Deputy Director / Manager | Pharmaceutical Services / Finance / Nursing Management /Primary Health Care | 4 |
| Assistant Manager | Orthopaedic & Surgical / Paediatrics / Primary Health Care | 3 |
| Operational Manager | Maternity Operating Theatre / Paediatrics | 2 |
| **Total** | | **15** |

**Source:** Author, 2022

Sampling is the process of selecting a specific subset, group or number of units of analysis from the total population targeted for data collection (Elder, 2009). Successful sampling relies on clearly identifying the population, the sampling frame, the sample, the sampling technique and ensuring representativeness. According to Saunders et al. (2019), the population in

sampling refers to the entire group of people or items that the researcher targets to infer study findings from; this population does not necessarily have to be people; it can be any unit that data will be collected from.

The sampling frame is the total list of the people or items from which a sample will be drawn, and the sample refers to the part of the population that will be units of analysis (Kabir, 2016). Saunders et al. (2019) defined the sampling technique as the method used to identify specific entities into a sample selected from the population. There are two types of sampling methods: probability sampling, which entails the random selection of a sample, and non-probability sampling, which involves non-random sample selection based on characteristics or convenience (Creswell, 2014). According to Saunders et al. (2019), probability sampling techniques commonly used in quantitative research include simple, stratified, cluster, systematic, and multistage sampling. On the other side, non-probability sampling includes quota sampling, snowball sampling, purposive sampling, self-selection sampling, critical case sampling, and convenience sampling (Gill, 2020). Figure 3.5 presents definitions of some non-probability sampling techniques, including purposive sampling, adopted in this study.

**Figure 0.5: Qualitative Research Sampling Methods Defined**

| Sampling Method | Pros | Cons |
|---|---|---|
| Convenience (volunteer) sampling: Potential participants volunteer to participate in the research study. | Easy, efficient, economical. | May not provide participants who can supply the best information. |
| Snowball (chain) sampling: Current participants recommend persons who might be willing to participate in the study. | Practical, cost-efficient, persons appropriate for study, less time to gain trust. | Quality of referrals may be problematic and/or limited. |
| Purposive sampling: Also call purposeful, judgmental, or selective sampling. The researcher intentionally selects participants who are knowledgeable about the phenomenon being studied. Includes maximum variation sampling, homogeneous sampling, typical case sampling, extreme (deviant) case sampling, and critical case sampling. | Ability to select participants most beneficial to the study, cost-efficient, variety of strategies. | May be challenging to locate information-rich participants. |
| Theoretical Sampling: Researcher samples to generate theory. Developed by Glaser & Strauss and is the hallmark of Grounded Theory (GT). | Essential to generate theory in GT studies, clarifies researchers understanding of emerging theory. | |

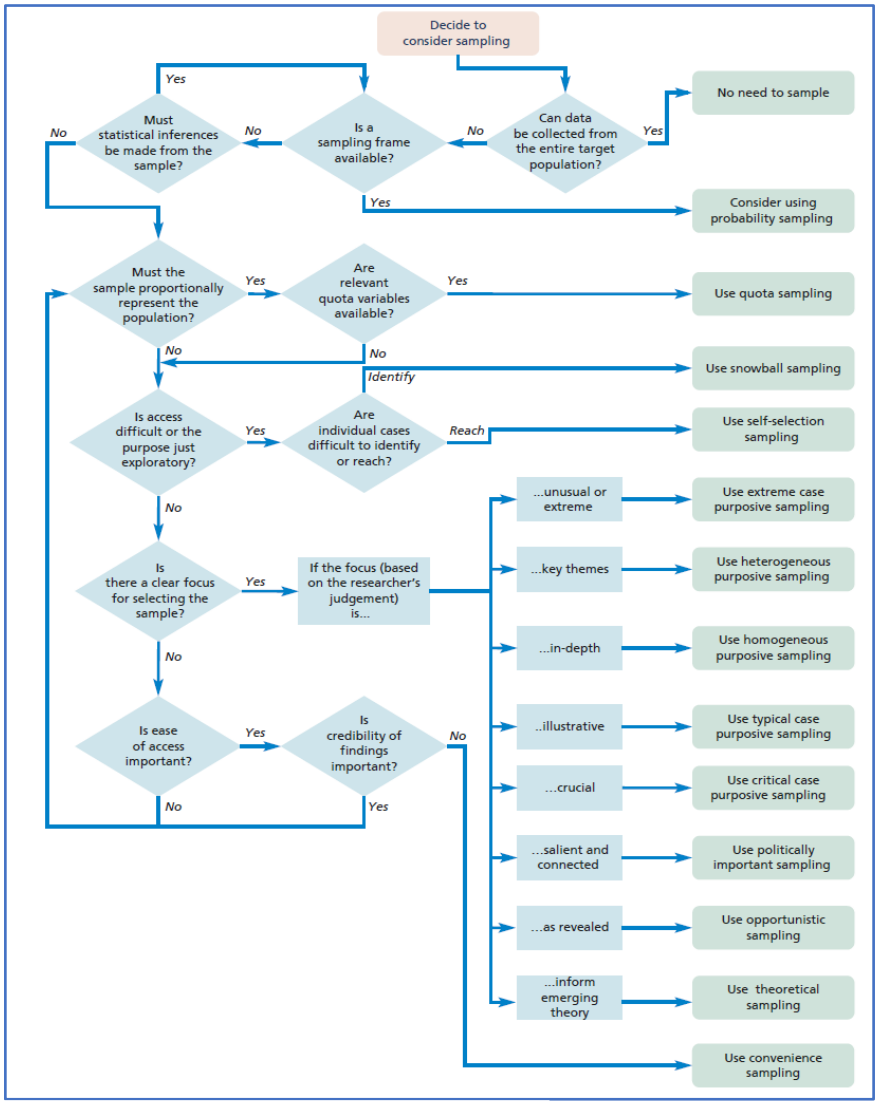
**Source:** (Gill, 2020, p. 580)

In qualitative or mixed method research, Saunders et al. (2019) advised that researchers ask themselves the below questions, illustrated in Figure 3.6, to assist in determining the appropriate sampling method.

The selection of a sampling method depends on the study's design and methodology, which are both informed by the nature of the research question and objectives (Kabir, 2016). Hence, Gill (2020) argued that samples in qualitative research are non-random because the researcher

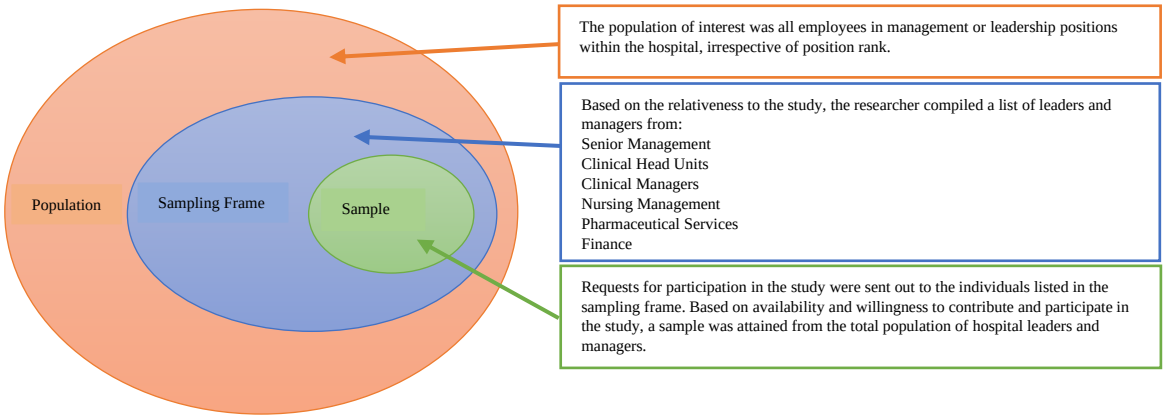
identifies the participants based on their characteristics best suited to answer the research question, such as the participant's experience, knowledge and willingness to participate. Therefore, this study employed purposive sampling because "*the concept of purposeful sampling is used in qualitative research. With purposive sampling, researchers must use own judgement to select cases that will best enable the answering of the research question(s) and to meet the study objectives. Hence it is sometimes known as judgemental sampling. Purposive sampling is often used when working with very small samples such as in case study research and when you wish to select cases that are particularly informative."* (Saunders, et al., 2019, p. 321). Figure 3.7 briefly describes the population targeted in this study, the sampling frame and how one attained the sample who participated.

**Figure 0.6: Selecting a Non-probability Sampling Method**




**Source:** (Saunders, et al., 2019, p. 316)

**Figure 0.7: Sampling in this study**




**Source:** Author, 2022

## 3.6 Validity and Trustworthiness

Validity in qualitative research is concerned with the truth value and integrity of the study findings (Polit & Beck, 2017). Moreover, Creswell and Miller (2000) argued that trustworthiness, authenticity, and credibility are the primary terms that address validity in qualitative literature, which are all based on demonstrating confidence that research findings are accurate from the researcher, participant or reader's standpoint. Unlike quantitative studies, where experimental or statistical strategies can be applied to ensure validity, qualitative studies are validated through trustworthiness and rigour dependent on truth value, consistency, neutrality and applicability (Maxwell, 1992; Noble & Smith, 2015; Stahl & King, 2020). Unlike quantitative studies, qualitative research has no expectations to result in the same conclusion or answer for coherence and credibility purposes (Leung, 2015). Because qualitative research is based on human experience; therefore, the process of conducting the study, accurately capturing the participants' narrative and presenting results mostly matter to the goal of trustworthiness (Polit & Beck, 2017).

There are various strategies that qualitative researchers can undertake for validity to ensure the accuracy and credibility of their findings. For instance, Lincon and Guba (1981) introduced four traditional aspects of a naturalist enquiry that researchers should be obligated to attend during the research process: *truth value, applicability, consistency and neutrality*. Expanding on the factors that eliminate results manipulation, Lincon and Guba (1985) outlined four rationalistic terms that create trustworthiness: *credibility, transferability, dependability, and confirmability.* These aspects and terms are described in Table 3.5.

**Table 0.5: Validity and Credibility**

| Naturalistic aspects of trustworthiness | Rationalistic terms of trustworthiness |
|---|---|
| **Truth Value -** precise reporting of the participants' views. | **Credibility** - research findings are congruent with participants' reality by accurately presenting the participants' contributions. |
| **Applicability -** determination of the extent to which study findings can be applicable in other contexts or with other participants. | **Transferability -** even though qualitative research does not aim for replicability, if the research findings are rich and thick in the description, they can portray applicability in situations similar to the phenomenon being studied. For instance, data collection from a sample that is a true representation of the population increases the degree of transferability. |
| **Consistency** - determination of whether study findings would be consistent in the case of replicating the study in a similar context or with similar participants. | **Dependability** - trust and reliability of the research findings. |
| **Neutrality -** true reflection of participants' perspectives free from researchers' biases, interests or views. This objectivity can be guaranteed by carefully selecting the appropriate research methodology. | **Confirmability** - elimination of the loss of credibility by getting close to objective reality to the best ability that qualitative research can get. |

**Source:** (Guba & Lincoln, 1981; Lincoln & Guba, 1985).

Similar to Lincon and Guba, Maxwell (1992, p. 285) presented five types of validity that researchers should be concerned about: descriptive validity, interpretive validity, theoretical validity, generalizability, and evaluative validity, arguing that such validity types fit the descriptive, explorative and explanatory nature of qualitative research. Irrespective of the author's descriptions of trustworthiness, the emphasis is on qualitative research being about understanding the participants' realities. Therefore, researchers must describe actions taken to rule out threats to the validity of the collected data in data analysis and presentation (Maxwell, 1992) mainly because validation of research findings takes place throughout the research process through the researcher employing procedures that ensure the credibility and accuracy of findings (Stahl & King, 2020). According to Noble and Smith (2015, p. 34), "qualitative researchers aim to design and incorporate methodological strategies to ensure the 'trustworthiness' of the findings". Following Noble and Smith's prescriptions, Table 3.6 presents strategies taken in this study to ensure the credibility of the research findings.

**Table 0.6: Credibility and Validity Strategies**

| Strategies taken to enhance credibility in this study | |
|---|---|
| Truth Value | -All notes from the field and communication details with participants were recorded and kept in a reflective journal.<br>-The study participants came from different units and levels of leadership, and the qualitative interviews/interview schedule allowed them to share in-depth experiences based on their knowledge, observation and participation in strategic leadership.<br>-Audio recording of the interviews allowed rigorous revisiting of data and clear capturing of participants' meanings. Thus, assisting with credibility in the discovered codes and themes as accurate participants' accounts. |

| | |
|---|---|
| Dependability | -Direct quotes and examples from participants in the presentation of results increases credibility and trustworthiness.<br>-Primary data was contextualised with secondary or published data on strategic leadership and change management (triangulation). |
| Conformability | -The study was conducted in an unfamiliar field, eliminating any form of bias or interest from the researcher. This unfamiliarity and the sampling, data collection and analysis methods guaranteed objectivity. Additionally, prolonged time was spent in the study field to understand strategic leadership in a public hospital setting.<br>-The study location was solely selected based on its unique nature of being a regional hospital that also serves as a district hospital due to its location and absence of CHCs in its vicinity. Study findings were drawn from participants' standpoints on the administered questions. |

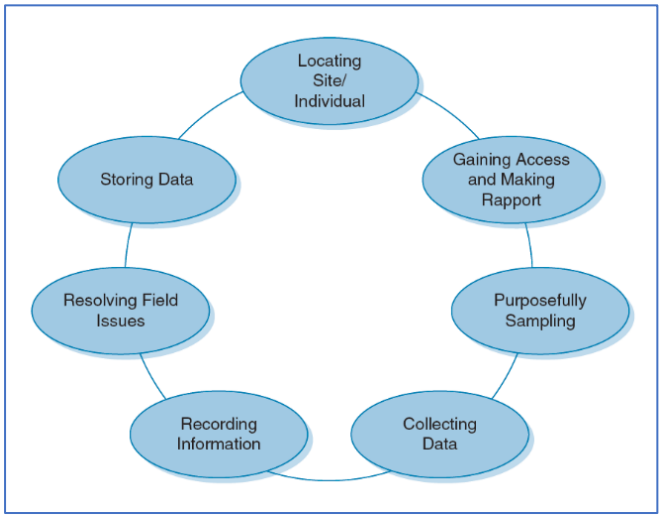
**Source:** (Noble & Smith, 2015, p. 35).

## 3.7 Data Collection

In research, data refers to facts that are yet to be collected by the researcher through various techniques or tools depending on the nature of the study to fulfil the research objectives (Baral, 2017). Giving a thorough description, Baral (2017, p. 84) explained that data can come *"in the form of facts, observations, images, computer program results, recordings, measurements or experiences on which an argument, theory, test or hypothesis, or another research output is based. It may be numerical, descriptive, visual or tactile. It may be raw, cleaned or processed, and may be held in any format or media".* Furthermore, Saunders et al. (2019) stated that data is categorised as either primary (first-hand sources) or secondary (external sources), and the form of gathering data depends on whether the study is a qualitative, quantitative, or mixed method.

Moving from describing data, the actual collection of it refers to a series of interconnected activities targeting gathering good information to answer the research questions (Creswell, 2014). For instance, as data collection occurs before analysis and presentation, the series steps include access or permission, the selection of sampling strategy, ethical considerations and other essential research processes. Figure 3.8 for data collection activities listed by Creswell and Table 3.7 present steps taken in this study.

**Figure 0.8: Data Collection Activities**




**Source:** (Creswell, 2014, p. 146)

**Table 0.7: Data Collection Activities of this Study**

| | |
|---|---|
| Locating Site and Individuals | The place to study was Mshiyeni hospital, and the research topic, questions and objectives enabled the identification of the target population within the hospital. |
| Gaining Assess and Rapport | The hospital was visited in quest of gaining access. The process was four-phased:<br>(i). The hospital acknowledged the request to conduct a study and issued a **support letter** with instructions to attain ethical clearance from the university and the KZN DoH, see *Appendix 6*.<br>(ii). The internal (hospital) support letter was submitted to the university, and **ethical clearance** was granted, see *Appendix 3*.<br>(iii). The support letter from the hospital and university ethical clearance were submitted with the research proposal to the Health Research Committee in the KZN DoH: Health Research and Knowledge Management (HRKM) Directorate. After evaluation, an **approval letter** to conduct the study in the hospital was attained, see *Appendix 4*. This letter was submitted to the relevant office in the hospital that had issued the support letter.<br>(iv). The approval letter from the HRKM and university ethical clearance was submitted to the hospital, and a **gatekeeper's letter approving** recruiting participants and collecting data was given, see *Appendix 5*. |
| Purposefully Sampling | Participation requests were sent to individuals in specific units and divisions whom the researcher compiled in a sampling frame who were purposefully selected due to having particular characteristics. |
| Collecting Data | Based on willingness, availability and consent, data were collected through semi-structured interviews, a focus group, and a self-administered digital questionnaire answered and emailed, some answered on the Google Form. |
| Recording Information | A tape recorder was used to capture both individual and group interviews. All participants consented to the recording of sessions. |
| Resolving Field Issues | The researcher can give two primary examples of field issues:<br>(i). Appointments - on various occasions, participants' availability changed without notice, and the researcher had to strategically manage rescheduling issues, especially with participants in top-management and medical leadership positions due to the demanding nature of their positions.<br>(ii). A request from participants to change the data collection approach from an individual to a group interview was resolved by the researcher and accommodated. |
| Storing Data | All primary and secondary research data is stored digitally for record and safety purposes. |

**Source:** Author, 2022

### 3.7.1 Primary Data

According to Saunders et al. (2019, p. 813), primary data refers to "data collected specifically for the research project being undertaken". For instance, data collected for the first time through specific data collection tools such as interviews or surveys describe primary data. Therefore,

the collected data that is presented and analysed in chapter four of this paper is primary data. Primary data in this study was collected in the following manner:

#### 3.7.1.1 Open Ended Research Questions

The researcher prepared sixteen open-ended questions (*Appendix 1)*, administered through interviews with available participants, and some were self-administered (internet mediated). Interviews are a common data collection method in qualitative research, particularly unstructured and semi-structured interviews because they are in-depth and face-to-face and allow the researcher to explore meaning from the experiences and perspectives of the interviewees (DiCicco-Bloom & Crabtree, 2006). Semi-structured interviews are pre-set open-ended questions scheduled to be dialogued between the researcher and participant in advance at a designated time in an organised manner (Saunders, et al., 2019). Furthermore, semi-structured interviews can be conducted with individuals or groups, commonly taking thirty minutes to a few hours to complete.

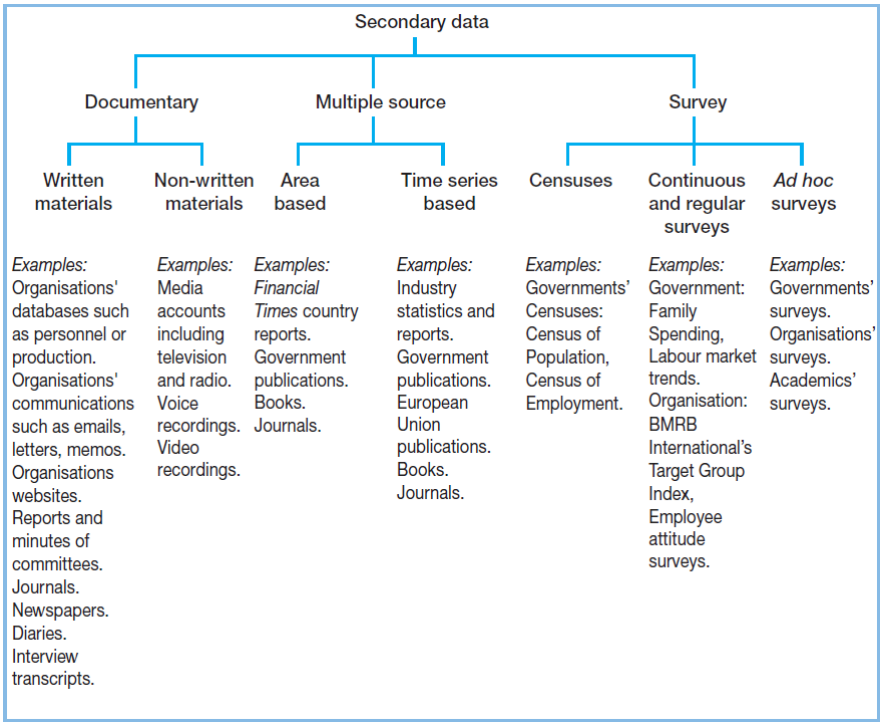
A focus group is an interview format whereby the interviewer interviews a group of participants ranging from two to eight (Creswell & Creswell, 2018). Furthermore, the same questions were uploaded on a Google Form, an administration software available as a web application where the researcher prepares questions and shares a link for participants to respond. Clicking the link enables participants to access the questions online; upon completion, participants click submit, and the researcher receives responses in real-time. Additionally, some questionnaires were emailed to participants and responses were emailed back by the participants. Sukamolson (2007, p. 16) describes this as the self-administration of research questions whereby "respondents fill out self-administered questionnaires themselves. Self-administered questionnaires are generally distributed through email. Upon receipt of the questionnaire, the respondent fills it out and returns it via mail to the researcher."

### 3.7.2 Secondary Data

Secondary data describes data already collected for other purposes and validated. This data can be raw (gone through minor statistical processing), published, numerical or qualitative in form which is reanalysed or summarised for use by researchers or writers (Saunders, et al., 2019). Figure 3.9 presents the various types of secondary data sources. In this study, secondary data sources were: unpublished dissertations and theses, published journal articles and books, internet sources, Health Systems Trust reports, and the DoH reports and policies, as well as

any other published data on leadership and change management in the public health care sector. Most of the data were already published, available in the public domain, and acknowledged adequately through referencing. A few secondary data can be categorised as raw data, which were internal policies or operation guidelines attained from the hospital records during data collection.

**Figure 0.9: Examples of Secondary Data Sources**

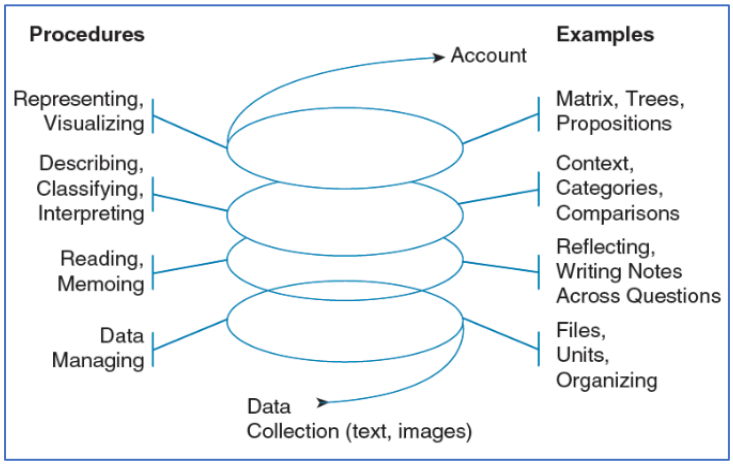



**Source** (Saunders, et al., 2019, p. 249)

## 3.8 Data Analysis

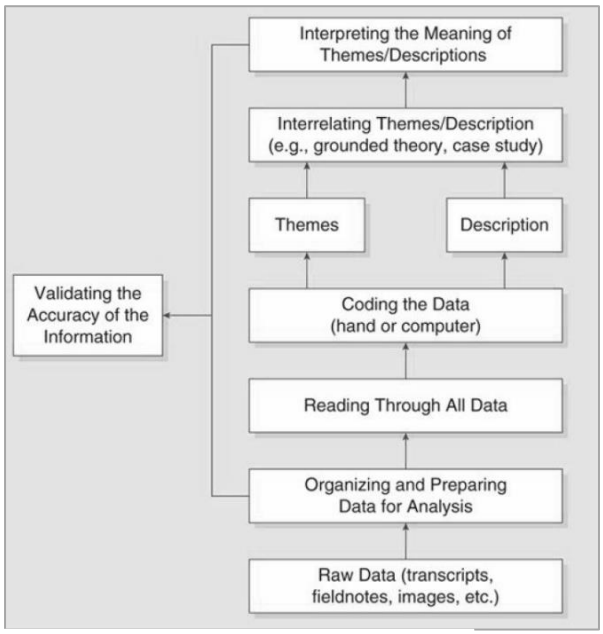
Data analysis is the process of structuring, organising and giving meaning to the mass of collected data (Marshall & Rossman, 1999, p. 150). Qualitative or quantitative data analyses differ in approach; however, what remains common is that whichever method is used must be logical, retain the richness of data and produce understandable meanings (Saunders, et al., 2019). The nature of collected data shapes the data analysis approach; therefore, data format, such as verbal, narrative characters, numerical or images, shapes the data analysis method (Development, 2006). Furthermore, Creswell (2013) argued that qualitative data analysis is not consisting of interconnected steps that are a spiral of activities (Figure 3.10). These series of interlinked activities involve organising the data, reading through the data, coding, organising themes, and presenting the data in the form of interpretation, see the outline in Figure 3.11 (Creswell, 2014).

**Figure 0.10: Data Analysis Spiral**




**Source:** (Creswell, 2013, p. 183)

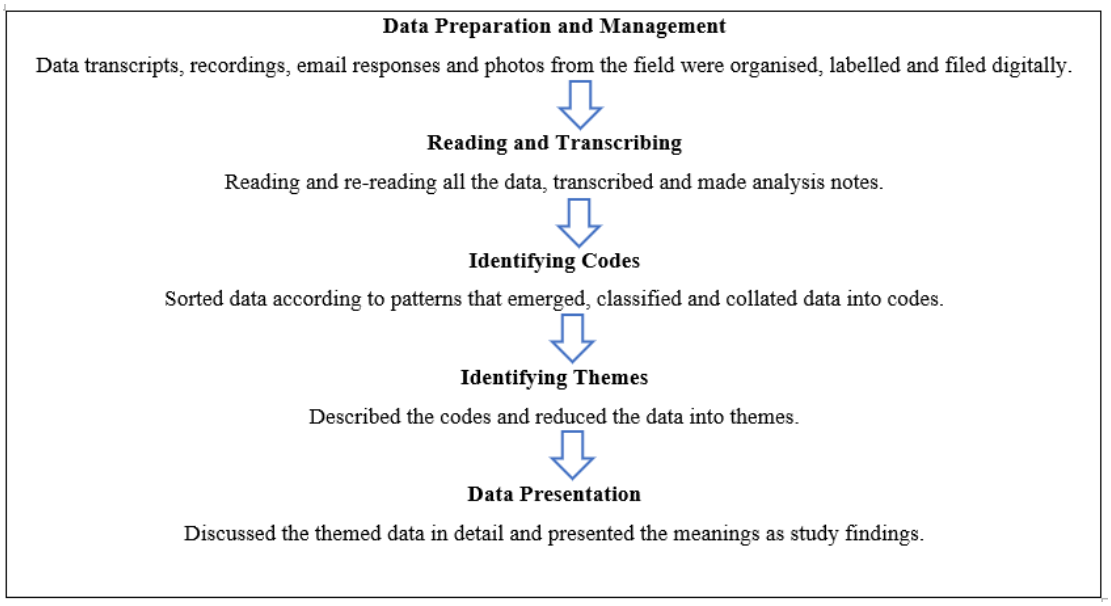
**Figure 0.11: Qualitative Research Data Analysis**




**Source:** (Creswell, 2014, p. 247)

There are various qualitative data analysis procedures; these include data display and analysis, phenomenological analysis, thematic analysis, template analysis, analytic induction, grounded theory, discourse analysis, narrative analysis and other descriptive analytical approaches (Saunders, et al., 2019). This study employed a thematic analysis. According to Braun and Clarke (2006, p. 79), thematic analysis "is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail". Table 3.8 presents the actions of thematically analysing this study's collected data.

**Table 0.8: Data Analysis**




**Source:** Author, 2022

## 3.9 Research Approach

Data collection and analysis in research can take an inductive or deductive approach (Saunders, et al., 2019). According to Bengtsson (2016), an inductive approach allows the collected data to determine the research themes and conclusions from the researchers' analysis, drawing meaningful subjects that answer the research questions. On the contrary, deductive reasoning is top-down; researchers look for existing subjects by hypotheses or principles (Bengtsson, 2016, p. 10). This study adopted inductive reasoning. This approach was followed on the basis that: *"the procedures of qualitative research, or its methodology, are characterized as inductive, emerging, and shaped by the researcher's experience in collecting and analyzing the data. The logic that the qualitative researcher follows is inductive, from the ground up, rather than handed down entirely from a theory or from the perspectives of the inquirer"* (Creswell, 2013, p. 22).

## 3.10 Ethical Considerations

Ethical concerns are significant, and researchers need ethical considerations to adhere to rules and protect research participants (Bengtsson, 2016). Saunders et al. (2019) explained that research ethics relates to the moral principles or standards of behaviour being methodologically sound and morally defensible in guiding the research process form: formulating and clarifying the research topic, selecting the research design, up to gaining access, collecting, processing,

analysing, and storing data. Figure 3.12 presents some examples of ethical considerations in qualitative research.

Ethical conduct followed in this study are as follows:

- Data was collected after receiving ethical clearance from the university, an approval letter to conduct the study at Mshiyeni hospital from the DoH HRKM - Health Research Committee, and an internal approval letter from the hospital.
- The research objectives, questions and purpose of conducting the study were communicated to the target population during the recruitment of participants.
- Prioritisation of privacy, voluntary participation, signage of informed consent, agreeing to record the interview sessions, and treating participants with respect was observed.
- Data analysis did not involve any form of bias or judgement from the researcher. The presented data is a true reflection of the participant's responses.

**Figure 0.12: Ethical Issues in Qualitative Research**

| *Where in the Process of Research the Ethical Issue Occurs* | *Type of Ethical Issue* | *How to Address the Issue* |
|---|---|---|
| Prior to conducting the study | • Seek college/university approval on campus<br>• Examine professional association standards<br>• Gain local permission from site and participants<br>• Select a site without a vested interest in outcome of study<br>• Negotiate authorship for publication | • Submit for institutional review board approval<br>• Consult types of ethical standards that are needed in professional areas<br>• Identify and go through local approvals; find gatekeeper to help<br>• Select site that will not raise power issues with researchers<br>• Give credit for work done on project; decide on author order |
| Beginning to conduct the study | • Disclose purpose of the study<br>• Do not pressure participants into signing consent forms<br>• Respect norms and charters of indigenous societies<br>• Be sensitive to needs of vulnerable populations (e.g., children) | • Contact participants and inform them of general purpose of study<br>• Tell participants that they do not have to sign form<br>• Find out about cultural, religious, gender, and other differences that need to be respected<br>• Obtain appropriate consent (e.g., parents, as well as children) |
| Collecting data | • Respect the site and disrupt as little as possible<br>• Avoid deceiving participants<br>• Respect potential power imbalances and exploitation of participants (e.g., interviewing, observing)<br>• Do not "use" participants by gathering data and leaving site without giving back | • Build trust, convey extent of anticipated disruption in gaining access<br>• Discuss purpose of the study and how data will be used<br>• Avoid leading questions; withhold sharing personal impressions; avoid disclosing sensitive information<br>• Provide rewards for participating |
| Analyzing data | • Avoid siding with participants (going native)<br>• Avoid disclosing only positive results<br>• Respect the privacy of participants | • Report multiple perspectives; report contrary findings<br>• Assign fictitious names or aliases; develop composite profiles |
| Reporting data | • Falsifying authorship, evidence, data, findings, conclusions<br>• Do not plagiarize<br>• Avoid disclosing information that would harm participants<br>• Communicate in clear, straightforward, appropriate language | • Report honestly<br>• See APA (2010) guidelines for permissions needed to reprint or adapt work of others<br>• Use composite stories so that individuals cannot be identified<br>• Use language appropriate for audiences of the research |
| Publishing study | • Share data with others<br>• Do not duplicate or piecemeal publications<br>• Complete proof of compliance with ethical issues and lack of conflict of interest, if requested | • Provide copies of report to participants and stakeholders; share practical results; consider website distribution; consider publishing in different languages<br>• Refrain from using the same material for more than one publication<br>• Disclose funders for research; disclose who will profit from the research |

**Source:** (Creswell, 2013, pp. 58-59)

### 3.11 Sensitivity to COVID-19 Regulations

All Covid-19 protocols were followed during this study. The initial recruitment of participants was digital to avoid physical contact. During contact sessions during data collection, the researcher complied with the wearing of the mask, temperature screening at the entry point of the hospital, and social distancing during interview sessions.

### 3.12 Study Challenges

In the conduction of this study, the researcher encountered the following challenges, which prolonged the study duration and affected the planned study timelines.

**Communication:** accessing and reaching most hospital staff via email was the most significant challenge. For instance, a low response rate was noted despite the assurance of delivery and read receipt of the email. Secondly, server-related issues, such as institutional work emails not being accessible to specific individuals, especially Nurses and Doctors, were noted, leading to the use of personal emails. To resolve this issue, several physical visits to the hospital were made. This action was effective as the researcher discovered that the lack of responses on the emailed participation request was not due to request decline as physical contact resulted in positive outcomes.

**Availability:** the nature or scope of work for Nurses and Doctors maximised the occurrence of missed appointments or non-availability of participants on scheduled time. For instance, most scheduled interview sessions were rescheduled because participants had to attend to emergencies without prior notice to the researcher. Similar to resolving the communication issue, physically visiting the participants opened an opportunity for the targeted individuals to share their contact details and preferred method of communication with the researcher. Additionally, this approach assisted greatly as the administrative staff assisted with guiding the researcher on the appropriate time to reach the participants whose availability was slim due to the nature of their positions, such as the hospital CEO. As a result, navigating the availability of the participants and rescheduling became easier.

**Participation:** a lack of willingness to participate in the study from certain individuals in critical positions was observed. Such action was quite contrary to the teaching and learning values of the institution. Participation in the study was voluntary, therefore the researcher noted and accepted the decline without any action. It should be noted that majority of the targeted

population welcomed the request, and the rejection was centralised to a specific department, regardless, the ethical action to take was to respect both positive and negative responses.

### 3.13 Chapter Summary

This research methodology chapter described and justified all the processes and methods adopted in this study. The chapter discussed the research design, philosophical position, sampling approach, data collection and analysis process, ethical considerations and challenges faced in this study. The following chapter will narrate the presentation and discussion of the empirical result under the auspices of the thematic analysis.

# CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

## 4.1. Introduction

This chapter presents a narrative passage to convey findings that emerged from data analysis of the study into the role, significance and impact of strategic leadership and change management at Mshiyeni hospital in today's volatile and complex era. The raw data collected was segmented and interpreted to draw sense and meaning from the text. It was further put back together as a detailed discussion and analysis of coherent and interconnecting themes and sub-themes from the participant's multiple perspectives. This chapter begins with presenting identified themes and demonstrating their connection to the research objectives and questions. It goes on to present the analysis and discussion of the research findings and concludes the chapter.

## 4.2 Summary of Findings

Empirical data showed that Mshiyeni hospital uses more than one leadership style. As cited by the participants, autocratic, democratic, transformational, visionary and situational leadership are the primary leadership styles used interchangeably in the hospital. Leaders carefully assess each situation and apply the most fitting style based on its likelihood of yielding positive results. Central to it all was the prioritisation of the flexibility to strategically employ a leadership style that would best accomplish specific objectives and best outcomes. The absence of a one-size-fits-all approach to leadership characterised strategic leadership at the hospital level.

Further findings showed that Mshiyeni hospital operates in a dynamic and complex environment surrounded by multiple challenges directly affecting hospital operations. Dominating the reported challenges were external factors such as budget limitation, which on its own demonstrated to result in a web of interconnected stressors which compromise hospital operations. For instance, the financial issues mentioned by the participants affected HR processes such as staffing, facility processes such as infrastructure maintenance and many other factors which affect the work environment handicapping successful performance and efficient delivery of healthcare services.

Having discovered the situational impediments, turbulence, and constant changes experienced, it was evident that the survival of the hospital and its proper operations resulted from the leadership actions, behaviours and interventions. These were noted to be the main things that

positively affected the performance of this hospital—showing that strategic leadership activities play a significant role in the hospital's performance.

Findings showed that Mshiyeni hospital has a sound understanding of change management. It was noted that at the hospital level, leaders could draw from the standard operating procedures provided by the provincial or national departments and adapt them through sound change management strategies. For instance, it was discovered that the hospital could customise internal change management approaches without deviating from the broad institutional prescriptions. The backbone of managing change was pointed out to be investing in planning and anticipating change. However, it was discovered that the hospital could improve managing unexpected and unplanned changes.

The hospital leaders inform change and empower employees to follow suit. The examples of changes and the hospital leaders' approaches demonstrated the hospital's flexibility and adaptability. They demonstrate that the hospital invests in planning for change and has a positive attitude towards change which is a good character given that it operates in a complex and constantly changing environment. The hospital has a sound performance management system which integrates service agreements and evaluation of performance, which can improve accountability. Overall, empirical evidence showed that strategic leadership positively impacts the service and operations of Mshiyeni Hospital.

### 4.3 Themes Presentation

Themes emerge from a thorough analysis of data sources such as fieldnotes, interview transcripts or reflective memos consisting of participants' lifeworlds through the coding process (Williams, 2008, p. 248). The researcher prepared these themes after close engagement and interactive reading, reduction, definition, redefinition and identification of patterns or substantial connections to produce meaning analysis (Williams, 2008; Yates & Leggett, 2016). This study grouped corresponding responses according to codes that emerged during data analysis. Further analysis led to the identification of themes and sub-themes, which were all linked to the research objectives. Each research objective consisted of specific research questions in the following manner: objectives one and two had four questions each, three for objective three and five for objective five, totalling 16 questions administered to the participants (see interview schedule in Appendix 1). Table 4.1 presents the themes and the related research objectives.

The presented themes are aligned with the study objectives and questions in the following manner:

**Objective One**

**Main Themes:** *The Leaders and their Organisation*

*Multiple Leadership Styles*

***Sub-theme****: Leader Behaviour*

The first objective of this study was to assess the existential strategic leadership style at Prince Mshiyeni Memorial Hospital. The questions under this theme targeted identifying the leadership style and obtaining participants' views on the relativeness of the leadership styles they use to the hospital objectives. Additionally, personal profiling questions were administered to tap into each participant's understanding of strategic leadership and to capture the actual actions to determine effectiveness in hospital management.

**Objective Two**

**Main Theme:** *Strategic Alignment*

***Sub-theme:*** *Organisational Endurance*

The second objective was to determine the impact of strategic leadership style on organisational performance. Participants were asked to identify the impact of strategic leadership on performance and service delivery in the hospital. Further probe into the state of the hospital as a workplace was made by asking participants to identify existing challenges in their workplace and provide mitigation strategies to these challenges.

**Objective Three**

**Main Themes:** *Preparedness: Expecting the Unexpected*

The third objective of this study was to investigate the leaders' perceptions of change management in public hospital management. Participants were asked to identify the changes experienced and speak to determine the impact of these challenges on hospital operations.

**Objective Four**

**Main Themes:** *Performance Management*

*Community Voices*

The fourth objective aimed to examine ways the hospital can improve its strategic leadership and management style in this rapidly changing era for effective and efficient performance.

Participants were questioned on the approaches used to address change and disruptions. Moreover, considering patient views and opinions as end-users of the hospital services were questioned.

**Table 0.1: Synchronisation of Objectives and Main Themes with relatable Sub-Themes**

| Study Objectives | Discovered Themes |
|---|---|
| To identify the current strategic leadership style at Prince Mshiyeni Memorial Hospital | The Leaders and their Organisation<br>Multiple Leadership Styles<br>*Sub-theme:* Leader Behaviour |
| To determine the impact of strategic leadership style on organisational performance | Strategic Alignment<br>*Sub-theme:* Organisational Endurance |
| To investigate the perceptions of leaders on change management in public hospital management | Preparedness: Expecting the Unexpected |
| To offer recommendations on how the hospital can improve the strategic leadership and management style in this rapidly changing era for effective and efficient performance | Performance Management<br>Community Voices |

**Source:** Author, 2022

## 4.4 Presentation and Discussion of Results

Qualitative data presentation is reporting empirical data interpretation through the communication of meaningful insights, drawn inferences and their implications to the research questions or objectives (Burnard, et al., 2008). Presentation of findings comes after careful data analysis, and researchers can use extracts from interviews, focus groups or any source of collected data to express meanings and justify the analysis (Attride-Stirling, 2001). Researchers do not need to use all the participants' responses. Focusing on expressive, meaningful data that holds weight and depth to the research problem is advisable. The writing of long extracts should be highlighted, indented, numbered and explained, while short extracts can be in standard sentence structure (Attride-Stirling, 2001). This study undertook thematic analysis which involves identifying codes, processing and evaluating them to derive themes, while the presentation of its findings involves reporting the multiple, logical meanings from interpretation as an unequivocal understanding or meaning solicited from participants' words (Casimir, et al., 2022).

This presentation of findings contextualised the participants' responses with secondary data from relevant publications, including those presented earlier in chapter two of this study. Discussions appropriately cited the participants' pseudonyms, and direct quotations from participants will be typed in italics for clarity, emphasis and easy identification purposes. It should be noted that the quoted text in this chapter four is not in formal academic language, as

these quotes are direct inserts of the participants' responses, free from the researchers' editing or paraphrasing.

### 4.4.1 The Leaders and their Organisation

The leadership role, position and experience in public hospital leadership guided the careful recruitment of the participants of this study. In the interview schedule, three research questions were targeted to draw a background profile of the participants and their workplace and to determine specific leader actions. These questions were as follows:

- How many years do you have in hospital management, and in your years of experience, what can you highlight as the most important aspect of public hospital management /leadership?
- In your leadership role within this hospital, to what extent do you participate in strategic planning and decision-making?
- What competencies would you consider as crucial in hospital leadership?

In the previous chapter, Table 3.4 gave a profile of the participants by outlining the designation and departments they work in. Extending this profile, Table 4.2 presents each participant's number of years in hospital leadership. It further lists the aspects and competencies pointed out by the participants as critical personal characteristics that influence strategic leadership in hospital management. It is argued that today's healthcare environment requires managers and leaders to have a wide range of competencies to manage operations and continuously adapt to new evidence, technologies or processes created by innovation or change (Porter-O'Grady, et al., 2018, p. 106). These authors further argue that adapting to the current environment requires specific knowledge to forecast strategically, innovatively, and creatively. Advance and develop effective structures of operating amid complexity.

Additionally, this profile describes the level of engagement in strategic decision-making within the hospital with examples of the roles played by the participants categorised in the low, medium or high value. Most importantly, Table 4.2 introduces the pseudonyms allocated to the participants. According to Given (2012), a pseudonym is a fictional name created by the researcher to give identity to a research subject or participant as an ethical code that satisfies anonymity and confidentiality. Participants were cited according to their pseudonyms throughout this empirical data analysis presentation section.

**Table 0.2: Participant's Introduction**

| Pseudonym | Years in hospital management | Important competencies | Key aspects | Role in strategic planning |
|---|---|---|---|---|
| Jane | 17 | -Good communication<br>-Constant & continual inclusion of staff<br>-Listening skills | ***Strategic leaders need to:***<br>-Be open to change<br>-Consider diverse inputs by valuing the participation and inclusion of all employees | ***Level of involvement:*** Low<br>***Example:*** Strategic engagement through reporting and proposing solutions to line management for acknowledgement. |
| Dave | 6 | -Communication<br>-Innovation<br>-Planning | ***Strategic leaders must value:***<br>-Accountability<br>-Strategic thinking<br>-Transparency | ***Level of involvement:*** Medium<br>***Example:*** Involved in the departmental, unit and internal leader's meeting sessions. |
| Linda | 3 | -Creativity<br>-Commitment<br>-Supportive | ***Hospital leaders must be:***<br>-Innovative in practice<br>-Willing to coach juniors<br>-Dedicated | ***Level of involvement:*** Medium<br>***Example:*** Engage in senior management strategic review, planning and implementation meetings. |
| Steve | 21 | -Passionate about people<br>-Commitment to serve<br>-Empathy and caring ethos<br>-Golden heart<br>-Diplomatic and clear communicator | ***Have a sound understanding of:***<br>-Health systems & policies<br>-Governance & service delivery<br>-Finance & resource management<br>-Human resource management<br>-The seven pillars of clinical governance | ***Level of involvement:*** High<br>***Example:*** Direct involvement in designing, planning and implementing strategic decisions. |
| Gill | 10 | -Planning and organising skills<br>-Implementation and monitoring skills<br>-Mobilisation skills<br>-Be able to inspire<br>-Know & understand the work environment | ***Prioritise:***<br>-Continuous learning<br>-Human resource management<br>-Teamwork<br>-Trustworthiness<br>-Leading by example | ***Level of involvement:*** High<br>***Example:*** Participate in the reviewing, planning, budgeting and other important decision-making sessions. |
| Alisha | 7 | -Knowledge<br>-Skilled and experience<br>-Education level and work experience must match the leadership position | ***Strategic leaders must be able to:***<br>-Align objectives/ targets with plans<br>-Employ effective performance evaluation mechanisms | ***Level of involvement:*** High<br>***Example:*** Have a sit in the departmental and committee meetings that deal with the hospital's strategic development. |
| Patrick | 11 | -Financial management skills<br>-Project Management skills<br>-Human Resource Management skills | ***Leaders need to be:***<br>Familiar with information and technology tools and systems | ***Level of involvement:*** High<br>***Example:*** Highly involved in shaping targets and strategies. |
| Nancy | 4 | -Democratic approach to problems | ***Strategic leaders should value:***<br>Participation and Transformational leadership | ***Level of involvement:*** Low<br>***Example:*** Engage through open consultation with the line manager. |
| Clare | 22 | -Knowledgeable<br>-Continuous learning<br>-Share knowledge and empower subordinates | ***It is important for leaders to:***<br>-Attend supervision and leadership courses<br>-Innovatively manage people | ***Level of involvement:*** Low<br>***Example:*** Minimal involvement, limited to departmental level. |
| Mary | 7 | -Communication skills<br>-Good relationship skills | ***Strategic leaders need to:***<br>-Listen well<br>-Maintain healthy relationships<br>-Have good decision-making skills | ***Level of involvement:*** Low<br>***Example:*** Can only influence the operational level strategic direction of the department. |
| Pam | 17 | -Flexibility<br>-Communication<br>-Critical thinking<br>-Patience<br>-Listening skills | ***Effective strategic leaders:***<br>-Develop positive relations with staff by being present, visible and approachable<br>-Get familiar with the employees and the environment around them<br>-Coach, instead of criticising<br>-Acknowledge and commend good efforts/achievements | ***Level of involvement:*** High<br>***Example:*** Great influence and involvement in setting strategic objectives of the hospital. |
| Mandy | 10 | -Management skills<br>-Fairness<br>-Firmness<br>-Sympathy | ***Strategic leaders are:***<br>-Multi-skilled<br>-Neutral and treat employees equally<br>-Approachable | ***Level of involvement:*** High<br>***Example:*** Involved in recommending strategic solutions to hospital challenges. |
| Mark | 10 | -Ability to manage crisis<br>-Ability to work with a constrained budget<br>-Ability to make the most out of limited resources and scarce skills<br>-Negotiation skills<br>-Manage stakeholders well<br>-Public and social media management | ***Strategic leaders' values:***<br>-Flexibility<br>-Accountability<br>-Leading with integrity<br>-Ability to unite diverse people<br>-Continuous improvement | ***Level of involvement:*** Low<br>***Example:*** Minimal involvement, only through suggestive inputs. |
| Sophia | 24 | -Understanding the leadership style<br>-Understanding the community being service<br>-Understanding management role/duties and that of employees | ***Hospital leaders need to:***<br>-Take management, leadership and financial management courses in addition to their health/clinical qualifications. | ***Level of involvement:*** High<br>***Example:*** Able to raise opinions and contribute to executive decision-making. |
| Gerald | 6 | -Good people skills<br>-Love and dedication to health service work<br>-Master to work with limited resources<br>-Cross-departmental and intergovernmental understanding for efficient stakeholder and referral management<br>-Efficient general office management | ***Hospital management needs to:***<br>-Be Compassionate,<br>-Have a positive attitude<br>-Communicate well and clearly | ***Level of involvement:*** High<br>***Example:*** Directly involved in the structuring and setting of hospital direction. |

**Source:** Author, 2022

The participants described their place of employment as challengingly unique and one of the busiest public hospitals in SA. The highlight of the uniqueness of this hospital emanates from its location, extensive roles and services it provides. For instance, Mshiyeni is officially a regional hospital located in Umlazi, South of eThekwini. Nevertheless, it plays the role of a district hospital and is currently piloting a sub-district PHC model. This hospital has eighteen clinics and two mobile clinics under its operation. Describing this complex characterisation, Steve explained that ordinarily:- *"Clinics form part of district management; Prince Mshiyeni is a regional hospital that is supposed to have at least two district hospitals around who refer patients to Mshiyeni. However, there is no referring district hospital for Mshiyeni".*

This existing mixture of regional and district health systems significantly broadens this hospital's roles and leadership demands. According to the KZN Department of Health (2014), the regional and district-level health services offered by Mshiyeni hospital are as follows (Table 4.3):

**Table 0.3: Health Services Offered at Prince Mshiyeni Memorial Hospital**

| District Services | Regional Services |
|---|---|
| 24 hr Emergency Services | Anaesthesiology |
| Eye Care | Casualty/Emergency Services |
| Family Medicine | Gynaecology |
| HIV/AIDS Management | ICU/High Care |
| Mortuary Services | Internal Medicine |
| Mental Health | Obstetrics |
| Obstetrics | Operating theatres |
| Paediatrics | Ophthalmology |
| Pharmacy | Orthopaedic Surgery |
| Primary Health Care | Psychiatry and Mental Health |
| Radiology | Radiology and diagnostic |
| Rehabilitation | Specialised OPD |
| Surgery | Surgery |

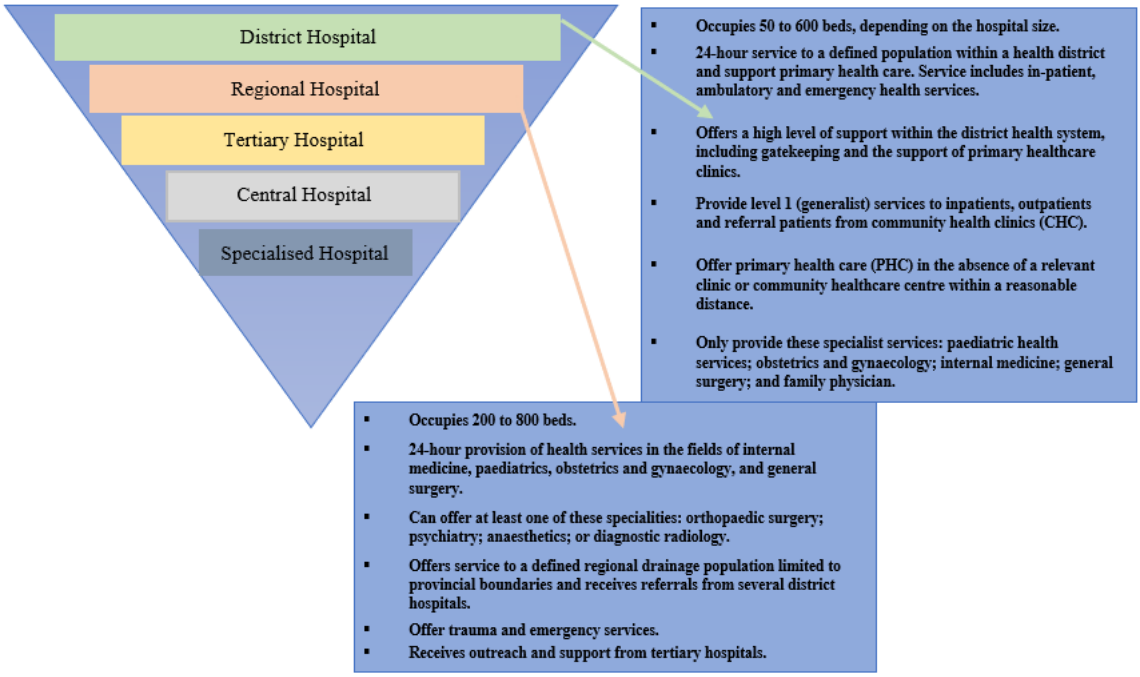
Table 0.3**Source:** (KZN Department of Health, 2014, p. 1).

Speaking from first-hand experience based on the extensiveness of services, Pam explained that Mshiyeni is :-*"The biggest hospital in the province. According to the latest statistics, we are the second biggest in the country and the busiest hospital. And nobody else can accommodate us. No one can accommodate us in eThekwini".* This highlighted

accommodation speaks to the absence of nearby district hospitals for referrals, concurring with Steve's description.

The National Health Act (Act No. 61 of 2003) classified public hospitals into five categories and stipulated operations for each category (Department of Health, 2012). Figure 4.1 lists the five hospital categories and presents some district and regional hospital-gazetted roles. The displayed characterisation of the district and regional hospital roles is specific and distinct. Mshiyeni's absorption of some regional hospital services justifies the reported complexity in operations and pressing demands expressed by the participants.

**Figure 0.1: Classification of Government Hospitals in SA**




**Source:** Adapted from (Department of Health, 2012)

Beyond the complexity of the hospital, five out of fifteen participants proudly shared that the Mshiyeni hospital MOPD is one of its kind in the country, as it is open 24 hours daily. The described magnitude of service demand is tremendous; the number of patient visits and birth rate in the maternity ward supports this description. Giving examples, Pam stated that: - "*The past three years, the hospital recorded about 30 000 outpatients monthly. Additionally, the maternity ward records a minimum of 1 200 up to a maximum of 1600 baby deliveries each month, with a record of 460 caesarean births monthly*".

All participants enshrined the significance of innovative, strategic and efficient healthcare provision to the community being serviced by Mshiyeni hospital. Concurrent to the

prioritisation of the commitment to the efficient delivery of the hospital objectives was the mention of an unavoidable and persistent challenge that hinders the fulfilment of this commitment being a constrained budget. This challenge of limited funds creates a web of interconnected challenges, which directly affect the quality and targeted standard of healthcare delivery by the employees and the institution. For instance, participants cited ageing infrastructure, shortage of staff, inability to recruit sufficient staff, and limited resources or equipment emanating from budget constraints. This challenge is not unique to Mshiyeni hospital; it is quite common in SA Health Sector service delivery structures. In the 2022 Local Government Summit, the SA Mister of Finance, Mr Enoch Godongwana, raised concerns that continuous budget cuts directly cause service delivery challenges (BusinessTech, 2022).

The state and nature of the hospital environment present a mismatch between the hospital demands and capabilities by efficiently satisfying service and performance demands. A noticeable repeated emphasis on the importance of innovative and strategic planning, thinking and operating as critical mechanisms that can enable strategic hospital leaders to make the most out of bare minimum was observed. In different words, all participants shared the prioritisation of strategically leading the hospital to meet its primary objective and provide quality healthcare regardless of the challenges. To cite a few, some participants stated that:

Gerald: As a leader, one has to *"strategically plan in depth and detail how to use the limited resource to produce quality service, knowing very well that you are compromised severely – be it staffing or finances, and funding".*

Pam: *"The budget is the biggest problem at the moment as it is getting cut".* Despite this problem: "*the hospital is trying to meet service delivery on healthcare and to give quality healthcare. In order to provide quality healthcare, our staff must give 100% dedication. So, you need your staff to give you a 100%. So, if you are not going to listen to your staff and you are not going to make them feel that they are important, you won't get their buy-in". Pam continued that "You will not get the services, you won't get any changes, and you won't get any improvement made, and you, yourself, as a leader, have to show this enthusiastic, positive attitude at all times. Even when things are bad".*

According to Jane: *"One of the visions and missions of the hospital is to provide good quality healthcare to the people from the catchment area. So, we are also working in a time of limited resources, the major one being the budgetary constraints, which leads to, you know, problems*

*with achieving the hospital's objectives".* In this case, strategic leadership is essential because it allows *"leaders set goals, objectives and puts out a plan to achieve goals, and, motivate staff, because a strategic leader knows how to motivate, guide and lead staff to achieve planned goals and objectives".*

Alisha: *"The hospital's objective is to provide efficient quality nursing care or patient care, prioritising the patient as our main customer".* Therefore, strategic leadership allows leaders to use a holistic outlook that considers short- and long-term goals and growth, enabling leaders to "accomplish the hospital's vision *through planning and proper utilisation of resources".*

Eleven out of fifteen participants described their institution further and acknowledged that the hospital has been in a structural change phase. This phase began with the introduction of a new CEO in 2019, tasked with meeting hospital targets, improving public perception of the hospital and creating an efficient value system. Sharing their experience of this transitional phase as leaders within the hospital, the participants used words such as *fine-tuning, turning-around, sharing the vision, paradigm-shift and creating a culture of change*. Standing out from the responses were some critical aspects that the participants believed to be important in managing change and service improvement, being the leaderships ability to:

- Ensure that there is unity towards one goal and objective. Additionally, it is essential to *"communicate the vision, mission, and core values with staff so that they understand their role within the organisation",* Steve stated.
- Value "*sitting down as managers or leaders at the beginning of the year to strategies on what will happen, how it will happen and how it will assist us because the aim at the end of the day is to improve patient care. If we do not have a vision of where we are going as a team, we will not be able to lead people under us",* said Sophia.
- *Understand change and be flexible to adapt because if done right, changes do not affect the stability of the hospital as long as they align with the vision and achieve the institution's objectives without violating ethics and code of conduct, especially modern era changes,* said Dave.

The key takeaway from this empirical evidence is that the leaders who participated in this study thoroughly understand their hospital and its role to the community, employees and all stakeholders. Most importantly, the following themed data results demonstrate the sound experience and understanding of strategic leadership and change management and its impact on the hospital.

### 4.4.2 Multiple Leadership Style

Insights form participants on existing leadership style and its relativeness to the realisation of the hospital objectives, all participants were aware of the leadership styles, the reason behind their utilisation and their impact on the hospital operations. Thirteen out of fifteen participants explained that the hospital does not use a single leadership style. Instead, it operates under a combined leadership approach made up of autocratic and democratic leadership styles.

Participants made it clear that using both autocratic and democratic or participatory leadership styles depends on the situation or context. The leaders employ a style that will yield positive results efficiently. Additionally, highlights of the dynamic nature, complexities, operational demands and service expectations were other drivers influencing the adoption of a mixed leadership style.

Sophia argued that,:-*"The most used style is democratic, but sometimes you cannot be democratic all the time. There are times when you need to be firm as a manager; there is some autocratic element, but not always*". Concurring, Gill stated that "*So right now, at Prince Mshiyeni, we have got all types of strategic leadership styles. The first type is more of a dictator type when one is an instruction from the higher-up, not a chance to participate. Then, at the same time also, you have the type where, as a leader with your people under you, you engage them. You explain the objectives and the advantages versus the disadvantages, and you get buy-in from them".*

Autocratic, also known as authoritarian leadership style, is where leaders take complete control of planning and decision-making without the contribution of subordinates a view supported by (Nwokocha & Iheriohanma, 2015). According to Bhargavi and Yaseen (2016), autocratic leadership is useful in urgent emergencies or crises requiring immediately decisive response, and leaders take complete control. These descriptions of autocratic leadership resonate with the participants' justification of its use being critical in specific situations requiring an instructional process or with the standard operating procedures. The participants' responses emphasised that autocratic leadership is not primarily about control or command; for it to be strategic, on the contrary it must be handled in an interactive manner.

According to Zervas and David (2013), the use of autocratic leadership relies on the leaders' ability to have a clear and compelling vision feeding into strategic planning, monitoring of the process and convincing subordinates to follow. Indeed, participants spoke at length about the

importance of strategic planning aligned with a clear vision and the hospitals' objectives. For instance, Steve mentioned that even when you are taking an autocratic approach: - *"Being strategic means that as a facility, we should have a clear vision. We should have a mission and clear core values that we subscribe under as a facility. Also, when you develop those strategies, you must know how and when to involve or not involve your team; it is about how you communicate".*

Moving to the other used style, democratic leadership, also known as participatory or leadership is a decentralised leadership style where leaders obtain subordinates' contributions or views in critical decision-making in the organisation (Dike & Madubueze, 2019; Carlin, 2019). Participants who mentioned this style used words such as seeking buy-in, open and active involvement of all employees, consultation and inclusion of all employees-say in decision-making. Speaking to the importance of a democratic leadership style, Pam stated that :-*"For strategic leadership in this hospital, there is very much democratic kind of leadership because you find when you are dealing with our staff and decision making if you do not involve all the heads and labour, you find that whatever decision you make gets thrown out. It will be challenged, and you will have a lot of protest action".*

However, participants argued that not all situations allow for democratic leadership. For example, most participants cited the flooding that affected the hospital, which led to leaders making operational decisions without the subordinates, which caused tensions, conflicts and resistance despite being an emergency. Such examples prove Nwokocha and Iheriohanma's (2015) argument that democratic leadership is good in theory. However, in practice, it is often confined to a slow decision-making process which takes much time and effort to reach targeted outcomes (Nwokocha & Iheriohanma, 2015). This argument concurs with this study's empirical evidence, as participants stated the downside of participative leadership being a time-consuming process due to the wide range of departments and stakeholders such as trade unions. Therefore, a democratic approach is ideal for sharing ideas and seeking innovative solutions from employees rather than urgent or structural decision-making contexts (Arif & Akram, 2018).

Nowadays, a suitable leadership style capable of responding to the dynamic change in the business environment is critical (Jony, et al., 2019). Considering the speed and complexity of today's competitive environment, strategic leaders need to be ambidextrous with ability to simultaneously implement diverse courses of action (Tushman & O'Reilly, 1996). Additional

to autocratic and democratic leadership, four participants, with two respectively, cited the use of transformative and visionary leadership in the hospital. According to Tucker and Russell (2004), transformational leaders promote organisational change acceptance and adoption as these leaders efficiently share the vision and inspire employees to follow it. Similarly, visionary leaders ensure that employees understand the mission, objective and direction of the organisation so that they know the role to play, align their interests with that of the organisation and be in the same which strategic leaders operate (Bass, et al., 2003; Yukl, 2006).

Giving a slightly different view that resonates with most of the characteristics of the four-mentioned leadership styles, one participant argued that since the selection of the fitting leadership style depends on the issue at hand, it technically means that the primary leadership style is situational leadership. Steve stated that, :- "*In my understanding, we use situational leadership style, as the styles vary. You can be a democratic leader, but the situation sometimes warrants you as a leader to also use autocratic leadership. Why? Because there are things that have timelines which need to be done immediately. If you sometimes allow democratic leadership, you might miss the timelines because you need to understand that people are not the same and situations are not the same*".

Concurring with Steve's point of view, most participants' description of the leadership styles utilised in the hospital was accompanied by an emphasis on choosing a style that would work for a specific situation. For instance, Gerald explained that situations that concern structural changes or affects the whole institution, including its stakeholders, such as trade unions, cannot be handled in a top-down approach. Such situations warrant a participatory leadership style. Even in the unpopular cases of two participants who mentioned different leadership styles, their responses emphasised that the situation points to the leadership style selection. For instance, Claire stated that "*the styles currently used in the Prince Mshiyeni are the visionary style, directive style and collaborative leadership style, depending on the circumstances".*

According to Ghazzawe et al. (2017), situational leadership considers that leaders have different characteristics and approach situations differently; therefore, this leadership style enables the application of supportive and directive dimensions that fit a given situation. Furthermore, situational leaders assess the situation, evaluate the aspects of their employee's commitment and abilities to perform productively or efficiently and then apply the appropriate leadership behaviour (Papworth, et al., 2009; Ghazzawi, et al., 2017). Indeed, the definitions of situational leadership resonate with the participants' assertions that the critical aspect of the

leadership style is the strategic application of an approach that will positively affect performance, productivity and solutions to a situation or planned targets.

These empirical assertions further share Jony et al. (2019) sentiments that leadership paves the way to greater organisational success, efficiency and performance if the leadership style responds to the employee's usability and the current competitive market. Indeed, today's V.U.C.A. world demands strategic leaders who can exercise a critical approach appropriate for the circumstances. Grouping and analysing the participants' identification of the leadership styles used in the hospital, Table 4.4 presents the participants' opinions on the reasons behind the identified leadership styles.

**Table 0.4: Participants' Identification of the Hospitals Leadership Style**

| Participant | Leadership style | Relevance and Significance |
|---|---|---|
| Mandy | Authoritative and Democratic | Specific situations require authoritative leadership, especially to get the house in order. However, introducing change requiring staff support and buy-in requires democratic leadership. |
| Alisha | Autocratic and Democratic | *"We have one that is autocratic and a democratic leadership style that keeps the ball rolling. But, the most that is used and functioning is the democratic style because it involves people, and they have inputs and participation within the organisation".* |
| Linda | Top-down and Participatory | Mostly, target-setting and planning decisions are senior management driven. Active involvement of various stakeholders exists, but it is limited. |
| Gill | Senior Management (top-down), Participatory and visionary leadership | *Most plans and operating procedures are decided at the national, provincial and district levels; they arrive at the hospital tailor-made. In the aspects of the institution, the leadership approach involves and values the inclusive participation of staff.* |
| Clare | Directive, visionary and corroborative leadership | *"The styles currently used in the hospital are the visionary style, directive style and collaborative leadership styles, depending on the circumstances. So that, I think, the most efficient is the collaborative style because it promotes communication and participation, which makes it easier to have input from the staff, and they will be involved in every decision taken in the facility".* |
| Mark | Authoritative | *Leadership in the hospital is top-down and takes on a multi-disciplinary approach whereby the board meets separately with top leaders, and different departments meet separately.* |
| Jane | Dictatorship | Instructions for operations come from the top, and they are *instructive. Even though the hospital uses this approach, strategic leadership is key because it allows leaders to be flexible and creative in engaging staff without making them feel instructed or dominated.* |
| Patrick | Transformational and coaching leadership styles | *Leaders have an open-door policy, and communication with stakeholders is valued. Moreover, leadership emphasises setting clear objectives and regular staff training to improve employees' understanding of their roles and expected performance.* |

| | | |
|---|---|---|
| Dave | Transformational leadership | *Given that the hospital is a government entity, this leadership style eliminates bias, makes leaders responsible, and provides a clear set of employee goals and activities.* |

**Source:** Author, 2022

The overall standpoint of the participants' responses concerning objective one of this study was to determine leadership style used at Prince Mshiyeni Memorial Hospital matches the description and characterisation of strategic leadership. In the second chapter of this study, strategic leadership was described as the various types of strategic activities characterised by strategic alternatives performed by senior managers in organisations (Yardan & Aydin, 2018, p. 877). It was further defined by Fry (2003) as leadership that prioritises vision, motivation and control through values or adaptability behaviours in leadership. The emphasis on visioning, flexibility, aligning planning with the hospital objectives and resources for strategic control and applying the appropriate leadership style based on its efficiency capacity suggest impactful strategic leadership traits.

Drawing from the above presented findings, it is evident that the leadership approach practiced by Mshiyeni Hospital leaders resonates with the contingency theory, which believes that leadership is not uniform. The contingency approach is of the view that leadership is often not static; it is contingent on people and situations (Daft, 2018). Indeed, the discussed participant's responses are in harmony with this theory as all participants emphasised that the hospital does not apply a one-size-fits all leadership approach. Instead, each leadership style applied to decisions in the hospital are informed by the situation or context based on being the most likely to yield positive results.

As discussed earlier in the second chapter of this study, Daft, (2018, p. 67) explained that "contingency means that one thing depends on other things, and for a leader to be effective, there must be an appropriate fit between the leader's behaviour and style and the conditions in the situation. A leadership style that works in one situation might not work in another situation". Correspondingly, findings of this study fit the suppositions of the contingency theory. Moreover, the strategic actions and behaviours of Mshiyeni hospital leaders further complement contingency approaches to leadership. Primarily because, the contingency theory originates from the need to provide managers with clear guidelines for choosing the most suitable or appropriate structure best fitting their organisations, which can affect the best performance (Burnes, 2005).

#### 4.4.2.1 Leaders' Behaviour

Emanating from the dominant theme of *multiple leadership* within the first objective, a notice of the significance of the manner of applying the leadership style resulted in the sub-theme of *leaders' behaviour*. The participants emphasised that certain behaviours contribute to the efficiency of the style. Twelve out of fifteen participants argued that the leadership style alone could not make the hospital meet its objectives or make employees more efficient. Instead, how the leader strategically utilises the leadership style creates either a positive or negative impact on the hospital and its employees.

Speaking on influential aspects of efficient leadership, Yukl (2012, p. 66) stated that "the essence of leadership in organisations is influencing and facilitating individual and collective efforts to accomplish shared objectives. An important objective in much of leadership research has been to identify aspects of behaviour that explain leader influence on the performance of a team, work unit, or organisation". Assertions from the participants shared similar beliefs as their arguments highlighted the importance of acting transparently, openly, and respectfully, communicating clearly and keeping a positive attitude in your behaviour as a leader. Argued that such behaviours from the leader influence how employees receive guidance and play their roles efficiently.

Elaborating further, Egan et al. (2019) argued that in a leader-follower relationship, a leader's behaviour is considerably related to various positive employee and organisational outcomes such as performance. Concurring, Kouzes and Posner (2010) asserted that leaders' behaviour directly impacts employees' productivity, motivation, effectiveness, commitment and feeling energised workplace. Empirical evidence of this study concurs with these arguments; for instance, Pam stated that: - "A*s a leader, you have to show enthusiasm and a positive attitude at all times. Most importantly, strategic leaders know how to motivate, guide and lead staff to achieve hospital objectives".* Similarly, Clare stated that: - "*Leaders could guide the improvement of staff attitudes which increases employee professionalism. It eliminates patient dissatisfaction, complaints and staff disciplinary cases. The hospital has a few strategies, such as frequently reciting the nurses' pledges in the wards and reading the code of conduct to motivate nursing employees".*

Literature shows that employees' perceptions of the workplace climate are shaped by the organisation's leadership style and behaviour (Momeni, 2009). Such assertions support the empirical discovery of this study, as ninety per cent of the participants cautioned against

overlooking the contribution of leader behaviour to efficient and strategic leadership. Further aspects highlighted by participants as essential behaviours that positively affect efficiency and improve service delivery within the hospital are presented in Table 4.5.

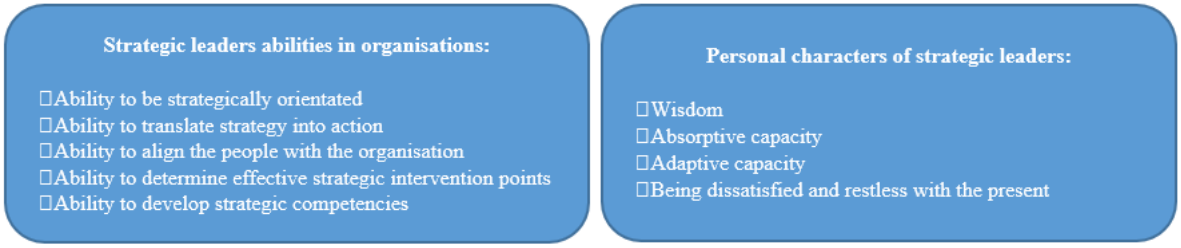
**Table 0.5: Important Leader Behaviours**

| Leader Behaviour | Participants Views |
|---|---|
| Adaptability | *"The hospital goes through constant change requiring leadership's adaptability to be at a quick pace,* Jane.<br><br>*As a regional hospital, there are complex dynamics; therefore, adapting to continuous changes is key to efficient service delivery,"* Mark. |
| Valuing strategic planning | *"Helps leaders to look beyond long-term goals and growth, allowing them to accomplish the hospital's vision through planning and proper utilisation of resources. Enables accomplishment of the vision, making of best decisions, productivity and innovation as careful planning mitigates challenges and informs sparing use of resources",* Alisha said.<br><br>*"It gives the organisation an indication of where it is going and why it needs to get there",* Gill. |
| Learning | *"Promoting staff to learn and conduct research ignites new ideas that improve healthcare services provision and innovation",* Steve.<br><br>*"Continuous provision of training, workshops and meetings for staff to get appropriate knowledge, skills and attitude to rendering effective, professional and compassionate care is essential. The same goes for hospital leaders; training improves communication, relationships and decision-making skills",* Mary stated.<br>*"Leaders must learn about their work environment, employees and stakeholders. It enables leaders to strategise better and make informed decisions on what works and what does not for specific teams",* Sophia. |

**Source**: Author, 2022

The presented discussions of the importance of leader behaviour in leadership practices correspond with Davies and Davies (2007) nine factors that characterise strategic leadership in the organisations' activities and personal behaviours of leaders. The participants emphasised that specific behaviours influence the leadership's ability to be strategic and efficient in the hospital. The discussed behaviours resonate with strategic leadership characterisation presented in Figure 4.2. Thus, giving an ideal picture of the strategic leadership practices in reaching the objective of delivering efficient healthcare services.

**Figure 0.2: Traces of Strategic Leadership Characteristics**

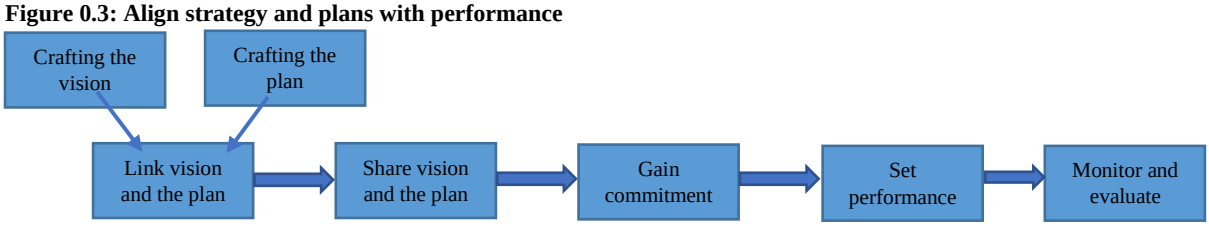



**Source:** (Davies & Davies, 2007, p. 30).

### 4.4.3 Strategic Alignment

The second objective was to assess the impact of strategic leadership style on the hospital's performance. Questions centred on tapping into the leadership's effect on performance, service delivery, by meeting hospital targets and experienced challenges. Evidence from participants indicated that the *strategic alignment of hospital plans with targeted outcomes* had been the primary strategic leadership approach to enhance performance and service delivery in a turbulent and challenging environment. Here are the main elements central to this alignment in Figure 4.3:

**Figure 0.3: Align strategy and plans with performance**




**Source:** Author, 2022

Strategic leaders are responsible for setting clear visions, tasks, objectives and policies to guide organisations towards performance (Kim & Mauborgne, 2002). The participants held similar views as they pointed out that hospital objectives and performance are guided by the precise setting of the vision and goals, which informs strategic planning and implementation. Elaborating on their operations, the participants explained that:

*"Deducing from the national and provincial health vision and strategies, as a facility at the hospital level, the leaders, in collaboration with employees, craft the hospital vision. All employees must understand this vision to contribute meaningfully towards it in terms of performance"*, echoed Steve. Elaborating further, Steve explained that the hospital develops an internal strategic plan. "*This plan is informed by the national policy, national strategic plan and the 10-point plan cascaded by the national department of health to the provincial department of health. Strategies emanating from this plan strategically cover current and future operations in the sense of annual, then three-to-five-years strategy. This is significant in strategically linking and aligning the hospital vision with the strategic plan".*

Furthermore, strategic alignment of vision and strategy is demonstrated in literature as a strategic leadership activity that improves performance. According to Liabotis (2007), strategic leaders achieve objectives and organisational performance by aligning strategy and sharing the vision and ideas with the employees. This ensures that "all organisational systems are working

together towards the achievement of the ultimate strategic intent put in place" (Riwo-Abudho, et al., 2012, p. 49). This is the reality at Mshiyeni hospital, and based on the participants' descriptions; this practice improves this hospital's performance.

Sophia opined that*: - "at the beginning of the year, we strategise as a team on how we want this year to look and plan properly, so strategic leadership is very critical and important to management. We plan in advance and can foresee what may happen, this improves our performance, and people come to us to benchmark. We had KCD and UGU, who came to us to benchmark so that we share our good practices. Before 2020, there were things, which improved drastically in 2021, which tripled when you look at the data because of how we plan and strategies. It is critical for us how we implement and monitor."*

Similar responses were observed from all participants, who positioned the alignment of the vision and strategic plan as the key driver of this hospital's performance. Following the strategic planning and clear set of the hospital's vision was the emphasis on communicating and sharing with the employees. Gerald cited a vital factor that: - "setting *a clear vision and strategic plans does not merely result in efficient performance. They only work if the leader understands the vision and plan and, in that understanding, influences employees to give their best performance".*

According to Smith et al. (2021), establishing a vision and deploying a strategy is only good if the leader inspires and persuades employees and stakeholders to assimilate. Therefore, leaders must be compelling and persuasive communicators who can fulfil widespread commitment throughout the organisation. Empirical evidence of this study drew this discovery from the participants' responses. One of the communication strategies shared by some participants was 'imbizo or izimbizo' or gathering sessions, which the hospital CEO convene for communication purposes. According to Pam: -*, "izimbizo sessions are held with all employees and stakeholders in their variety. For instance, individual sessions for the five trade unions that operate in the hospital, a session for the doctors, nurses, cleaners and so forth".* This strategic approach is crucial for effective communication as the CEO uses language understood by the group in session.

*"Communicating clear directions makes employees aware of what needs to be done. It forms a basis for monitoring performance by linking the job description with the departmental strategy employees' performance and achieving desired health outcomes can be monitored*

*concurrently" as articulated by* Gill. Sharing similar sentiments, Pam stated that:- "E*ffective communication increase employee awareness, buy-in and commitment, which can be monitored and evaluated to determine the performance and effectiveness of the leadership style". While: - "Poor communication to either cleaners, porters, support service staff, or even the clinical service would result in resistance, if not, poor performance would affect the entire system",* said Steve.

Once everyone is familiar with and committed to the hospital's vision and strategy and aware of the personal, departmental and institutional role, accountability measures can be attached for performance measurement purposes. It was explained that employees sign performance agreements based on their job profile and responsibilities. The hospital uses the PMDS, a tool used in the public service to assess policy implementation, organisational objectives and individual performance in state facilities. The PMDS improves leadership effectiveness in accomplishing hospital objectives.

According to Cooper and Nirenberg (2004, p. 1), leadership effectiveness is "the successful exercise of personal influence by one or more people that results in accomplishing shared objectives in a personally satisfying way to those involved". Furthermore, Hao and Yazdanifard (2015) argued that effective leadership is one of the most critical parts for organisations to sustain their business despite experiencing challenges. Effective leadership is a common goal for all public hospitals (Rust & de Jager, 2011). Indeed, it was observed in this study that the participants emphasised that all the hospitals' initiatives towards improved performance and efficient service delivery related to leadership efficiency. Speaking to the consequences of monitoring performance, participants stated that:

*"Monitoring and evaluating the performance of the employees and the organisation guide the hospital to deliver quality service",* as mentioned by Alisha.

*"Good performance agreements accompanied by the leaders' quality and just monitoring can improve services as the hospital can have lesser complaints, threats from participants and minimal litigations",* Steve.

Monitoring progress helps the hospital maintain good performance and improves service delivery." *The impact of performance evaluation and strategic leadership on service delivery is good. However, other factors limit the achievement of good performance and optimal service delivery, such as budget constraints",* Jane.

From these responses, it is evident that the hospitals' efforts partially satisfy certain aspects of leadership effectiveness but not complete organisational efficiency due to the dynamic and complex nature of the public healthcare sector. For instance, Gill stated that: - "D*espite good strategic leadership, performance assessments and employee efforts to be at their best, the hospital's performance had been a roller coaster because of issues beyond the operational level, which are external, like limited resources and finances"*. Machuki and Aosa (2011) have cautioned that external environmental factors can have elements that influence organisational performance due to their ability to alter the organisation's internal trajectories and leadership capacities. Gill's shared experience and other participants' assertions demonstrated that, hospitals' performance is indeed affected by external forces. This led to the determination of organisational endurance as a sub-theme of the second objective of this study.

#### 4.4.3.1 Organisational Endurance

One of the research questions under the second objective of this study probed the challenges experienced in the hospital and their mitigation strategies. Responses were common across most participants, whilst some were department specific. There were dominant challenges reported by all the participants, such as budget constraints, limited or poor resources and staff shortages. Whilst some few challenges were departmental specific, see Table 4.6. Drawing from the participants' responses, it was evident that the hospital has been operating under multiple challenges in addition to the expected stressors from service demands. This justifies the participants' argument that resource and staff shortages limit efficiency and productivity.

**Table 0.6: Hospital-based Challenges**

| Experienced Challenges |
|---|
| Limited resources<br>-Medical resources<br>-Infrastructure<br>-Transportation |
| Financial resources shortage<br>-Annual budget reduction<br>-Limited funds |
| Human Resources (HR)<br>-Staff shortage |
| Supplier issues |
| Increasing patient numbers |
| Safety challenges |
| Increasing disease burden |
| Staff attitude |
| Litigation |
| Network issues |
| Large water bills |

**Source:** Author, 2022

Organisational endurance refers to the noticed high tolerance for problems and frustrations demonstrated by the hospital leaders of Mshiyeni hospital without being overwhelmed. It speaks to the leadership practices of strategically navigating the hospital towards efficiency in a demanding and challenging environment. The primary challenge cited by all participants was the issue of financial shortages (Table 4.7). A few descriptions of the challenges by the participants were as follows:

**Table 0.7 Financial Challenges at Prince Mshiyeni**

| **Financial:** |
| --- |
| *"Shortage of Financial and Human Resources are a major challenge",* Patrick.<br><br>Concurring, Pam explained that *"the budget is the biggest problem at the moment as the budget's getting cut, and we are getting more and more stress to meet higher targets of quality care with less staff, less equipment, and less everything".*<br><br>Elaborating further on the issue of financial constraints, Steve stated *"the finance that we receive from the public sector is not sufficient or is not equal to the demands of the service that people can get, the service is direly needed. But the budget that we have does not equate to that".* |

**Source:** Author, 2022

The reported challenge of financial shortages is not limited to Mshiyeni hospital only. Budget cuts and operating on low financial resources are common in the SA public sector. Literature shows that the achievement of organisational goals results from the correlation between employee performance and organisational productivity (Abbas, et al., 2019). Arguably, financial shortages automatically decrease the organisation's capacity to achieve objectives and productivity because of limitations associated with insufficient money. The financial battles faced by public hospitals seem to contradict with the constitutional healthcare mandate, healthcare policies and national health frameworks, which enshrines the goal of achieving efficient and quality healthcare service in SA.

Financial issues tend to extend to other aspects of the organisation by creating a web of interrelated challenges. For instance, in the participants' responses, it was evident that challenges of staff shortages, ageing infrastructure, and limited resources stemmed from financial restrictions or problems. Examples of challenges stemming out of financial issues (Table 4.8):

**Table 0.8 Challenges Resulting from Budget Cuts**

| Emanating from financial limitations |
| --- |
| *"Financial constraints and too much workload, which puts a strain on the already stretched employees",* Gill. |
| *"The unavailability of resources, both the human capital and the material resources, due to the lack of funds and litigations",* Alisha. |
| *"Network connection issues compromising yet cannot be prioritised under strict budget. For instance, the hospital adopted an electronic patient filing system, however it has not been operational due to network issues",* Sophia. |
| *"Human resource is a big challenge because the population is increasing everyday while hired personnel is decreasing. People who are leaving the service by retirement or labour turnover are not replaced. The only strategy we have is to make 1 person do a job of 2 or more people and we all know where does this lead to (unhappy employees, absenteeism, burn-out, etc.)",* Dave. |
| *"Transportation issue is a significant challenge, the hospital does not have sufficient fleet to be utilised for community outreaches, household and technical visits to clinics outside the hospital. Due to budget constraints, resources such as state government branded cars cannot be secured",* Gerald. |

**Source:** Author, 2022

Such responses give a practical picture of why public hospitals and clinics remain overly burdened, pressured by high reports of inefficiency, poor outcomes, unsatisfactory performance, and bad public reputation as reported by (The Presidency, 2018; Public Service Commission, 2018; Competition Commission, 2019; Ngobeni, et al., 2020). The participants shared some initiatives used to solve or mitigate the experienced challenges:

*"The facility has submitted numerous requests for additional budget and we were not successful. However, the facility has engaged educational institutions surrounding the facility for In-service students to assist the process",* said Patrick.

Limited financial resources: *"Means that you have always to come up with innovations because we won't get the stuff that you want",* Steve.

*"The hospital tries to emphasise accountability, consequent management and monitoring of complaints in order to intervene and respond timeously to service delivery or staff attitude complaints which minimise potential of litigation cases",* Gerald.

*"The hospital has a bad history as it was in a very bad state with horrendous service delivery and bad staff attitude. The number of patients was high but quality of care was bad. However,*

*change in leadership is cleaning this history up and improvements are visible. The turnaround strategy involves an increased communication with employees and engagement in decision making, finding solutions and when seeking innovative ideas for improvements",* Pam.

*"As PHC is mote community based than facility-based, it operates outside the hospital. There has been an issue of numerous hijackings of state vehicles and robbery of nurses and facilities at gunpoint, causing trauma for employees. Leadership has tried mitigation approaches such as getting key stakeholders involved, such as Ward Councillors, the SAPS Station Commanders, the eThekwini Mayor and even the Police Minister Cele. Additionally, the provincial Security Department has been engaged with the proposal of installing CCTV cameras and panic buttons",* Sophia comprehensively elucidated.

Strategic decision-making, communication, customer orientation, and abilities to adapt to change are essential leadership capabilities that can guide leaders to endure and be resilient during organisational chaos and dysfunctional challenges for improved efficiency (Knight, 2014; Cham, et al., 2021). Additionally, Alessandri et al. (2015), explained that workplace conditions and individual-level factors directly affect performance. Indeed, the standpoint of the participants agrees with the views posited by these authors. Empirical views of the participants suggested that:

- Within the facility, leadership has been strategic in efficiently managing operations and navigating the hospital towards efficiency collectively with employees.
- The hospital's work environment is mostly challenged by broader issues or emanating from the external environment but powerful enough to affect hospital operations and performance. This has made strategic leadership activities seem 'not enough' to push the hospital to meet its objectives.

As a result, the participants argued that:

"*The hospital, like any other government institution, is facing challenges with budget cuts, freezing of posts and ailing infrastructure. Additional challenges from COVID-19 in 2020, the 2021 July riots and the April/May 2022 floods made Mshiyeni hospital a very difficult place to work in. Therefore, leadership cannot be measured in isolation where the environment is not conducive for optimal performance",* Dave.

Sharing similar sentiments as Dave, Mark shared that *"Mshiyeni hospital is a difficult working environment. Many unsuccessful leaders have come and go, others received promotions elsewhere in the Department of Health. The current management, despite all of my criticism, is stable and reasonably effective despite their hands being severely tied because of rigidity from head office and do listen to the workers, albeit one has to go to extremes to get results. The current CEO have used flexibility to intervene in crises".*

*"No, we are not always meeting our targets, for instance, due to staff shortages. So, even if you are willing to meet your target, it is almost impossible as the staff is not equal to the patient ratio",* Mandy.

Furthermore, Jane added that *"You know, people from outside don't understand the pressure and the constraints that we have, the ever-increasing disease burden without much increase in resources. It's always make do with what you have, and even with less, we do even more".*

Concurring, Alisha stated that *"The hospital has been performing very well, despite challenges of Covid-19 Pandemic, the looting, the floods, inability to employ staff or buy resources and the hospital litigations - where huge amounts of money were demanded, and we were unable to plan successfully to execute our duties because we were just faced with that moratorium". Additionally, "The hospital has been functioning well, but some factors affected its performance. We haven't been meeting our targets as such in terms of production because of some factors that were affecting the hospital institution as a whole, yet we have performed well operationally in managing the hospital and employees" according to Alisha.*

*"Obviously, the hospital has not been meeting its target set, and I would not say it is due to the leadership. It is due to resource constraints and pressures placed upon the hospital. Therefore, the leadership has been trying, and they are under so much pressure. Therefore, this pressure manifest itself amongst staff, and we have a large amount of burnout among staff. They are getting physical ailments, off sick for a long period. We have mental stress, and people are extremely frustrated, leading to people leaving the service",* Jane.

Dave, Mark, Jane and Alisha's shared experiences point to the noticed high level of resilience qualities possessed by most of the leaders interviewed in this study. This resilience is evident in the practices and initiatives of solution-based and continued confrontation of situations irrespective of constraints without being overwhelmed. This argument is made based on resilience being the process of the organisations 'bouncing back' from adverse events (Hartwig,

et al., 2020). The implementation by Mshiyeni hospital, was not succumb to turbulence and constraints but working harder to meet envisioned and planned performance standards. Additionally, some departments have been meeting targets even though the hospital as a whole has not.

Experiences from the literature that characterise resilience are as follows:

- The pharmacy department have had a vacant position for a pharmacist assistant for the past 5 years due to being labelled as a non-exempted position because of budget constraints. The pharmacy has been overburdened by work as it provides pharmaceutical services to 18 primary healthcare facilities. It has been the leader's responsibility in this department to solve problems strategically and deliver services efficiently. As a response, the leader utilised the experiential learning programme by taking in students for training, automatically reducing the gap as the students can assist. Reacting to this example, Gill argued that in the current state of the hospital, as a leader, *"You must always be on the look as to how you will mitigate the challenges because, at the end of the day, it is still your responsibility to ensure that services are being provided and service delivery is not compromised".*

- For a while, hospital leaders have to improvise and do more with less. For instance, Pam shared that: "*Since 2015, the hospital was not hiring non-critical staff. However, with leadership changes, things improved and became more open and transparent".*

- *So, within the systems, we didn't hire them for years. We haven't hired finance for years. We did not hire the lower categories of nurses for years, social workers, speech, that sort of thing. Therefore, those were the initial budget cuts, but it was done very quietly. It wasn't as publicised as now", Pam stated.*

- *"From close monitoring of the issues that lead to litigations, the hospital discovered that the biggest litigation has been coming from maternity. Creatively dealing with this issue, one of the leaders at the executive management level took on the responsibility of temporarily heading maternity. This involved full presence in maternity in order to observe and identify problems first-hand and bring in policy and procedural corrective measures. Furthermore, this initiative enabled tracking employee steps (monitoring the theatre, tracking the duration of taking the patient in, duration taken to cut and tracking*

*the time of the whole delivery process). A discussion followed this up in cases of adverse PSI report to discuss prior to getting a complaint or major complaint that could lead to litigation" Pam further illustrated.*

According to Dunphy and Stace (1993), different organisations face different situations; therefore, it is strategic for leaders to apply different strategies varying with specific changes or situations. The practical examples from participants show that the hospital use solution-based approaches, and they are improving on quickly evolving, adapting and being flexible to act based on the issue at hand. Such actions can be associated with the contingency approach to leadership, which believes that leadership is often not static; it is contingent on people and situations (Daft, 2018). It further corresponds with the view that strategic leaders are visionary and transformative and can utilise their wisdom and unique abilities to respond to the complexities of both internal and external environments (Jaleha & Machuki, 2018).

According to Burns (1978), a transformational approach to leadership entails a mutual relationship between leaders and followers who are motivated and driven enough to jointly advance the organisation to a higher level. This high commitment and devotion to performance is a transformed approach whereby leaders redesign employees' perceptions, values, and aspirations (Burns, 1978). The transformational leadership theoretical stance is in harmony with findings of this study as leaders showed that they innovatively applied approaches that would influence and motivate the employees to best effect change to achieve hospital objectives.

### 4.4.4 Preparedness: Expecting the Unexpected

Change is a factor that is common in today's unpredictable world, which operates in a space of complexity, uncertainty and unpredictability (Iskandar, 2019). According to Oliver (1997), change refers to any form of transition from a known state or phase becoming different. Moreover, Stobierski (2020) stated that the concept of change within the organisational context refers to any alterations of significant components of the organisation, such as the organisational culture, internal processes, or technologies. The participants shared a similar understanding of change as they described it as introducing or implementing new operations, systems and practices within the hospital.

According to Çalişkan, "organisations and managers who can adapt to change on time can have the chance to survive, while those who cannot are lost in this cycle of change" (Çalişkan, 2018,

p. 803). Thus, making the observed sound knowledge and experience with change management observed by the participant strengthens the hospital. For instance, Mark expressed that: "*in nature, healthcare is fluid, it requires continuous adjustment, which is why most personnel in this field are familiar with change, turbulence, uncertainty and challenge".*

Adding further, Linda explained: "*the hospital is strategic when it comes to change management. For instance, the process involves planning and providing alternative solutions, such as virtual platforms, during the sudden changes that occurred during the Covid-19 pandemic".*

Nancy added that *the hospital engages with staff, introduces the changes and offers training for efficiency purposes.*

Most participants highlighted the importance of organisational preparedness and willingness to change and manage change efficiently. Arguing that if the facility has a change management plan and an understanding of the culture of change, it minimises disruptions or resistance. This standpoint resonates with the contextualisation of change management as the method of initiating transformation activities in a planned and strategic manner to ensure that the changes relate to the organisational strategy (Dominguez, et al., 2015). Sharing their views, participants stated that:

"*When it comes to change management, as a leader, that forms part of your drive. Because as I said, initially, when you develop a culture change, it is a process. There will be a lot of resistance, and as leadership, you need to have a united front towards change management processes, meaning you need to have a clear organisational change management plan as an organisation that is planned very carefully",* Steve.

*"Change is good because it teaches you new things, and obviously, change is not something easy. So, you'll find that sometimes there is a disruption in the service, but because you're always prepared, you have ways to resolve that",* Gill.

Oliver (1997) explained that change results from either internal or external forces that create a need for change. The examples of operational changes introduced due to the pandemic are an example of change influenced by external factors. Moreover, the reported system changes from manual operations to using computers in the hospital shared by Mandy describe internally driven changes.

Participants were asked to share their experiences of change in the hospital. Most responses indicated that the hospital operates in a dynamic and constantly changing environment, it invests in planning and finding effective approaches to introduce and manage change. Below are some key notes on change within the hospital context:

*"The hospital is going through a very volatile time, and with all the reduction in the budget, the inability to buy new equipment, monitoring of utilisation of staff, you know, everything is getting re-looked at, re-analysed, trying to find better ways. And what we do is, we sit down, and we wreck our brans on how can we make things work better with what we've got".* Pam.

*Given the issue of the pandemic, the hospital has been facing many changes which disrupt normal operations and compromise care, especially since a large number of staff members died during the pandemic,* Clare.

The introduction and management of change take on different approaches in the hospital. For instance: "*when implementing operational changes, the staff is workshopped, trained and referred to psychologists where need be. The aim of in-service training staff prior to the adoption of new practices is to ensure employees understand what is expected from them",* as explicated by Mary.

*"People do not want new things or change, and there is resistance towards it. We have activities where there are new good things, especially in PHC there is always change. So, as a manager, you must have a strategy on how you talk to your staff so that they accept the change to avoid resistance". You can focus at the early adopters, and then other facilities (late adopters) can follow once they see the change implemented in other facilities",* Sophia.

Pam also spoke of the early and late adopters' approach and explained that: *"Change definitely brings about uncertainty. It does sometimes cause disruptions because people have to adjust to the new way of doing things, and it's a good thing, though. The problem with us as humans, including myself, you like stability, you like things to be done as you've done it forever, and it brings security. Staffing used to change; once staff are used to change happening, and you discuss with them the changes, you can keep making changes, not too fast, not too many, and you'll have to read them as to if they're happy or not".*

Similarly, Mandy argued that: "*Change can cause disruptions as there will be people resisting to change. It is important to communicate the need for change and then gradually introduce*

*new operations slowly, for familiarity and adaptation. However, leaders must have other strategies in cases of unpredictable change pandemic"*, Mandy.

Jane shared that the COVID-19 period introduced a lot of changes in the hospital. The issue was that these changes were not optional; therefore, in a way, that experience has influenced the change tolerance of employees. Explaining this position, Jane argued that: *"Changes has made our hospital management much stronger and more efficient management because they were thrown with so many challenges and happening at such a rapid pace that they had to deal with anything and everything was thrown at them".*

As the participants were asked to share the changes experienced at the hospital and their effect on the facility, most participants cited that the hospital has a change management plan. The plan guides leaders on ways to manage change efficiently. For example, Mark cited the introduction of the LOGIS system, a procurement-to-payment function system. This change was not well received by employees due to its technicality. However, training and reassuring employees of the benefits such as reduced paperwork, easy access to reports, and reduced paperwork for audit trail increases buy-in and acceptance of the change.

### 4.4.5 Performance Management

Questioning the participants on measures that the hospital employs to keep leaders or managers accountable for their actions, it was evident that the hospital primarily focuses on performance management. All responses pointed to the EPMDS as a system that keeps employees accountable. According to the DPSA (2007, p. 10), the EPMDS is a performance management system that is "aimed at planning, managing and improving employee performance. The aim of performance management is to optimise every employee's output in terms of quality and quantity, thereby improving the department's overall performance and service delivery". Describing its use within the hospital, the participants explained that:

*"The EPMDs track performance of all employees, from the Cleaner up to the CEO, which asses the completion of responsibilities or targets. Poor performance gets a mark-down, and it can lead to disciplinary action"*, Pam.

*"The performance management process is clear, it peer reviews, assesses performance then punishes or awards based on the outcome. Good performance is awarded a performance bonus, and poor performance gets performance discipline or induction"*, Linda.

*"Performance agreement, quarterly reviews, and also consequence management". Consequence management involves evaluating the reasons behind poor performance and offering support or discipline"*, Steve.

Speaking to the importance of monitoring performance, Clare stated that *"It is important to supervise staff, monitor them and continually provide feedback on their performance and have a vision and mission they need to follow".*

Performance Management involves setting goals, responsibility, accountability and monitoring, and analysis of outcomes with the intent of improving performance. Fundamentally, common measures of performance should be aligned with the organisation's strategic objectives (Excardo, 2018). The participants' analysis resonates with this description of performance management. These findings speak to transactional leadership theory which is centred on attaching rewards to the performance of followers (Goodwin, et al., 2001, p. 759). This theory posit that employees are expected to meet their contractual obligations and expectations and accomplish their duties to ensure the organisation meets its objectives. Moreover, Burns (1978) explained that transactional leadership does not ordinarily strive for cultural change; it uses the existing culture and focuses on the performance of employees.

### 4.4.6 Community Voices

Public hospitals exist to offer service to patients, making the recipients of hospital services the primary customer. Therefore, the fourth objective included a question on the hospital's initiatives of attaining patients' opinions or review of services. The aim was to see the extent of considering hospital views in the hospital's strategic planning or decision-making. Responses from participants indicated that the hospital has numerous initiatives for patient complaints, opinions and service experience. Drawing from the participants' responses, the hospital has seven platforms that receive and attend to end-user concerns, which are listed and discussed in Table 4.9. Moreover, the hospital has two offices that handle the various initiatives. There are: "*The Public Relations Office is responsible for addressing patient concerns in the hospital, and the Monitoring and Evaluation Office, assisted by nursing students from the on-site campus surveys"*, Steve.

**Table 0.9 Patient Engagement Initiatives at Mshiyeni Hospital**

| Patient Engagement Initiative | Description |
|---|---|
| Complaint mechanism | Patients submit their complaints about service. |
| Suggestion boxes | The hospital has boxes where patients can share suggestions for ways to improve its services. |
| Hospital board | This platform is the representative of the community, which holds meetings quarterly. The board members are appointed by the executive committee (MEC) member to represent the community. |
| Clinic Committees | The DoH MEC appoints committee members to represent the community. |
| Open days | The hospital hosts meetings with the communities where information on the services and share the direction of the hospital.<br><br>The hospital captures and attends to the community's issues in these sessions. |
| Social media | The hospital monitors, communicate and respond to views, complains or comments shared via social media platforms. |
| Patient experience of care service surveys | These surveys are conducted quarterly, and a questionnaire is issued to patients to complete.<br><br>This questionnaire on a rating of service covers the environment, cleanliness, waiting time, treatment issues, food, linen and medication. Service starts with the environment and cleanliness; we talk about waiting time, we come to the treatment issues, and we come to food, linen and medication.<br>The collected data is analysed, and the findings give a picture of the trend of patient experiences and views. |

**Source:** Author, 2022

All participants named and discussed the patient complaint and recommendation platforms. According to Reader, et al. (2014), a patient complaint is a good mechanism that is able to bring forward healthcare delivery problems and provide the hospital with insights into problems experienced by the people they serve. This argument resonates with the participants' standpoint as they highlighted that:

*"I can say that our people have now learned to complain, and if the OM doesn't attend to the issues, they contact me by telephone or other methods. As management, we guide them on the steps to follow regarding their complaints. Apart from attitudes, these complaints help us; sometimes, we identify the need to train our nurses through them",* Sophia.

*"Our public is very vocal, and we listen to them because you've got the hospital board as well, which is the voice for the public. Then you've got the war rooms where they can also talk. The counsellors come and speak to us if there are problems as well. Our CEO tries to meet with the counsellors, and they come in as well",* Pam.

*"We consider them to improve the quality of patient care. Okay, the patients are called if there is a problem or maybe a complaint, and their redress will be done, and then the quality improvement will be done to ensure that the same mistake doesn't occur again in future",* Mary.

*"I would say management takes the input of the patients to a large extent. Remember, we always go by the motto of, in most cases; the customer is always correct right now. This is a client and end-user. Therefore, what they feel and experience is very important. They might have misperceptions, but we have to clear those misperceptions. So, we take a large account of how they felt and what was the exact problem. Then we investigate fully, even at our level, we investigate fully and write our reports, and we are included in meetings with the patient and family to explain what happened. So, I don't think we try to brush things under the carpet",* Jane said.

In addition to the multiple platforms that cater to patient voices, the hospital prioritises capturing the patient's realities through a Bato Pele committee. *"We have a Batho Pele committee that promotes the issues of Batho Pele training and customer care training to ensure that our staff members understand how to serve our clients (patients). They are particularly our frontline staff members",* Steve. Patient complaint consideration demonstrates patient-centeredness, and it helps healthcare facilities examine their practices, improve service and diagnose errors (Siddiq & Zaman, 2016). Literature shows that leadership and management approaches can improve healthcare delivery, which results in focused, developed, and efficient individuals and groups committed to achieving healthcare goals effectively (Ellis & Kell, 2014; Edwards & Saltman, 2017; Asaria, et al., 2022). The consideration and recognition of end-user experience, satisfaction and suggestion avenues are a resemblance of leadership's commitment to the efficient delivery of healthcare. It is one of the ways that the hospital seeks to improve performance.

### 4.5 Chapter Summary

This chapter presented a consolidated analysis of findings from empirical data collected from fifteen research participants. The presented findings were selected based on their accurate fitting to the objectives and questions of this study. These empirical findings were contextualised with relevant literature on the subject matter.

# CHAPTER FIVE: RECOMMENDATIONS, FUTURE STUDIES AND CONCLUSION

## 5.1 Introduction

This chapter presents an integration of research findings, recommendations, future studies, managerial implications and conclusions linked to the research objectives, as well as an overall conclusion of the discussions of this study. This chapter also presents recommendations emanating from critical observations made from the empirical evidence of this study.

## 5.2 Integration of Research Findings

### 5.2.1 Objective One

Mshiyeni hospital utilises more than one leadership style. The interchangeably used leadership styles in the hospital are autocratic, democratic, transformational, visionary and situational leadership.

The context always informs the selection of the leadership style. Leaders carefully assess each situation and apply the most fitting style based on its likelihood of yielding positive results. Concurring, Vera and Crossan (2004, p. 226) argued that "an ideal strategic leader would be able to identify and exercise the leadership behaviours appropriate for the circumstances". This was the observed standpoint at Mshiyeni hospital. Participants explained that it is their duty as leaders to be flexible to strategically employ a leadership style that would best accomplish specific objectives and best outcomes. Supporting this approach, Anderson (2015, p. 1) stated that ordinarily, "a one-size-fits-all approach to leading people can result in mediocre impact, and mediocre results. The most effective leaders are able to adjust their style to best it the task and the team". Therefore, leaders should not mistakenly assume that selecting a leadership style is a function based on their preference. Instead, they should take it as a strategic choice motivated by the capacity to best address the demands of a particular situation (Goleman, 2006).

As empirical evidence of this study pointed out at Mshiyeni hospital, there is no one-way or one size fits all leadership. Instead, situations determine the necessary approach, and the leader flexibly adopts the appropriate style. This approach to leadership showed flexibility in thinking as it acknowledged that leadership could not be understood in a vacuum separate from the environment, situation, or state in which the hospital operates. It was observed that democratic

leadership in the hospital is mostly about buy-in and avoidance of non-compliance. Authentic and meaningful participatory leadership exist but at a minimal level. Therefore, the commonly used autocratic approach fits the context and broadness of the hospital. Primarily because of the emphasised consultation, communication and engagement of stakeholders and employees even in the use of a top-down approach, even though their engagement is on an only-to-know-basis. The leaders' understanding of the hospital and its employees supports the acceptance of autocratic leadership and the strategic utilisation of their competencies to maintain healthy leader-follower relationships. Therefore, in any utilised leadership style, the behaviour and approach taken by leaders influence efficiency.

Strategic leadership characterisation in the hospital includes:

- The strategic planning, operations and management are aligned with the hospital's vision of providing quality and efficient healthcare.
- Leaders are flexible to change and adapt to various leadership behaviours.
- The leaders effortlessly utilise their competencies to improve performance despite the turbulence, change and constraints.
- Adaptive and resilient capability to respond to the dynamic, challenged and uncertain environment
- Capability to adjust the hospital in response to the external environment forces
- Maintenance of direction and purpose despite multiple challenges

### 5.2.2 Objective Two

Empirical data showed that Mshiyeni hospital operates under a dynamic and complex environment characterised by several challenges that directly affect operations. Yes, problematic and external factors such as financial issues create a web of stressors that confronts a conducive work environment handicapping successful performance and efficient delivery of healthcare services.

Amid the situational impediments, turbulence, and constant changes, the hospital operates under the leadership actions, behaviours and interventions are the main things that positively affect the performance of this hospital. Thus, leads to the conclusion that strategic leadership activities play a significant role in the hospital's performance. This conclusion was drawn from the literature proposition that to be effective, and organisations need increased flexibility, innovation, adaptability, and strategic approaches to leadership that can effectively synch with

today's existential complex and constantly changing environment (Orchard, 1998). All the factors characterised by Orchard were raised by the participants as main practices that guide leadership at the hospital.

The reality is that Mshiyeni hospital is confronted with severe challenges that handicap successful employee performance and efficient delivery of healthcare services. The resilience and strategic approaches employed by the hospital are the main elements that keep the hospital afloat instead of being overwhelmed and sunk by the multiple challenges it operates under. Strategic planning, ensuring the shared vision and strategic alignment of hospital plans with targeted outcomes as some strategic actions that work for the hospital. These practices by hospital leaders resonate with the characterisation of strategic leadership as the ability to invest in planning, visioning and exploiting available competencies and resources to maintain current efficiency while simultaneously considering long-term success despite the turbulence and change (Levinthal & March, 1993; Rowe, 2001; Hitt, et al., 2010).

It is not easy to judge the organisational performance based on the impact of the leadership style because of these two factors:

- The operations and overall hospital environment are greatly affected by external factors. Therefore, the institutional-level leadership style will not be sufficient to reasonably determine the hospital's overall performance. For instance, the hospital has been failing to meet its targets due to budget constraints and other factors perpetuated by it, such as severe staff shortages or ailing and insufficient resources.
- The judgement of hospital performance or rating of leadership efficiency is problematic in the context of Mshiyeni hospital. This is because of the existing contradicting elements being the expectation of efficient performance and service delivery in the absence of a conducive environment and resources.

There is absolutely no alignment between the hospital healthcare demands or expected outcomes and the adequate supply or availability of resources. This conclusion is supported by the following example of some primary contradicting factors which should be aligned.

| |
|---|
| Reduced budget **VS** Increasing healthcare service demands (increasing patient numbers and diseases) |
| Increased service demands **VS** Limited resources to operate (staff shortages, over worked staff, aging infrastructure, equipment shortages) |
| Limited resources **VS** Quality and efficient delivery of serve/patient care |

Conceptual and empirical data demonstrated that strategic leadership actions influence organisations' performance. Quality of leadership and leadership behaviour plays a critical role in determining organisational success and enhancing employee job satisfaction (Ezenwa, 2017). At an operational level, the currently employed leadership approach improves some aspects of the hospital, such as:

- Employee commitment
- Improved staff attitude
- Improved employee performance
- Improved tolerance and resolving of challenges
- Acceptable change management
- Improved communication and participation of staff

### 5.2.3 Objective Three

The Mshiyeni hospital has a sound understanding of change management. Standard operating procedures from the provincial or national departments inform most change management strategies.

The hospital is capable of customising internal change management approaches without deviating from the broad institutional prescriptions. The hospital manages well changes that were anticipated and planned for. It needs to improve in managing unexpected and unplanned changes. This proposition is based on Mintzberg (1987), who cautioned against the reliance on a deliberate strategy which is strategic plans formulated in advance of implementation and advice in relying on emergent strategic planning where leaders devise solutions to problems and changes as they arise. In this manner, crafting strategies as situations emerge promotes flexible responses to the constantly changing environments and reflects the leader’s abilities to stay attuned to existing patterns to prepare for any change (Mintzberg, 1987; Berry, 2007).

### 5.2.4 Objective Four

The hospital leaders inform change and empower employees to follow suit. The examples of changes and the approaches that hospital leaders used demonstrate the hospital's flexibility and adaptability. They demonstrate that the hospital invests in planning for change and has a positive attitude towards change which is a good character given that it operates in a complex and constantly changing environment. According to Berry (2007, p. 339), planning that considers the mission of the organisation, stakeholders and creative actions to achieve targeted

results and move the organisation forward during both normal and complex terrains. It was evident that Mshiyeni hospital leaders who participated in this study had a similar understanding of the disruptions that can be introduced by change. They even shared similar approaches to anticipating and mitigating resistance to change, which is another good character to note. This speaks to the alertness, awareness and readiness to adapt to change.

The hospital has a sound performance management system which integrates service agreements and evaluation of performance which can improve accountability. Performance management affects the organisation's productivity and performance (Obeidat, et al., 2018). Therefore, investing in effective performance management systems may positively affect Mshiyeni hospital.

All participants did not thoroughly describe the consequence management of the hospital.

The hospital has multiple channels that allow patients to complain, complement or raise suggestions.

## 5.3 Recommendations Based on Study Findings

***Objectives One and Two:***

### 5.3.1 Recommended Improvement

It is undeniable that operational and service demands exceed hospital costs. This condition traps the hospital in impossible situations because the probable consequence of performing short-staffed, with ageing equipment and limited resources, is likely to be poor outcomes and unsatisfactory performance. In addition to this state, the hospital operates in a dynamic and challenging environment with an increasing disease burden and demand for service. Given the socioeconomic development state of the country as a whole which is contextualised by increasing unemployment and poverty rates, it is clear that the current constrained financial state of public institutions will persist. Therefore, strategic and effective leadership alone will not suffice to improve all the challenges that influence poor hospital performance.

Mshiyeni hospital leadership should look beyond meeting organisational goals and focus on controllable factors that concern improving employee performance and efficient delivery of the limited and constrained healthcare services the hospital can provide. This approach that looks beyond the bigger picture involves strategically managing small institutional factors that matter the most. For instance, leadership should focus on curbing negative staff attitudes or levels of

service negligence to minimise service complaints and litigation cases. It is highly recommended that the hospital maintains its strategic leadership approach but navigates it sparingly.

***Objective Three:***

### 5.3.2 Concerted Change

The assimilation of change, mainly brought by V.U.C.A. and the 4IR, presents both opportunities and threats. The hospital should not ignore the fast phase of technological advancements and digitalisation. Although there is a budget constraint challenge, it is recommended that the hospital should consider investing in technologies that will support staff activities. Perhaps such an approach can dilute staff shortage, and the over-working of the limited staff can improve service delivery. Undoubtedly, accelerating innovation strategies in public service delivery is costly, risky, and an unfamiliar practice; therefore, strategic planning, strategic leadership and strategic orientation are necessary. As a country tainted by a poor record of efficient and successful policy implementation and service delivery, taking an alternative approach to invest in technology should be driven by strategic planning before implementation.

### 5.3.3 Focus on Individuals

At the organisational level, the Mshiyeni hospital has a plan-based approach to change management. However, it is recommended that the hospital considers an approach that is holistic and caters for complexity, such as the ADKAR model of change. The acronym ADKAR stands for Awareness, Desire, Knowledge, Ability and Reinforcement, which are five elements considered key organisational change drivers (Hiatt, 2006, p. 43). This model argues that organisations can communicate, introduce change and train employees but still fail to successfully manage if the facilitation of change ignores some of these factors. For instance, not being aware of why the organisation needs to change and what will be the effects of this change can result in poor change management. The Characterisation of the ADKAR model that the hospital can learn from is demonstrated in Figure 5.1.

**Figure 0.1: Five Elements of the ADKAR Model of Change**

<table>
<tr><th>Awareness</th><th>Desire</th></tr>
<tr><td>• Understanding<br>• Why change is necessary is the first key aspect of successful change.<br>• This step explains the reasoning and thought that underlies a required change.<br>• Planned communication is essential.</td><td>• Decision<br>• personal decision to support the change and participate in the change.<br>• desire to support and be part of the change can only happen after full awareness of the need for change is established.<br>• building desire for the individual and creating a desire to be a part of the change.</td></tr>
<tr><th>Knowledge</th><th>Ability</th></tr>
<tr><td>• providing knowledge about the change, achieved through normal training and education methods.<br>• transferring knowledge, like coaching, forums and mentoring, formal training.<br>• two types of knowledge need to be addressed:<br>1. knowledge on how to change (what to do during the transition)<br>2. knowledge on how to perform once the change is implemented.</td><td>• Ability = is the difference between theory and practice.<br>• how to change is in place (theory) the practice, individual needs to be supported.<br>• needs of time and can be achieved through practice, coaching and feedback.</td></tr>
<tr><th colspan="2">Reinforcement</th></tr>
<tr><td colspan="2">• is an essential component in which efforts to sustain the change are emphasized,<br>• ensuring that changes stay in place,<br>• individuals do not revert to old ways - can be achieved through positive feedback, rewards, recognition, measuring performance and taking corrective actions.</td></tr>
</table>

**Source:** (Boca, 2013, p. 249)

***Objective Four:***

### 5.3.4 Envisaged Reform

The state of operations, hospital infrastructure, resources and high demand for service observed at Mshiyeni hospital resembles most of the public hospital environment in SA. The DoH has long proposed an envisaged reform through the National Health Insurance (NHI) which will address the challenge of inadequate resources to efficiently meet the healthcare needs of the entire population (Department of Health, 2020a). It is recommended that the department of health take greater steps towards realising the efficient provision of quality healthcare for all through NHI, given the challenging state of public hospitals, as it currently does not meet its legislated mandate.

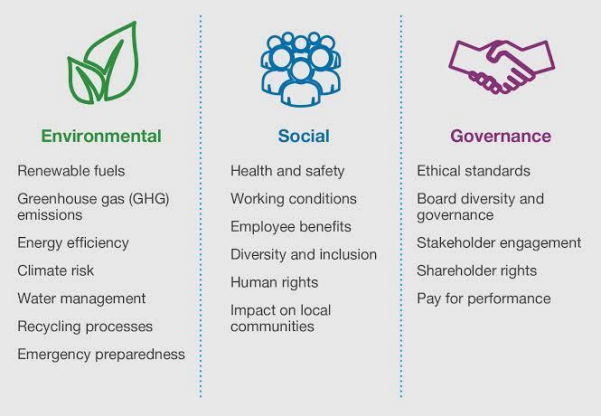
### 5.3.5 Paradigm shift and adaptation with flexibility or agility

Based on the participant's responses, the mentioned adaptation and flexibility approach that is applied in the hospital's management primarily considered the political, economic and social factors. Other critical factors, such as technology and governance, were not prominent. It is

therefore highly recommended that the hospital leadership embrace the environmental, social and governance (ESG) pillars as it may improve healthcare service and delivery.

In a recent study on the impact of COVID-19 on the healthcare landscape in SA, the PwC Network (2022) found that the pandemic placed a significant strain on the healthcare systems. According to this Network, the pandemic forced institutions to employ alternative strategies such as virtual technology and collective responsibility amongst stakeholders, as the aim was to provide health services despite a global challenge. It became evident that innovation, research and development and solution-oriented factors are instrumental in problem and change management. Therefore, increasing ESG will guide public healthcare management to focus beyond just the social pillars, which involve improving access and quality of health. Inclusion of the environmental pillar involves innovation, digital transformation, sustainable use of resources and ecological footprint. Attention to improving corporate governance, accountability and improved risk management should be paid by expanding the scope or policy of the existing consequence management. This can be achieved by embedding accountability and consequence management in the hospital's culture. Figure 5.2 presents an example of ESG factors that can strengthen the resilience and efficiency of the hospital.

**Figure 0.2: ESG Pillars**




**Source:** (World Economic Forum, 2021).

## 5.4 Recommendation for Future Studies

The constitutional mandate on access and provision of healthcare in SA and the national healthcare objectives and policies are clear on the aspiration of efficient provision of quality healthcare. However, the financial provisions for public healthcare facilities seem to not match the service demands in a manner that can enable public hospitals to deliver their service

sufficiently. It is recommended that future research probe into this matter at an executive level within the health department to get an idea of how the health department idealises its public institutions to execute its services in the context of the existing constrained resources state. Perhaps a demonstration of practising within the current resource provisions from the finance decision-makers could give practical guidance to hospitals and clinics on the ground.

## 5.5 Conclusion

The efficient delivery of quality healthcare services is of utmost priority for public healthcare facilities. Therefore, public hospitals are tasked with offering healthcare services successfully and productively. Statistics presented in this study showed that, nationally, about 83% of the entire population of SA relies on public healthcare (Ngobeni, et al., 2020). Further discussions showed that in addition to servicing the masses, public healthcare faces several challenges: lack of resources, especially finance, staff shortages, ageing infrastructure, and the increasing number of patients and diseases.

Literature demonstrated the concern of public healthcare capacity, efficiency, and capability of sustainable service delivery as SA demonstrate poor health outcomes worse than any low-income country, despite being a middle-income country. Statistics showed that DoH receives a significant budget allocation from the National Treasury annually. Despite the constitutional mandate, healthcare policies, frameworks, significant budget allocation and expenditure, public hospitals and clinics remain overly burdened, pressured by high reports of inefficiency, poor outcomes, unsatisfactory performance, and bad public reputation. Against this background, a thorough consultation of literature on strategic leadership and its impact on the severely challenged, ever-changing context of the public health system was conducted.

Literature shows that it is the responsibility of leaders to optimally render health sector demands and service outcomes in public hospitals. Strategic leadership was characterised as an important tool that can efficiently drive organisations to success despite complexities, shocks, and all forms of is one of the effective tools for efficient management, and its effect on managing complexities, change and other forms of turbulence. Empirical evidence from a qualitative thematic analysis revealed that Mshiyeni hospital operates in a complex and demanding environment. The hospital tackles extensive responsibilities of regional and district hospital services in an overly populated location mostly made up of socio-economically challenged communities with constrained HR and financial resources. Keeping the hospital operational at a satisfactory level is the strategic actions, behaviours and approaches employed

by the leaders at the hospital level. The study findings clearly showed that planning, flexibility to adapt, instilling the vision and applying a suitable leadership style or approach contingent on the situation are the primary strategic leadership practices that have improved some aspects of the hospital's performance.

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# APPENDICES

## Appendix 1: Interview Schedule

**Appendix 1: Interview Schedule**

**Duration: 30 Minutes**

**Objective 1 - To identify the current strategic leadership style at Mshiyeni hospital**

1. What are the existing strategic leadership styles at PMMH, and which one would you consider the most efficient leadership style for improving the hospital's performance? Why?
2. How do the existing leadership styles link with the hospital objectives?
3. Strategic leadership is important in an organisation; what is your opinion on this statement?
4. In your role as manager in the hospital, to what extent do you participate in strategic planning and decision-making?

**Objective 2 - To determine the impact of strategic leadership style on organisational performance**

5. What is the impact of strategic leadership on performance and service delivery?
6. How has the hospital been performing in the last three years in terms of meeting its targets, and what has been the leadership role in this?
7. What competencies would you consider as crucial in hospital leadership?
8. What challenges do you experience as leaders of the public hospital, and what strategies do you have in place to mitigate these challenges?

**Objective 3 - To investigate the perceptions of leaders on change management in public hospital management**

9. Considering the volatile nature of the modern era, has the hospital management experienced any changes, and how did they respond to these changes?
10. In your experience, how have these changes affected the stability or norms of the hospital management /leadership operations?
11. Ordinarily, change can introduce uncertainty and disruptions in organisations; what is your opinion and experience on this statement?

**Objective 4 - To examine how the hospital can improve the strategic leadership and management style in this rapidly changing era for effective and efficient performance.**

12. What are the systems or strategies used by leaders to address change or disruptions?
13. Public service is accompanied by accountability; what measures does the hospital use to keep leaders /managers accountable for their actions?
14. Does the hospital have monitoring and evaluation systems to assess leaders'/managers' performance?
15. Does the hospital have initiatives enabling end-users (patients) to offer their opinions and experience of services? If yes, to what extent does the hospital leadership consider public input in their strategic planning or decision-making?
16. How many years do you have in hospital management, and in your years of experience, what can you highlight as the most important aspect of public hospital management /leadership?

## Appendix 2: Informed Consent Letter

**Appendix 2: Informed Consent Letter**

**UNIVERSITY OF KWAZULU-NATAL**
**GRADUATE SCHOOL OF BUSINESS AND LEADERSHIP**
**Master of Business Administration Research Project (MBA)**

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Email: hssrec@ukzn.ac.za

Dear Respondent,

I, Knowledge Lungisani Zungu, am an MBA student in the Graduate School of Business and Leadership of the University of KwaZulu-Natal. You are invited to participate in a research project titled "*Strategic leadership and change management imperatives in a volatile era: a case study of Prince Mshiyeni Memorial Hospital*".

This research aims to investigate the role of strategic leadership and the importance of change management at Prince Mshiyeni Memorial Hospital to determine their impact on hospital management and performance in this era of unpredictable constant change.

Your participation will be valuable in understanding the specifics of strategic leadership and change management at Prince Mshiyeni Memorial Hospital. It is hoped that the study results will be a meaningful contribution to the public hospital management/leadership as it will draw lived experiences from practitioners of Prince Mshiyeni Memorial Hospital.

Your participation in this research project is voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. There will be no monetary gain from participating in this research project. Confidentiality and anonymity of records identifying you as a participant will be maintained by the Graduate School of Business and Leadership, UKZN.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee [**Approval Number: HSSREC/00003615/2021**].

If you have any questions or concerns about participating in this study, please contact me or my supervisor / HSSR Ethics Committee at the contact details listed above.

Sincerely,

**Researcher's signature**: [redacted] **Date:** 15 June 2022

*This page is to be retained by the participant.*

**Informed Consent Letter**
**UNIVERSITY OF KWAZULU-NATAL**
**GRADUATE SCHOOL OF BUSINESS AND LEADERSHIP**

**Master of Business Administration Research Project (MBA)**

**Researcher:** Knowledge Lungisani Zungu
207507231@stu.ukzn.ac.za
**Supervisor:** Dr Tony Ngwenya (031 260 7825)
Ngwenyat2@ukzn.ac.za
**Research Office:** HSSREC (031) 260 8350/3587
Email: hssrec@ukzn.ac.za

**CONSENT**

I.....(full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participate in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire.

**Audio Recording:** Yes / No

**SIGNATURE OF PARTICIPANT** **DATE**

..... 15/06/2022

*This page is to be retained by the researcher.*

# Appendix 3: UKZN Approved Ethical Clearance

**Appendix 3: UKZN Approved Ethical Clearance**

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

13 December 2021

**Knowledge Lungisani Zungu (207507231)**
**Grad School Of Bus & Leadership**
**Westville Campus**

**Dear KL Zungu,**

**Protocol reference number:** HSSREC/00003615/2021
**Project title:** Strategic leadership and change management imperatives in a volatile era: a case study of Prince Mshiyeni Memorial Hospital
**Degree:** Masters

## Approval Notification – Expedited Application

This letter serves to notify you that your application received on 26 October 2021 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **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.**

This approval is valid until 13 December 2022.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,

[redacted]

---
**Professor Dipane Hlalele (Chair)**

**/dd**

# Appendix 4: KZN-DoH Research Approval

**Appendix 4: KZN-DoH Research Approval**

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email: [redacted]
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management

NHRD Ref: KZ_202110_003

**Dear Mr KL Zungu**
(UKZN)

**Approval of research**

1. The research proposal titled **'Strategic leadership and change management imperative in volatile era: A case study of Prince Mshiyeni Memorial Hospital'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at Prince Mshiyeni Memorial Hospital.

2. You are requested to take note of the following:
   a. *All research conducted in KwaZulu-Natal must comply with government regulations relating to Covid-19. These include but are not limited to: regulations concerning social distancing, the wearing of personal protective equipment, and limitations on meetings and social gatherings.*
   b. *Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.*
   c. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*
   d. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete to* ***HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200*** *and e-mail an electronic copy to hrkm@kznhealth.gov.za*
   e. *Please note that the Department of Health shall not be held liable for any injury that occurs as a result of this study.*

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yo[redacted]

**Dr E Lutge**
Chairperson, Health Research Committee
Date: 11/02/2022

Fighting Disease, Fighting Poverty, Giving Hope

# Appendix 5: Letter of Approval to Conduct Research at Mshiyeni Hospital

**Appendix 5: Letter of Approval to Conduct Research at Mshiyeni Hospital**

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

**DIRECTORATE: Senior Manager: Medical**

Postal Address : Mangosuthu Highway, Private Bag X 07, Mobeni
Physical Address
**Name of Directorate: Prince Mshiyeni Memorial**
**Tel**: 0319078317 **Fax:** 0319061044 **Email address: myint.aung@kznhealth.gov.za**
www.kznhealth.gov.za

**Enquiry: Dr M AUNG**
**Ref No: 39/RESH/2021**
**Date: 30/09/2021**

**TO: Mr Knowledge Zungu**

**RE: LETTER OF APPROVAL TO CONDUCT RESEARCH AT PMMH**

Dear Researcher;

I have pleasure to inform you that approval has been granted to you by PMMH to conduct research on **"STRATEGIC LEADERSHIP AND CHANGE MANAGEMENT IMPERATIVE IN VOLATILE ERA: A CASE STUDY OF PRINCE MSHIYENI MEMORIAL HOSPITAL"**.

Please note the following:

1. Please ensure this office is informed before you commence your research.
2. The institution will not provide any resources for this research.
3. You will be expected to provide feedback on you finding to the institution.

**The management of Prince Mshiyeni Memorial Hospital reserves the right to terminate the permission for the study should circumstance so dictate**.

With kind regard

[redacted]

MYINT AUNG
Senior Medical Manager & specialist in Family Medicine
MBBS, DO(SA), PGDip in HIV (Natal), M.Med.Fam.Med (natal), PhD
Tel: 031 9078317; Fax: 031 906 1044
myint.aung@kznhealth.gov.za

# Appendix 6: Letter of Support to Conduct Research at Mshiyeni Hospital

**Appendix 5: Letter of Support to Conduct Research at Mshiyeni Hospital**

**KWAZULU-NATAL PROVINCE**
HEALTH
REPUBLIC OF SOUTH AFRICA

**DIRECTORATE: Senior Manager: Medical**


Postal Address : Mangosuthu Highway, Private Bag X 07, Mobeni **Name of Directorate: Prince Mshiyeni Memorial**
Physical Address
**Tel**: 0319078317 **Fax:** 0319061044 **Email address: myint.aung@kznhealth.gov.za**
www.kznhealth.gov.za


**Enquiry: Dr M AUNG**
**Ref No: 39/RESH/2021**
**Date: 30/09/2021**

**TO: Mr Knowledge Zungu**

**RE: LETTER OF SUPPORT TO CONDUCT RESEARCH AT PMMH**

Dear researcher;

I have pleasure in informing you that support has been granted to you by Prince Mshiyeni Memorial Hospital (PMMH) to conduct research on "**STRATEGIC LEADERSHIP AND CHANGE MANAGEMENT IMPERATIVE IN VOLATILE ERA: A CASE STUDY OF PRINCE MSHIYENI MEMORIAL HOSPITAL**".

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received approval of your study from the Provincial Health Research and Ethics Committee (PHREC) in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The PMMH will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to PMMH.
6. You are required to contact this office regarding dates for providing feedback when the research has been completed.

Should the following requirements be fulfilled, a Permission/ Approval letter will follow.

- Full research protocol, including questionnaires and consent forms if applicable.
- Ethical approval from a recognized Ethic committee in South Africa

[redacted]

MYINT AUNG
Senior Medical Manager & specialist in Family Medicine
MBBS, DO(SA), PGDip in HIV (Natal), M.Med.Fam.Med (natal), PhD
Tel: 031 9078317
Fax: 031 906 1044
myint.aung@kznhealth.gov.za

## Appendix 7: Turnitin Report

**Appendix 5: Turnitin Report**

Strategic Leadership and Change Management Imperatives in a Volatile Era: A Case Study of Prince Mshiyeni Memorial Hospital

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