



**UNIVERSITY OF
KWAZULU-NATAL**

**INYUVESI
YAKWAZULU-NATALI**

**Exploring the effects of Collaborative Global Health Partnerships in the Ministry of
Health and Child Care's Monitoring and Evaluation systems in Zimbabwe**

By

Zacharia Grand

218087400

A Research Dissertation

For

Doctor of Public Administration

**School of Management, Information Technology, and Governance, College of Law and
Management Studies**

Supervisor: Professor Sybert Mutereko

October 2022

DECLARATION

I declare that: Exploring the effects of Collaborative Global Health Partnerships in the Ministry of Health and Child Care's Monitoring and Evaluation systems in Zimbabwe is my unaided work. It is being submitted for a Doctor of Administration degree at the University of KwaZulu Natal, School of Management, Information Technology, and Governance, College of Law and Management Studies, Durban. It has not been submitted before for any degree or examination at another university. Signed: [REDACTED] Date: 19th of October 2022

DEDICATION

I dedicate this thesis to my wife Catherine and kids Anopaishe, Kunenyasa, Taropafadzwa, and Mukundi for their moral support during the journey. I remain indebted to them for allowing me to be an absent and virtual father.

ACKNOWLEDGMENTS

I want to acknowledge the professional and thorough guidance received from my supervisor Professor Sybert Mutereko. His approach to mentorship influenced my academic and broader leadership skills during the course of this journey. I would have given up without his guidance and direction during the most challenging times. He remained available to guide, including at odd hours of the day. For this reason, I remain grateful for going beyond the call of duty.

I also acknowledge the financial support I received from the Health Economics and AIDS Research Division (HEARD), which provided a scholarship to enable my studies and stay in South Africa. I particularly acknowledge Cailin Hedderwick for her professional and caring demeanour during all our engagements and her administrative support during the study. I also acknowledge the Glenmore Pastoral Centre, specifically Tracy Wesley and her family, for providing me with ‘a home away from home’ during my stay in South Africa. Likewise, I remain grateful to my fellow Ph.D. friends at the Centre, Patience Obianuju, Sarah Khanakwa , Warren Mukelabai Simangolwa , Emmanuel Asiamah, Joyce Mlay, Agness Nyabigambo, Ntobeko Ndlovu, Anil Lonappan, Kwabena Asare, and Garikai Membele for the useful conversations and encouragement during the journey. Lastly, Professor Magezi and family, thank you for your moral and general support to my family during the whole period.

ABSTRACT

Global Health Partnership support for monitoring and evaluation (M&E) policy and practice has strengthened Zimbabwe's public health system. Recent evidence suggests that hybrid governance systems such as partnerships can play an essential role in co-producing and co-financing public health policies and programmes. Most public governance studies have embraced this approach as progressive. However, scholarly arguments on collaborative partnerships have missed an opportunity to fully investigate their effects on local health systems from a critical constructivist and dialogic policy approach to capture local partner reflexivity and resistance to external influence in public health policy planning and implementation. As a result, the current scholarly approaches to the collaborative partnership discourse have failed to account for the limits of agentive reflexivity in a global public health space tilting towards neoliberalism.

This study used a qualitative case study approach, drawing from the Collaborative Governance of Partnership and Critical Discourse analytic frameworks to illuminate the effects of dialogic and discursive soft power encounters and its impact on M&E policy and practice in Zimbabwe. Data were collected using a documentary review of M&E policies and key informant interviews with Ministry of Health M&E staff.

The findings suggest that collaborative partnerships for health have resulted in (un)intended effects that include digital exclusion of local partners, competition among partners, threats to sovereignty, fear of job losses, brain drain from government among other unanticipated challenges. As a result, the study argues that collaborative partnerships for M&E are contested spaces in which Global Health Partners(GHPs) revive old paternalistic aid tactics through control of governing rationalities that promote the local reproduction of neoliberal, market-oriented ideas that influence and shape the 'co-creation' of M&E policies in Zimbabwe. The study further observes that the Ministry as a local partner apply various soft power strategies that include victimhood, extraversion, obsfucation and discourse control to counter GHP influence contrary to the key tenets of collaborative partnership for M&E.

The study concludes that government counter-discourse and soft power strategies are perverse reflections and performative reproductions of neoliberal rationalities by converted local responsible agents who (un)knowingly contribute to maintaining partnership power imbalances in favour of Global Health Partners.

Contents

DECLARATION	i
DEDICATION	ii
ACKNOWLEDGMENTS	iii
ABSTRACT	iv
List of Acronyms	xiv
CHAPTER ONE: BROADER VIEW OF THE STUDY	1
1.1 Introduction.....	1
1.2 Background to the problem.....	1
1.3 Statement of the problem	4
1.4 Aim of the study.....	6
1.5 Research objectives.....	6
1.6 Research questions.....	6
1.7 Significance of the study.....	6
1.8 Justification of the study	7
1.9 Methodology	8
1.10 Definition of key terms	8
1.11 Structure of the dissertation	10
1.12 Summary of this chapter	12
CHAPTER TWO: THEORETICAL FRAMEWORK AND REVIEW OF RELATED LITERATURE	13
2.1 Introduction.....	13
2.2 Collaborative governance models	13
2.2.1 Model of collaborative governance.....	13
2.2.2 Integrated framework for a collaborative governance regime	14
2.2.3 Governance of Collaborative	15
2.2.4 Government–Non-profit Partnership Model	15
2.3 Justification for the NPG models for this study	16
2.4 Critical Discourse Analysis theoretical framework	18
2.5 Justification of the use of Critical Discourse Analysis in this study	20
2.6 Conceptualising global health.....	21
2.6.1 The Nexus between public, international, and global health	22
2.6.2 International health	22
2.6.3 Global health.....	22

2.7 Conceptualising partnerships in global health	24
2.7.1 Partnerships in pragmatic-instrumental literature	25
2.7.2 Partnerships in critical-ideological literature	25
2.7.3 Partnerships in critical-governmentality literature.....	26
2.7.4 Partnerships in critical-constructivist literature	26
2.7.5 Partnerships in post-constructivist literature.....	27
2.7.6 Partnerships in post-truth literature.....	27
2.8 Global health partnerships	28
2.9 Types of global health partnerships	29
2.10 Conceptualising monitoring and evaluation	30
2.10.1 Monitoring	30
2.10.2 Evaluation	31
2.11 The political and technical side of monitoring and evaluation	32
2.11.1 The political side of monitoring and evaluation	32
2.11.2 The technical side of monitoring and evaluation	33
2.12 Types of GHP monitoring and evaluation systems.....	34
2.12.1 World Bank monitoring and evaluation systems	34
2.12.2 The Global Fund monitoring and evaluation systems.....	36
2.13 Mechanisms of Global Health Partnership’s influence on local M&E and governance systems	37
2.13.1 Monitoring and evaluation policy agenda-setting and institutional control.....	37
2.13.2 Norm diffusion and standardisation of monitoring and evaluation discourses in health programmes.....	38
2.13.3 Monitoring and evaluation rhetoric and discourse control.....	39
2.13.4 Framing of M&E issues in policy and practice in LMICs	39
2.13.5 Effects of monitoring and evaluation conceptual boundaries	40
2.13.6 The performativity of global health monitoring and evaluation systems as technologies of soft power.....	41
2.13.7 Role of monitoring and evaluation champions	41
2.13.8 Rebranding and effacement strategies	42
2.13.9 Monitoring and evaluation artefacts and policy influence.....	43
2.13.10 Mechanism of power expression by local health partners in partnerships.....	43
2.13.11 Social Capital as a source of power in Partnerships	44
2.13.12 National health legislation	44
2.13.13 Power of street-level bureaucrats in health partnerships.....	45
2.13.14 Bureaucratic socialisation as power in health partnerships.....	45
2.14 Impacts of global health partnerships on the six WHO building blocks.....	46

2.14.1 Impacts of GHPs on the financing of local country M&E health systems.....	46
2.14.2 Impact of GHPs on health information reporting in local health M&E systems	47
2.14.3 Impact of GHPs on local M&E systems for service delivery	48
2.14.4 GHP impact on M&E for human resources for health.....	48
2.14.5 GHP impact on pharmaceutical and medical technology systems.....	49
2.14.6 GHP impact on whole government health M&E systems.....	49
2.15 Chapter summary	50
CHAPTER THREE: RESEARCH METHODOLOGY AND METHODS.....	51
3.1 Introduction.....	51
3.2 Paradigmatic perspectives of the study	52
3.2.1 Interpretivism.....	52
3.2.2 Ontology of Interpretivism.....	53
3.2.3 Epistemology of Interpretivism	53
3.2.4 Axiology of interpretivism.....	54
3.3 Research design	54
3.4 Research methodology	56
3.5 Study site.....	57
3.6 Population and sampling.....	57
3.6.1 Study population	58
3.6.2 Sampling	58
3.6.3 Recruitment Strategy.....	60
3.7 Data collection and description of instruments.....	61
3.7.1 Interviews.....	62
3.7.1.1 Interviews with head office M&E staff (Harare)	63
3.7.1.2 Interview with provincial M&E staff.....	64
3.7.2 Document review	64
3.8 Data analysis	66
3.9 Ethical Consideration.....	67
3.9.1 Informed Consent.....	67
3.9.2 Explicit authorisation	68
3.9.3 Confidentiality and anonymity.....	68
3.9.4 Protection from harm	68
3.10 Research Limitations	69
3.11 Conclusion	69
CHAPTER FOUR: GLOBAL HEALTH PARTNERSHIPS AND THE MONITORING AND EVALUATION SYSTEM IN ZIMBABWE.....	70

4.1 Introduction.....	70
4.2 Background to M&E systems in Zimbabwe	70
4.3 Interactions of GHPs and the health system in Zimbabwe	71
4.3.1 Monitoring and evaluation in the first decade from 1980-1990.....	72
4.3.2 The Economic Structural Adjustment Programme (ESAP) period, 1991-1996	73
4.3.3 The development of M&E in the crisis period 1997-2009.....	74
4.3.4 The Transitional period 2010-2020.....	75
4.4 Key stakeholders in the health M&E system in Zimbabwe	76
4.4.1 State actors	76
Monitoring and Evaluation in Government Ministries	77
The National AIDS Council of Zimbabwe	77
The Parliament of Zimbabwe.....	77
4.4.2 Non-state actors.....	78
Academic actors.....	78
Voluntary organisations for professional evaluation	78
4.5 Summary of the chapter	79
CHAPTER FIVE: SOFT POWER STRATEGIES, M&E DISCOURSES AND IMPACTS ON PUBLIC HEALTH MONITORING AND EVALUATION POLICY AND PRACTICES IN ZIMBABWE.....	80
5.1 Introduction.....	80
5.2 Monitoring and evaluation discourses	80
5.2.1 Dominant economic discourses in M&E policies	82
5.2.2 Participatory discourse in M&E Policies	83
5.2.3 Scientific discourse in M&E policies and practice	85
5.2.4 Technological discourse as governing technologies	87
5.2.5 Results-based discourse in the policy and practice of M&E in Zimbabwe.....	89
5.2.6 Country-led discourse in the policy and practice of M&E in Zimbabwe	91
5.2.7 Human rights-based discourses as technologies of power	92
5.2.8 Health security and emergency discourses	93
5.3. Soft power strategies influencing and shaping M&E policy and practice in Zimbabwe	95
5.3.1 Use of monitoring and evaluation artefacts as soft power tools	95
5.3.2 Provision of M&E policy advisory and consultancy services.....	97
5.3.3 Support for monitoring and evaluation champions	99
5.4 Discussion.....	100
5.4.1 Dominant economic discourses in M&E policies	101
5.4.2 Participatory discourse in M&E policies	102

5.4.3 Scientific discourse in M&E policies.....	103
5.4.4 Technological discourse as governing technologies	105
5.4.5 Results-based discourse in policy and practice of M&E in Zimbabwe	106
5.4.6 Country-led discourse in the policy and practice of M&E in Zimbabwe	107
5.4.7 Human rights-based discourse as technologies of power.....	108
5.4.8 Framing Health as an emergency and security issue	110
5.5. Soft Power Strategies	111
5.5.1 Monitoring and evaluation artefacts as governing technologies	111
5.5.2 Provision of M&E policy advisory and consultancy services.....	112
5.5.3 Support for monitoring and evaluation champions	113
5.6 Chapter Conclusion	115
CHAPTER SIX: LOCAL M&E PARTNER RESOURCE AND POWER RATIONALISATION MECHANISMS AND STRATEGIES IN THE PARTNERSHIP FOR HEALTH IN ZIMBABWE	
6.1 Introduction.....	117
6.2 Mechanisms and strategies for rationalising power imbalances in partnerships.....	117
6.2.1 Recourse to constitutional and sovereignty power.....	119
6.2.2 Enforcement of clear policies and guidelines	121
6.2.3 Use of memoranda of understanding as a government source of power in partnerships ...	122
6.2.4 Bureaucratic power as procedure and orderliness.....	123
6.2.5 Victimhood as a strategy	125
6.2.6 Extraversion and obfuscation strategies.....	126
6.3 Discussion.....	127
6.3.1 Constitutional and sovereign power.....	127
6.3.2 Enforcement of policies and guidelines	130
6.3.3 MoUs as a government source of power in partnerships for health.....	131
6.3.4 Bureaucratic power as procedure and orderliness socialisation.....	132
6.3.5 Victimhood and polarisation as a strategy	134
6.3.6 Extraversion and obfuscation.....	134
6.4 Conclusion	137
CHAPTER SEVEN: THE IMPACT OF THE GOVERNMENT- GHP COLLABORATIVE GOVERNANCE SYSTEM ON THE PUBLIC HEALTH ADMINISTRATION AND M&E SYSTEM IN ZIMBABWE	
7.1 Introduction.....	138
7.2 Global Health Partnership impacts on governance and public health M&E system.....	138
7.2.1 GHP-supported M&E leads to digital exclusion.....	141
7.2.2 Normalisation of Parallel M&E systems.....	142
7.2.3 Digital disruption of M&E data capture and reporting	144

7.2.4 GHP M&E funding as a source of contests and conflicts	145
7.2.5 Partnerships for M&E as threats to national sovereignty.....	147
7.2.6 GHP M&E funding and patron-clientelism	148
7.2.7 GHP Capacity building facilitating the brain drain in the health sector	149
7.2.8 Promoting mute and perverse practices	151
7.2.9 Threats to employment opportunities.....	153
7.2.10 Promoting conceptual boundaries and “othering” effects.....	154
7.2.11 Coordination challenges due to competition for visibility and leadership.....	155
7.3 Discussion.....	156
7.3.1 GHPs-supported M&E facilitating digital exclusion	157
7.3.2 Normalisation of Parallel M&E systems.....	158
7.3.3 Digital disruptions in M&E.....	159
7.3.4 Contested nature of GHP-supported M&E	160
7.3.5 GHPs as threats to national sovereignty.....	162
7.3.6 Patron-clientelism	163
7.3.7 GHP support as a facilitator of the M&E brain drain in the health sector	164
7.3.8 Promoting mute and perverse practices	166
7.3.9 GHP-supported M&E as a threat to employment	167
7.3.10 “Othering” and conceptual boundaries	168
7.3.11 Weakened coordination due to competition for visibility and leadership.....	169
7.4 Chapter conclusion.....	172
CHAPTER EIGHT: IMPACT OF GHP GLOBAL M&E TECHNICAL AND FINANCIAL ASSISTANCE ON WIDER PUBLIC HEALTH M&E SYSTEM-STRENGTHENING INITIATIVES IN ZIMBABWE.....	174
8.1 Introduction.....	174
8.2 Effects of GHP support on broader health M&E systems in Zimbabwe	174
8.2.1 Support for human resources for health in the health system	176
8.2.2 GHP support of Health Information systems	177
8.2.3 Support for governance and leadership in the health system	179
8.2.4 Finance for health and contributions to the national financial accountability systems	180
8.2.5 Monitoring and evaluation of pharmaceutical and medical technologies	182
8.2.6 Support for health service delivery	185
8.3 Discussion.....	187
8.3.1 Human resources for health	188
8.3.2 Support for health information.....	189
8.3.3 Support for leadership and governance for M&E	190

8.3.4 Finance for health.....	191
8.3.5 Pharmaceutical and medical technologies	193
8.3.6 Health Service Delivery	195
8.4 Chapter conclusion.....	197
CHAPTER NINE: SUMMARY, RECOMMENDATIONS, AND CONCLUSION	199
9.1 Introduction.....	199
9.2 Summary of Research Objectives and Research Questions.....	199
9.3 Overview of the study	200
9.3.1 Chapter One: Background and outline of the research problem	200
9.3.2 Chapter Two: Theoretical understanding of the impacts of GHPs on local health M&E systems in Zimbabwe.....	200
9.3.3 Chapter Three: Research methodology and methods.....	200
9.3.4 Chapter Four: Global Health Partnerships, Monitoring, and Evaluation in Zimbabwe	201
9.3.5 Chapter Five: Soft power strategies, M&E discourses, and their impacts on public health monitoring and evaluation policy and practice in Zimbabwe	201
9.3.6 Chapter Six: Local M&E Partner Resource and power rationalization Mechanisms and Strategies in the Partnership for Health in Zimbabwe	202
9.3.7 Chapter Seven: The Impact of the government-GHP collaborative governance system on the public health administration and M&E system in Zimbabwe	203
9.3.8 Chapter Eight: The impact of GHP global M&E technical and financial assistance on wider public health M&E system-strengthening initiatives in Zimbabwe.....	204
9.4 Summary of Findings.....	206
9.4.1 Research Objective One and Research Question One	207
9.4.1.1 Soft power strategies, M&E discourses, and impacts on public health monitoring and evaluation policy and practices in Zimbabwe.....	207
9.4.1.2 Conclusion	209
9.4.2 Research Objective Two and Research Question Two	209
9.4.2.1: Local M&E partner resource and power rationalisation mechanisms and strategies in the Partnership for Health in Zimbabwe	210
9.4.2.2 Conclusion	212
9.4.3 Research Objective Three and Research Question Three	212
9.4.3.1 The impact of the Government-GHP collaborative governance system on the public health administration and M&E system in Zimbabwe.....	212
9.4.3.2 Conclusion	215
9.4.4 Research Objective Four and Research Question Four.....	215
9.4.4.1 Impact of GHP global M&E technical and financial assistance on wider public health M&E system-strengthening initiatives in Zimbabwe	216
9.4.4.2 Conclusion	218

9.5 Contributions to public administration theory and public health governance	219
9.5.1 Contributions to theory	219
9.5.2 Contributions to public health governance	220
9.6 Overall Recommendation of the Thesis	221
9.6.1 Government should consider Critical Discourse Analysis as an integral part of public health policy analysis.....	221
9.6.2 The government should invest in strong, locally driven leadership and governance programmes to ensure effective representation in collaborative partnerships	222
9.6.3 Global Health Partners should consider, respect, and acknowledge the power of local system partners for effective collaborative partnership results	222
9.6.4 The government and GHPs should adhere to a clear collaborative partnership policy direction to avoid covert contests.....	223
9.6.5 Government should consider investments in locally initiated electronic health systems ..	223
9.6.6 Collaborative partnerships should focus on the whole health sector rather than selected interventions.....	223
9.7 Limitations	224
9.8 Conclusion	225
List of Appendix	239
Appendix A: Provincial level Interview Questionnaire	239
Appendix B Ministry of Health Head Office Interview Questionnaire	241
Appendix D: UKZN Ethics Clearance	243
Appendix E: Medical Research Council of Zimbabwe Ethics Clearance letter.....	244
Appendix F: Informed Consent Form.....	245

List of Tables

TABLE 2 1 SUMMARY OF THE COLLABORATIVE FRAMEWORKS	16
TABLE 2 2 COMPARISONS OF GLOBAL, INTERNATIONAL AND PUBLIC HEALTH	24
TABLE 3 1: STUDY SAMPLE POPULATION	60
TABLE 3 2: LIST OF CODED STUDY PARTICIPANTS	61
TABLE 9 1 : SUMMARY OF RESEARCH OBJECTIVES AND QUESTIONS	199

List of Figures

FIGURE 4 1 RESEARCH FLOW PROCESS	55
--	----

List of Matrices

MATRIX 5 1 KEY DISCOURSES AND SOFT POWER STRATEGIES SHAPING AND INFLUENCING M&E POLICY AND PRACTICES	81
MATRIX 5 2 DISCUSSIONS ON KEY DISCOURSES AND SOFT POWER STRATEGIES SHAPING AND INFLUENCING THE POLICY AND PRACTICE OF M&E IN ZIMBABWE.....	115
MATRIX 6 1 SUMMARY OF FINDINGS ON MECHANISMS AND STRATEGIES BY THE MINISTRY OF HEALTH TO RATIONALISE RESOURCE AND POWER IMBALANCES IN PARTNERSHIPS	118
MATRIX 6 2 SUMMARY OF DISCUSSIONS ON MECHANISMS AND STRATEGIES BY THE MINISTRY OF HEALTH TO RATIONALISE RESOURCE AND POWER IMBALANCES IN PARTNERSHIPS	136
MATRIX 7 1: SUMMARY OF THE RESULTS ON GHPs’ IMPACTS ON THE GOVERNANCE AND M&E SYSTEM IN ZIMBABWE	139
MATRIX 7 2: SUMMARY OF THE DISCUSSION ON THE IMPACTS OF GOVERNMENT-GHP COLLABORATIVE PARTNERSHIPS FOR M&E ON THE PUBLIC HEALTH GOVERNANCE SYSTEM IN ZIMBABWE.....	171
MATRIX 8 1 :SUMMARY OF FINDINGS FOR GHP AND MINISTRY OF HEALTH POWER STRATEGIES’ IMPACT ON BROADER M&E SYSTEM IN ZIMBABWE	175
MATRIX 8 2 :SUMMARY OF DISCUSSIONS ON GHP AND MINISTRY POWER STRATEGIES’ IMPACT ON BROADER M&E SYSTEMS IN ZIMBABWE	197

List of Acronyms

BMGF	Bill and Melinda Gates Foundation
CCM	Country Coordinating Mechanism
CDA	Critical Discourse Analysis
COP	Country Operational Plan
DALY	Disability Adjusted Life Year
DFID	Department for International Development
ESAP	Economic Structural Adjustment Program
FGDs	Focus Group Discussions
GATS	General Agreement on Trade and Services
GAVI	Global Alliance for Vaccines and Immunization
GBD	Global Burden of Disease
GFATM	Global Fund to Fight HIV, TB, and Malaria
GHP	Global Health Partnerships
GNU	Government of National Unity
GoZ	Government of Zimbabwe
HIV/AIDS	Human Immuno-Deficiency Syndrome
HSS	Health System Strengthening
IHME	Institute for Health Metrics and Evaluation
IMF	International Monetary Fund
LFA	Log Frame Analysis
LFM	Logical Framework Matrix
LGBT	Lesbians, Gays, Bisexuals and Transgenders
LMICs	Low and Middle-income Countries
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MoHCC	Ministries of Health and Child Care
NAC	National AIDS Council
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organisations
NPM	New Public Management
PBF	Performance Based Funding
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PRSPs	Poverty Reduction Strategy Papers
RBM	Results-based Management
RCTs	Randomised Control Trials
SADC	Southern African Development Community
SAPs	Structural Adjustment Programmes
SDGs	Sustainable Development Goals
SPHC	Selective Primary Health Care
TB	Tuberculosis
UHC	Universal Health Coverage
UNDP	United Nations Development Program
USA	United States of America
WB	World Bank
WHO	World Health Organization
ZimASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZIMPREST	Zimbabwe Programme for Economic Transformation

CHAPTER ONE: BROADER VIEW OF THE STUDY

1.1 Introduction

Global Health Partnerships (GHPs) have become the preferred governance model for strengthening monitoring and evaluation systems in low- to middle-income countries (LMICs). They have supported the Ministry of Health and Child Care disease-specific M&E data collection and reporting systems in Zimbabwe since the early 2000s. However, their active engagement coincided with adopting Zimbabwe's radical economic policies, making external direct funding for government policy and planning difficult. This study aims to shed light on the impact of GHPs' support for M&E, specifically using Critical Discourse Analysis (CDA) and New Public Governance (NPG) theory as analytical frameworks to understand the relational nature of key public health partners for M&E in Zimbabwe. The background and problem description provide historical context to the challenges that sparked interest in the study. Similarly, the research aim, objectives, and questions provide a more focused direction for the qualitative study, focusing on the Ministry of Health and Child Care as a case study. The significance and limitations of the study are also discussed, and the chapter concludes with a description of the structure of the thesis.

1.2 Background to the problem

Zimbabwe's health policy landscape evolved in 1980 when the country gained political independence from Great Britain. Key policy changes included an expansionary strategy to address colonial-era geographic and demographic imbalances in public health that favoured urban and white-populated areas. The focus was on the poor and was in line with the 1978 Alma Ata recommendations. As a result, the government introduced Primary Health Care (PHC) in the first decade, as well as the expanded immunisation programme and infrastructure development. The government's partnerships in health involved United Nations agencies such as the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), which provided technical and financial support through government ministries and departments. Policy support complemented the government in achieving health equity. The M&E system focused on collecting social indicators in health, education, and social services, with most indicators performing better than most countries in southern Africa by the mid-1980s (Kanyenze and Kondo, 2011).

The early 1990s saw significant changes in the health and social sectors, including the active involvement of the private sector in direct financial and technical support to public health policies through the introduction of Economic Structural Adjustment Programmes (ESAPs).

The World Bank and IMF proposed far-reaching social policy changes through support for public service reforms in Africa and other developing countries as part of the broader post-Washington neoliberal consensus. Technical and financial support included a commitment by the government to embrace market fundamentalism and reduce government involvement in social service delivery. A commitment to establishing M&E systems to track progress in policy implementation was also among the conditions for support. Between 1991 and 1995 the country implemented the reforms with limited success. The policies resulted in underfunding health and social services, which led to a decline in key indicators for children's, maternal, and common diseases. Subsequent interventions, such as the Heavily Indebted Poor Countries (HIPC) programme and the Poverty Reduction Strategy Papers (PRSPs), had similar frameworks that did not result in significant positive policy changes in Zimbabwe.

Policy failures continued despite the World Bank and IMF insistence on the local ownership and control of policy processes through the PRSP process. The most important contribution of this period is the government's awareness of the importance of M&E systems, accountability, transparency, and a focus on results. However, GHP interventions focused on the private sector strengthened specific interventions such as HIV, TB, and malaria. The approach differed from the primary health care approach advocated by WHO to a modified private sector-oriented selective primary health care (SPHC) approach. The new approach, conceived by Julia Walsh and Kenneth S. Warren, was financially supported by private GHPs such as the Rockefeller Foundation, which funded a follow-up conference to Alma Ata in Bellagio, Italy, in 1979 (Cueto, 2004).

Beginning in the 2000s, new collaborative partners emerged to join the growing paradigm of New Public Governance. These hybrid and networked organisations were initiatives of the UN, Western governments, global corporations, and private foundations such as the Bill and Melinda Gates Foundation (BMGF). These hybrid governance partners, such as the Global Fund to Fight HIV, TB, and Malaria (GFATM, 2001) and the Global Alliance for Vaccines and Immunization (GAVI, 2000), had additional dynamics that enabled meta-governance in contrast to the bureaucracy of UN and governments. In 2006 the U.S. government established the President's Emergency Plan for AIDS Relief (PEPFAR) to provide similar bilateral support for HIV, TB, and malaria. PEPFAR collaborated with most GHPs on all global health programmes, becoming an integral partner in health collaboration. The comparative advantage of these GHPs is that they can mobilise funding and technical support from governments and private companies, resulting in increased funding for the selected diseases. Hybrid GHPs

became the most widely accepted global governance framework throughout the millennium decade (Buse and Harmer, 2007).

Zimbabwe's radical economic policies in the Millennium Decade led to political strife, with most GHPs withdrawing direct support from the government and the U.S. government and EU countries imposing economic sanctions. Despite these challenges, the National Health M&E and Information System was recognized at the regional level by the Southern African Development Community (SADC) in 2004 (Osika *et al.*, 2010: xvi). In 2005 the United Nations Development Program (UNDP) initiated Results-Based Management (RBM) to revitalise the public service, which had been underfunded due to a lack of direct donor funding and shrinking government budgets. However, the M&E programme lacked support from the GHP and civil servants, who did not accept the additional paperwork without improved working conditions (Kanyenze and Kondo, 2011: 372). Despite the challenges, the RBM has sparked an important M&E discourse that has (re)defined the policy and practice of data collection, analysis, storage, retrieval, and dissemination in Zimbabwe.

Global developments in M&E, such as the Paris Declaration on Aid Effectiveness and the 2005 High-Level Forum on the Millennium Development Goals (MDGs) for Health (HLF), contributed to an ongoing M&E discourse that emphasises country ownership, the alignment and harmonisation of systems, and results-based management at the country level. These values define the new GHPs that continue to support Zimbabwe through nongovernmental organisations (NGOs). These agreements made it difficult for government systems in Zimbabwe to work together. Therefore, critical policy approaches became necessary to understand the relational power processes and their impact on M&E policies. Partnership discourse shaped official policy processes and official documents despite the overt conflicts and disputes between the government and GHPs throughout the millennium decade. These observations prompted the study to understand the motives and mechanisms of partners in collaborations.

After the period of instability from 2002 to 2008, conditions improved slightly between 2009 and 2013. A government of national unity (GNU) among the main political parties led to improved engagement between the government and GHPs, resulting in an enhanced flow of funds for health M&E. For example, during the 2014-2016 fiscal period GFATM and PEPFAR provided 77.7% and 19.9% of the total budget for M&E and surveys respectively, while the government's contribution was 0.13% (PEPFAR Zimbabwe, Country Operational Plan, 2016).

The GFATM M&E budget for the HIV grant in Zimbabwe during the same period was US\$13 million, representing 4.2% of the total grant budget of US\$311 million. More than 95% of this budget was spent on strengthening the routine reporting system (Jain and Zorzi, 2017: S97).

In the post-GNU period, GHPs supported the development of the first National M&E Policy in 2015 and the Health Sector Performance Monitoring and Evaluation Guidelines and Strategy in 2018. Similarly, GHPs provided technical and financial support to the National Health Strategy 2016-2020 and the National Council HIV Strategic Plan 2015-2020 AIDS. This summary of events raises important policy questions about the motives and mechanisms of political influence on the Zimbabwean health system. Other important questions arise regarding the proliferation of GHPs, which has led to competition among them. The creation of PEPFAR in 2006 is a significant development that raises questions about the role of the U.S. government in creating the Global Fund in 2001. These are questions that prompted the critical approach of this study.

1.3 Statement of the problem

A sound monitoring and evaluation system are essential for successfully implementing national development policies, programmes and projects, and ensuring efficient and effective service delivery. In Chapter Two, Section 9(1) of the Constitution, the government of Zimbabwe mandates that government policy processes are systematic, coordinated, simplified, results-oriented, reliable, and effective through extensive research and external partnership consultative processes coordinated by the Office of the President and Cabinet (Zimbabwe, 2015a; Zimbabwe, 2018; Osborne, 2006). According to New Public Governance (NPG) theory, partnership-based consultation processes enable various interdependent stakeholders to participate in multiple policy-making and public service delivery processes (Osborne, 2006). These inter-organisational relationships and governance processes focus on service effectiveness and outcomes, with trust, relational capital, and relational contracts as primary governance mechanisms.

In this process, the government and global health partners should jointly develop and deliver M&E strategies and services based on mutual trust, country ownership, harmonisation, and external alignment with national policy and management for development outcomes (Zimbabwe, 2015b; GoZ(b), 2016; Zimbabwe, 2018; Wickremasinghe *et al.*, 2018). Global Health Partners' role is to promote mutual benefit, national alignment, harmonisation, and the achievement of national goals and priorities for policy and practice for M&E in the country (Görgens and Kusek, 2010; Organization, 2009; Lopez-Acevedo and Krause, 2012).

Unfortunately, GHPs' distrust of government, competitive behaviour and neoliberal goals for market-based health systems have resulted in weakened and uncoordinated M&E structures that are unable to generate, analyse and report integrated national health information for evidence-based decision-making on time (Osika *et al.*, 2010; Zungura, 2012; D'Aquino *et al.*, 2019; Saunders, 2020; Zimbabwe, 2018). The GHPs' use of co-optive and coercive post-conditionality programmes and financial reporting strategies on the government and local implementation partners have led to a donor-dependent, disruptive, exclusionary, and uncoordinated system in which the government has minimal control in the collaborative partnership (Armstrong *et al.*, 2019; Jain and Zorzi, 2017; Zeng *et al.*, 2018).

Recently researchers have shown an increased interest in understanding the effects of GHPs on local health M&E systems in LMICs. For instance, Nabukalu *et al.* (2019) reviewed health sector M&E challenges tracking Sustainable Development Goal (SDG) 3 in six countries, focusing on the indicator selection pattern and the extent of multi-sectoral collaborations. They concluded that weak institutional capacity, the fragmentation of M&E functions, inadequate domestic financing, insufficient data availability, weak dissemination, and the unsatisfactory utilisation of M&E are some of the factors negatively impacting the system.

Similarly, Kanyamuna *et al.* (2020) examined the role of actors outside the government in strengthening the country monitoring and evaluation system in Zambia. They established that donor support was not flexible but fundamentally restricted to areas of donors' interest as opposed to national monitoring and evaluation priorities. In another study, Kimaro and Fourie (2017) found that the evolution of M&E in Africa resulted from internal and external forces aimed at achieving results, accountability, and the proper use of resources.

However, much of this research on global health partnerships' effects on M&E systems has been descriptive, prescriptive, and technocratic, focusing on the direct negative and positive impact of financial and other material contributions to local health systems. The studies have also excessively focused on M&E as a good governance and transparency framework to counter perceived corrupt LMIC bureaucracies and for upward accountability to the external financiers. Surprisingly, the studies have not critically analysed and interpreted GHPs' deficiencies in accountability and transparency that shape and influence local M&E policies and practices, especially processes that involve the application of unspectacular soft and ideational power mechanisms and strategies to gain unfair advantage in the collaborative

partnerships for health M&E systems. Consequently, little is known about how these effects shape and influence policy and practice for M&E in LMICs.

1.4 Aim of the study

Drawing on the Ministry of Health and Child Care case study in Zimbabwe, this study identifies and analyses the unspectacular mechanisms, strategies, and effects of Global Health Partnerships on the M&E system from 2000 to 2021.

1.5 Research objectives

1. To investigate the M&E discourses and soft power strategies that shape and influence the policy and practice of public health M&E systems in Zimbabwe.
2. To analyse the mechanisms and strategies that the Ministry of Health deploys to rationalise the resource and power imbalance in the partnership for health in Zimbabwe.
3. To unpack the impact of the government-GHP collaborative partnership on the public health governance system in Zimbabwe.
4. To examine how GHP and local health partnerships have impacted on the broader M&E system beyond the disease and donor-specific M&E systems in Zimbabwe.

1.6 Research questions

1. How do GHP M&E discourses and soft power strategies shape and influence the policy and practices of public health M&E systems in Zimbabwe?
2. What are the mechanisms and strategies the Ministry of Health and Child Care deploys to rationalise its resource and power imbalance in the partnership for health in Zimbabwe?
3. What impacts does the government-GHP collaborative partnership for M&E have on the public health governance system in Zimbabwe?
4. To what extent do the GHP and local health M&E partnerships impact on the broader M&E system beyond Zimbabwe's disease- and donor-specific M&E systems?

1.7 Significance of the study

This study contributes significantly to scientific knowledge about the impact of collaborative Global Health Partnerships on the health M&E system by identifying and analysing the unspectacular mechanisms and strategies of GHPs and the Ministry of Health and Child Care that have far-reaching adverse effects. Through qualitative thematic and critical discourse analysis of primary and secondary data, the findings of the study revealed that collaborative partnerships for health M&E systems represent the (re)branding and perpetuation of colonial

goals of economic and political control through the support of M&E systems as part of post conditional (a)political strategies. Frosty relations between Zimbabwe and its major Western funding partners have contributed to unstable and unpredictable cooperation that has required unspectacular approaches to influence and shape policy direction without confrontation. The study is significant because the strategies, mechanisms, and impacts have been identified and analysed to provide policy and theoretical insights for action. While most studies have focused on the descriptive financial and material contributions of GHPs to local health systems, this study takes a different approach by highlighting the little-discussed and hidden aspects of collaborative partnerships and providing new scholarly perspectives on the topic through the Zimbabwean experience. Therefore, the study contributes to understanding the factors hindering the development and sustainability of the M&E system in Zimbabwe.

1.8 Justification of the study

Interest in collaborative health partnerships stems from the pervasive ways health governance structures have taken over the global health landscape over the past two decades. Despite their epistemic and financial contribution to M&E systems in LMICs, little progress has been made at the country level. The concept of GHPs has attracted considerable scientific and policy attention in recent years, but its undeniable ‘good’ intentions and discourse emphasising equity and mutual benefit have conveniently shielded it from critical scientific and policy evaluation. As a result, its unintended negative consequences are under-discussed and unknown at the policy and practice levels. Interestingly, the discourse on GHPs for M&E has received more attention from Western-influenced scholars who approached the debates from an instrumental perspective, disregarding the contextual, dialogic, and social constructivist impressions and unintended impacts of GHPs from a developing country perspective (Beran et al., 2016; Jones and Health, 2016; Kelly et al., 2015; Mercer et al., 2018; Ramaswamy et al., 2016). Their geographic and epistemic biases therefore (un)intentionally perpetuate postcolonial goals as the ideational mechanism of health post-conditionality. Interestingly, most current debates on collaborative GHPs for M&E have focused on biomedical technocratic approaches, with little attention directed to the politics of collaborative partnerships for health. As a result, little is known about the practical contestations and politics of global health partnerships at the local health system level. The current study, which applies New Public Governance theory and critical discourse analysis, is therefore warranted as it helps to unpack, analyse, and inform the discourse on partnerships for M&E from the perspective of pragmatic policy and public administration.

1.9 Methodology

The appropriate research methodology for this study is a qualitative research technique based on the Ministry of Health and Child Care case study. The qualitative research technique is the most appropriate data control method to validate the study's findings on the complex social network of global health partnerships for M&E.

In addition, the interpretive paradigm allows for uncovering salient issues, access to tacit, taken-for-granted, intuitive understandings of partnership issues, and an appreciation of participants' local meanings rather than imposed external biases. In addition, the research design, research approaches, population and sample are all part of the research methodology design. The method of data collection, quality control, and data analysis used in this study is also part of the discussion of the research methodology. The tools used for data collection include key informant interviews and document analysis. The data analysed are subjected to in-depth and comprehensive analysis using thematic and critical discourse analysis.

1.10 Definition of key terms

Global Health Partnerships

According to Buse and Walt (2000), Global Health Partnerships are state and non-state actors' governance arrangements, emphasising the desire to achieve shared goals in specific areas of global health. The scholars described them as 'global public-private partnerships' (GPPPs). The definition narrows down to cooperation between the actors and reflects the scope and the (f)actors, highlighting the type of their relationship. Similarly, Carlson (2004) and the British Department for International Development (DFID) propose the expression Global Health Partnerships (GHPs) to define a collaborative relationship among multiple organisations sharing risks and benefits to achieve shared goals. Unlike Buse and Walt, Carlson focuses on the goals and formal structures instead of the actors. For Buse and Harmer (2007), the focus is on institutionalised initiatives with the primary objective of addressing global health problems, in which public and for-profit private sector organisations have a voice in collective decision-making. Joint decision-making involving public and private-for-profit organisations is the crucial factor in this perspective.

Monitoring

Global Health Partnerships (GHPs) generally concur on the definition of monitoring apart from the semantic differences in GHP-specific policy documents. For this discussion, the WHO

(2016) practical guide on conducting research and assessments of monitoring and evaluating Digital Health Interventions provides a valuable starting point for understanding the concept of monitoring. The report refers to monitoring as the continuous collection and analysis of data to compare implementation progress against expected results. The report further suggests the routine collection, review, and analysis of electronic and purposively collected data which measure implementation fidelity and progress towards achieving intervention objectives. The inclusion of electronic processes is understandable due to the focus of this report, but in practice most developing countries still use manual and hybrid systems. The definition compares favourably with those of other GHPs like the World Bank and the Organization for Overseas Economic Development (OECD). These two GHPs define monitoring as:

A continuous function that uses the systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds (Zall Kusek and Rist, 2004).

The above definitions commonly agree on the systematic and routine or continuous nature of data collection against specific or purposively selected and expected results. However, the second definition includes explicitly accounting for main stakeholders and measuring progress against the use of allocated funds.

Evaluation

The WHO (2016) characterises evaluation as the systematic and objective assessment of an ongoing or completed intervention to determine the fulfilment of objectives, efficiency, effectiveness, impact, and sustainability. Likewise, Zall Kusek and Rist (2004) emphasise the systematic and objective assessment of ongoing or completed projects, programmes or policies. The focus is on design, implementation, and results. This process aims to determine the relevance and achievement of objectives and to promote efficiency, effectiveness, impact and sustainability. Providing credible, helpful information that feeds into evidence-based decisions forms the basis of the evaluations. The process also involves documenting lessons learned in the iterative learning process to benefit local beneficiaries and funding partners. Unlike inward-focused monitoring, evaluation has an outward focus, drawing lessons beyond direct intervention support.

1.11 Structure of the dissertation

The dissertation consists of nine chapters. Chapter One sets the study's background and outlines the background to the research problem, the statement of the problem, the aims of the study, the research objectives, the research questions, the significance and the justification of the study, the methodology, and the definition of key terms. The chapter lays the foundation for the thesis by summarising the key issues to be addressed in the subsequent chapters regarding the effects of collaborative GHPs on the local health M&E system in Zimbabwe. It concludes by outlining the layout and flow of the chapters of the dissertation.

Chapter Two presents the theoretical frameworks for collaborative governance. The New Public Governance (NPG) is the overarching theoretical framework for the study. Other collaborative models, such as the Integrated framework for collaboratives (by (Emerson and Nabatchi, 2015), the model of collaborative governance by (Ansell and Gash, 2008), the governance of collaborative by (Vangen et al., 2015), the Government-NGO Partnership by (Brinkerhoff, 2002) and the CDA by (Fairclough, 1989; Fairclough, 2001b) are presented as scaffolding frameworks. The chapter demonstrates how these models complement one another to provide a comprehensive understanding of the effects of GHPs on the local health M&E system. The individual strengths and weaknesses and justification for selecting these models are presented. The chapter also reviews relevant literature demonstrating the various critical approaches to the subject of Global Health Partnerships. The chapter debates and discusses intersections between 'Global Health' and 'Partnerships,' M&E and governance systems, the political and technocratic aspects of M&E and the World Bank and the Global Fund M&E systems as GHP examples.

Chapter Three describes the research methodology and methods, highlighting the philosophical interpretivism paradigm, the qualitative design, the case study research strategy, the data collection tools for key informant interviews, in-depth interviews, and the processes of documentary review. The chapter also examines the research population and the research approach adopted. The sampling techniques discussed are purposive and snowball techniques aligned to the non-probabilistic nature of the qualitative study. Moreover, the chapter outlines ethical issues, the protection of research subjects, the voluntary nature of participation, and assurances that the qualitative data will be managed for authorised use only. The Chapter also discusses the documentary review of the selected four key national M&E policy documents. These are the National M&E Policy, 2015; the Health Sector Performance, Monitoring, and Evaluation Policy Guidelines and Strategy, 2018; the National Health Strategy 2021-2025; and

the Zimbabwe National HIV Strategic M&E Plan, 2015-220. The chapter concludes by highlighting some of the limitations encountered.

Chapter Four examines the current M&E system in the country. The chapter chronologically presents the GHP support for M&E, highlighting the critical interactions since 1980, when the country became politically independent from British rule. Likewise, the chapter discusses the roles of key stakeholders of the M&E system and the impacts of these GHP interventions identified in the literature.

Chapter Five addresses the first research objective and question by identifying the discursive and soft power strategies and mechanisms that influences and shape M&E policy and practice in the health M&E system in Zimbabwe. Through thematic and CDA-identified dominant pro-economic, participatory, technological, scientific, country-led, human rights, health emergencies, and results-based discourses in reviewed M&E policy documents and through key informant interviews with Ministry, National AIDS Council and FACT staff. Likewise, the use of M&E artefacts, M&E champions, and policy advisors and consultants, soft power strategies are identified and discussed.

In Chapter Six the study identifies mechanisms and strategies for maintaining power by the Ministry, the recourse to Constitutional provisions, and the reliance on MoUs and M&E policies and guidelines. Other identified strategies include the recourse to bureaucratic power as a technology of influence, the deployment of strategies like victimisation and polarisation, extraversion and obfuscation Strategies. The specific mechanisms include acceptance, resistance, and ambivalent responses to policy advice on global programs like the MDG and SDGs. In the acceptance model, weak states use rhetoric and actions to influence the design of global health policy; they then adopt that policy. Resistance as a strategy means that local partners try to reframe the health problem or deny its severity in order to control the local policy agenda. On the other hand, ambivalence is present when local partners express covert policy opposition through weak participation and inconsistent implementation of recommendations coming from outside. These strategies, which provide valuable insights into understanding the positive and negative covert effects of GHPs on local health M&E systems, are rarely discussed in conventional partnership discourses.

Chapter Seven presents the impacts of the government-GHP collaborative partnership for M&E on the public governance system, demonstrating the unanticipated disruptive and exclusionary effects on the local health system. The chapter answers the third research objective and question

of the study. The adverse effects identified and discussed include the normalisation of M&E parallel systems, digital disruptions of systems, conflicts and contestations, patron-client relations, threats to national sovereignty, the brain drain, mute and perverse practices, digital exclusion, threats to regular employment, ‘othering’ and conceptual boundaries, and competitive behaviour for visibility and leadership.

In Chapter Eight, the effects of GHPs on the broader Ministry of Health M&E system are presented within the WHO framework for strengthening health systems. The presentation discusses the effects on human resources for health, finance for health, service delivery, health information systems, pharmaceutical and medical technologies, leadership, and governance.

Lastly, Chapter Nine presents the recommendations and conclusions of the study. The chapter draws from the discussion presented in all the previous chapters to draw policy implications for theory and practice in Zimbabwe.

1.12 Summary of this chapter

The chapter describes the study's context and presents the problem statement, the aims, the research objectives, the research questions, the significance and justification of the study, the methodology, and the definition of key terms. The chapter concludes with an outline of the thesis.

CHAPTER TWO: THEORETICAL FRAMEWORK AND REVIEW OF RELATED LITERATURE

2.1 Introduction

The previous chapter presented the background of the research and the problem statement, highlighting the research objectives and questions, and presented an outline of the thesis. This presentation was critical in showing the issues that sparked an interest in conducting this research. The current chapter builds on these ideas to determine what current theoretical and literary debates say about collaborative policy processes and their implications for local healthcare systems. This chapter identifies connections, strengths, and weaknesses and justifies the selection of particular models to generate knowledge on this topic. In addition, reviewing the relevant literature helps link theory to practice, which contributes to understanding the political environment of public health policymaking in Zimbabwe. The chapter addresses the linkages between global health, partnerships, monitoring, and evaluation through examples of World Bank and Global Fund support in LMICs. Finally, a preliminary overview of the impact of GHPs in LMICs is presented to suggest what to look for in GHP-government collaboration in Zimbabwe.

2.2 Collaborative governance models

The previous section discussed the broader theoretical framework of NPG and NPS governance. The discussion has helped establish the theoretical framework that guides new thinking in public service delivery. The following sections discuss the collaborative governance models that shed further light on NPG theory and provide a better understanding of the topic under study. These are the Collaborative Governance Model, the Integrated Framework for Collaborative Governance, Collaborative Governance, and the Government-Non-profit Partnership Model.

2.2.1 Model of collaborative governance

The Collaborative Governance framework developed by Ansell and Gash (2008) provides a baseline understanding of the governing arrangement in which public agencies and non-state stakeholders engage in a consensus-oriented decision-making process driven and deliberated by the private and civic sectors collaborating with the government to implement public policies and manage public programmes. The framework has six main characteristics: initiatives by public agencies, the involvement of non-state actors, direct and active participation in decision-making by public agencies, a formalised forum that organises and meets consensus-oriented decisions collectively, and a focus on collaboration on public policy or public management.

The scholars also emphasise the tripartite partners' deliberate, collective, collaborative, and direct engagement in solving public policy issues. These characteristics differentiate collaborative governance from other loose arrangements.

The strengths of the above framework are its pragmatic acknowledgment of power, resource, and knowledge asymmetries, constraints of incentives on participation, and the imported baggage of mistrust in the initial encounter to build a consensus-oriented vision by the tripartite partners. These three factors are crucial in reflecting and interrogating the gaps between the policy and practice of collaborative governance arrangements.

[2.2.2 Integrated framework for a collaborative governance regime](#)

The integrated framework for a collaborative governance regime by Emerson *et al.* (2012) focuses on the processes and structures of public policy decision-making and management that emphasises thinning boundaries between the public sector and the private and civic spheres. It harnesses the comparative advantage of the tripartite partners to achieve public policy goals that any partner cannot efficiently and effectively accomplish individually. Shared motivation, collective capacity, and principled engagement are the key assumptions of this model. A successful collaborative partnership should induce action leading to the desired joint, shared, and principled policy outcomes. Thus, the framework relies on the public, private, and civic sectors' inputs, throughputs, and outputs to produce the desired outcomes. Unlike Ansel and Gash, Emerson *et al.* contextualise collaborative governance as a system designed to make sense of the whole. Thus, the approach has the advantage of recognising internal and external forces that facilitate or militate against integrated collaborative governance regimes. To that extent, the framework provides a helpful scaffold for building new insights into collaborative governance systems.

However, linear systems assume the conversion of inputs to outputs and outcomes, a reductionism that rarely exists in practice. Partnership practices exhibit political contestations and self-centred interests. Thus, linear systems tend to oversimplify complex and contested processes that involve partners with different values and mandates from their constituencies. Like Chris and Ansel's Model of Collaborative Governance, the framework assumes that the tripartite partners unproblematically represent the interests of the citizens. Evidence of elite capture involving unholy alliances of career politicians and civic and private sector leaders presents a danger to efficient, effective, and affordable public service delivery. Likewise, the assumption that privileging civil society and the private sector enhance legitimacy,

accountability, and transparency is contextual rather than factual. Cases of mega corruption involving the private sector and civic organisations have become too widespread to ignore.

2.2.3 Governance of Collaborative

The Governance of Collaborative by Vangen *et al.* (2015) focuses on the transformative leadership role and power of any partners to initiate a shared agenda. The partner does not always have to be the government. Any partner with the capacity to use instruments like plans, committees, and workshops to rally towards an agreed and shared public policy agenda takes the lead. The post-structuralist model prioritises processes, actors, and structures to convert ideas into actions. The actors direct, coordinate and allocate resources for the collaborative partnership while accounting for the efficient and effective delivery of goal-oriented activities.

The model's emphasis on transformative leadership rather than ideological and hierarchical structures enables the efficient provision of public services through collaboration. However, the framework fails to anticipate the challenges that arise due to the power imbalances and self-directed interests that either quicken or stall progress. Collaboratives are inherently politically contested terrain, and opportunism and the abuse of power characterise these relations. Regardless of the partner who wields more power, skewed power relations create potentially problematic collaborations. Thus, the model insufficiently assumes that the system improves when private and civic organizations participate. The model is suitable in settings with solid governance systems. Therefore, their efficacy in LMICs remains inconclusive. But evidence of strong private-civic influence remains a concern for affordable and equal access to health and social services in most developing countries. The problem arises from arrangements that outsource critical services to influential and unelected private and civic organisations in contexts with weak governments.

Moreover, the model inadequately assumes the absence of ideological biases among the partners in such collaboratives. To that extent, the model lacks pragmatism as it takes a mechanical approach to public policy issues. Collaborations based on genuine trust and selfless interests rarely exist in practice and in a post-truth world. Despite its contributions, the model may not adequately address the practical dynamics of governing collaboratives for public policies.

2.2.4 Government–Non-profit Partnership Model

The Government-Non-Profit Partnership model emphasises mutual dependence and organisational identity as key definitional dimensions (Brinkerhoff, 2002). These factors differentiate it from other arrangements like contracting, extension, and co-option. Mutuality

underlines the importance of respect for the rights and responsibilities of each actor in the partnership. Value and maximum benefit for each partner are the shared goals of the collaboration. Furthermore, interdependence rather than progressive reliance on each other plays a vital role in stabilising power imbalances. Given these values, Brinkerhoff argues that partnership is a superior form of collaboration to supplier or production contracting (Brinkerhoff, 2002).

Additionally, mutuality implies equality in decision-making (co-creation) and co-production instead of domination of the weaker partners. However, critical scholars question the pragmatic-instrumental approach to partnerships, considering most partners' ideological and self-centred practices in such collaborations. Table 2:1 is the researcher's summary impression of the collaborative frameworks.

Collaborative partnership model	Author(s)	Key collaborative focus	Institutional design/implementation structure
NPG Theory	(Osborne, 2006)	Inter-organisational governance, trust, or relational contracts,	Plural and pluralist governance structure
Model of Collaborative Governance	(Ansell and Gash, 2008)	Trust building, commitment to process, shared understanding, face-to-face dialogue, intermediate outcomes	Participatory inclusiveness, forum exclusiveness, clear ground rules, process transparency
Integrated framework for a collaborative governance regime	(Emerson <i>et al.</i> , 2012)	Principled engagement, joint capacity, shared motivation	Inter-governmental
Governance of collaborative partnerships	(Vangen <i>et al.</i> , 2015)	Structure, process, actors, goal congruence, tensions, accommodates power imbalances, participation, empowerment, no ideology	Inter-governmental structures, heterarchical, based on ideas and resources
Government-Non-Profit	(Brinkerhoff, 2002)	Trust, mutual dependence, co-decision making	Inter-governmental, organisational identity

Table 2 1 Summary of the collaborative frameworks

Source: Researcher's compilation based on cited sources

2.3 Justification for the NPG models for this study

The previous sections have discussed the five main collaborative governance models, highlighting the theoretical assumptions and their limitations in an environment of weak

governance systems such as in Zimbabwe. Despite the aforementioned limitations, the study draws on the conceptualisations of collaborative governance by Osborne, Ansel, and Gash, Emerson *et al.*, Vangen *et al.*, and Brinkerhoff to argue that partnership discourses obscure the impact of GHPs on local health M&E policy and practice in Zimbabwe. The gaps identified substantiate the study's argument that problematises GHPs' support for M&E systems based on unequal power relations obscured by discourses. The collaborative governance theory's emphasis on trust, mutual benefit, neo-corporatist values and intergovernmental relations as a panacea for the challenges of public sector service delivery is beneficial to the analysis in this study because it enables critical thinking about the extent to which collaborative health partnerships in unstable governance systems such as in Zimbabwe achieve their intended effects at the level of policy formulation and implementation. In this sense, Osborne, Ansel, Gash, Emerson, et al., Vangen et al., and Brinkerhoff's conceptualisation of collaborative partnerships help us understand how support for health M&E partnerships negatively affects policy and practice in Zimbabwe. In this context, the attention that collaborative governance approaches pay to the need for transformative leadership, the non-ideological focus on resource capacity, and the insistence on heterarchical relationships are also valuable in highlighting the practical gaps between theory and practice in collaborative partnerships in Zimbabwe.

In Pakistan, researcher Bano (2019) discusses partnerships and the good governance agenda to improve service delivery through the state-NGO collaborative model. He highlights the importance of transformative leadership as presented in the collaborative models of Ansel and Gash, Emerson *et al.*, and Vangen *et al.* In this study, Bano concludes that the privatisation of primary health clinics, a school sponsorship programme and a low-cost sanitation cooperation programme have indeed improved service delivery. However, the researcher laments that these collaborations have not been able to develop into sustainable partnerships beyond donor support.

Similarly, Cheng (2019) discusses government-NGO partnerships involving ten NGOs in the Ohio River Basin region of the U.S. and raises crucial questions regarding the insufficient attention paid to various forms of collaboration with non-profits, including the increasing influence of non-profits and the diminished power of government. Cheng argues that non-profits have great potential and can play a more critical role in public service delivery through partnerships between government and non-profits. Similarly, Mendonça *et al.* (2019) and Aveling and Jovchelovitch (2014) show how partnerships can improve the participation of

marginalised groups in Brazil in critical public health issues such as HIV and AIDS. The two studies are consistent with Ansell and Gash (2008) model of collaborative governance in that they shed light on the role of weaker partners and the transformative influence of sensitive leadership in collaborative partnerships. For example, Aveling and Jovchelovitch observe the role of the social capital of a local NGO that performed a gatekeeping function in accessing drug gang-controlled favelas in Brazil. The partner had contextual influence in collaboration with the London School of Economics and UNESCO. The collaborative governance models discussed earlier thus offer helpful insights into local knowledge systems and social capital as sources of soft power for local partners. Notwithstanding the epistemic and technical influence of organisations such as the London School of Economics and UNESCO, they have had to rely on a very local and underfunded NGO for this collaboration.

In addition, Haque (2020) takes a critical look at government-NGO partnerships and highlights their negative impact on local service delivery in Bangladesh. The researcher finds that collaborative partnerships between government and NGOs lead to corruption, the erosion of government commitments, the politicisation of local development programmes, the introduction of commercial practices in local NGOs, and involvement in questionable accountability practices (Haque, 2020). Notwithstanding the limitations of collaborative governance theories, the examples discussed confirm the value of this conceptual framework by demonstrating its positive contributions and limitations in partnership policy and practice for M&E in Zimbabwe.

2.4 Critical Discourse Analysis theoretical framework

The previous discussion has introspected the four collaborative governance models, detailing the merits and shortcomings of each model. The debate was crucial in providing a framework for understanding the conceptual and practical aspects of collaborative governance as the new direction for thinking about public policy and service. However, the frameworks have not adequately addressed the issues of power imbalances in the tripartite collaborative arrangements. As a result, the current discussion introduces the fifth model, the Critical Discourse Analysis (CDA), to fill in the gaps identified to achieve a more comprehensive understanding of public governance models.

In a broader context, CDA represents frames, narratives, and normative appeals in interactive communications and the underlying ideologies, public philosophies, and values they represent (Barlow and Thow, 2021). Thus, the study uses the CDA to reveal the hidden meanings in

collaborative governance arrangements in the interactive text (policies) and spoken words (interviews). Scholars such as Van Dijk (2005) have shown that CDA is a powerful tool for identifying and resisting power. Hence its selection for this study. He asserts that it unpacks the abuse of social power, inequality, and dominance in social institutions and reveals the use of power and ideology.

Similarly, Fairclough (2001b) explores CDA as a linguistic tool that powerful institutions or individuals deploy to sustain social inequality and its use in the domination and exploitation of others. From this perspective, CDA provides a valuable framework to illuminate the ideological and power gaps identified in the collaborative partnership models. Likewise, Khan *et al.* (2020) offer a helpful conversation that illustrates the dialogical use of language in the current study to create contextually and socially relevant knowledge and meaning.

The current study adopts a critical stance toward collaborative governance for health partnerships; hence the CDA approach provides the necessary scaffolding to build a case for critical approaches to collaborative governance. Likewise, the pioneering work of Michel Foucault asserting discourse as a complete perspective that enables the researcher to investigate institutional oppressions and subjugations justifies the current study's choice of this approach. The theorist popularised the post-structuralist school of thought and introspected explicitly on the relationship between discourse, thought, and social practices, which forms the basis for the current framework to understand the effects of collaborative GHPs on the health of M&E systems.

In locating the utility of CDA in the current study, Fairclough's Three Dimensions of Discourse perhaps provide the most comprehensive theoretical model to understand the productive use of language in Global Health Partnerships. In alignment with this study's dialogical and constructivist epistemology, Fairclough (2001b) characterises language as an intrinsic part of society and a socially conditioned process. This characterisation sheds light on the argument that global development and global health have an intrinsic language in a socially conditioned environment of collaborative partnerships. Language and society have a dialectical symbiotic relationship in which they shape each other to co-create meanings. Thus, the effects of GHPs, a dialogical CDA framework involving the people actively participating in the processes, enable better views of GHPs. In this process, language attains its meaning only in a societally and contextually relevant environment.

Furthermore, the strength of CDA is its amalgamation of the three levels of analysis of the actual text (description), the discursive practices (interpretation), and the larger social context (explanation) (Fairclough, 2001b). Text is the verbal record of communication, including its oral or written forms. In alignment with the current study's qualitative methodological analysis, these manifestations of thoughts, in concrete words, provide a reliable site of policy analytic inquiry. On the other hand, discursive practices are the rules, beliefs, norms, and mental models that influence social communication procedures (Aggarwal, 2016). Discursive practices also include the dialogical social construction of meaning during communications processes. They represent the worldviews and contextual biases of the dialogue. Finally, the political, economic, cultural, social, and technological institutions (schools, academia, media, and religious affiliations) form the larger social and institutional context that influences and shapes the thinking processes and social identities.

However, the limits of CDA are that the pioneers of this approach were either focusing on local contexts (Michel Foucault) or biased towards linguistic, grammatical, and textual analysis (Fairclough and Van Dijk). As a result, the broad application of this approach has not occurred in introspection on global development affairs to illustrate the use of language for hegemonic purposes. However, their conceptualisation of language as socially and contextually relevant provides the basis for the critical approach of this current study toward neoliberal influence on GHPs at the local health systems level. As will be elaborated further, the neoliberal common sense in every aspect of life (health, social services, business, religion, politics) creates a conducive environment for a common, socially, and contextually appropriate language that justifies partnerships as progressive governance approaches. Thus, CDA provides a critical view that identifies power relations and struggles of power and the deployment of discursive activities to construct and maintain unequal power relations (Yazdannik *et al.*, 2017).

2.5 Justification of the use of Critical Discourse Analysis in this study

Despite the weaknesses identified, this study draws on the work of Fairclough (2001b) and Van Dijk (2005) to argue that CDA is one type of discourse analysis that aims to 'understand, expose, and ultimately resist social inequality' (Van Dijk, 2005: 352). It focuses on the relationship between discourses and elements of social practices such as policymaking. Drawing from Fairclough (2001a), Cummings *et al.* (2020a) argue that CDA is a crucial framework for policy analysis as it can identify dominant, marginal, oppositional, or alternative discourses within policy texts such as policy documents and speeches. Fairclough's emphasis on discourse as representing networked social order in which some aspects of meaning-making

are dominant or mainstream while others are marginal, oppositional, or alternative is beneficial for analysis in this study. It allows us to think through and identify how discourses in collaborative partnerships for health are used to foreground or background certain aspects in M&E policy documents that negatively impact practice in Zimbabwe. To this end, Fairclough's conceptualisation of CDA is generative in understanding how GHPs use textual and semiotic discursive soft power strategies to maintain their dominance in collaborative partnerships for M&E in Zimbabwe. Here, Fairclough's attention to language as a social practice is also valuable in informing the dialogic and social constructionist views of local M&E practitioners on the unintended effects of GHPs on the public health M&E system in Zimbabwe. As a post-structuralist approach to policy analysis, CDA can help uncover, interpret, and understand the limitations of the collaborative partnership framework. Thus, CDA complements collaborative governance models by addressing power, ideology, and resource imbalance that affect collaborative partnership practices. Furthermore, scholars such as Shaw assume that conceptualising politics as discourse allows those with a vested interest in politics to 'reach the parts that other theories and methods cannot' (Shaw, 2010). Therefore, to understand the influence of GHPs on M&E policy and practice in Zimbabwe, CDA can facilitate the exploration of the dialogic partnership between theory and practice in policy analysis.

Likewise, Larsson (2018) also provides a critical poststructuralist reflection on network governance frameworks that highlight ideational and discursive power that potentially creates subjects and power asymmetries and challenges institutional change. He interrogates conceptual power sources from a neo-institutional perspective, raising crucial points about their (un)intended effects on political processes and how they can generate stability and change. Thus, the researcher argues for incorporating CDA into collaborative governance. Similarly, in another helpful article, the researcher highlights the current challenge in network governance that overlooks power relations and the need to adopt CDA approaches that consider hidden power relations in network governance systems (Larsson, 2019).

2.6 Conceptualising global health

This section discusses the evolution of global health in the context of its links with public and international health. The section begins with a discussion on public health, international health, and global health. The presentation helps put global health into its proper context before conceptualising partnerships.

2.6.1 The Nexus between public, international, and global health

At a national level, public health is an approach to health service provision at a population level characteristic of the modern state that emerged in the mid-19th century in countries like England, continental Europe, and the USA (Koplan *et al.*, 2009b). As a result, health interventions requiring cross-border interventions became necessary as international mobility became more accessible and frequent. The subsequent discussion briefly addresses how countries address infectious diseases across borders. Thus, the issues of international health and partnerships required to address the challenges become pertinent to the subject under study.

2.6.2 International health

Historically, ‘international health’ was the term used for health work abroad, following colonial trajectories and geographies in developing countries and often with the academic content of infectious and tropical diseases, water and sanitation, malnutrition, and maternal and child health (Koplan *et al.*, 2009b). To date, many academic institutions have broadened their pedagogical programmes to include issues such as chronic diseases, injuries, and health systems. For example, Koplan *et al.* (2009b) provide valuable discussion on international health, highlighting the current discourse's shortcomings that focus on technical and financial support exclusively for epidemics and pandemics in the developing world. The limits of this definition are its inability to acknowledge the global nature of epidemics like covid-19, that are not restricted to developing countries alone. The flight of health skills from developing to developed countries shows that everyone is at risk of epidemics, regardless of geographic boundaries.

2.6.3 Global health

The term ‘global health’ remains fraught with varying epistemological assumptions and asymmetries. The pragmatic-instrumental view of Western theorists and scholars has not helped clarify this concept. Even global health anthropologists still inadequately understand and define this concept. Thus, Eichbaum *et al.* (2021) assert that ‘global health’ remains a ‘convenient, but artificial construct developed by High-Income Countries (HICs) to (*inadequately*) describe health care routinely practiced in LMICs’ (emphasis added). Koplan *et al.* (2009a) provide a more inclusive definition of Global Health:

An area for study, research, and practice that prioritizes improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions, involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration, and is a synthesis of population-based prevention with individual-level clinical care.

However, the definition remains too broad, and a breakdown of general terms like collaboration could provide better insights. The buzzword ‘collaboration’ is subject to varying interpretations in governance systems. Scholars clarify what constitutes global health beyond the focus on cross-border health challenges. They suggest a focus on any health issues of a transnational nature posing challenges to many or all countries affected by transnational determinants of health, such as climate change or urbanisation, and requiring multinational solutions. The scholars add that infectious diseases such as dengue, influenza A (H5N1), and HIV are global. However, global health should also address communicable and non-communicable health issues, including road traffic injuries, migrant-health work, and the migration of health workers, among other challenges. Thus, the ‘global’ in global health is more about addressing the scope than the location of the problem (Koplan *et al.*, 2009a). Moreover, global health, like public health but unlike international health, focuses on domestic and cross-border health disparities and beyond the ‘undisputed good’ intentions of capacity-building initiatives to address the equality and equity issues in the training and distribution of the health care workforce. Thus, the internal and transnational brain drain issues interest global health.

The last question relates to the interdisciplinary scope of global health. The concept focuses on complementary and interdisciplinary technical advice from diverse disciplines like political science, international relations, public health, sociology, psychology, and social work, which provide valuable insights for comprehensive responses. The focus is on population-level prevention while embracing curative, rehabilitative, and other aspects of clinical medicine and the study of basic sciences. Table 2:2 below provides a summary of the three concepts

	Global Health	International Health	Public Health
Geographic Reach	Focuses on issues that directly or indirectly affect health but that can transcend national boundaries	Focuses on health issues of countries other than one's own, especially those of low-income and middle income countries	Focuses on issues that affect the health of the population of a particular community or country
Level of cooperation	Development and implementation of solutions often require global cooperation	Development and implementation of solutions usually require binational cooperation	Development and implementation of solutions do not usually require global cooperation
Individuals or populations	Embraces both preventions in population and the clinical care of individuals	Embraces both prevention in populations and clinical care of individuals	Mainly focused on prevention programmes for populations
Access to health	Health equity among nations and for all people is a major objective	Seeks to help people of other nations	Health equity within a nation or community is a major objective
Range of disciplines	Highly interdisciplinary and multi-disciplinary within and beyond health sciences	Embraces a few disciplines but has not emphasised multi-disciplinarity	Encourages multi-disciplinary approaches, particularly in health sciences and social sciences

Table 2 2 Comparisons of Global, International and Public Health

Source: (Koplan *et al.*, 2009a)

The common ground in the three concepts is the priority focus on population-based prevention; the concentration on poorer, vulnerable, and underserved populations; the multidisciplinary and interdisciplinary approaches; the emphasis on health as a public good; the importance of systems and structures; and the participation of several stakeholders.

2.7 Conceptualising partnerships in global health

The previous sections have clarified the difference between public, international and global health. The discussion has helped define the focus of the partnerships under consideration in this study. Contrary to aid and charitable gifts that portray explicit unequal power relationships, partnership suggests relations based on equality, respect, reciprocity, and ownership (Dolan, 2011). The major conceptual challenge of partnerships is the loose interchangeable (ab)use of terms like collaboration, association, cooperation, participation, networks, and co-production, among others (Ansell *et al.*, 2020; Kelemen and Rumens, 2019; Koppenjan *et al.*, 2019; Lima; Vangen *et al.*, 2015). The current literature emphasises reciprocity, accountability, joint decision-making, respect, trust, transparency, sustainability, and mutual interest as critical factors in partnership (Ansell *et al.*, 2020; Kelemen and Rumens, 2019; Koppenjan *et al.*, 2019; Lima; Vangen *et al.*, 2015; Larsson, 2019). Other more conventional definitions topicalise equality in decision-making and mutual influence as key distinguishing partnership characteristics (Brinkerhoff, 2002). The following sections provide

more critical perspectives on the merits and shortcomings of the current conceptualisation of partnerships.

2.7.1 Partnerships in pragmatic-instrumental literature

The starting point in partnership literature is the ideal and expected perspective which views the partnership as a valuable and necessary arrangement that is unproblematically implementable. The literature assumes that partnerships empower local communities to implement initiatives based on mutuality, trust, and reciprocity (Brinkerhoff, 2002). The pragmatic-instrumental partnership literature considers the shift from paternalistic (neo)colonial literature to post-conditionality discourses as a positive development designed to correct the colonial power imbalances in dignity and influence between local and global partners through empowerment and country-led leadership. The assessment of policy implementation follows linear means-end trajectories. Barnes (2011) provides helpful insights into the logic and limits of this conceptualisation. While the literature acknowledges partnership imbalances, it suggests using managerial interventions like capacity building, guidelines, rules and regulations, monitoring, and evaluation, among other mechanisms, to correct the imbalances. However, the literature fails to anticipate the political and business motives of international partners and the agency of local partners.

2.7.2 Partnerships in critical-ideological literature

The critical-ideological literature draws from scholars like Abrahamsen (2004), who conceptualise a partnership as a strategy or mechanism that relies upon unspectacular approaches to advance neoliberal ideology through soft power strategies. The strategies do not have to rely on aggressive physical or coercive programmes but on persuasive and attractive processes like education, religion, entertainment, and managerial procedures like M&E, among others. Thus, these scholars assert that every activity has underlying ideological effects regardless of its (un)conscious presence. They consider partnerships as neither real nor as facilitating equality or the transfer of power to actors in poorer countries, as suggested in the pragmatic-instrumental literature. For example, Baaz (2005) indicates that partnership languages are rhetorical disguises or (mis)representations that rebrand the old-style paternalistic intentions of colonial projects. Thus, partnership discourse depoliticises and nullifies opposition to dominant economic interests through language.

However, the literature erroneously assumes a linear and unproblematic coherence of neoliberalism. As Barnes (2011) and Patterson (2018) acknowledge, the practice of neoliberalism in partnerships has all the ingredients of competition, collusion, and even

"dirtier" tactics that are at odds with the relationships of reciprocity and trust depicted in the critical-ideological literature. Similarly, the perceived weaker partners sometimes apply extraversion and obfuscation strategies to 'translate, consume, appropriate and even remanufacture the partnership rhetorical disguise to their benefit' (Barnes, 2011; Patterson, 2018). The contests and conflicts that characterise partnerships and the local agentive reflexivity and appropriation of partnership opportunities make this literature inadequate to explain partnerships comprehensively.

2.7.3 Partnerships in critical-governmentality literature

The critical-governmentality literature borrows from Michel Foucault's ideas about knowledge and power. The critical perspective suggests that partnership relationships rely on deploying subtle, complex, and productive workings of power to influence the agenda-setting processes. Scholars in this category argue that some partners deploy ideational and soft power strategies that appear to empower yet restrains local action in poorer countries through technically depoliticising the governance of development (Abrahamsen, 2004; Li, 2007). Thus, the critical governmentality illuminates the partnership 'black box' suggesting that it is a liberal attempt by western authorities and agencies to remotely influence, define, shape, improve, and therefore govern (through mental conditioning) the conduct (or behaviour) of actors in poorer countries (Barnes, 2011). Their arguments are logical and provide valuable partial insights into understanding the unspectacular but persistent challenges in global development initiatives. The literature further suggests that partnerships work through soft power strategies to (re)educate and (re)configure local decision-makers habits, aspirations, and desires in ways that benefit and promote neoliberal narratives. The aim is to achieve conditioning and (re)producing modern and self-disciplined citizens who subscribe to the neoliberal common sense by enlisting them as responsible agents of their liberal development (Barnes, 2011; Sastry and Dutta, 2013).

However, the literature also over-emphasises the coherence of external influence and minimises the local agentive reflexivity and resistance to some interventions. Discussions on extraversion and obfuscation in Uganda, Botswana, and Rwanda provide ample evidence against this simplified partnership literature (Patterson, 2018; Seekings, 2020).

2.7.4 Partnerships in critical-constructivist literature

The critical-constructivist partnership literature provides a balanced 'middle-ground' perspective between critical ideological and critical governmentality perspectives (Barnes, 2011). The literature acknowledges the dialogical nature of power and the role of local actors

in partnerships. Furthermore, the critical-constructivist literature correctly acknowledges the social life of actors in their social environment. Thus, to borrow from Fairclough's conceptualisation of discourse, partnerships should be interpreted, explained, and understood by locating the self in the other's language, culture, and experiences (Fairclough, 1989). However, the critical-constructivist perspective views the role of local reflexivity in partnership from a bystander's point of view. The literature does not consider the role of the researcher in co-creating knowledge. The following section discusses post-constructivism literature that addresses this gap.

2.7.5 Partnerships in post-constructivist literature

The post-constructivist perspective argues that knowledge is dialogically co-created in conversations. The literature addresses knowledge gaps in the social constructivist perspective that wrongly assumes knowledge creation as a unidirectional and monolithic process involving the transfer of pre-defined knowledge from one person to another based on experience and context (Boas and McNeill, 2004). It depicts knowledge as arising from a fusion of horizons, as an encounter that depends on the dialogical conversations of the parties involved (Aveling and Jovchelovitch, 2014). In essence, a post-constructivist discourse overcomes the critical-constructivist limitations by suggesting participants' dialogical and dialectical involvement in conversation (Roth, 2013). Roth provides a helpful discussion on post-constructivism in teaching and learning. Similarly, works by Sastry and Dutta (2013) provide valuable insights into the dialectical approach to understanding the common sense status of neoliberalism through PEPFAR involvement in HIV programmes in countries like Malawi. Recently, Liwanag and Rhule (2021) called on global health development practitioners from the developing world to build a culture of action-oriented reflexivity through dialogue in their institutions. Thus, post-constructivism inducts the knowledge players into their social and cultural environment to create, interpret and explain meanings. However, the approach appears to address discourse as dialogue and fails to address how written texts should be interpreted.

2.7.6 Partnerships in post-truth literature

The emergence of 'post-truth' literature coincides with the rise of conspiracy theories and the waning of trust due to the questionable use and communication of scientific knowledge. Post-truth interrogates the deliberate misinformation agenda that dismisses established scientific facts in favour of false ideas and the speaker or author's emotional identity. The new term also refers to a society where 'objective facts are less influential in shaping public opinion than appeals to emotion and personal belief' (Fridlund, 2020). The context in which the term finds relevance includes political and social events and attitudes frequently perceived as threatening

the established scientific and political knowledge. Thus, the distrust of science that characterises post-truth society is degenerative and destructive of neoliberal ideas like vaccine efficacy and democracy.

Kwok *et al.* (2021) make compelling arguments about post-truth recontextualisation or the ‘pedagogisation of knowledge’ and the ‘biopoliticisation of neoliberal responsabilisation’. These two ideas explain the use of knowledge, self-awareness, and risks, capitalising on the uncertainties and insecurities of contested ideas such as partnerships, vaccines, and climate change. The strategies include using (mis)information to trigger fear of the loss of control and security intrinsic to neoliberal governance in ways that prompt and persuade individuals and collective agents to see themselves as responsible for their fate and health (Kwok *et al.*, 2021). Thus, the post-truth literature suggests deliberate misinformation as a strategy to control and influence specific narratives in partnerships. Scholars like Fridlund (2020) cite Donald Trump’s ‘a little hyperbole does not hurt’ as an example of the wilful deployment of alternative facts in partnerships. The perspective is helpful in its acknowledgment of official government lies as a policy in global relations.

2.8 Global health partnerships

The previous section has provided foundational critical perspectives on partnerships in literature. The presentation has helped to conceptualise global health partnerships, as discussed in this section. The current section discusses the terminological transitions of GHPs and types of GHPs. Four GHPs are discussed: advocacy, research and development, access, and financing GHPs. The discussion is crucial as it helps delineate the GHP conversation regarding the financing of GHPs, under which the Global Fund is categorised.

According to Buse and Walt (2000), global health partnerships are state and non-state actors’ governance arrangements, emphasising the desire to achieve shared goals in specific areas of global health. The scholars describe them as ‘global public-private partnerships’ (GPPPs). The definition narrows down to the cooperation among the actors and reflects the scope and the (f)actors, highlighting the type of their relationship. Similarly, Carlson (2004) and the British Department for International Development (DFID) proposed the expression Global Health Partnerships (GHPs) to define a collaborative relationship among multiple organisations sharing risks and benefits to achieve shared goals. Unlike Buse and Walt, Carlson focuses on the goals and formal structures instead of the actors. For Buse and Harmer (2007), the focus is on institutionalised initiatives with the primary objective of addressing global health problems, in which public and for-profit private sector organisations have a voice in collective

decision-making. Joint decision-making involving public and private-for-profit organisations is the crucial factor in this perspective.

The WHO, on the other hand, proposed Global Health Initiatives (GHIs), which include a wide array of actors and activities in global health that are not reducible to joint decision-making alone. The definition also pays attention to the arrangement's functions more than the details of governance structures or actor assemblages (Rushton and Williams, 2011). It represents structured plans for financing, resourcing, coordinating, and implementing disease control across at least several countries in more than one region. The widened definition includes bilateral and multilateral programmes like the Global Fund, the US President's Emergency Plan for AIDS Relief (PEPFAR), and the World Bank's Multi-Country HIV/AIDS Program (MAP). Likewise, the definition accommodates private foundations like the Bill and Melinda Gates Foundation. These definitions are crucial in clarifying the shifts in the conceptualisation of these collaborative governance structures. The changes reflect the underlying ideological and pragmatic goals.

2.9 Types of global health partnerships

The current discussion provides insights into the functions and types of GHPs. The conversation helped conceptualise the focus of the study. The current section provides further conceptual clarity by identifying the four major types and functions of GHPs. Sonja Bartsch in Rushton and Williams (2011) discusses the four main types: advocacy, research and development, access, and financing GHPs.

Advocacy Partnerships focus mainly on raising awareness among policymakers, practitioners, and the public of specific illnesses or health conditions. The most common examples include the 1998 WHO-initiated Roll Back Malaria and the Stop TB Partnership.

Research and Development (R&D) Partnerships, on the other hand, promote research and development to address 'wicked' global health challenges in an imperfect world market. They overcome these market and policy failures by harnessing comparative advantages, sharing risks, and pooling financial and expert resources from public and private sector actors. The idea is to activate and stimulate research innovations that address controllable and avoidable diseases at affordable prices for resource-constrained countries. The various vaccine partnerships are examples of these GHPs.

Access Partnerships focus on improving medicines procurement through price reductions or donations. Some common examples include the Diflucan Partnership Program, a Pfizer's

antifungal medicine Diflucan being made available at no cost to governments and NGOs in Southern countries.

Financing Partnerships primarily provide financial development assistance for health. Examples include the Global Fund and the GAVI Alliance. Sonja Bartsch discusses the contributions of the Global Fund since its establishment in 2001, signing grant agreements worth US\$ 10.2 billion by 2007, while the GAVI had committed US\$ 3.7 billion through the GAVI Fund since 2000 (Sonja Bartsch in (Rushton and Williams, 2011)).

However, Bartsch poses critical questions regarding the GHP's role in providing additional resources considering that the public sector contributes the lion's share of the finance to these initiatives. Likewise, the sustainability of these GHPs is not guaranteed, especially in times of economic crisis and tight public budgets. Moreover, the reliance on private philanthropic actors like the Gates Foundation poses governance challenges as they dominate the boards of these GHPs. Furthermore, they lack accountability regarding sharing information about their operations and activities. Bartsch expresses concern about the influence of the GHP on the independence of governments in procuring alternative medicines. GHPs do not allow alternatives to locally approved essential medicines because they provide their own preferred medicines. As a result, ethical issues arise in supporting partnerships for health. The profit orientation of the private sector also leads to concerns regarding using these partnerships to monopolise and distort the market.

2.10 Conceptualising monitoring and evaluation

The discussion above has addressed the contested definitions, conceptualisation, and types of global health partnerships (GHPs), their contributions, and contradictions between their policy and practice. The current discussion focuses on the conceptualisation of the monitoring and evaluation of such GHPs to situate their effects on local health systems. Though they intersect in real life, this section discusses the concepts of monitoring and evaluation separately in order to illustrate how GHPs conceptualise these processes. The approach helps to simplify the closely intertwined and complementary processes for conceptual clarity.

2.10.1 Monitoring

Global health partnerships (GHPs) generally concur on the definition of monitoring, apart from semantic differences in GHP-specific policy documents. For this discussion, the (WHO, 2016) practical guide on conducting research and assessment of monitoring and evaluating digital health interventions provides a valuable starting point for understanding the concept of monitoring. The report refers to monitoring as the continuous collection and analysis of data to

compare the progress of implementation against the results initially expected. The report further suggests that there should be routine collection, review, and analysis of electronic and purposively collected data, which measure the implementation fidelity and progress towards achieving the objectives of the intervention. The inclusion of electronic processes is understandable due to the focus of this report, but in practice, most developing countries still use manual and hybrid systems. The definition compares favourably with other GHPs, such as the World Bank and the Organization for Overseas Economic Development (OECD). These two GHPs define monitoring as:

A continuous function that uses the systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds (Zall Kusek and Rist, 2004).

The above definitions commonly agree on the systematic and routine or continuous nature of data collection against specific or purposively selected and expected results. However, the second definition includes explicitly accounting for main stakeholders and measuring progress against the use of allocated funds. This conceptualisation concurs with scholarly views discussed earlier that insist on including actors and their roles in the GHP definitions. However, just as GHP definitions are elusive in practice, contrary to theory, the monitoring process is neither systematic nor routine. The linear input-output-outcome conceptualisation of monitoring contrasts with the messy and chaotic practice. The arguments will become more easily apparent after the discussion of the evaluation. The critical question that monitoring answers is whether the intervention is working as intended, measuring changes in performance over time, and allowing course corrections to improve the fidelity of the implementation.

2.10.2 Evaluation

The WHO (2016) characterises evaluation as the systematic and objective assessment of an ongoing or completed intervention to determine the accomplishment of objectives, efficiency, effectiveness, impact, and sustainability. Likewise, Zall Kusek and Rist (2004), citing OECD (2002), emphasise the systematic and objective assessment of ongoing or completed projects, programmes, or policies. The focus is on design, implementation, and results. This process aims to determine the relevance and achievement of objectives and to promote efficiency, effectiveness, impact, and sustainability. Providing credible, helpful information that feeds into evidence-based decisions forms the basis of the evaluations. The process also involves documenting lessons learned in the iterative learning process to benefit local beneficiaries and

funding partners. Unlike inward-focused monitoring, evaluation has an outward focus, drawing lessons beyond direct intervention support.

The conceptualisation above raises critical questions regarding the theory and practice of evaluations. For example, the descriptive term ‘objective’ in both definitions is problematic in a critical-constructivist global health environment. What constitutes an ‘objective’ procedure varies with place and time. Likewise, the role of objectivity in a social world is unclear, and objectivity may not be desirable in a social context where language and experiences define multiple worldviews. Thus, it is perhaps not desirable to pursue objective evaluations that may not be implementable. However, these arguments do not advocate thump-sucking and chaotic disorder in evaluations. Evaluations should follow generally accepted procedures incorporating the lived experiences of the evaluated local beneficiary population. To that extent, evaluations will be considered systematic and objective according to local standards. If these are the assumptions of the above two definitions, that suffices as conceptually sound in global health M&E. Outside the dialogical and dialectical critical constructivist world of local beneficiaries, objectivity is neither desirable nor practical in global health.

[2.11 The political and technical side of monitoring and evaluation](#)

The preceding discussion has highlighted the gap between policy, monitoring, and evaluation practices. That discussion ushers us into the debates about these concepts. The major arguments pertain to the (a)political and technocratic perspectives to monitoring and evaluation. The following section briefly discusses the two approaches.

[2.11.1 The political side of monitoring and evaluation](#)

The discussion in this section highlights the political aspects of M&E despite its technocratic portrayal in most pragmatic-instrumental literature. Scholars such as Zall Kusek and Rist (2004) have highlighted the political side of this concept by emphasising the role of resource mobilisation as a contributor to politics. They asserted that M&E brings transparency and accountability that can shake corrupt and autocratic systems of government, which in turn triggers resistance to change. As a result, its implementation requires political consciousness. They propose the engagement of M&E champions to facilitate the institutionalisation of M&E and minimise resistance. They also assert that results-based M&E can strengthen governments by reinforcing the demonstration of outcomes. They argue that a focus on results supports economic and governmental programmes and policies that could contribute to poverty reduction, higher economic growth, and a wide range of development goals.

However, the asymmetrical distribution of resources, institutional capacity, and ideational power are of concern in M&E partnerships (Dolan, 2011). Dolan asserts that development agencies use the convenience of partnership rhetoric and discourse to legitimise their role in development. Thus, M&E represents a political, subtle form of external power imposition by GHPs on local partners. Similarly, Fridlund (2020) discusses the performativity of post-truth politics, illustrating the use of emotions, deception, and hyperbole in political discourse. In this process, M&E data provides the necessary ‘evidence’ to support specific ‘post-truth’ positions in partnerships for global health programmes.

Similarly, Makuwira (2018) discusses power and development in practice, specifically highlighting global development agenda-setting contestations. Makuwira argues that genuine evidence of programmes initiated and implemented by ordinary people is rare. He argues that donor funding has played a crucial role in how power affects local and national NGOs. He illustrates the negative effects of upward accountability to donors by funding partners. Thus, the political side of M&E is a crucial discussion point that enables a comprehensive understanding of collaborative partnerships for health. The biomedical and technocratic approaches to M&E miss the opportunity for multi-disciplinary inputs from political science, international relations, and sociology, among other perspectives that provide better insight into M&E. The following section expands this argument by discussing the technical side of M&E.

2.11.2 The technical side of monitoring and evaluation

The technical monitoring and evaluation aspects have received more attention in public health, management, and global development literature for over two decades. The focus has been on technical aspects such as institutional capacity building and designing and building a reporting system that can produce trustworthy, timely, and relevant information on the performance of government projects, programmes, and policies. The literature also suggests experience, skill, and institutional capacity requirements. According to Zall Kusek and Rist (2004), the minimum requirements for functional results-based M&E systems include the ability to construct indicators successfully; the means to collect, aggregate, analyse and report on the performance data, the indicators, and their baselines; and management with the skill and understanding to know what to do with the managerial utilisation of the information for decision making. More recent debates emphasise the role of technology as M&E systems aim to collect more granular and person-centred data (Klecun, 2016; WHO, 2016). Likewise, other scholars emphasise the role of statistics and big data as necessary in conceptualising our understanding of M&E in healthcare (Stevens *et al.*, 2018). However, the technocratic approaches fail to acknowledge

the social context in which M&E systems function. The challenge with technocracy is its tendency to silence the qualitative aspects of M&E, which is crucial in providing a comprehensive understanding of the M&E processes.

The challenge with technocratic M&E approaches is the obsession with statistics, or what Adams (2016) calls the tyranny of statistics. Similarly, Gimbel et al. (2018); (Shukla et al., 2016) refer to 'rituals of verification' to emphasize engagement with audit-like review of numbers in M&E processes. Grane (2013), also highlights how the excessive focus on indicators or "indicatorism" has silenced the "E" from the twin M&E processes, resulting in less emphasis on the evaluation function. Likewise, Bartl et al. (2019); (Shore and Wright, 2015) also draw our attention to the new challenge of "governance by numbers." Their observations underscore the influence of M&E statistics beyond their technical role as decision support. The algorithms speak to the adverse effects of GHP-supported M&E systems that increasingly adopt private-sector audit cultures with minimum consideration for the descriptive aspects of M&E data. As a result, scholarly interest has challenged old sayings like 'numbers speak for themselves' or 'numbers do not lie.' It is necessary to expose the political and business interests behind the drive toward algorithmic governance (Bartl *et al.*, 2019; Fukuda-Parr *et al.*, 2014; Jablonka and Bergsten, 2021; Storeng and Béhague, 2014; Erikson, 2015; Erikson, 2016). The use of technical tools like the log frame matrix is another point of scholarly contention. Makuwira (2018) addresses this concern, highlighting this tool's technical faults that have become synonymous with development aid. He specifically addresses its failure to capture the social struggles of ordinary people in global development reporting using the tool. Thus, successful M&E systems should harness the comparative strengths of political and technocratic aspects to provide a comprehensive analysis to inform decision-making.

2.12 Types of GHP monitoring and evaluation systems

The discussion on the political and technical aspects of M&E in the previous section was crucial in providing a comprehensive analytic framework that informs evidence-based decision-making. The current section deliberates on the World Bank and the Global Fund M&E systems. These are the two M&E systems with greater multilateral effect on local health M&E systems in LMICs.

2.12.1 World Bank monitoring and evaluation systems

Through its global initiatives like the Highly Indebted Poor Countries (HIPC) in the mid to late 1990s and the Millennium Aids Project (MAP), the World Bank (WB) emphasised M&E

as a strategy to reinforce effective collaboration among partners in LMICs. It actively expanded M&E systems through technical and financial support to National AIDS Councils in LMICs. The strategy emphasised M&E collaboration among public, private, and civic partners in LMICs as a condition for financial and technical support (Zall Kusek and Rist, 2004). The collaborations involved support for M&E capacity building as an essential component of the technical partnerships with local health partners in LMICs. For example, in 1996, the World Bank's Highly Indebted Poor Countries (HIPC) initiative made monitoring and evaluation pre-conditional to all its global financial and technical assistance as part of its comprehensive proposals to reduce the external debt of the world's poorest and most heavily indebted countries. The comprehensive debt restructuring strategy sought to stimulate private sector-led growth and improvement in the social sector indicators.

The ESAP and the Poverty Reduction Strategy Papers (PRSPs) initiatives of the mid to late 1990s are other World Bank initiatives that promised debt relief and concessional lending to LMICs that implemented M&E reforms as part of the poverty reduction programme plans to track progress and lessons from the programmes. Thus, apart from improving aid delivery gaps identified in the HIPC programme, the PRSPs aimed to strengthen country-led M&E systems for LMICs to ensure accountability and transparency in implementing the poverty reduction programmes. The PRSP strategy required the government, civil society, and private sector to co-produce and co-implement national plans linked to measurable indicators and a monitoring and evaluation system (Zall Kusek and Rist, 2004).

However, the World Bank used soft and coercive power to influence the comprehensive implementation of these M&E initiatives in LMICs. For example, the PRSP programme thrived on country-led discourse while guiding the countries on how to produce their national plans. The programme provides M&E artefacts like templates and guidelines to facilitate financial disbursements. Threats of financial withdrawal for failure to comply with laid down procedures were some of the coercive measures available during the financially unstable years of the 1990s. Another challenge with this collaboration is the donor-centric M&E system that prioritises accountability and interests to account for and demonstrate legitimacy with little broader impact on the LMICs' economies (Zall Kusek and Rist, 2004).

2.12.2 The Global Fund monitoring and evaluation systems

In its 2017-2022 Data Use and Improvement Framework, the Global Fund introduced its current M&E system that promised to build sustainable national M&E systems. The strategy involved fostering country ownership through investments in data systems based on one country-led M&E plan, supporting integrated Health Information Systems (HMIS) country platforms, and ensuring the use of existing country platforms and processes for data analysis and use. The GHP promised to promote data analysis and use to strengthen analytical capacity and the use of data for decision-making. The goal was to be achieved through supporting sub-national data analyses and ensuring efficient resource distribution to achieve the set goals. Moreover, the Global Fund promised to facilitate ongoing learning processes and feedback loops through evaluations and reviews, to strengthen in-country programme and data quality assurance processes, and to facilitate annual programme evaluations and assessments. Finally, the Global Fund sought to use the diversification and multiplication of partnerships to accelerate implementation. The strategy included engaging with stakeholders and reaching out beyond the Ministry of Health to the Ministries of Finance and Social Welfare and the planning and health statistics departments.

However, scholars such as Cashin (2012) identified areas in the Global Fund and the World Bank M&E systems where minimal progress had been made. Firstly, both systems excessively focus on people-centred indicators and targets, ignoring the analytic processes. Secondly, the approaches are complex and burdensome for nascent M&E systems in LMICs. Thirdly, Cashin argues that both systems conveniently focus on the number of people-centred indicators and targets that ignore local beneficiaries' qualitative aspects. The lack of qualitative aspects in these M&E systems represents a considerable gap and missed opportunities to collect data that inform local decision-making and learning for improvement.

Similarly, their focus on specific issues or diseases undermines local systems and misses opportunities to provide timely sector-wide information benefiting the whole Ministry or government by providing information as a public good. The disease-specific approaches have segmented government efforts with adverse effects on accounting for results beyond the health sector. The GHPs failed to balance agency-specific effectiveness against Ministry or government-wide impact. Moreover, the concept of local 'reciprocity' in the Global Fund system perpetuates and reinforces power asymmetries in which local partners are dependent on the GHPs, yet the local partners, including resource-poor countries, also contribute to the

Global Funds. The discussion, therefore, succeeded in identifying these aspects that militate against the spirit of partnerships and reinforce power imbalances and systems that rely on technocratic approaches to M&E. The lack of support for qualitative methods for M&E remains one of the adverse effects of GHP support for local health systems in LMICs.

2.13 Mechanisms of Global Health Partnership's influence on local M&E and governance systems

The discussion on the World Bank and the Global Fund M&E systems in the previous section has provided helpful insights into GHP's positive and negative unintended effects on the local health M&E systems. The discussion also served as a precursor to a consideration of the soft power mechanisms through which GHPs influence local health M&E systems in LMICs. The specific strategies discussed in this current debate are norm diffusion and agenda setting, the standardisation of M&E discourses in health programmes, rhetoric and discourse control, the framing of M&E issues in policy and practice, the effects of conceptual boundaries, Global Health M&E systems as technologies of soft power, the role of monitoring and evaluation champions, rebranding and effacement strategies, and monitoring and evaluation artefacts. The discussion will conclude by presenting the mechanisms of local health partner influence on GHPs in the partnerships. The mechanisms include social capital as a source of power in partnerships, national health legislation, the role of street-level bureaucrats in health partnerships, and bureaucratic socialisation as power in health partnerships.

2.13.1 Monitoring and evaluation policy agenda-setting and institutional control

One of the soft power strategies identified in the literature is the influence through the control of the policy agenda of the local health system in LMICs. Rothman (2011) characterised agenda-setting influence as 'an art' from a game theory perspective. The scholar discussed this approach by illuminating expert power, scientific knowledge, and technocratic approaches in international relations. The approach conceals the political nature of agenda setting while emphasising the science and technologies to justify its adoption. According to Rothman, global health partners capitalise on their international reputation, legitimate and expert power, and control of the discourse as tools and mechanisms to influence local policies through attraction and technical advice. Several examples from the literature confirm Rothman's observations. Taylor and Harper (2014) demonstrate how the GFATM successfully convinced the local partners to ensure HIV, TB, and malaria are on the national agenda in Uganda, convincing the partners to move from the UN-supported sector-wide approaches (SWAps).

Similarly, Armstrong *et al.* (2019) warn that the external influence of Global Fund structures on local agenda setting in Malawi, Tanzania, and Zimbabwe risks becoming a ‘political theatre’ due to a lack of genuine collaborative engagement with the local partners in budgeting and other procedural processes. Likewise, Cummings *et al.* (2018) apply a CDA framework to illustrate how agenda-setting GHPs emphasise ‘pluralist-participatory’ discourse at the policy and agenda setting stage and a ‘techno-scientific-economic discourse’ at the policy implementation level. Khan *et al.* (2018) discuss how GHPs in Cambodia and Pakistan use evidence-based rhetoric to finance pre-determined HIV agenda items ahead of other more pressing challenges like mental health. These examples help to illustrate the harmful unintended effects of GHP interventions on local agenda-setting processes in LMICs.

2.13.2 Norm diffusion and standardisation of monitoring and evaluation discourses in health programmes

The concept of norm diffusion involves setting generally accepted standards of doing M&E through circulating ideas and tools to support the system. The World Bank has a reputation for initiating and circulating influential global ideas. Nay (2014) describes the World Bank as a ‘knowledge’ bank and ‘norm’ entrepreneur. This characterisation acknowledges the leadership role of the Bank in creating and circulating powerful ideas, especially its leadership in M&E. By ‘normalisation’ Nay refers to the graduation of concepts from a restricted application of knowledge to perhaps a common sense acceptance among a wider audience through extensive use by wider stakeholders, including decision-makers, experts, analysts, practitioners, beneficiaries, and stakeholders. Norm diffusion is also spreading through the use of technology in M&E. Sastry and Dutta (2013) discuss neoliberal global ‘common sense,’ or ‘doxa,’ while Smith (2018) introspects the concept of data ‘doxa’ to illustrate the normalisation of the datafication and invasion of human privacy through intelligent wearables that generate private information about habits and health that is susceptible to commercial (ab)use.

Likewise, the World Bank has invaded the global development space with major development concepts and buzzwords like Results-Based Management and Performance-based Funding, among other economic ideas (Cornwall and Eade, 2010; Schnable *et al.*, 2021). In one of its research publications, the World Bank confirmed that it achieves its goals more effectively through the diffusion of knowledge than through grant-making (Knack *et al.*, 2020). In this study, the researchers asserted that support for policies or norm diffusion had a more significant

impact than financial support in LMICs. Its reputation as an epistemic and knowledge leader accords legitimacy to the organisation as a financing, research, and development GHP.

Moreover, most of its M&E indicators and programme targets mediate norm diffusion in LMICs. This discussion has illustrated how GHPs use soft power to diffuse ideas unspectacularly at the local health systems level.

2.13.3 Monitoring and evaluation rhetoric and discourse control

The use of rhetoric and discourse control closely relates to norm diffusion and agenda setting as GHPs can apply the strategies simultaneously. Rothman (2011) argues that in typical game theory, international development partners may control how discussions on specific issues occur. The technique involves the foregrounding of key messages and backgrounding unfavourable conversations. In this process, rhetoric is unleashed against some actors to align with the desired discourse.

Khan *et al.* (2018) observe that GHPs like the World Bank and WHO applied inter-sectoral leverage strategies in Pakistan and Cambodia to determine how the recipient country was perceived globally in ways that influenced the countries to align with desired health policies. Negative coverage of these countries had the undesired effect of affecting their tourism sectors. Similarly, Taylor and Harper (2014) observe that rhetoric and discourse control played a crucial role in accepting the Global Fund projects in Uganda. The Global Fund convinced the government to adopt its approaches despite its disruptive effects on the existing SWAps.

2.13.4 Framing of M&E issues in policy and practice in LMICs

Another strategy for policy influence by GHPs is framing the policy issues. It is a powerful linguistic tool that relies on texts, symbols, and meanings to influence policy and practices in LMICs. In global health Rushton and Williams (2012) demonstrate how the framing of linguistic, cognitive, and symbolic power to identify, label, describe, interpret and address problems plays a determining role in policy and practice. Similarly, Fukuda-Parr (2016) discusses the MDGs and SDGs, asserting that framing determines the definition of issues, the explanation of causes, and the justification of policy responses and priorities. The Fukuda-Parr makes an important observation and demonstrates that the framing of most MDG targets and indicators had the unintended effect of marginalizing ongoing strategic processes for people empowerment and transforming economies with adverse impacts on poverty reduction and women's political voice.

Similarly, Shiffman and Shawar (2022) discuss how framing global health issues could shape differences in levels of priority of attention and resources they receive from global health organisations. Through a review of scholarship on global health policy-making processes to examine the role of framing in shaping global health priorities, Shiffman and Shawar identify the influence of three framing processes—securitisation, moralisation and technification. With ‘securitisation’ they refer to an issue's framing as an existential threat, ‘moralisation’ is an ethical imperative, and ‘technification’ is a wise investment in science. These framing processes concern more than the public portrayal of issues. They characterise framing as a socio-political process with contestation among actors in civil society, government, international organisations, foundations and research institutions. Shiffman and Shawar refer to the deployment of various forms of power to advance frames to secure attention and resources for the issues that concern them. As Rushton and Williams (2012) assert, understanding the target audience's more profound paradigms or beliefs about the subject matter determines the success or failure of this strategy to influence policy and practice in M&E.

2.13.5 Effects of monitoring and evaluation conceptual boundaries

Conceptual boundaries involve a specific ‘position taking’ which occurs when actors overtly or covertly relate entities separated by a boundary (Kislov *et al.*, 2017: 1426). In this context, boundary work refers to the conceptual demarcation of knowledge creation, decoding, and transmission in various contexts or communities. The boundaries could include how scientific knowledge is distinguished from lay or non-scientific pursuits. GHPs as ‘boundary organisations’ frame, diffuse and set global M&E knowledge production agendas due to their privileged epistemic and legitimate power as international organisations.

Scholarly evidence of the negative effects of conceptual M&E boundaries includes works by Peters (2016) and Mueller-Hirth (2012). They demonstrate how expatriates and international NGOs influenced the type of local information reported to external audiences in a global project in Angola and South Africa. The expatriate managers used their conceptual discretion to exclude local knowledge that provided evidence for informed responses in favour of the expectations of external audiences of the project reports. In Cambodia, Aveling and Jovchelovitch (2014) observed that ‘conceptual boundaries between the GFATM and its local partners in a collaborative HIV program in led to the privileged pre-occupation with quantitative targets and indicators as the local partners chased the performance-based targets set by the Global Fund.’ The mechanisms of influence included expatriate staff using rhetoric

and discourse control, framing in the translation of global scientific information into formats that are useful for local policymaking, and mediating conflicts (Gray, 2016; Nay, 2014; Rushton and Williams, 2012). Their global physical and conceptual influence asserts them as legitimate knowledge translators through subtle but effective softer power strategies, including the norm diffusion of the new M&E lexicon and practices to partners in LMICs.

2.13.6 The performativity of global health monitoring and evaluation systems as technologies of soft power

The performativity of the technical logic of M&E as a governance and accountability mechanism is another strategy that GHPs deploy to influence policies in LMICs. Mueller-Hirth (2012) raises legitimate concerns about the technical approaches that donor-funded M&E systems expect local partners to adopt. The unintended effect of this approach is its performative effects (posturing) rather than the delivery of intended results, as it masks and neglects the politics of M&E policy making and implementation. Moreover, the monologic interpretation of knowledge evolves from the problematic exclusive preference for quantitative measurements as the gold standard in M&E. The GHP approaches to enable and shape particular roles and values impacting organisational cultures (Mueller-Hirth, 2012). The roles and values often contradict the local knowledge systems, resulting in local M&E systems with logic that performs or facilitates the external reporting of M&E processes rather than that delivers results for locally relevant decision making and learning.

Thus, M&E has become a political technology that accomplishes governing through ‘rituals of verifications’ from afar (Mueller-Hirth, 2012). The GHPs, as active ‘bridge-builders’ and ‘norm entrepreneurs’ in global health, support M&E expertise, vocabularies, and practices that give rise to calculation techniques central to neoliberal governing rationality in the development domain and shaping the behaviour and practices of local health partners (Mueller-Hirth, 2012; Nay, 2014). Thus, the deployment of intermediary GHP processes and roles like capacity building, research, lobbying, advocacy, and local health partners' training programmes are central to the bridge-making and norm entrepreneurship processes that promote governing logic that focuses externally on governing from afar. Thus, GHP support for local M&E systems invokes the concept of governmentality as a technology of performing through the reproduction of pliable modern liberal economic local actors.

2.13.7 Role of monitoring and evaluation champions

The appointment of M&E champions is one key mechanism GHPs deploy to facilitate policy influence and practice in an establishment in LMICs. Lopez-Acevedo and Krause (2012)

discuss the role of champions who are strategic placements to advocate the institutionalisation of M&E in government departments. Their role is to influence policy and the practice of M&E from the supply side of the system by persuading colleagues to embrace specific approaches and resource allocations that facilitate the creation of a government-wide M&E system. Storeng *et al.* (2019) discuss the value of local and expatriate reproductive health and family planning champions to influence locally contested and sensitive policies, including abortion, in Malawi and South Sudan. Their roles included technical support in drafting policy documents for maternal health and family planning documents. In South Sudan the champions successfully framed contentious medical abortion and family planning as reproductive health strategies to achieve the MDGs.

However, the sustainability of champions in low-resource and donor-dependent countries remains challenging. Using financial and other incentives remains problematic as it creates a dependency syndrome with the result that poorly resourced countries may not sustain a project beyond donor support. The use of champions therefore has the unintended effect of prolonging the government's dependence on GHPs and preventing them from addressing their staffing deficiencies

2.13.8 Rebranding and effacement strategies

Global Health Partnerships also apply strategies such as (re)branding and effacement as mechanisms to influence policy and the practice of M&E in LMICs. The techniques involve the local registration of international NGOs as local trusts while downplaying their global identity to ensure local acceptance. Storeng *et al.* (2019) illustrate how international NGO staff play 'wilful ignorance' on contentious issues that undermine broader diplomatic relations as part of their effacement strategies to win local trust. In this process, expatriate staff avoid active participation in controversial health subjects but secretly recruit and support local staff to advocate policy changes. The approach contradicts the GHP's desire for maximum visibility, public profiling and branding, as they aim to convince local policymakers that they, the locals, oversee the processes and outcomes. Other strategies deployed by international NGOs in Malawi and South Sudan include deploying champions working in the Ministry's key departments and operational offices housed in the Ministry.

Furthermore, deploying techno-scientific discourse is another effacement strategy identified by Storeng *et al.* (2019). The strategy includes emphasising the technical advisory role on human rights standards, M&E evidence, and guidelines on abortion to inform national policy processes

while downplaying or ‘effacing’ the political nature of their roles and the influence of their outside donors. For example, the international NGOs capitalised on expert and moral authority, financial resources, and pro-abortion discursive frames to influence policy decision-makers and help shape policy options in Malawi and South Sudan. Moreover, the study underscores power relations, how it is exercised and its effects on global health. It demonstrates how international NGOs remotely and invisibly deploy normative and epistemic power via their national counterparts. Gore and Parker (2019) also observe how GHPs energise the grassroots mobilisation of local policy elites and eventually displace rights-based and feminist discourses as they emphasise technical public health knowledge in the local programmes they support.

2.13.9 Monitoring and evaluation artefacts and policy influence

In the previous discussion, despite its limited value in capturing local experiences, the ubiquity of the Logical Framework provided insights into some of the GHP M&E artefacts that perform rather than capture and report the local dynamics of M&E. The list of M&E artefacts playing influential performative roles in M&E includes GHP guidelines, protocols, plans, and frameworks. Using an example from Tanzania, Coultas (2020) provides a dialogical case illustrating how international development agencies encourage local practices that perform the logic of rigid predictability aligned to international reporting rather than meeting local needs. Regardless of the difficulties in collecting locally relevant data, their donor contractual requirements provided limited options to adapt the donor M&E tools to capture local experiences.

While some scholars have identified the person-to-person ‘othering’ effects of power imbalances, Coultas discusses the ‘self–other’ relations in evidence-making involving person-to-artefact interdependencies through the monitoring and evaluation intervention. This insightful observation bears testimony to the power imbalances between GHPs and local partners expressed through M&E artefacts. The evidence shows that the M&E artefacts wield power and represent the invisible presence of the GHPs from afar. In this process, Coultas successfully illustrates the conflict between the local implementer's perspectives and the perspective of the artefacts. As a result, the dialogical approach reconciles the GHP logic at odds with local realities. Until this is corrected, pretentious reporting of M&E results leads to perverse self-silencing by local partners.

2.13.10 Mechanism of power expression by local health partners in partnerships

The previous discussion addressed the mechanisms that GHPs deploy to influence local partner M&E policy and practice. In the current debate, the literature partly addresses the second

research question by delving into the relational nature of power in partnerships for health and how the local partners rationalise and counterbalance their weak position in the partnership. Thus, Michel Foucault's conceptualisation of power provides the discussion framework for the section. The discussion focuses on social capital, street-level bureaucracy, bureaucratic socialisation, and national legislation as some of the mechanisms and strategies local partners deploy to counter GHP's influence on local M&E and practice in LMICs.

2.13.11 Social Capital as a source of power in Partnerships

The contribution of local people to community networks is an essential source of power for local health partners. Recent studies have shown the importance of social capital and local mobilisation in shaping local and global health policies (Campbell, 2020). Campbell asserts that social capital represents the community's contribution to externally supported community interventions based on community norms and trust. The concept has not received adequate attention in health partnerships. LeBan (2011) affirms that social capital in a community and in the national health system actors are critical elements. LeBan further suggests the need for more research and consideration of social capital as the seventh building block of a well-functioning health system. Other scholars have demonstrated how social capital plays an important role in measuring the stigma index among people living with HIV for evidence-based decision-making stigma reduction (Yam *et al.*, 2020). The study highlights the importance of social capital in research by relying on peer-to-peer and the 'snowball recruitment' of peers for the investigation to succeed in the Dominican Republic.

Likewise, Aveling and Jovchelovitch (2014) discuss the 'gatekeeping' and 'snowball' power of local NGO partners working with specific populations like drug-injecting users in an HIV and AIDS research partnership in Brazil. The study relied on the gate-keeping social capital of the local partner organisation in accessing drug-injecting clients for the study. The collaboration involved a local NGO, UNESCO, and the London School of Economics. Similarly, successful interventions for key populations rely on the cooperation of peer-to-peer trust within the transgender communities. Thus, social capital represents local power with the potential to transform evidence-based M&E systems and to address social ills.

2.13.12 National health legislation

Using legal and quasi-legal national health legislation is another strategy at the government's disposal to ensure GHP-supported programmes align with national priorities and policies. Storeng *et al.* (2019) demonstrate the South Sudan government's use of local regulations to counter international policy influence on sensitive issues such as abortion laws. The scholars

demonstrate the contested political policy environment in which governments activate local legislation to counter global effacement strategies and to influence change in family planning and abortion laws. This give-and-take relationship sees governments winning in some cases while losing other issues to GHP's influence. Storeng *et al.* also note the government consolidation of legislation prohibiting foreign interference in local policy processes to safeguard their sovereignty. Invoking sovereignty and international laws constitutes the use of another source of power by local governments against global influence on policies. Likewise, Cheng (2019) discusses using formal agreements such as a memorandum of understanding as some of the tools at the disposal of governments to rationalise GHP's influence on local health systems.

2.13.13 Power of street-level bureaucrats in health partnerships

The concept of street-level bureaucrats is valuable to understanding relational power in policy-making via the discretionary decisions of lower-level staff (Lipsky, 2010). The concept productively captures individuals' dilemmas in public service and shows the pragmatic role of discretionary power missed in most policy processes. Borrowing from Michel Foucault's conceptualisation of power as relational, the concept of street-level bureaucracy provides valuable insights into the contradictions between top-down policies and the practical realities of policy implementation. The concept of the logic of appropriateness and consequence (March and Olsen, 2004; Schulz, 2014) explains how lower-level staff makes appropriate decisions based on local logic and available resources rather than stated policy positions that sometimes deviate from local experiences. Scholarly interest in this concept is increasing in public administration and work on collaborative partnerships (Arnold, 2020; Ferreira *et al.*, 2020; Zhang *et al.*, 2021). The scholarship encourages the development of street-level entrepreneurship to harness creative and pragmatic feedback capable of improving policy and practice (Arnold, 2020; Zhang *et al.*, 2021). Thus, local discretionary power is a source of influence against the GHP policy's effect on local health systems. However, this power source may not provide valuable contributions to the policy process if bureaucrats fail to acknowledge the need for a dialogical approach to the process.

2.13.14 Bureaucratic socialisation as power in health partnerships

Bureaucratic socialisation is another concept closely related to those dealt with in the previous discussion. Oberfield (2014) highlights how public-sector entrants develop the knowledge, attitudes, and behaviours necessary to function as bureaucrats. The concept borrows from the pathology theory of bureaucracy, which views the public sector as slow and sometimes

counterproductive. Chakrabarty and Kandpal (2012) also discuss the ‘bureaupathological’ syndrome as conceptualised by Victor Thompson. While Thompson defines this syndrome as ‘the behaviour pattern of insecure people using their authority to dominate and control others,’ the current study recognises this practice differently as productive reflexivity by local partners appropriating bureaucracy as a power source in partnerships. Thus, the concept provides a helpful understanding of the government’s instrumental use of this practice to remind external partners of where the real power lies. Okeke (2018) and Herrick (2018) provide valuable introspection on how a government as a local partner ultimately has the power to decide on any externally funded project, regardless of its financial and technical deficiency. Bureaucratic socialisation is one strategy they use to slow down external partners and align them to national processes. Taylor and Harper (2014) highlight the Ugandan government’s bureaucratisation of the Global Fund’s financial disbursement system as a form of protest aimed at disrupting the UN-supported Sector Wide Approach (SWAp).

2.14 Impacts of global health partnerships on the six WHO building blocks

The previous discussion provided snippets of GHP soft power mechanisms for influencing local health M&E systems in LMICs. The discussion helped provide insights into the unspectacular methods that rarely get attention as sources of influence in pragmatic partnership literature and practice. The focus was also on specific donor programs in LMICs. The current discussion focuses on the GHP’s financial and technical support beyond the specific projects to include contributions to all of the six key areas that build successful health systems. Thus, the influence on finance for health, human resources, medical and pharmacy supplies, leadership and governance, service delivery, and health information forms the basis of the current discussion, which partly answers question four of this study.

2.14.1 Impacts of GHPs on the financing of local country M&E health systems

The discussion of types of Global Health Partnerships highlighted the positive role of GHPs in funding global health programmes in LMICs (Rushton and Williams, 2011). The Global Fund ensures that M&E activities have at least 5% of the total budget allocation. However, evidence shows that GHP funding is a convenient strategy to influence local health M&E policies (Buse *et al.*, 2012). Khan *et al.* (2018) demonstrate how GHPs in Cambodia and Pakistan emphasised the ‘burn rate’ as an indicator of success, regardless of the programme outcomes. The pressure to spend GHP budgets is a perverse response to funding partner pressure to meet spending and programme targets. Moreover, critical literature shows that the obsession with financial accountability and transparency has imported audit-like cultures into M&E discourses (Shore

and Wright, 2015). These scholars raise concerns regarding the financialisation of M&E and the excessive focus on accounting, auditing, and economic concepts like data auditing, verification, programme investments, assets, income, returns on investments, and value for money at the expense of addressing the qualitative aspects of beneficiaries in M&E plans and targets. The unintended impact of such discourse in M&E is that programme success becomes measurable and reducible to financial returns and the prudent use of funds at the expense of achieving social transformation. Moreover, the financial discourse promotes upward accountability to the GHP donors with less downward accountability to the beneficiaries. Likewise, the literature provides adverse evidence suggesting that financial support to some LMICs is replacing national budgets for health (Farag *et al.*, 2009). Such unanticipated effects foster government irresponsibility and corruption in the health sector.

2.14.2 Impact of GHPs on health information reporting in local health M&E systems

The investments in health information systems have significantly improved data collection and analysis processes in LMICs (Jain and Zorzi, 2017). The investments in data analytics software have improved data visualisations and infographics to communicate M&E evidence in LMICs. The GHP's support has improved data packaging and visual simplification for easy consumption by local policymakers and analysts. According to Lundkvist *et al.* (2021), data visualisation helps 'bridge the gap' between policy and practice. O'Connor *et al.* (2020) assert that data visualisation is the 'New Science,' while Comai (2014) judges its merits as a 'decision-making support' system. Likewise, Jacob (2020) suggests that data visualisations 'bring out the hidden stories in numbers and figures.' These characterisations reflect the positive attributes of technology in adding value to health information.

However, the negative impact of data visualisation is that its interactive and visual impact is largely used to report on positive aspects of GHP-supported programmes, reinforcing practises that ignore and mask the social pain and struggles of local populations (Gray, 2020; Hill, 2020; Nærland, 2020; Suman, 2020). The focus has been mainly upward rather than on the audiences of beneficiaries. Scholars also raise concerns about data visualisation illiteracy as widening the gap between GHP-supported programmes and local communities. Interpreting data visualisations requires local policymakers and beneficiaries to have data analytic skills to make sense of the visuals. Thus, instrumental views of health information may require balanced introspection when evaluating their contribution to evidence-based decision-making.

2.14.3 Impact of GHPs on local M&E systems for service delivery

The delivery of health services to the lowest sectors of society is one key indicator of a functional health system. As a result, GHPs rely on M&E information to decide on local health systems' technical and financial support to achieve that goal. Introducing decentralised service delivery models is one strategy that GHPs have contributed to attaining primary health goals and universal health coverage. Such client-centred approaches have simplified and adapted the provision of HIV services in ways that better serve the needs of PLHIV and reduce the unnecessary burdens on the health system (Grimsrud *et al.*, 2016). The approach considers the population's changing health needs without compromising the public health approach. The approach nullified the catastrophic impacts of out-of-pocket expenditure for HIV and non-HIV-related illnesses in LMICs. The evidence suggests that the system has sustained HIV programmes in resource-constrained environments and decentralised services to meet HIV clients' needs at less expense (Grimsrud *et al.*, 2017; Larson *et al.*, 2020; Ssempijja *et al.*, 2020).

Nevertheless, the approach increased the demand for granular person-centred data, increasing the burden of clinicians' data collection, analysis, and reporting responsibilities. Gimbel *et al.* (2018) show the increasing documentation demands placed on clinicians due to the decentralised GHP-supported programmes in Tanzania. Their study reveals that district medical doctors spend nearly thirty days per quarter preparing different GHPs reports. In the process, M&E requirements compromise the time available for clinical practice. Additionally, collecting and analysing person-centred data invites the risk of infringing on personal data if the system does not adequately provide for confidentiality.

2.14.4 GHP impact on M&E for human resources for health

Financial and technical assistance for human resources for health is a key intervention by GHPs to strengthen health systems in LMICs. In recent years GHPs have been instrumental in establishing and capacitating M&E departments in Ministries of Health in LMICs (Mapitsa *et al.*, 2019). Herrick and Brooks (2018) reiterate an essential observation that human resource capacity building has become an 'undisputed good' for GHP interventions such as GFATM. However, new evidence suggests that they also create unintended impacts like conflicts between the donor-supported and non-supported staff. For example, Craveiro and Dussault (2016) and Herrick and Brooks (2018) provide helpful insights into GFATM programme financial assistance fuelling tension between staff competing to attend M&E capacity-building workshops that provide an additional source of foreign currency income for the underpaid staff

in Angola and Sierra Leone. The GHP support created a ‘per diem syndrome,’ which ‘instrumentalised and commodified’ M&E capacity-building programmes (Herrick and Brooks, 2018).

Furthermore, Vernon (2020) affirms that funding NGOs can effectively drain the public sector of resources and skilled personnel. Craveiro and Dussault (2016) reveal how GHPs negatively contributed to an internal brain drain in Angola, as they recruited from the most experienced and qualified government human resources pool. As a result, GHP assistance weakened the local health M&E systems they sought to strengthen.

2.14.5 GHP impact on pharmaceutical and medical technology systems

In its 2010 publication on the M&E of the building blocks of a health system, the WHO framework for health systems pays particular attention to strengthening pharmaceutical and medical technologies as being vital for health systems (WHO, 2010: 60). The functions include monitoring access to essential medicines to improve service delivery, leadership, and governance. Nonetheless, insights from countries such as the Lao People’s Democratic Republic have provided helpful indications of the potential negative impacts of GHPs like the GFATM in supporting local health systems. The introduction of parallel data collection and reporting systems for pharmaceutical and medical equipment distribution is one adverse effect of this GHP support (Mounier-Jack *et al.*, 2010). The intervention introduced new M&E tools rather than integrating them into existing systems. Thus, the GFATM contributed to parallel procurement, drug supply, and M&E systems in the Lao People’s Democratic Republic.

2.14.6 GHP impact on whole government health M&E systems

Global Health Partnerships’ official policy documents cite support for the broader health systems beyond their HIV, TB, and malaria programmes as some of their national health system objectives. As a result, the health system strengthening discourse commonly justifies GHP's presence in most local health systems. In Zambia, Kanyamuna *et al.* (2020) provide helpful insights into GHPs' continued neglect of assistance to the whole government M&E systems, negating the government’s effort to launch a whole government M&E system (WGM&ES). Apart from non-financial and technical support for strengthening the entire governmental health system, GHPs often get criticism for supporting parallel M&E systems in LMICs. Similarly, Craveiro and Dussault (2016) assert that strengthening the whole government health system in Angola has never been the objective of GHPs operating in that country. Thus, GHPs appear to establish parallel health M&E systems to avoid collaborating with government data collection and reporting.

2.15 Chapter summary

This chapter has described the current theoretical and conceptual frameworks and debates useful to understanding the intended and actual impacts of GHPs on the local health M&E system in Zimbabwe. The chapter has discussed Osborne's (2006) New Public Governance theory (NPG) and related collaborative governance theories such as Ansel and Gash's collaborative governance model, Emerson *et al.*'s integrated framework for collaborative governance, Vangen *et al.*'s governance of collaborative and Brinkerhoff's government-non-profit partnership models. The discussions have highlighted the frameworks' key propositions, merits, and limitations in the current study context. In addition, the debates in the chapter have helped position the focus of the present study. As against most public and international health studies, the current research is interested in collaborative governance systems that transcend local and international borders and health issues affecting global regions and that pose threats to the world. The concept of partnerships and its various conceptualisations in literature have been discussed. The identified partnership perspectives are pragmatic instrumental, critical ideological, critical-governmentality, critical-constructivist, critical-post constructivist, and post-truth approaches. Discussing these perspectives is crucial to linking global health to the various conceptualizations of partnership. The discussion also included types of GHPs and partnerships to address access to medicines, research and development, advocacy, and financing needs in LMICs. The debate later expanded to conceptualise M&E, providing working definitions, examples of GHP M&E systems, and the political and technical aspects of M&E. The chapter concluded with a discussion of the discursive and soft mechanisms and strategies GHPs use to influence and shape local M&E policies and their effects on the broader M&E system through the World Health Organization's Six Building Blocks for strengthening health systems.

CHAPTER THREE: RESEARCH METHODOLOGY AND METHODS

3.1 Introduction

The previous chapter discussed global health, partnerships, and M&E systems at the global level. The discussion provided valuable insights into the theory and practice of GHPs discussed M&E concepts, and gave examples of collaborations that shed light on the local partnership arrangements for health in Zimbabwe. The current chapter builds on the theoretical and conceptual frameworks for GHPs, discussing the GHPs' interactions with Zimbabwe's health M&E system. The chapter is important for providing experiences that directly relate to the current chapter on research methods and methodology. The chapter confirms the validity of the problem statement. It informs the research methodology and methods described in the current chapter, which outlines the philosophical and paradigmatic basis of the qualitative research design, the research strategy, the population, the sampling, and the data collection and analysis method. The social constructivist ontology, the value-laden, subjective epistemology, and the interpretivist paradigm are briefly discussed in relation to the study's objectives. The data collection (interview and documentary review) and analysis methods are also discussed, including the steps taken to process and present the data. The purpose of following systematic, practical procedures is to provide valid, dependable, reliable, and confirmable data to be able to reach firm conclusions regarding the effects of GHPs on the local health M&E systems. The methodology section ultimately contributes to answering the four research questions, which are as follows:

1. How do GHP M&E discourses and soft power strategies shape and influence the policy and practices of public health M&E systems in Zimbabwe?
2. What are the mechanisms and strategies the Ministry of Health, and Child Care deploys to rationalise its resource and power imbalance in the partnership for health in Zimbabwe?
3. What impacts does the government-GHP collaborative partnership for M&E have on the public governance system in Zimbabwe?
4. To what extent do the GHP and local health M&E partnerships impact on the broader M&E system beyond Zimbabwe's disease- and donor-specific M&E systems?

The specific aspects discussed in this section are the research paradigm, the research design, the strategy, the study site, the data collection tools, the study population, the sampling

techniques, data quality, ethical considerations, informed consent, confidentiality, protection from harm, and the limitations of the study.

3.2 Paradigmatic perspectives of the study

Paradigms are preferred ways to understand reality, build knowledge, and gather information about the world. A researcher's paradigm may differ based on his or her grasp of ontology (the nature of reality), epistemology (the nature of knowledge), axiology (the values associated with research domains and theory building), or methodology (strategies for recording, collecting, and analysing data) (Tracy, 2013: 38). Ontology has to do with what we believe about the nature of reality, epistemology has to do with how we know what we know, and axiology has to do with what we believe to be true. There are five paradigms commonly used in research: Positivism, Post-positivism, Constructivism/Interpretivism, Transformativism, and the Postcolonial Indigenous Paradigm. Positivism assumes that the scientific method is the only way to determine truth and objective reality. It argues that the methods, techniques, and procedures used in the natural sciences provide the best framework for studying the social world. In addition, the paradigm emphasises facts and causes of behaviour that are derived directly from experience. Positivists hold that the objects around us exist and have meaning whether we are aware of them or not (Wagner *et al.*, 2012). Post-positivism focuses on falsifying theories, as opposed to positivism, which focuses on verifying theories. Constructivism/interpretivism addresses questions about reality as experienced by others. The transformative/emancipatory paradigm emerged in response to criticisms of both the positivist and constructivist/interpretivist paradigms for their inability to emancipate and transform communities outside the developed world. Research designs such as critical social science, participatory action research, and feminist designs fall under this emancipatory paradigm (Wagner *et al.*, 2012). The postcolonial indigenous paradigm is based on the worldviews of disempowered and historically oppressed groups such as aboriginal peoples in Australia, Maoris in New Zealand, Native Americans, and the indigenous inhabitants of former colonies. In this study, the constructivist/interpretivist paradigm is applied to examine the lived experiences of local M&E personnel concerning the impact of GHPs. Unlike the radical postcolonial paradigm, the constructivist/interpretive paradigm is the more appropriate worldview advocated in partnership discourse as a soft post-conditionality strategy.

3.2.1 Interpretivism

As a philosophical approach, interpretivism assumes that the most appropriate way to study or research the social order is through the individual's instinctive interpretation (Creswell, 2007).

In this paradigm, research is conducted to interpret elements of the study and thus incorporate human interest into a study. The main focus of the interpretive paradigm is to analyse and understand the subjective world of human experience, thoughts, or meanings. In essence, it is about understanding the point of view of the subject under study rather than the observer's perception.

In interpretivism the focus is on understanding individuals and how they interpret the world around them. Thus, the most crucial principle of the interpretive paradigm is the notion that reality is socially constructed (Creswell, 2007; Kumar, 2011; Tracy, 2013; Wagner *et al.*, 2012). As a result, this paradigm is also called the constructivist paradigm, where the theories accompany research rather than preceding it.

3.2.2 Ontology of Interpretivism

The science of studying what constitutes reality constitutes ontology (Creswell, 2007: 16). One may adopt an ontological stance or a stance toward the nature of reality. In this study, the relational or constructivist orientation informed the ontological orientation of understanding the topic as a decidedly social and political problem. The researcher viewed the topic as dynamic and as requiring constant renegotiation, debate, and interpretation, considering the power imbalances that characterise such inter-organisational relations in real life (Patel, 2015). The ontological core assumption is that social and political phenomena rely on context- and time-specific events. Thus, the meaning of policy ideas, like the idea of partnerships, is constructed, contested, legitimised, and perhaps even strategically appropriated socially and politically in and through existing relations of power (Barnes, 2011: 58).

3.2.3 Epistemology of Interpretivism

Epistemology refers to “how the researcher knows what she or he knows” (Creswell, 2007: 16). Epistemologically, the beliefs, values, and first-hand experiences of the key players involved in the interaction of the GHPs, and the responsible government ministry provide lived experiences that define the impact of GHPs on the local health M&E system. Unlike Positivist epistemology, in which knowledge is meaningful and valuable only when objectively observable, the interpretivist perspective relies on the subjective creation of meaning by the researcher, based on a critical literature review and the responses of the key informants involved in the study. This inquiry into the nature of knowledge and truth revolves around the beliefs and values of the participants in the research and similar

experiences from current debates in critical literature concerning collaborative partnerships as the new public governance model. Wagner *et al.* (2012) assert that epistemology helps determine the methods of investigating the problem and generating evidence. In this case, primary data from interview responses and similar peer-reviewed secondary data helped define the "truthiness" of the assumptions and beliefs underlying the researcher's views. Similarly, the productive use of language was a fundamental frame of reference for understanding the social context in which the impact of M&E on the local health system was experienced and interpreted by research participants.

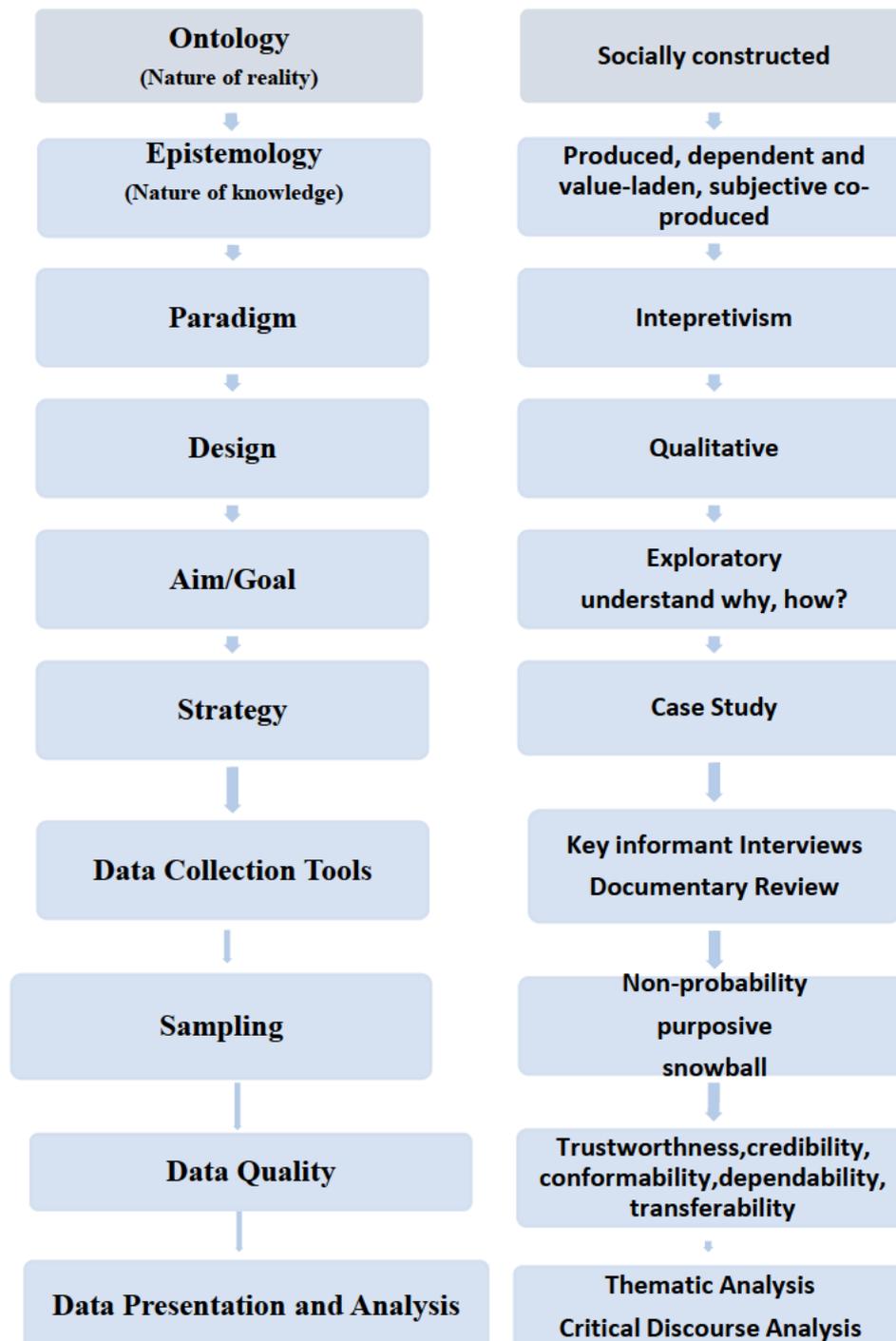
3.2.4 Axiology of interpretivism

Axiology is 'the role of values in the research' (Creswell, 2007: 16). Values determine the paradigm chosen for this research, the choice of topic, the methods of data collection and analysis, the interpretation of results, and how they are reported. Axiologically and in alignment with interpretive views, this study assumes that generating knowledge and creating realities about GHP impacts depend on the provisional values constructed from participants' experiences across time and space. Thus, the researcher approached the participants' values, realities, and responses as non-predetermined (Patel, 2015). The approach aligns with the dialogical creation of meaning through verbal interactions.

3.3 Research design

A research design represents the 'complete process of research, from conceptualising a problem to drafting research questions and on to data collection, analysis, interpretation, and sharing' (Creswell, 2007: 5). Likewise, Kumar (2011) defines it as a procedural plan that the researcher adopts to answer questions validly, objectively, accurately and economically. It outlines the researchers' choices and supplies justifications for each step. A good design combines relevance to the purpose of the research with the economy in the research journey. The inductive qualitative research design aligns well with public governance approaches to understanding the contested terrain of global health partnerships. Figure 3.1 illustrates the research methodology for this study

Figure 3 1 Research flow process



Source: Researcher's conceptualization based on various sources

The research design is qualitative or descriptive and uses a case study method. The design suggests that qualitative data can be systematically gathered, organised, interpreted, analysed, and communicated to address real-world concerns. Moreover, it is action-oriented and based on contextual wisdom or knowledge. Tracy (2013) refers to this approach as praxis-based or ‘phronetic research.’ According to Tracy, *phronēsis* is ‘prudence’ or ‘practical wisdom.’ Thus, the qualitative research approach generates value-based, context-specific, interactively constructed, and action-oriented knowledge. The design helps clarify deliberately identified problems and outlines how things can be done differently based on the understanding that there are no definite answers to the questions.

The exploratory nature of this study means that there is no single version of the answers to the questions that arise from the problem under study. In line with social constructivist ontology, subjective and value-based epistemology, and the interpretivism paradigm, the approach assumes that perception starts from a self-reflexive subjective position and that the social and historical aspects of the issues under study precede individual motivations and actions (Tracy, 2013: 4). Also, the assumption that communication is identity-forming for the researcher and the researched is consistent with dialogic knowledge creation, which recognises that the information generated is more beneficial to some than to others. In addition, qualitative methods are better suited for investigating phronetic questions about morality and values because of the dynamic changes in the landscape of global health partnerships. Contextual explanations and situated meanings of ongoing meaning-making are essential to understanding ongoing change. Qualitative research is primarily based on inductive reasoning. It has the advantage of allowing the reformulation of the research problem as well as of the data collection strategies during data collection to capture either the ‘totality’ of a phenomenon or specific aspects for more in-depth investigation (Kumar, 2011: 67). These flexible features allow for deeper reflection and analysis to ensure the credibility of the process.

3.4 Research methodology

This study used a qualitative approach to a case study. Qualitative research is scientific research or inquiry that seeks to answer questions by gathering evidence and providing results that are applicable well beyond the immediate boundaries of the study. The results of qualitative research are descriptive and can be used to understand complex social processes, capture critical aspects of a phenomenon from the perspective of study participants, and uncover beliefs, values, and motivations that drive competitive behaviour in collaborative partnerships.

The exploratory nature of this study justifies the selection of a case study as the research method. A ‘case’ is a bounded entity, a person, an organisation, a behavioural condition, an event, or another social phenomenon (Yin, 2011: 6). In a case study design, ‘the “case” selected becomes the basis of a thorough, holistic, and in-depth exploration of the aspects of interest’ (Kumar, 2011: 123). A case study must be a bounded system, an entity in itself, or a fixed subject/unit that is either representative or extremely atypical. The case study also uses very flexible and open-ended data collection and analysis techniques (Kumar, 2011).

The advantage of a case study is its flexibility to collect more detailed information than in other designs. Yin asserts that when data collection and analysis are done systematically, case study findings can be generalised through analytic generalisation (Yin, 2011: 6). However, despite its dynamism in studying relevant, real-world situations and addressing crucial research questions, it is sometimes considered as a method of last resort. This perception is linked to its exploratory nature –it often serves only as a prelude to a more rigorous study (Yin, 2011: 6). However, such views represent a traditional, sequential, and hierarchical view of social sciences as case studies, like experiments and surveys, have both an exploratory and experimental phases. Similarly, the study acknowledges some scholars' concerns about case studies because of the perceived bias and subjectivity of the approach. In contrast to these views, the study considers the subjective interaction of the participants and the researcher with the case as central to the success of the research (Tracy, 2013). As a self-reflexive research tool that is aware of bias and subjectivity, the background of the case study is essential to understanding the topic under study. Thus, the case study remains one of the best approaches to understanding contextual issues like the effects of GHPs on particular M&E systems, such as that employed by Zimbabwe’s Ministry of Health and Child Care.

3.5 Study site

Each study has a research site. It is the physical space where the study takes place. In this study, the Ministry of Health and Child Care in Zimbabwe's Head Office and the provincial offices were the research site. The Ministry’s M&E departments are well established at the national and provincial levels, and GHPs like the Global Fund and PEPFAR have consistently collaborated with the Ministry in their setup and ongoing operations since 2002.

3.6 Population and sampling

In any research, there is a population to which the study is directed. And when the population is too large to reach, the researcher develops a strategy to select a smaller population, called a

sample, to help conduct the study. Thus, this section discusses the research population and the sample.

3.6.1 Study population

Every social science study has a study population. The study population is the people from whom you want to get perspectives about the topic of the study. It could be a group of people living in an area, employees of an organisation, a community, or a group with particular issues (Kumar, 2011). In the current case, the study population is all the monitoring and evaluation officers currently engaged by the Ministry to perform M&E functions at the head office and provincial offices located in Harare, Manicaland, Midlands, Mashonaland East, Mashonaland West, Mashonaland Central, Masvingo, Matabeleland North and South, and Bulawayo. They are professionals with at least a bachelor's degree in M&E, Public Health, or Social Sciences. They also perform functional management roles such as coordinating programmes and financial aspects of M&E for GHP-supported and government-funded programmes. According to the consolidated staff returns report of 2019, there were seventeen established positions in post at the head office and ten at the provincial level (Health Service Board Online, 2022). In addition to the government posts, the Global Fund supports five M&E staff for HIV, two for TB, and two for malaria. The nutrition department and the reproduction units have one M&E member of staff each, based at the head office. Thus, the total M&E population is thirty-eight staff members.

The inclusion rules were that the Ministry should have engaged the participant as an M&E staff member at the head office or provincial offices for the past five years. In addition, the person should coordinate M&E for the HIV, TB, and malaria programmes. Moreover, the member of staff should be financed through GHPs for salaries and other work-related support. Thus, M&E staff from Nutrition, Reproductive Health, and other departments at the national level were excluded from this study.

3.6.2 Sampling

Sampling is the process of selecting a few respondents (a sample) from a bigger group (the sampling population) that forms the basis for understanding the topic of interest (Kumar, 2011).

This study employed purposive sampling, a judgmental process of identifying those who can provide the best information to achieve the study's objectives. The researcher deliberately chooses data that fit the parameters of the project's research questions, goals, and purposes (Tracy, 2013). In this study, the researcher worked on a plan jointly with a senior M&E coordinator to select those M&E staff who, in our opinion, was likely to have the required

information and be willing to share it for this study. The process involved identifying specialised and knowledgeable personnel who perform M&E functions in Zimbabwe's public health M&E system.

The technical nature of the topic under study required a deliberate and purposive selection of participants to elicit their views and experiences in working with key GHPs supporting the country's health system. The selected participants included two senior M&E coordinators who had worked at the Ministry's headquarters for over ten years. The two had previous experience at the M&E implementation level, so their involvement provided historical and current experience at the implementation and high-level policy levels. Similarly, five M&E staff were selected from the Department's HIV programme because they actively coordinated the HIV grant with GHPs. The selected staff were closely involved in coordinating specific M&E for programmes such as voluntary medical male circumcision (VMMC), antiretroviral treatment (ART), the prevention of mother-to-child transmission (PMTCT), and HIV testing programmes (HTS). The HIV grant is the largest collaborative grant regarding financial disbursements and staffing. Two additional staff members were selected from the tuberculosis programme and one from the malaria programme.

Finally, five participants were selected from five provinces where GHPs receive the country's most financial and technical assistance. They are among the senior provincial-level staff with roles beyond disease-specific programs. All participants had more than five years of experience in the ministry as provincial M&E officers. The purposive selection of participants familiar with the issues under study reduced the difficulty of contacting ideal respondents and allowed for comprehensive and rapid data collection. Their experience working with GHPs provided more helpful information in answering the research questions from a dialogic and constructivist perspective. This sampling was beneficial for constructing a historical reality and describing the GHPs' little-known collaborative experiences over the years (Rubin and Babbie, 2016). Table 3:1 shows the study sample population.

Table 3 1: Study Sample Population

Organization	Population	Sample	Sampling method
Ministry of Health and Child Care Head Office Directorate	Senior M&E staff-Head Office	2	Purposive
Ministry of Health and Child Care Head Office M&E Staff	Monitoring and Evaluation Officer-HIV program	5	
Ministry of Health Provincial M&E	Monitoring and Evaluation-TB program	2	
Ministry of Health and Child Care District Staff	Monitoring and Evaluation-Malaria program	1	
	Monitoring and Evaluation- Provincial level	5	
Total		15	

3.6.3 Recruitment Strategy

The participants for the key informant interviews were recruited with guidance from a senior M&E coordinator in the ministry based on the availability and willingness of the targeted staff. The researcher wrote a notification email about the approved planned interviews for the study with the Ministry M&E staff. The email was followed up with a phone call to expedite the process after a lapse of one week without a response. The coordinator acknowledged receipt of the email and indicated that he supported the plan. The coordinator led the conversation on which officers to include in and exclude from the study. We agreed to exclude staff with less than five years of experience in the Ministry. This decision was based on the consideration that intensive M&E activities started in 2015 with the engagement of provincial M&E officers. Moreover, five years is generally considered a reasonable amount of experience for middle- to senior-level engagements in the Ministry and the civic sector. We also agreed on including staff from the HIV, TB, and malaria programmes that deal with GHPs, such as the Global Fund and PEPFAR, to have active and ongoing collaborative partnership arrangements with the Ministry.

After agreeing on the inclusion and exclusion criteria, the coordinator informed the potential respondents at head office and provincial levels about the researcher's plans, including direct emails and phone calls to the identified staff. Then the researcher called all the identified participants to explain the objectives and steps for the data collection process and confirm their willingness and availability for the interviews. Once the date was agreed upon, the researcher sent out an email with consent forms and a zoom link to the proposed respondent with the date and time for the interview. Reminder emails were sent out two days before the interview. On the interview date, the respondents were asked if their environment allowed them to proceed

with the interview. If confirmed, the next step involved re-reading the consent forms and allowing questions or clarifications before the interviews. After the clarifications, the researcher explained that the interviews would take between forty-five and sixty minutes.

The researcher also asked permission to record the interviews to facilitate data transcription and later analysis. The discussions would start after the oral authorisation to record the proceedings had been given. Of the proposed twenty-five interviews, fifteen materialised. Two interviews involved senior M&E Officers at the Head Office, five officers for the HIV programme, two for the TB programme, one for the malaria programme in Harare, and five from the provincial offices outside Harare took place. Table 3:2 below shows the list of the respondents to the study

Table 3 2: List of Coded Study Participants

	Respondent Code	Sex	Organization	Level
1	KII-TC	M	MoHCC	National
2	KII-IC	M	MoHCC	National
3	KII-STHE	F	MoHCC	National
4	KII-LN	M	MoHCC	National
5	KII-AC	M	MoHCC	National
6	IDI-ZD	F	MoHCC	Provincial
7	IDI-AM	M	MoHCC	Provincial
8	IDI-CN	M	MoHCC	National
9	KII-TT	F	MoHCC	National
10	IDI-JK	M	MoHCC	Provincial
11	IDI-CN	M	MoHCC	Provincial
12	KII-PZ	M	MoHCC	National
13	IDI-TF	M	MoHCC	Provincial
14	IDI-IT	M	MoHCC	National
15	IDI-MM	M	MoHCC	National

3.7 Data collection and description of instruments

This section discusses the data collection methods and instruments. The primary sources of data collection for this study were key informant interviews and the documentary review.

3.7.1 Interviews

According to Alpi and Evans (2019), interviews remain one of the most critical data sources in qualitative case study research. Interviews are guided question–and–answer conversations or exchanges of views involving two persons conversing about a theme of mutual interest. Qualitative interviews provide opportunities for ‘mutual discovery, understanding, reflection, and explanation via a path that is organic, adaptive, and often energizing. Interviews elucidate subjectively lived experiences and viewpoints from the respondents’ perspectives’ (Tracy, 2013: 132). They enable the researcher to stumble upon and explore complex phenomena that may otherwise be hidden or unseen.

Interviews are conducted either face-to-face or mediated. In a face-to-face interview, the interviewer contacts the interviewee directly and attempts to elicit information, beliefs, or opinions on the topic. The process should have a specific purpose or goal. The process may involve structured or unstructured discussions. However, this researcher used mediated online interviews due to the Corona Virus pandemic. Mediated interviews are done via technological media such as cell phones, computers, or other hand-held devices (Tracy, 2019). The researcher engaged in virtual synchronous interviews that mimicked ‘face-to-face’ interviews (Tracy, 2019). The interviews were done through the Zoom platform. The synchronous interviews also provided opportunities to probe and follow up on issues that required further clarification. Thus, the approach facilitated the dialogical creation of knowledge through conversations as in face-to-face physical interviews. Moreover, this method had the added advantage of requiring few logistical arrangements, as no traveling was required. However, challenges such as being on a poor network affected the quality of the interviews and rendered some respondents initially targeted for interviews simply inaccessible.

Another advantage of using interviews in the current study was that respondents used specific vocabulary and language to explain their thoughts in the context of collaborative partnerships. Likewise, it enabled the researcher to access information on past events, buried emotions, and information left out of formal documents or omitted from sanitised histories, reflecting the viewpoints of the power holders (Tracy, 2013). The above factors qualified interviews as an appropriate data collection method for the current study.

Interviews can be structured or unstructured. Structured interviews utilise an interview schedule with a list of questions repeated in the same order with standard wording like a ‘theatre script’ (Tracy, 2013). On the other hand, unstructured interviews are more flexible and organic. The interviewer uses a list of flexible questions or bullet points as a rough guide to the

conversation, stimulating discussion and probing for more insights instead of insisting on a one-sided dictation (Kumar, 2011; Tracy, 2013). This approach gives the researcher and the interviewee power and allows them the flexibility to discuss issues as they arise. The current study used the unstructured approach based on the researcher's direct involvement in the organisation. Structured interviews would have been necessary if the process involved research assistants. The research questions prepared provided broad guidelines for the discussion, which moved naturally from one issue to another. This helped to reduce the time taken for the interviews, as overlapping issues were addressed as they arose. The researcher's understanding of the subject made it possible to focus on crucial topics that had a bearing on the research questions. The researcher's understanding of the topic and previous professional experience in the ministry brought with it a greater responsibility to carefully manage the interview process to avoid leading or biased questioning. These factors were carefully considered in the interview process to meet the study's trustworthiness criteria: Credibility (corresponds to internal validity), Transferability (corresponds to external validity), dependability (corresponds to reliability), and Confirmability (corresponds to objectivity) (Kumar, 2011).

3.7.1.1 Interviews with head office M&E staff (Harare)

The researcher interviewed two senior M&E staff and eight officers at the Ministry head office in Harare. The two interviews with senior officers constituted key informant interviews facilitating the expression of experiences and emotions rarely expressed in official spaces (Rubin and Babbie, 2016). The approach allowed for different sub-questions or probes per each interviewee's responses. The advantage of this approach is that it accommodated the interpretive philosophical view of the respondents' subjectivity of knowledge and experiences. The respondents provided wide-ranging, rich insights into the mechanisms and strategies that GHPs deploy to influence and shape M&E policies in the country. Their strategic position linking policy and sub-national level experiences gave them a bird's eye view of the challenges and benefits of the system over the years. The senior staff had the added advantage of direct experience working with GHP representatives nationally and internationally on policy levels through training programs and engagement meetings. The approach allowed respondents adequate room to express themselves, providing data-rich perceptual and emotional content. The data contributed much to the researcher and the respondent's co-creation of answers to the exploratory research questions requiring diverse views (Babbie, 2016). The researcher was able to solicit and gather a wide range of opinions from the respondents, resulting in a rich pool of

information that guided the responses to the research questions, as reflected in chapters five through eight of this study.

Similarly, the interviews with the eight M&E officers elucidated specific views pertaining to the HIV, TB, and malaria programmes since they received different grants. Although the objective was not to compare experiences, the responses provided nuanced insights into common challenges the officers experience collaborating with GHPs such as the Global Fund and PEPFAR. The advantage of interviewing this group of officers was their intimate involvement with their specific programmes, which allowed them to provide graphic descriptions of some of the unspectacular but very effective methods of influence by GHPs. The officers also contributed intimate experiences from meetings and programmes that involved GHPs representatives, as they had attended senior M&E meetings that dealt directly with the particular disease targeted in their programme.

3.7.1.2 Interview with provincial M&E staff

Five provincial M&E staff managed to participate in the interviews. Due to the rural geographic location of some provincial capitals, it was difficult to connect with the other five proposed staff due to bad network connectivity for Zoom or telephone interviews. However, the five who participated provided valuable insights into their critical subject areas, drawing from the strategic positioning that allows them to perform M&E functions for all disease and programme components for the Ministry. Unlike the head office staff, who are disease-specific, the provincial team had the added advantage of experiences with other programmes and were able to provide insights into question four of the study, which seeks to understand the GHPs' influence on policy and practice beyond the HIV, TB and malaria programmes. The staff at this level had the added advantage of experiences from the district and health facility levels and NGOs they collaborate with at provincial and district levels.

3.7.2 Document review

Document analysis involves using an integrated and conceptually informed method, procedure, and set of techniques to locate, identify, retrieve, and analyse current documents for their relevance, significance, and meaning (Altheide, 2013). In a chapter contributed to Wagner *et al.* (2012), Silva argues that documentary analysis is an important data source in research, suggesting that researchers like Marx, Weber, and Durkheim used it to provide valuable insights into various subjects. Silva notes that the interest of social scientists in documentary review is in the content rather than what people do with the documents. The document's meaning, the context of its production, and the interactions resulting from it are of interest to

researchers. Most document reviews focus on the texts, but researchers should also consider the contexts of their production. They exist in a frame of reference that provides context to their meaning creation.

The document review was the main data collection method in the current study. It provided the text for the thematic and CDA of the key M&E policy documents analysed in the study, corroborating the findings derived from the interviews. Four key M&E policy documents were purposively selected, reviewed, and analysed: the National Health Strategy 2021-2025, the National M&E Policy, 2015, the National HIV Strategic Plan 2015-2020, and the Health Sector Performance Monitoring and Evaluation Guidelines and Strategy, 2018. These four documents were purposively selected to represent the past and current Ministry policy directions. Apart from providing publicly available information to guide key informant interviews and to avoid asking questions where the replies would consist of publicly available information, the four documents provided rich text and context for in-depth analysis. Moreover, the documents furnished background information on the organisation's 'history, information about rules, policies, basic facts, and figures' (Tracy, 2013: 83). The steps followed in reviewing the documents included formulating the research problem, requesting and retrieving the documents from the Ministry of Health, and analysing and interpreting the key messages of the policy documents. The analysis combined a thematic and discourse analysis of the text and other key semiotic aspects or how words and other symbolic communication systems are used in the key policy documents.

The approach has gained scholarly interest as part of the increasing scholarship on CDA in policy analysis (Briant, 2017; Cummings *et al.*, 2018; Cummings *et al.*, 2020b; Fukuda-Parr, 2016). While the current study was not meant to be a linguistic, paragraph-by-paragraph, or text-by-exhaustive text analysis, it provided ample evidence through analysis of the text and structure of the policy documents to confirm the use of discourse to influence and shape local M&E policies and practices. The study's findings provide sufficient preliminary indications for more profound paragraph and text-by-text analysis to expose more evidence of GHP influence through expressly incorporated terminology. Through its use of CDA, the study was able to counter the three commonly cited weaknesses of documentary review. The purposive selection of the documents and the purposive omission or commission of specific information by powerful voices were identified and analysed through CDA.

3.8 Data analysis

Data analysis is about organising and making sense of the oral and written text derived from the interviews and document analysis. The data analysis process for this study began with reading and rereading the data, recording analytical reflections, and transcribing or reviewing the transcriptions of the interviews. Data transcription is the conversion of embodied interviews into usable data or creation of typewritten records from audio recordings (Tracy, 2013). While the data transcription could be done manually or electronically, the researcher used Otter Transcription software to convert the Zoom audio files into written text. This process helped reduce the time that the manual route would have taken. The Otter software had the added benefit of providing the text documents within 10 to 15 minutes and provided an integrated fact-checking system that allowed for immediate comparison of the oral and written data. Fact-checking was essential in which the researcher reviewed the interview transcripts for accuracy. This process was critical given the differences between the artificial intelligence-based Otter software and local English pronunciation, which is not readily recognized by the software. Thus, the system and process ensured data quality control and improved data quality, credibility, and dependability for qualitative research in conformity with acceptable research findings (Kumar, 2011). Aside from these few challenges, transcription was vital to the data analysis. It facilitated a close examination of the data, which was essential for interpretation. Due to the flexibility of qualitative research, data transcription as a social construct depends mainly on the research objectives and allows the researcher to create detailed summaries of the interviews and transcribe only the essential quotes (Tracy, 2013) (see Miller, 2007 in Tracy, 2013).

The transcribed text was imported into the 2019 NVIVO Version 12.6 for qualitative Thematic Analysis (TA). The thematic analysis involved identifying specific patterns or themes in the key informant and documentary review data. The method helped identify key subjects and sub-issues that answered the research questions (Guest *et al.*, 2011). The NVIVO software simplified the coding of the interview, the document analysis, and the literature review data into common themes. The software helped integrate key discussion themes.

One of the differences between quantitative and qualitative research lies in the use and meaning given to validity and reliability in the study. The debate revolves around whether these concepts can or should be applied in qualitative research, given the framework of qualitative research. In the broader sense, validity refers to a research instrument's ability to demonstrate that it finds out what it was designed for, and reliability refers to the consistency of results over repeated

use (Kumar, 2011). Because qualitative research examines responses to research questions using various methods and procedures that are both flexible and evolving, it becomes challenging to ensure the standardisation of research instruments and processes. As a result, this study draws inspiration from Guba and Lincoln's framework, which applies concepts like credibility (parallel to internal validity), transferability (parallel to external validity), reliability, and confirmability (parallel to objectivity) to judge the goodness and quality of the constructivist study (Kumar, 2011).

Similarly, the approach drew inspiration from Trochim and Donnelly (2007), who made similar comparisons between internal validity (credibility), external validity (transferability), reliability (dependability), and objectivity (confirmability). Based on these categorisations, the study's internal measurements, data quality, and analysis processes upheld the standards of credibility, transferability, dependability, and confirmability. As indicated earlier, researchers have applied similar approaches like CDA in critical policy analysis bringing refreshing new insights into the subject (Briant, 2017; Cummings *et al.*, 2018; Cummings *et al.*, 2020b; Fukuda-Parr, 2016).

Although CDA has no one standard, the study adopted one proposed by Cummings *et al.* (2020a). The approach involves four phases and appropriate steps in each stage. The phases include identifying a topic, selecting and analysing text, describing how the text was created, the discourses identified in your analysis of the text and the discourses which have been identified, and finally, a possible way forward past the dominant discourse, creating new discourses, narratives, and arguments (Cummings *et al.*, 2020a: 104-105).

3.9 Ethical Consideration

The researcher followed ethical research procedures in line with established rules for qualitative research addressing professional sensitivities and protecting the respondents from potential harm (Kumar, 2019). Protecting research subjects from harm was prioritised in the data analysis process (Saunders *et al.*, 2009). The study was also performed under strict guidance from the UKZN ethical standards committee and the Zimbabwe Medical Research Council standards. All participants were informed of the risks and responsibilities of their participation. The participants were also assured of the confidentiality of all discussions and feedback privacy.

3.9.1 Informed Consent

All participants gave express consent to participate in this study of their own volition. There was no pressure on participants to contribute to the research. Getting consent also involved a

concise explanation of the research objectives, the steps to be followed, and how it might affect the respondent (Cohen *et al.*, 2011). The researcher discussed informed consent issues with the participants. This is a standard procedure with qualitative researchers (Kumar (2019). Discussing the potential harm to the research participants before the interviews help ensure informed participation. The procedure allowed the potential respondents to make informed decisions on their participation in the research.

3.9.2 Explicit authorisation

An authorisation is permission granted to a researcher to access the participants and documents required for the performance of the study. The explicit authorisation concept grants access to sensitive resources to those who have been granted permission. The researcher obtained permission from the University of KwaZulu Natal and the Ministry to conduct the study through research ethics approval. In addition, explicit permission was obtained from the Ministry's M&E Coordinator, and the participants in the study before the data collection commenced.

3.9.3 Confidentiality and anonymity

In a politically polarised environment such as Zimbabwe, the researcher prioritised respect for confidentiality and the anonymity of the participants in the research. Research material from participants was confined strictly to this research project alone. Additionally, the names and addresses of the participants in the study are not revealed, as it would be unethical to reveal these details (Babbie, 2016). Likewise, Kumar (2019) emphasises that the guarantee of the anonymity of the participants is vital in such a study as this. Where anonymity could not be guaranteed, i.e., where the participants were too few or too obvious, the individual responses were not linked to them, and any information that could lead to others determining which participant said what was hidden. This study conforms to these confidentiality and anonymity suggestions.

3.9.4 Protection from harm

The researcher determined the extent and level of potential harm to the participants before commencing the study, as suggested by Kumar (2019). The research process aimed to avoid harming the participants as a standard rule. The researcher ensured that the threat of 'harm or discomfort in the research is not greater than that ordinarily encountered in daily life' (Kumar, 2011: 197). The harm avoided in the study included emotional harm when asking for sensitive, embarrassing, or discomforting information (Babbie, 2016). Additionally, participants were protected from participating in the study without being sanctioned adequately by their

organisations. The researcher informed the participants of their option to excuse themselves from participating in the whole study or part of the interview if they were uncomfortable doing so. Consent was sought from the participating organisations to ensure that the participants were not penalised for being involved in the research.

3.10 Research Limitations

While all proposed GHPs and local partners could have been included in the study, limited accessibility due to Covid 19 restrictions and GHPs' unwillingness to cooperate led to a change in strategy and a focus on the government staff perspective. These changes resulted in a missed opportunity to obtain GHP representatives' perspectives on the impact of their support for M&E in Zimbabwe. However, the perspectives of the government staff interviewed provided useful information that saturated the key discussion points. Likewise, GHPs public policy documents also helped fill in the information gaps created due to the change in the strategy.

3.11 Conclusion

This chapter has discussed the social constructivist ontology, the subjective and judgemental epistemology, and the interpretive paradigm as the philosophical guidelines for the study. The qualitative research design has also been discussed, aligning with the philosophical and interpretive paradigm. The chapter has further discussed the case study strategy and the reasons for its selection for the study. Key informant interviews and documentary reviews are the two data collection methods discussed in the chapter. Similarly, non-probability sampling and its advantages have been discussed. The purposive or judgemental sampling and snowballing were identified as more appropriate for the topic, specifically dealing with the experiences of M&E officers in the Ministry of Health and Child Care. Snowball sampling provided backup in cases where an identified respondent was not available for the interview and was asked to nominate someone in their place. Finally, data quality issues have been discussed against parameters like credibility, transferability, conformability, and dependability. The Otter and NVIVO are the transcriptions and qualitative analysis tools used in the study. The Thematic and CDA approaches are discussed, and steps are taken to conduct the processes. The study's limitations in view of the COVID-19-related restrictions and the lack of GHP cooperation have also been discussed in this chapter.

CHAPTER FOUR: GLOBAL HEALTH PARTNERSHIPS AND THE MONITORING AND EVALUATION SYSTEM IN ZIMBABWE

4.1 Introduction

The previous chapter discussed this study's research methods and methodology, demonstrating its qualitative strategic fit into the study design, study population selection, data collection methods, data analysis, and its final presentation. The chapter elaborated on the nature of knowledge (epistemology) and nature of reality (ontology) and how it helps in understanding the effects of GHPs in implementing M&E programs in the health sector in Zimbabwe. The specific issues discussed in this chapter include the development of the M&E system from 1980, when United Nations Agencies like the WHO and UNICEF were active partners for health and the changes that ensued in the 1990s when private sector funding partners like the World Bank and the International Monetary Fund (IMF) took a more active interest in health financing in Zimbabwe. The chapter concludes with a discussion of the critical state and non-state stakeholders in the system

4.2 Background to M&E systems in Zimbabwe

In 2015 the Zimbabwean government committed to institutionalising and professionalising the monitoring and evaluation functions. In pursuit of the Vision “Towards an Empowered Society and a Growing Economy,” the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) 2013–2018 policy laid out the Government of Zimbabwe’s renewed commitment to ensuring a strong culture of the M&E of all its policies, programmes and projects. Through the financial and technical support received from international partners, the government renewed its initial commitment to results-based M&E initiated in 2005. Through the Management for Development Results (MfDR) programme the government subscribes to the principles of the Integrated Results Based Management (IRBM) system, ensuring improved government accountability and transparency in the management of public resources and quality service delivery.

The government acknowledges the importance of sustaining a robust monitoring and evaluation system for successfully implementing national development policies, programmes, and projects and ensuring efficient and effective service delivery (GoZ(a), 2015). The health sector M&E system drew its policy direction from the National Monitoring and Evaluation Policy for Zimbabwe, providing the necessary framework to institutionalise M&E in the health sector (MoHCC, 2018).

The National Monitoring and Evaluation Policy and the health sector performance monitoring and evaluation policy guidelines and strategy thus aim at providing a systematic, coordinated, simplified, results-oriented, reliable and effective mechanism through a collaborative process with its local and international private and civic funding and technical partners. Therefore, developing the policies for Zimbabwe involved extensive research and drawing lessons from the experiences of other countries. The Office of the President and Cabinet's role has been instrumental in providing policy direction in the collaborative consultations for drafting and finalising the M&E policy documents. The development of the policies fulfills essential constitutional requirements in terms of Chapter 2, Section 9(1), which states that ‘the State must adopt and implement policies and legislation to develop efficiency, competence, accountability, transparency, personal integrity, and financial probity in all institutions and agencies of Government at every level and every public institution....’(Zimbabwe, 2015a).

Through the formulation of these policies, the Government of Zimbabwe has a good chance of addressing its most significant challenge and weakest link in implementing policies, programmes, and projects. The M&E policies provide guidance and credence to achieving results through correct diagnosis. The policies help guide the government to ensure efficient and effective service delivery in the wake of an increasingly policy-conscious citizenry that demands quality service delivery from the government, particularly in health and other social services.

4.3 Interactions of GHPs and the health system in Zimbabwe

Five significant sources primarily fund the Zimbabwean public health M&E system, namely, the Global Fund to fight HIV, TB, and Malaria (GFATM); the President’s Emergency Plan for AIDS Relief (PEPFAR); the government through the national Budget; the National AIDS Trust Fund; and other bilateral donors like the Department for International Development (DFID). The PEPFAR, Zimbabwe, Country Operational Plan of 2016 noted the central role of GHPs in providing technical and financial assistance to the country. For example, in the 2014-2016 financial period, the GFATM provided 77.7% and PEPFAR 19.9% of the total M&E and surveys budget against a government contribution of 0.13 % (PEPFAR, Zimbabwe, Country Operational Plan, 2016). The GHPs made significant contributions, but few scholarly conversations have addressed their unintended effects on the M&E system in the country. The available literature has focused on positive material contributions such as human resources for health and significant pharmaceutical and medical procurements for HIV, TB, and malaria programs. As a result, little is known about the effect on the Zimbabwean health system of the

soft power mechanisms and strategies attached to receiving financial support from the GHPs. This knowledge gap motivated the performance of the current research, which focuses on the non-assuming and less obvious interactions of GHPs and local systems and their unspectacular effects on the systems. The research interest was also prompted by the lack of knowledge about why the M&E systems should be so weak, despite over two decades of GHP support. A discussion of the development of M&E since 1980 is presented in the following sections to address this topic. The period covered is crucial for contextualizing the post-independence policy changes linked to GHP involvement.

4.3.1 Monitoring and evaluation in the first decade from 1980-1990

In 1980 Zimbabwe gained its political independence from British colonial rule. The government's policy focused on correcting inherited colonial disparities between rural and urban health, white and black. As a result, the first national development policy focused on 'equity in health' to address the gaps. The policy shift also reflected the new government's desire to promote equity by focusing on accessibility to health for all rather than the ability to pay for health services (Kanyenze and Kondo, 2011). Moreover, the service delivery planning model emphasised the expansion of the public health infrastructure, expanded child-focused programmes on immunisation, the accelerated training of health professionals, malaria control, and regulation of the private health market. In 1982 the Zimbabwe government officially adopted a primary health care system to help achieve these expanded programmes. The Ministry of Health's M&E systems focused on reporting progress on service decentralisation and infrastructure projects. The key indicators focused on measuring infrastructure development and social determinants of health.

In the mid-1980s, the government began interacting with GHPs, mostly UN agencies and bilateral institutions assisting in health and education. The collaborative efforts led to a growth in social indicators resulting in a slightly higher share of GDP expenditure than most Southern African countries in 1985. Although the concept of M&E was not fully developed, the financial and technical support also addressed data processing and reporting needs (Makadzange, 2020). Collaborative efforts between the government and its international partners contributed to improved social indicators, with infant mortality declining from 90 per 1000 in 1980 to 53 per 1000 in 1988. Similarly, child immunisation coverage increased from 25% to 80% over the same period. The malnutrition prevalence rate also dropped from 22% to 12% (Kanyenze and Kondo, 2011). Since 1980 the central government planning authorities have expressed consistent and sustained interest in improving both the quantity and quality of M&E data in

response to the perceived need for better information on the effectiveness and implementation of the state's health programmes.

At a micro level, the Ministry of Health and Child Welfare introduced a policy document, 'Planning for Equity in Health,' the Zimbabwe Health for All Action Plan of 1986. In this document, the government provided an M&E plan for all the programmes and services required to address the prevailing health challenges from 1985-1990. Due to the sustained efforts to improve the health status of most citizens, Zimbabwe achieved some of the most rapid improvements in health indicators for nutrition and demographic indicators of all sub-Saharan African countries (Kanyenze and Kondo, 2011). In what became known as the 'Health for All by 2000' programme, the government upgraded the skills of nurses, environmental health, and other primary health care workers and sent them out to reach the previously underserved populations in rural Zimbabwe. At a government-wide level, the Ministry of Finance, through the National Planning Agency (NPA), undertook most of the M&E functions for public sector investment.

In 1989 collaborative partnerships between the Zimbabwe government and the United Nations Development Program (UNDP) facilitated technical assistance for government M&E. An expatriate evaluation specialist worked with local experts and conducted M&E systems assessments known as the Khan and Mahlahla 1989 study (Mazikana and Brushett 2002). Similarly, the government led a Public Service Review Commission that made wide-ranging M&E recommendations through the Kavran Report of 1989. The appointment of this Commission was a signal by the government that it intended to adopt systematic ways of collecting and processing M&E data for decision-making. Key findings of this Commission included the need for government reforms to strengthen policy coordination, performance management, and monitoring and evaluation.

4.3.2 The Economic Structural Adjustment Programme (ESAP) period, 1991-1996

In the 1990s, the government of Zimbabwe collaborated with the International Monetary Fund (IMF) and the World Bank through the ESAP to strengthen the delivery and monitoring of social indicators. Among the post-conditionality strategies by the IMF and the World Bank included a commitment by the government to adopt national M&E systems (Makadzange, 2020). Thus, to implement the strategy, the government had to place greater emphasis on rolling out the public sector investment programme of which a conceptual M&E framework was one pillar. This M&E framework provided the basis for subsequent M&E policies. The public sector investment M&E conceptual framework outlined implementation monitoring,

project completion reports, performance monitoring, and impact evaluations as key aspects of the system. In 1994 the government introduced the National Economic Planning Commission (NEPC) to operationalise the M&E plan under the Office of the President and Cabinet (OPC). The specific role and responsibilities of the NEPC included monitoring and evaluating policy implementation and the impact assessment of projects and programmes (Mazikana and Brushett, 2002).

Further collaboration with the World Bank in 1996 led to the engagement of a World Bank consultant to introduce the new M&E system. The key stakeholders of the M&E system were primarily government ministries and departments collaborating with the NEPC as the M&E apex body responsible for coordinating and directing the M&E processes. The NEPC's role in this system was to develop the capacities of the line ministries, maintain a database of projects and programmes at an apex level, and ensure the effective utilisation of the M&E results. The system also tied M&E to the capital budget, making it mandatory for ministries to carry out prescribed M&E activities to get allocations, effective at the beginning of the fiscal year 1999. With this new system, the primary responsibility for M&E rested with the line ministries and their constituent departments. The ministries then created institutional structures for M&E, with designated focal point people or units for M&E.

Despite operational challenges, the collaborative efforts successfully introduced the M&E culture into government. Some strategies to ensure the adoption of M&E included directly linking it to the public sector investment programme (PSIP). Every year the NEPC issued a circular inviting ministry to submit forecasts for the PSIP, a move that made it mandatory for M&E reports to be submitted as required. The ministries' approval of the PSIP bids was also made contingent on the M&E requirements being met. Moreover, financial disbursements from the Vote of Credit were tied to submitting quarterly M&E reports as specified in the PSIP circular. Thus, the World Bank applied coercive and soft power strategies to influence the government's adoption of an M&E culture.

[4.3.3 The development of M&E in the crisis period 1997-2009](#)

The crisis period between 1997 and 2009 shook the foundations of the collaborative partnerships between the Government of Zimbabwe and its major health partners. The government's radical economic policies during the late 1990s and early 2000s triggered economic and social shocks in the economy, which was yet to recover from the unfavourable indicators of the ESAP period. The impact of ESAP coincided with political developments that led to demands for compensation to liberation war veterans for their role in fighting the

colonial system. The collaborative partnerships collapsed as the private sector, labour unions, and external funding partners withdrew their support for social policy programmes (Musemwa, 2011). The external funding partners instituted coercive strategies like sanctions to influence the government away from populist radical transformative policies (Mararike, 2019).

In 2005 collaborative partnerships between the government and the UNDP facilitated the granting of financial and technical assistance to implement the Results-Based Management (RBM) Programme. The collaborative partnership sought to rebuild and strengthen the public sector's capacity to plan, implement, monitor, and evaluate public policy. Other global initiatives like the Paris Declaration on AID effectiveness contributed to the revival of support for M&E in the country. The RBM programme focused on three pillars: the Integrated Development Plan (IDP), which concentrates on long-term goals; the results-based budgeting system; and the results-based personnel performance system. The overarching M&E function connected these three. Since 2005 a complete set of IRBM guidelines and training manuals for capacity building has been made available to trainers and IRBM implementing agencies.

The Public Service Commission and the Office of the President and Cabinet led the collaborative efforts to implement the programme (UNDP, 2014). The system includes the Zimbabwe Integrated Performance Management System (ZIPMaS), a management information system (MIS) to ensure the accurate capture and processing of all M&E information for evidence-informed decisions. The system also facilitates ministry staff to upload annual plans that clearly show outputs and key result areas to an electronic platform. The system has two main modules, one that enables regular electronic data updates into the system to track progress (monitoring module) and another that generates electronic quarterly performance reports on ministries' outputs (reporting module) (UNDP, 2014).

4.3.4 The Transitional period 2010-2020

The transitional period revived collaborations following the installation of a Government of National Unity (GNU) involving the Movement for Democratic Change (MDC) and the ruling party, ZANU (PF). However, the collaborative partnerships with major external donors remained loose, as they preferred to provide direct financial disbursements to NGOs rather than the government. GHPs like the Global Fund had stopped direct government disbursements in 2008 following concerns about financial transparency in previous funds. However, the UN mobilised external donors to reconsider financial and technical direct assistance to the country. As a result, a multi-donor rescue package, the ZIMFUND, was established in collaboration with the African Development Bank (Makadzange, 2020). The process involved a collaborative

plan under the Zimbabwe United Nations Development Assistance Framework (ZUNDAF) 2012-2015, which emphasised strengthening the national M&E coordinating structures across all the ministries. Other national processes included partner support for the national economic blueprint, the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) 2013-2018, the Constitutional Amendment number 20 of 2013, and the development of a National M&E Policy in 2015. The collaborative partnership between the government, the World Bank, and the African Development Bank facilitated the development of the first national M&E Policy. The process ushered in a second attempt to institutionalise M&E in official government business in ways that met international best practices.

Similarly, the ZimAsset policy framework had a clear M&E section that reflected the influence of civic and private sector partners like the World Bank and the African Development Bank. The policy, which was underpinned by results-based management, set key result areas, targets, and responsibilities for key sectors of the economy. Similarly, the National M&E policy outlined the RBM focus, key stakeholders' roles, and the system's reporting structures (Zimbabwe, 2015b). In 2018 another collaborative partnership involving the government, the Global Fund, PEPFAR, the World Bank, and other bilateral partners resulted in developing the Ministry of Health and Child Care's performance monitoring and evaluation guidelines and strategy. The policy formed part of the operationalisation of the national M&E policy, with specific reference to health issues.

4.4 Key stakeholders in the health M&E system in Zimbabwe

The key institutions in monitoring and evaluating public sector programmes in Zimbabwe include state and non-state actors. State actors include the legislature (Portfolio Committee on Health), the academic institutions, and the executive (Ministry of Health and Child Care). On the other hand, non-state Actors such as the United Nations agencies, non-governmental organisations, religious organisations, development partners, and the diplomatic community play a crucial role in monitoring and evaluation in Zimbabwe. In addition, the private sector and voluntary associations also play an essential role in the M&E system in Zimbabwe.

4.4.1 State actors

The previous section provided a synopsis of the GHP-government collaborations for M&E for the past four decades. The discussion was crucial to understanding the evolving nature of the collaborations and some of the mechanisms of policy influence. The current section discusses the role of the Office of the President and Cabinet (OPC) in coordinating M&E functions across government ministries and departments.

Monitoring and Evaluation in Government Ministries

The development of M&E systems in government ministries appears to follow ministries with civic and private sector collaborative partnerships. The Ministry of Health and Child Care has more collaborative arrangements than any other government Ministry or department and has the most developed M&E system. It is the first and only known ministry that successfully operationalised the national M&E policy when it launched its Performance Monitoring and Evaluation Guidelines and Strategies in 2018. The M&E Policy Guidelines and Strategy provided strategic direction and guidelines for the 2016-2020 National Health Strategy. Moreover, collaborative partners like the Global Fund provided financial and technical assistance to build the National M&E Directorate through support for the Director and Deputy Director positions and M&E Officer positions at national and provincial levels. The partners also established a Program Coordination Unit (PCU) to facilitate the coordination of the programme, M&E, and financial management processes (MoHCC, 2018). The partners also provided support for procuring computer hardware and software and various training programmes for M&E staff at national and subnational levels.

The National AIDS Council of Zimbabwe

The National AIDS Council of Zimbabwe has also benefited from collaborative partnerships for M&E through initiatives like the World Bank's Millennium AIDS Project (MAP) and computer equipment and software funding. The Joint United Nations Program on AIDS (UNAIDS) also collaborated with NAC to roll out most M&E systems, including the Country Response Information System (CRIS) for HIV key indicators. The financial and technical assistance included human resources for M&E and database officers at national and provincial levels. Its major current collaborating partners include UNAIDS, WHO, PEPFAR, the GFATM, and the Ministry of Health. Its significant contributions to the development of M&E systems include the consistent development of National HIV Strategic M&E plans and costed M&E plans over two decades. The organisation collaborates with private and civic sectors to operationalise the twelve components of M&E prioritised by the UNAIDS and the WHO. It remains one of the key coordinating boards for global HIV and TB targets, with the responsibility to generate and report on some global indicators on behalf of the country (Zimbabwe National AIDS Council, 2014).

The Parliament of Zimbabwe

The Zimbabwe parliament plays an oversight role in developing the national M&E system through the direct involvement of the Portfolio Committee for Health. The Committee has been involved in developing the health sector performance monitoring and evaluation policy

guidelines and strategy. The Committee has also benefited from regional collaborative partnerships involving organisations such as the African parliamentarians' network on development evaluation (APNODE), and M&E capacity-building initiatives from organisations such as the Southern African Parliamentary Support Trust (SAPST), UNDP, and the Africa Capacity Building Foundation (ACBF).

4.4.2 Non-state actors

These main actors provide technical and financial support to government and local health NGOs (Makadzange, 2020). Mazikana and Brushett (2002) observe that non-state actors, mainly bilateral and multilateral organisations, NGOs, and foundations, played a significant role in developing the national M&E system by providing technical and financial support. For example, the UN agencies, the African Development Bank, PEPFAR, CDC, and World Bank have been primarily involved in developing M&E policies and capacity-building initiatives at the local health system level.

Academic actors

The academic institutions provide training in M&E as their contribution to the development of the system. Universities such as Lupane, the University of Zimbabwe, and the National University of Technology, among others, provide academic courses in M&E and evaluation consultancies and training. The training programmes range from certificates to graduate and post-graduate qualifications in M&E. The universities also collaborate with private and civic organisations to provide these courses. For example, through CDC and PEPFAR, USAID provides scholarships for a Master in Public Health at the University of Zimbabwe.

Voluntary organisations for professional evaluation

The role of voluntary organisations for professional evaluation (VOPEs) is also increasing in supporting the growth of the evaluation profession in the country. Organisations with global, regional, and national M&E associations exist in the country. For example, the Zimbabwe Evaluation Society collaborates with UNICEF and the government in promoting M&E and evaluations in the country. In a recent publication, Amisi *et al.* (2021) observe that VOPEs are key in strengthening the supply of quality, credible and valuable evaluations and in encouraging governments to develop policies to monitor and evaluate performance as a strategy to enhance accountability, transparency, and learning. The Zimbabwe Evaluation Society (ZES) was established in 1999 and relaunched in 2013 through financial support from GHPs such as UNICEF. Its role involves developing and managing evaluation consultants and organising evaluation conferences. For instance, in 2015, ZEA, in collaboration with the Africa

Capacity Building Foundation (ACBF) and other development partners in Zimbabwe, jointly organized an M&E capacity-building workshop in line with the 2015 Year of M&E aimed at building the capacity of evaluators (ZES, 2016).

4.5 Summary of the chapter

This chapter reviewed the M&E system in Zimbabwe since the 1980s and described the government's interaction with UN GHPs in the 1980s and with private sector partners from the 1990s. It has detailed the successes of the 1980s when social and health indicators in the country were performing better than in most Southern African countries. In addition, the chapter has provided a synopsis of the leading state and non-state actors for M&E. These include the parliament, the National AIDS Council, government ministries, NGOs, voluntary organisations for professional evaluations (VOPEs), and academics. The chapter observed that before the market-based reforms in the health sector, significant gains were achieved in setting up M&E systems. The period in which the Economic Structural Adjustment Programme (ESAP) was active (1991-1995) and subsequent years into the millennium saw increased M&E collaborations involving the World Bank and IMF, but the returns on that investment were not commensurate with the financial and technical investments. The unstable years of 1997 to 2008 were the most difficult, with limited progress made on M&E collaborations. Slight improvements were realised during the Global Political Agreement 2009-2013 and in the post-GPA period 2013-2020. Key M&E milestones discussed include the development of the national M&E policy and the health sector Performance Monitoring and Evaluation Guidelines and Strategy, 2018. Likewise, the role played by GHPs such as the Global Fund in the establishment of the M&E Directorate, the human resource, computer hardware, and software support has also been discussed. The discussion helped provide a baseline understanding of existing literature about GHPs' collaborative interactions with the health system.

CHAPTER FIVE: SOFT POWER STRATEGIES, M&E DISCOURSES AND IMPACTS ON PUBLIC HEALTH MONITORING AND EVALUATION POLICY AND PRACTICES IN ZIMBABWE

5.1 Introduction

The previous chapter provided a synopsis of the M&E system in Zimbabwe, highlighting the contributions of key collaborations between private and civic partners for the past four decades. The chapter described the roles of the key stakeholders in the collaborative M&E system and significant milestones and achievements over the period. The current chapter builds on this secondary information by presenting primary data to comprehensively understand the GHPs' contributions to this system over the years. While the previous chapter addressed some of the coercive and material mechanisms of policy influence, the current chapter focuses on the soft and unspectacular approaches of GHPs deployed to navigate the unstable policy environment from the 1990s onwards. In addressing the first research question, the study applies the New Public Governance and Critical Discourse Analysis (CDA) to introspect the control effects of discourse as a soft power strategy. The specific discursive themes identified are participatory, technological, scientific, country-led, human rights, health emergencies, and results-based discourses. The chapter begins by presenting the findings and follows the presentation of crucial discussions through the two frameworks mentioned above. The last part of the chapter is the conclusions drawn from the results and the arguments.

5.2 Monitoring and evaluation discourses

This section thematically and discursively presents the key M&E discourses to answer part of research question one: *How do GHP M&E discourses and soft power strategies shape and influence policy and practices of public health M&E systems in Zimbabwe?* The chapters draw from documentary reviews of four national M&E policy documents and interviews with key M&E staff from the Ministry of Health, the National AIDS Council, and a local NGO. The section is based on the argument that discourse control represents an influential under-discussed source of power in partnerships that influences and shapes M&E policy and practices in Zimbabwe. The key discourses identified in this study are the dominant economic discourse, the participatory or partnership discourse, and the scientific, technological, results-based, country-led and human rights discourses. The following Matrix 5:1 provides a summary of the result

Matrix 5 1 Key Discourses and soft power strategies shaping and influencing M&E policy and practices

Sub-theme/sub-question	Participant responses	Source/s
Dominant economic discourses in M&E policies	<i>In charting the nation's development agenda guided by the recently adopted economic Blueprint ZimASSET, my government has formulated a National Monitoring and Evaluation Policy.</i>	National M&E Policy 2015
	<i>This National Health Strategy (NHS) 2021-2025 seeks to consolidate the gains made by the previous investments by the government, development partners, the private sector, and communities at large</i>	National Health Strategy 2021-2025
Participatory/partnership discourse in M&E Policies	<i>The involvement of key stakeholders, among them the public sector, the private sector, development partners, academia, and civil society is highly commendable (National M&E Policy, Chief Secretary to the President and Cabinet)</i>	National M&E Policy 2015
	<i>Participatory and consultative approaches were used in developing this extended National M&E Plan. The development of the M&E plan was spearheaded by the NAC with support from NRMEAG and UN agencies.</i>	Zimbabwe National M&E Plan 2015-2020
Scientific discourse in M&E policies and practice	<i>The highest newly introduced level is the high-level cutting-edge Quinary level. This level was introduced to spearhead research and development with linkages with higher and tertiary education institutions, the manufacturing sector, and the MOHCC's new divisions of Biomedical Engineering Science and Pharmaceutical /Biopharmaceutical Production</i>	National Health Strategy 2021-2025
	<i>The best measure of indicators like prevalence should be coming from population-based surveys. In situations where we don't have a population-based survey, that's when you can use estimates.</i>	KII-IT
Technological discourse as governing technologies	<i>The MOHCC will accelerate the implementation of the electronic logistics management information system to improve end-to-end data visibility, timely reporting of accurate data, accurate quantification, and reduced stock losses.</i>	National Health Strategy 2021-2025
	<i>EHR is heavily digitalised, but small NGOs and some government departments are not heavily digitalised.</i>	KII-TC
Results-based discourse in policy and practice of M&E in Zimbabwe	<i>Implementation, monitoring, and evaluation of the National Health Strategy (NHS) will be anchored on the Integrated Results-Based Management (IRBM) system, a management tool adopted by the Government of Zimbabwe (GoZ)</i>	National Health Strategy 2021-2025
	<i>If it's for your programme, you go down to the specific indicators and say, which indicators are we tracking? Then how are they performing? When you analyse, you can see and compare trends; you can pick the high numbers out of thresholds. Those are the results.</i>	IDI-AM
Country-led Discourse in policy and practice of M&E in Zimbabwe	<i>Monitoring and Evaluation of the NHS 2021-2025 will use an integrated and comprehensive health system approach built firmly on a single country-led M&E platform, the MoHCC Directorate of Performance Monitoring and Evaluation (DPME).</i>	National Health Strategy 2021-2025
Human rights-based discourses as technologies of power	<i>On the UN human rights aspects, that's the other(avenue) to say no, no, no, no the human rights, you must make sure that all people access these services like for example, you know, our policy as a Ministry, I mean the position as a country that we don't recognize same-sex marriages or people that do such practices as such.</i>	KII-LM
	<i>Every citizen and permanent resident of Zimbabwe has the right to have access to essential health care services, including reproductive healthcare services (Constitution of Zimbabwe Amendment No 20 of 2013)</i>	National Health Strategy 2021-2025
Health security emergency and conspiracy discourses	<i>So, you see, we go back to the conspiracy theories, where we begin to think probably HIV was manufactured in the labs, COVID was manufactured in the labs so that Africans would die, and so on.</i>	IDI-AM
Use of monitoring and evaluation artefacts as soft power tools	<i>It's a comprehensive Excel Logical Framework where the Ministry writes its demands. It starts with the programmes, the finance, human resources, and M&E departments, who write their department demands, then submit them to the coordination unit, which puts everything together, and then discussions ensue.</i>	KII-TC
	<i>So, they (partners) are not coming to dictate, they are coming with their interest, but the bigger brother is the Ministry. So, much attention should be given to what the Ministry wants.</i>	IDI-AM
Provision of M&E policy advisory and consultancy services	<i>The Ministry of Health and Child Care would like to acknowledge Mr. Bernard Mwijuka and Dr. Mutsa Mhangara, the consultants who wrote and brought the document together.</i>	Health Sector Performance M&E Guidelines and Strategy, 2018
	<i>The Office of the President and Cabinet is deeply indebted to all the participants who made the exercise a success.</i>	National M&E Policy, 2015
Support for monitoring and evaluation champions	<i>The idea is quite good because you have a narrow, narrow, and specific objective, which you want to push so that the Ministry can see the results for making sure that they invest, for instance, in champions, like me.</i>	KII-TC
	<i>Obviously, conflict arises when you see a champion working very hard and well remunerated for their work.</i>	KII-TC

5.2.1 Dominant economic discourses in M&E policies

The first crucial finding of the study is that the dominant economic discourse is a central feature in all recent national M&E policies guiding the health response systems and governance in Zimbabwe. The study was interested in understanding the extent to which the pervasive use of economic terms, texts and symbols in GHPs-supported health programmes represents a strategy to influence local M&E policies and practices in Zimbabwe. The study sought to gain more insight into the effects of this unspectacular approach on the government's policy agenda setting and policy outputs in the country. Drawing from Critical Discourse Analysis (CDA), the study identified discursive markers such as the topicalisation and reproduction of pro-economic terms as indicators of the effects of GHP's dominant economic discourse in Zimbabwe's policymaking processes. The study provided evidence from excerpts of the National M&E policy and the National Health Strategy 2021-2025 to illustrate the findings below:

*In charting the Nation's development agenda guided by the recently adopted **economic Blueprint** ZimASSET, my government has formulated a National Monitoring and Evaluation Policy. A **results-oriented** public sector geared toward contributing to sustainable development, **economic growth**, and the well-being of citizens efficiently and effectively require a well-defined framework that clearly outlines the guidelines for assessing **outputs, outcomes, and impacts** of Government programs and project priorities within stipulated timeframes. (President of Zimbabwe, National M&E Policy, President of Zimbabwe).*

*This National Health Strategy (NHS) 2021-2025 seeks to consolidate the gains made by the previous **investments** by the government, **development partners**, the **private sector**, and **communities** at large. I am aware of the **emerging threats** that could easily erode the gains made, but this National Health Strategy (NHS) 2021-2025 presents an **opportunity** for all stakeholders to reset the health sector in a **sustainable and resilient mode**. (Minister of Health and Child Care-National Health Strategy, 2021-2025).*

The two extracts from the foreword by the country's President and Minister of Health provide valuable insights into adopting pro-economic language in the two policy documents. The inescapable use of terms like 'economic blueprint,' 'economic growth,' 'investments,' 'private sector,' 'sustainable development,' 'efficiency,' and 'effectiveness' are among some of the keywords that provide cues to the policy influence of GHPs like the World Bank and Global Fund that provide financial and technical advice for the drafting and circulation of these two

M&E policy documents. The study offers a critical perspective on these terms and argues that they are not random placements in these policies. Their strategic placements in key sections of the policy documents, for example, the foreword of the policy documents, and the offices of the speakers, the President, and the Minister of Health, represent the effects of tactical policy lobbying by GHPs involved in the policy agenda setting for health in the country. Drawing from Michel Foucault's power as relational and as governmentality, the study argues that the pervasive presence of these terms represents the reproduction of GHP rationalities at the highest levels of policy influence in the country's health system.

Moreover, an inter-discursive approach to the health policy context and text since 1980 reveals valuable insights into the government's policy shift from the pro-social discourse of the 1980s to the current pro-business language since the early 1990s following the introduction of ESAP. Similarly, the specific mention of the private sector, development partners, and communities at large reflect the active involvement of private, non-governmental collaborative partners with private business and civic interests in the health M&E policymaking and practices in Zimbabwe. The GHPs like the World Bank and Global Fund are driven by private sector funding, and they provide financial and technical support to most of the collaborative government partners to lobby for and advocate policy changes friendly to businesses and the public. As a result, their involvement in collaborative partnerships for health is closely linked to advancing the business interests of their funding partners. Consequently, the study concludes that the pro-business language identified in the cited policy text represents GHP policy influence on the government policy which shifts from pro-social to liberal policies aligning with the advancement of the more active involvement of the private sector in public health service delivery.

5.2.2 Participatory discourse in M&E Policies

The second finding of this study relates to the inter-discursive use of the participatory or partnership discourse in the M&E policy documents reviewed. The second observation relates closely to the first finding as the participatory discourse emphasises the private sector, the civic sector and communities as key stakeholders in co-planning and co-decision making on crucial health issues in the country. The central thesis of this approach is advocating decentred power from the government to a heterarchical collaborative governance structure that is free from government bureaucracy to ensure efficient, effective, and economical delivery of health services. Drawing from the National M&E policy, 2015 and the Monitoring and Evaluation Plan for the extended Zimbabwe HIV and AIDS National Strategic Plan, 2015 – 2020, the

policy terms and terminology observed suggest the use of participatory discourse as a powerful discursive tool with a linguistic influence on the policy and practice of M&E in the country. Take, for example, extracts from the policy documents below that show the government's high regard for the collaborative participatory partnership in the policy and practice for M&E in the country:

*The Office of the President and Cabinet is deeply indebted to **all the participants** who made the exercise successful. These are the Rapid Results Initiative (RRI) Team, an Inter-Ministerial Team that was set up to lead the process under the leadership of the Office of the President and Cabinet; the African Community of Practice country coaches who guided the process; African Development Bank (AfDB) and the World Bank (WB) for their financial support and active. The involvement of key stakeholders, among them the **public sector, the private sector, development partners, academia, and civil society**, is highly commendable (National M&E Policy, Chief Secretary to the President and Cabinet)*

***Participatory and consultative approaches** were used in developing this extended National M&E Plan. The development of the M&E plan was spearheaded by the NAC with support from NRMEAG and UN agencies. (Monitoring and Evaluation PLAN for the extended Zimbabwe HIV and AIDS National Strategic Plan, 2015 – 2020).*

The above text provides valuable insights into the policy influence of the private, civic, and community partners through the accepted norms of participatory engagements in policy and practice for health. The use of terms and phrases such as 'The Office of the President and Cabinet is deeply indebted to all the participants who made the exercise successful' represents the partners' unspectacular influence on the government and the collaborative partnership. The topicalisation and reproduction of participatory and consultative language in these two government policy documents represent policy influence that translates into implementation modalities that involve all the concerned partners. The inter-discursive reference to partners from academia also provides cues as to their influence on policy through pedagogical soft power strategies like participatory policy training and development programmes. Thus, policy epistemic and expert influence forms part of the tools that GHPs unleash through offering academic research and training.

Similarly, the involvement of GHPs in participatory processes such as the National AIDS Council coordinated NRMEAG reflects the immense influence of GHPs, private companies,

civic organisations and the governments they represent in the collaborative, participatory processes for policy in Zimbabwe. The Advisory Group involves members from the most prominent multilateral and bilateral GHPs like the World Bank, the Global Fund, the WHO, PEPFAR, and DFID, among others. Given the neoliberal economic persuasion of these GHP-supporting countries and corporates, the study concludes that the participatory and partnership discourse plays an important role in persuading local policymakers towards pro-business policies in the provision of health care, which is crucial in politically unstable environments such as Zimbabwe. This study fears that participatory discourse could be reduced to tokenism that conceals and effaces the Gramscian hegemonic GHP policy influence through neoliberal governing rationalities that promote business models that exclude equitable and affordable health for all.

5.2.3 Scientific discourse in M&E policies and practice

The third interesting finding of the study is that scientific discourse is another central theme in most national M&E policy documents in Zimbabwe. Scientific discourse involves jargon and exclusive terminology emphasising uncontested systematic medical health research processes. The study observes the reproduction and topicalisation of scientific discourses in ways that silence oppositional discourses to the proposed plans and approaches by collaborative partnerships. The study draws attention to the unintended effects of this productive use of jargon and approaches that may not be contextually relevant now, considering the resource constraints in the country. An excerpt from the National Health Strategy 2021-2025 below illustrates the argument regarding the Ministry's plans to introduce another higher-level tier responsible for research and development:

The highest newly introduced level is the high-level cutting-edge Quinary level. This level was introduced to spearhead research and development with linkages with Higher and Tertiary Institutions, the manufacturing sector, and the MOHCC's new divisions of Biomedical Engineering Science and Pharmaceutical /Biopharmaceutical Production (National Health Strategy 2021-2025).

An inter-discursive approach to the above text reveals the GHP's influence on the Ministry's policy through academic expert power of scientific research and development for public health in the country. At face value, the policy proposal is incontestable due to the 'undisputable good' that scientific discourses appropriate to themselves in public health settings. Using terms such as 'high-level cutting-edge', 'research and development', 'biomedical engineering', and 'higher and tertiary institutions' invokes uncontested legitimacy and justification for the

Ministry to implement the new policy based on tested ideas by respected institutions of higher learning.

However, the critical question is whether the focus on the quinary level is based on participatory evidence or represents the private sector's aspiration and that of technocrats often divorced from everyday struggles by poor people who require access to affordable essential health. These populations usually do not require sophisticated interventions but essential services at primary and secondary levels. As a result, the focus on the quinary level could eventually benefit the private sector and academic institutions with little immediate benefit for the poor in the current situation in the country. The study draws attention to the potential misdirected collaborative investments at the quinary level at the expense of equipping the primary and secondary levels of the public health system. The study therefore observes a pattern similar to that evident in the first finding, in which the collaborative governance system has influenced policy shifts from the Ministry's Primary Health Care (PHC) approach to a Selected Health Care Approach (SHC).

Moreover, the study implicates private sector interests in the scientific discourse. For example, the National Health Strategy 2021-2025's reference to 'medical tourism' on page 69 substantiates this concern, framed in the research and development context. The consideration of 'medical tourism' may not be a priority for a low-resource and constrained health system failing to meet essential primary health services.

Moreover, the scientific discourse has normalised using scientific data analysis and reporting approaches, such as HIV estimates, modelling, surveys, randomised control trials (RCTs), and disability adjusted life years (DALYs), among other techniques. These GHP-supported approaches represent the 'golden standard' in public health research, yet they problematically present one side of the research story about Zimbabwe. As a result, the quantitative approaches have become the uncontested authentic source of public health information in Zimbabwe. Two excerpts from an HIV plan and key informant response illustrate this finding below:

The Zimbabwe Population-based HIV Impact Assessment (ZIMPHIA) 2016 results estimate that approximately 1.2 million people aged 15 to 64 live with HIV (PLHIV) in Zimbabwe. This number varies slightly with software models, where the HIV estimates software for the number of adults (15 years +) living with HIV was 1.35 million people (1,349,070) (Monitoring and Evaluation PLAN for the extended Zimbabwe HIV and AIDS National Strategic Plan, 2015 – 2020).

The best measure of indicators like prevalence should be coming from population-based surveys. In situations where we don't have a population-based survey, that's when you can use estimates. The estimates are calibrated because they are in a position to take into consideration the previous population-based survey that has also been conducted to estimate the future population-based survey, what they call the Bayesian modelling, and in that regard, we are sure that even the estimates, don't give estimates that are out of certainties. So, it's credible that we use population-based surveys and use the estimates (Participant KII-IT).

The above excerpts reveal the privileged position of quantitative scientific approaches to understanding the scope and scale of epidemics like HIV in the country. While the cited approaches provide valuable scientific information about epidemics, they have created the unintended effect of crowding out investments to strengthen systems for collecting actual programme data at the programme implementation level. The study draws attention to the forgotten fact that 'estimates are estimates' and do not replace the need for absolute facts and figures where possible. Yet the estimates are unproblematically presented as official facts and figures in the public health space in the country. The lack of critical discussion on these issues emanates from the 'undisputed' space that science occupies in public health policy. This uncontested position derives its influence and power by deploying discursive modalisation and hedging techniques. For example, the formulation 'This number varies slightly with software models' is a hedging technique in scientific discourse that silences potential methodological arguments about the estimated figures. The caveat silences opposition through the acknowledgment of alternative routes to solve the same problem. Similarly, KII-IT's use of epistemic modal markers like "we are sure" and "it's credible" shows the reproduction of GHP scientific rationalities that promote uncontested scientific methods such as HIV estimates as credible scientific approaches to epistemological and ontological questions about the HIV epidemic in Zimbabwe.

Based on these findings, the study concludes that GHP-supported scientific discourses silence oppositional discourses through depoliticisation and descriptive technical language to address the social aspects of health, thereby problematically promoting one-sided public health policies in the country.

[5.2.4 Technological discourse as governing technologies](#)

The fourth study finding draws from the pervasive reference to the use of information and communication technologies (ICTs) as a separate theme from the scientific approaches that

also benefit much from the ICTs in health. The study draws specific attention to the deterministic and functional orientation toward digital governance in health to enhance data collection, analysis, storage, and reporting for clinical information, pharmaceutical procurement logistics, and programme management purposes. An excerpt from the Health Sector Performance Monitoring and Evaluation Strategy and Guidelines 2018 and the National Health Strategy, 2021-2025 illustrates this observation:

The MOHCC will accelerate the implementation of the electronic logistics management information system to improve end-to-end data visibility, timely reporting of accurate data, accurate quantification, and reduced stock losses. The Electronic Logistics Management Information System linked to EHR and DHIS2 and develop a link with all private-sector health facilities to have private-sector health consumption linked separately to eLMIS/DHIS2. This will be coupled with several initiatives to facilitate implementation (National Health Strategic Plan, 2021-2025).

The extract above inter-discursively reflects the collaborative deployment of technological and pro-private sector discourses in health partnerships. The text shows the influence of processes that promote the interoperability of electronic pharmaceutical and medical procurement and distribution systems to enable efficient and cost-effective quantification, procurement, and logistical distribution of health technologies for profit. The use of terms and phrases like ‘improve end-to-end data visibility, timely reporting of accurate data, accurate quantification, and reduced stock losses’ reflects the productive and instrumental views about technology as a panacea for the current challenges facing the Ministry’s quantification and distribution challenges. Yet, in practice, the availability of these systems alone does not solve the challenges. The approaches often ignore the social effects of technology on health systems.

Similarly, the Health Sector Performance M&E Guidelines and Strategy 2018 reiterate this ICT-enabled policy position. The anticipated effects are the same for other programme data. However, the pragmatic-instrumental approach perhaps benefits the private sector’s investments in the technological systems that facilitate efficiency, effectiveness, and economy for maximum profits. The thesis draws attention to this discourse’s unproblematic presentation of ICTs as being indisputably good for improving clinical, procurement, and programme management decisions. The study provides primary dialogical evidence to counter the instrumental view of ICT-enabled collaborations in the country. Take, for example, a response from KII-TC below:

EHR is heavily digitalised, but small NGOs and some government departments are not heavily digitalised. As I say, they are forced to retreat to their tools and systems at the end of the day. One perfect example is the young girls and adolescents in their programme code-named DREAMS. ... So those are excluded, I can say, from the Ministry's programming. It is called Digital exclusion (Participant KII-TC).

The above primary evidence contradicts the secondary policy evidence about ICT-enabled systems in the health sector in the country. The technological discourse in the policy document is silent about the digital exclusion of small partners and the unintended creation of parallel systems. Yet participatory and technological discourses claim to empower these small NGOs and governments as equal partners. Additionally, the approach is reductionist as it equates data collection to knowledge creation. Ideologically, the text implicates neoliberal imperatives and objectives. The health technologies facilitate efficient and effective clinical, pharmaceutical, and management decision support systems that enable business through improved uptake of medical and pharmaceutical products. Based on these findings, the study concludes that the instrumental deployment of technological discourses represents a source of power influencing collaborative partners for health through the attraction of ICTs as enablers for efficient and effective public health processes.

5.2.5 Results-based discourse in the policy and practice of M&E in Zimbabwe

The fifth finding of the study is the productive deployment of results-based discourse in all recent and current M&E policy documents reviewed and through interview responses. The results-based discourse promotes M&E measurement beyond inputs, processes, and outputs to include outcomes and impacts. The discourse portrays this approach as an improvement from the traditional M&E approach that focuses on inputs and processes. Moreover, the results-based discourse conceals the problematic positivist prism through which collaborative partnerships mechanically anticipate results through linear input-process-output assumptions in complicated social and health challenges in the country. The deterministic approach to knowledge creation unproblematically assumes that inputs convert to outputs, outcomes, or impacts as a pre-determined process. As a result, the results-based discourse encourages a performative and accountability focus non-beneficial to local struggles and immediate needs. An excerpt from the National Health Strategy, 2021-2025 illustrates the argument below:

Implementation, monitoring, and evaluation of the National Health Strategy (NHS) will be anchored on the Integrated Results-Based Management (IRBM) system, a management tool adopted by the Government of Zimbabwe (GoZ) for the implementation of its programs. The IRBM system institutionalizes accountability among all leaders and personnel for the outputs and outcomes of their departments and units and their linkage to the NHS goals and objectives (National Health Strategy, 2021-2025).

The above excerpt reinforces the instrumental and performative effects of results-based discourse and a positivist epistemology that assumes M&E results pre-exist “out there” and require M&E artefacts like log frames to discover and report them. Contrary to the study's post-constructivist and dialogical approach to knowledge creation, it problematically assumes that facts and figures adequately represent results. The attempts to portray the measurement of outcomes and impacts do not help address this reductionist approach, as the use of proportions or percentages betrays the default bias towards quantitative expressions of every aspect of life. Thus, policy results-based discourse unintentionally reduces complex social and health problems into facts and figures. The excerpt from IDI-AM below illustrates the privileged position of quantitative measures as results at the policy implementation level. The response to a question as to what constitutes results presents the argument below:

If it's for your programme, you go down to the specific indicators and say, which indicators are we tracking? Then how are they performing? When you analyse, you can see and compare trends; you can pick the high numbers out of thresholds. Those are the results. So probably they can be immediate results that you're just seeing, then there can be some impacts, to say, if there is a recurrence of this kind of results, how does that translate to public health in the community? So, you collect your data, you analyse, then when you are done with your analysis, you have now aligned your statistics to the narratives, the story behind the numbers; that's when you can say, I think I got a result, and this result means this, then you can make decisions now (Participant IDI-AM).

The above text reveals the topicalisation of numbers, statistics, trends, and thresholds ahead of the community narratives. The only time narratives are mentioned is when explaining the statistics, numbers, trends, and thresholds. This response substantiates the performativity and instrumentality of the triumphant preference for quantitative over qualitative measures in Zimbabwe's M&E system. Yet, Results-based Funding (RBF) and approaches remain popular

as mechanisms for delivering public health in the country. The unintended effects of these approaches include mute and perverse reporting that gives an impression of progress when the local beneficiaries derive limited value from the interventions. Based on these findings, the study concludes that results-based discourse leads to reductionism in health policies and encourages mute and perverse practices among local partners.

5.2.6 Country-led discourse in the policy and practice of M&E in Zimbabwe

The sixth finding on discourse control relates to GHPs promoting country-led narratives in ways that accord local agency and responsibility, giving a false impression of local control of policy priorities and programmes. The country-led discourse or country ownership originates from the OECD-initiated Paris Declaration on Aid Effectiveness of 2005, which emphasised ensuring LMICs have control over national development policy processes. However, the study argues that the involvement of GHPs like OECD in conceptualising country ownership reflects the post-conditionality deployment of soft power from a critical-ideological and critical-governmentality literature perspective. It suggests that GHPs govern from afar through freedom as they advocate local partner autonomy to manage their policy process. As a result, the study further argues that the country-led discourse in local M&E policy documents reflects the GHP influence from afar. An excerpt from the current National Health Strategy 2021-2025 illustrates the point below:

Monitoring and Evaluation of the NHS 2021-2025 will use an integrated and comprehensive health system approach built firmly under a single country-led M&E platform, the MoHCC Directorate of Performance Monitoring and Evaluation (DPME). Working closely with the other essential units, such as the Health Management Information System, this platform will meet all the data needs of the country and allow progress towards attaining the goals and objectives specified in the NHS, as well as national, regional, and international commitments such as the SDGs. The health sector, including development partners and CSOs, is expected to unite under this single-M&E platform (National Health Strategy 2021-2025).

The above excerpt provides valuable clues as to the influence of GHP governing rationalities in the policy document. Country-led discourse aims to accord agency power to country-level decision-makers regardless of the contrary evidence in practice. A critical analysis of the text reveals the success of this approach. For example, the modal emphasis through words like ‘firmly under a single Country-led M&E platform’ and ‘unite under this single-M&E platform’ reveals the perceived government leadership of the collaborative partnership of M&E for

health. However, the modal word ‘expected’ also implies acknowledgment of work-in-progress. Thus, modalisation, lexicalisation, and topicalisation of key ownership terminology represent the GHPs governing rationalities at play from a distance. Moreover, the lack of definitional consensus on what constitutes country-led or country-owned processes makes the strategy effective as GHPs settle for convenient interpretations that give them control from afar. It allows GHPs to obfuscate and conceal their real intentions in the partnerships.

The conclusion drawn from the findings points to a collaborative arrangement that delays or denies real, local control of national health discourse and priorities while allowing GHPs to govern from afar. Thus, the country-led terms fit into the strategy as they give the impression of local control of M&E policy processes. However, the post-conditionality strategy reveals the full GHP control through local autonomy and non-interference as local representatives do the job. Thus, the country-led discourse performs rather than delivers autonomy in the collaborative partnership as local partners reproduce GHP objectives to secure continued financial and technical support.

5.2.7 Human rights-based discourses as technologies of power

The previous discussion on country-led discourse aligns with the current study's findings that human rights discourse also features prominently in local M&E policy. The pervasive nature of this discourse is revealed through the citation of Constitutional human rights in all key M&E policy documents. Excerpts from key informant interviews and the Constitution of Zimbabwe illustrate this finding below. The Constitution of Zimbabwe Chapter Four, Part Two, Section 76 provides for the Right to Health. It provides that:

Every citizen and permanent resident of Zimbabwe has the right to have access to essential health care services, including reproductive health care services (Constitution of Zimbabwe Amendment No 20 of 2013)

A critical review of this prominently cited Constitutional provision shows that it derives from universal human rights conventions primarily resulting from GHP, private sector advocacy work. Thus, GHPs ensure national constitutionalism to hold the government accountable to policy positions advocated on global platforms that have legitimacy and power over national policies. Based on this observation, the study argues that GHPs ensure that the rights-based discourse is productively included in all national M&E policy documents to achieve policy implementation, especially for locally contested issues transcending moral, cultural, religious, political, and social boundaries. While responding to a question on his thoughts about GHP's

support for human rights-based strategies in M&E collaborations, KII-LM affirmed this argument:

On the UN Human Rights aspects, that's the other (avenue) to say no, no, no, no the human rights, you must make sure that all people access these services like for example, you know, our policy as a Ministry, I mean the position as a country that we don't recognize same-sex marriages or people that do such practices as such. But they hide through the UN under the Rights Convention as they push some programmes to target those groups in their funding (Participant KII-LM).

The above response confirms the productive use of rights-based discourse to remind the government about universal health rights, including those considered immoral by local standards. The statement demonstrates the GHPs' inter-discursive deployment of human rights and health from global commitments. The strategy invokes the UN's legitimacy and universal respect as a neutral player. Thus, GHPs draw on this power to influence the government on the UN Conventions that govern same-sex marriages, including Men-Having -Sex-with Men. The discourse inter-discursively draws from the UN's human rights, legitimacy, and expert influence.

However, KII-LM's response also shows the oppositional discursive resistance to GHP's influence in practice. Using modal markers and lexical phrases like 'you know our policy as Ministry' and 'they hide through UN' shows the negative attitude towards the influence of policy practice. Similarly, KII-LM's pre-suppositional response expecting the interviewer to know the government's common position on the issue reflects the gravity of the opposition to the approach. Based on these findings, the study concludes that rights-based discourse represents a source of power by both sides of the collaborative partnership debate.

5.2.8 Health security and emergency discourses

The last finding relates to the discourse that portrays health as a security and emergency issue. The discourse inter-discursively deploys jargon and refers to programmes that raise the alarm and fear as a strategy to hasten the local authorisation process for GHPs to implement programmes locally. Thus, programmes like HIV, TB, and malaria are sometimes portrayed as catastrophic emergencies that require urgent global interventions. The instrumental reference to health as a security emergency circumvents local processes and procedures to rely on global guidelines. Thus, GHPs influence local policymakers to align their programmes to global health regulations.

For example, the National Health Strategy 2021-2025 asserts that Zimbabwe is a signatory to global health emergency regulatory frameworks like the International Health Regulations (IHR) 2005 for Preparedness, Prevention, Detection, and Responding to Public Health Emergencies. This study argues that while emergencies do not respect boundaries, the discourse around emergency planning and funding increasingly reflects instrumental uses in Zimbabwe's contexts. As a result, the country's current strategy to fully implement the National Action Plan for Health Security (NAPHS) is an example of GHPs' influence on health securitisation discourse. The strategy also aims to strengthen legislation, coordination, and the prevention of public health emergencies, laboratory systems and surveillance, health information systems (HIS), risk detection, communication, and event-based reporting. The lexical deployment of military terms like surveillance, security, and risk detection shows how international regulations influence local policies and practices. The terms implicate the increasing association between global health and biological warfare. Thus, discourse, in this case, can influence policies that respond to global risks.

However, the tactical inter-discursive deployment of scientific and oppositional discourses conceals and neutralises such conversations as conspiracy theories. Highly virulent epidemics and pandemics like HIV, Covid-19, and Ebola are examples of diseases that have created inconclusive debates apart from the need for emergency responses. When asked about the effects of epidemics and pandemics on Zimbabwe's M&E policy and practice, IDI-AM remarked that:

I am sure these terminologies would come out of science. It's not like someone just woke up and shouted pandemic etc. I think people study issues to do with how fast it is spreading, the reproduction numbers, and there's much science that informs whether people should be on high alert and should be informed and, you know, things like that. Because the way these, it is a way of marketing, so that, you know, our response rate is also alerted, is also well prepared for than when it just come, and we think there's no harm, you know (Participant IDI-AM).

The above response shows how science appropriates the power to define pandemics and health emergencies. Here the answer is aimed at disproving associated 'lab theories' about epidemics and pandemics. However, phraseology such as 'terminologies would come out of science' and 'much science' reflects the deployment of techno-scientific terms that hedge and silence oppositional discourse like the 'lab' and conspiracy theories. The strategies depoliticise

epidemics and pandemics through scientific discourse. Based on these findings, the study concludes that apart from genuine global plans to respond to emergencies, security and emergency discourses have an underlying productive function in achieving other political and security objectives in a post-truth global health environment.

5.3. Soft power strategies influencing and shaping M&E policy and practice in Zimbabwe

The previous section identified the eight discourses associated with GHPs and their effects on the M&E policy and practice in the country. The discussion helped answer the first part of research question one, which deals with M&E discourses that shape and influence policy and practice for M&E. The current section addresses the soft power strategies that GHPs deploy to influence the policy and practice of M&E. Soft power involves attraction, persuasion, and co-option rather than coercion to get collaborative partnership support on specific policy positions. The specific soft power strategies identified are M&E artefacts, the provision of M&E policy advisory services, and the support for M&E champions. The section wraps up with discussions and conclusions on the key aspects of the findings presented in that chronological order.

5.3.1 Use of monitoring and evaluation artefacts as soft power tools

One of the surprising findings in this context was the productive use of M&E artefacts like the policies, plans, strategies, and frameworks in the collaborative partnership for M&E. The study observed the inter-discursive and inter-textual deployment of soft power strategies and mechanisms like expert and legitimacy power to influence the adoption of GHP M&E tools, frameworks, and plans. As reputable organisations close to the UN and other global tertiary institutions for higher learning, GHPs wield expert and legitimate power over local health partners who find the M&E artefacts attractive and sources of continued financial and technical support. An excerpt from a statement by one of the Ministry of Health M&E specialists illustrates the power of the M&E Logical Framework on local processes and procedures. While responding to a question on the role of GHP M&E tools, KII-TC described how the Global Fund Logical Framework guides the funding proposal writing processes in the Ministry of Health and Child Care. The excerpt below illustrates the process:

It's a comprehensive Excel Logical Framework where the Ministry writes its demands. It starts with the programmes, the finance, human resources, and M&E departments, who write their department demands, then submit them to the coordination unit, which puts everything together, and then discussions ensue. And there's a separation; the template has clear separation, all the issues that have got to do with HR issues or got to do with specific programmes like HIV. There's also a specific section for

procurements and a specific section for travel related. Lately, they have also included COVID-19 commodities as well. So yes, there's a template, a well-developed template that guides and makes the process faster and more efficient (Participant KII-TC)

The above excerpt shows that the Global Fund Logical Framework is more than just a tool. It represents the power of the originator of the tool. More importantly, it means the governing authority of the originator through co-option and the anticipation of further funding through the correct use of the template to answer the proposal's requirements. Thus, the Global Fund governs the conduct of the Ministry of Health from afar. The Global Fund does not need to enforce the guidelines to ensure its religious completion physically. By its association with the Global Fund, the tool wields attractive power and authority associated with legitimacy and expert authority, and above all, its power to facilitate financial support. Thus, GHPs understand this situation and productively design and recommend specific tools for performing M&E processes. An organisation's experience of using these tools represents an added advantage for local partners in the competitive world of NGO funding. Thus, attraction and voluntary co-option form the basis of the policy influence through M&E artefacts.

Furthermore, GHPs also prey on the unspectacular effects of governing rationalities of local partners false sense of self-awareness and autonomy, including their previous experience implementing donor projects and ability to use their M&E tools. An excerpt from IDI-AM below illustrates this point as he reiterates the voluntary choice to adopt GHP M&E tools:

So, they (partners) are not coming to dictate, they are coming with their interest, but the bigger brother is the Ministry. So, much attention should be given to what the Ministry wants. Then there are extras which also come which might be talking in terms of the partner like if you look at our indicators that we are reporting in the Generic Report, as you look at the PEPFAR Monitoring Evaluation and Reporting (MER) guidelines, there are many similarities across indicators (Participant IDI-AM).

The above respondent's insistence that GHPs do not come to dictate confirms the opposite and represents effective reproduction of neoliberal partnership discourse and local partner's false sense of self-awareness and mutuality, sometimes mistaken as local agency reflexivity. Alternatively, a textual analysis of the phrase "*they are not coming to dictate*" also confirms the existence of non-coercive strategies and implies the attractive power of GHPs as the reason for the Ministry's adoption of the PEPFAR tools. However, a contextual reading of the conversation reveals that the Ministry adopts GHPs tools as part of the post-conditionality

strategies by PEPFAR to ensure that the government collects and reports on specific indicators. As a result, there are ‘PEPFAR’ and ‘Global Fund’ indicators and targets in Zimbabwe. Similarly, there are ‘PEPFAR’ and ‘Global Fund’ operational districts. These characterisations show GHPs artefacts' effects as soft power strategies influencing the Ministry’s policies and practices. At the individual level, government M&E staff with knowledge and experience of using these artefacts stand a better chance of gaining employment with these GHPs or coordinate GHPs programs within the Ministry. Thus, the M&E tools influence institutional and individual behaviour.

However, the rigid focus of some of these artefacts creates performative and perverse practices not beneficial to local partners as they focus on getting the next financial disbursement. The frameworks have the power to include and exclude specific issues through deliberate selection processes by the donor, depending on the donor’s priorities for the period. For instance, excluding non-communicable diseases (NCDs) in most GHP artefacts does not resonate with the evidence suggesting an increase in these diseases.

Based on the findings, the study concludes that the collaborative governance system has influenced policy shifts from the Ministry’s Primary Health Care (PHC) approach to a Selected Health Care Approach (SHC).

5.3.2 Provision of M&E policy advisory and consultancy services

Another interesting finding is that GHPs use the provision of M&E policy advisory and consultancy support as a soft power strategy to incorporate their priority M&E issues on the national agenda. Thus, hiring M&E policy consultants relies heavily on the candidates’ knowledge and experience of using the M&E artefacts discussed in the previous section. Moreover, consulting and drafting the policy documents represents a site for power struggles and opportunities for influence through incorporating key phrases and words, as argued under the dominant pro-business discourse in the previous discussion. Excerpts from the Zimbabwe Health Sector Performance Monitoring and Evaluation Strategy and Guidelines 2018 and the National M&E Policy, 2015 provide cues that substantiate this research finding:

The Ministry of Health and Child Care would like to acknowledge Mr. Bernard Mwijuka and Dr. Mutsa Mhangara, the consultants who wrote and brought the document together. Sincere thanks are also extended to Dr. Robert Mudyiradima, the Principal Director of Policy, Planning, Monitoring and Evaluation, and Dr. Rugare

Kangwende, the Director of Performance Monitoring in the Division of Policy, Planning, Monitoring, and Evaluation, for overall guidance and steering the development of the document. The MoHCC is most grateful to Dr. Davies Dhlakama, M&E Manager in the Program Coordination Unit of the MoHCC, and Dr. Miller for the special technical assistance provided (Zimbabwe Performance Monitoring and Evaluation Strategy and Guidelines, 2018).

The above excerpt reveals the authoritative position and influence of M&E policy consultants in drafting and finalising crucial M&E policies. The collaborative partnership for M&E and its outputs represents a site for relational, conceptual, and ideological contestations involving the policy advisors and local bureaucrats. For example, acknowledging the consultants ahead of government officials in the excerpt reflects a power hierarchy and protocol that characterise GHP's relations with local partners. It represents the GHP's influence over the local health partner, which is acknowledged later in the paragraph.

Moreover, hiring private consultants suggests the influential role of the private sector in collaborative partnerships for M&E. Outsourcing government services is part of the new governance system that promotes the private sector's active involvement in public health policy and practice.

However, the unintended effect of outsourcing policy advisory services is the opportunity cost for internal staff to learn the skills they are employed to practise. The drafting of government policies should be among policy and M&E department staff competencies. Thus, it promotes a state of perpetual external dependency. The government's weak leadership in this area has ripple effects and poses more significant risks to the country. In the case referred to, drafting government policies should be a task for elected or appointed officials who can be held accountable through the national process in case of disputes. Thus, the increasing involvement of unelected consultants in delivering crucial government processes like policy formulation and drafting poses a threat to national sovereignty through the government's potential abdication of national duty. Moreover, the arrangement represents missed opportunities for internal staff to learn critical skills that improve their relevance in government.

In conclusion, policy advisory and consulting services represent an avenue for GHP's influence on the policy and practice of M&E in Zimbabwe. The expert and legitimate power of GHPs allows them to exercise authority over local health systems through advisory services.

However, the influence sometimes has unintended effects, including missed opportunities for local staff to learn and potential threats to national sovereignty by outsourcing crucial government processes to private individuals and companies.

5.3.3 Support for monitoring and evaluation champions

The previous conversation on M&E artefacts and policy advice through consultancy represents the mediation and champion role of GHP-supported staff in policy and practice for M&E. This study observes that consultants and advisors use M&E artefacts to influence policy and practice from outside, GHP-supported champions initiate changes internally. In generic discourse, the term ‘champions’ refers to advocates who ensure the institutionalisation of M&E processes in the Ministry. A collaborative arrangement for M&E between GHPs, such as the Global Fund, allows the secondment of M&E staff to facilitate specific M&E in government departments. KII-TC illustrates how the process operates and what it looks like at the street level of the Ministry of Health:

The idea is quite good because you have a narrow and specific objective, which you want to push so that the Ministry can see the results to ensure that they invest, for instance, in champions like me. So, because of that, I think there's ample evidence that if you want to make sure that you improve a specific area, you must look at champions who can be custodians of those areas. Make sure they are planted within the government, so there won't be discord but continuous development. So, the use of champions makes sure that there is consistency that there is sustainability (Participant KII-TC).

The text above provides valuable cues as to the soft power influence of M&E champions in the Ministry. The lexical and modal use of terms like ‘push for a specific objective,’ ‘results,’ ‘invests,’ ‘evidence,’ ‘consistency,’ and ‘sustainability’ demonstrates the advocacy and energetic nature of champions in the M&E system internally. The language that KII-TC uses also substantiates the pro-economic discourse discussed earlier. Thus, champions carefully promote using GHP-aligned terminology that promotes business language in local M&E systems. Terms like ‘invest,’ ‘result,’ and ‘sustainability’ reveal and betray this neoliberal influence. They represent a governing technology for GHPs from within the establishment. However, this global ‘politically correct speak’ often does not directly benefit the local systems but results in perverse and mute practices aimed at continued access to GHP financial resources.

Furthermore, the study found that the dual reporting for champions in Zimbabwe sometimes creates disharmony and open conflict in the Ministry. While some respondents justify parallel reporting in some instances, it also creates silos and uncoordinated data collection and reporting pathways. Similarly, the better remuneration for champions also creates disgruntlement in the Ministry's human resources establishment. While responding to a question on the challenges champions experience in the ministry, KII-TC remarked that:

Obviously, conflict arises when you see a champion working very hard and well remunerated for their work. They are supposed to work with unmotivated, you know, public service workers who know very well that the champion is getting reasonable remuneration for pushing the agenda, seemingly for the Ministry, but they end up saying it's an agenda for the NGO. But it is an agenda for the Ministry, and you mostly have that conflict in HR (Participant KII-TC).

The unintended effects of the strategic placement of champions include conflicts and loss of staff morale among public health servants. Moreover, questions of trust arise in the collaborative partnership as champions are accused of pushing the NGO agenda. Thus, the role of champions in practice contrasts with the pragmatic-instrumental perspectives in official policy documents.

In conclusion, M&E champions play an integral role in supporting the institutionalisation of M&E but create challenges associated with staff conflicts and promote discourses that may encourage perverse and mute practices, facilitating continued access to GHP funds rather than delivering services for the population.

5.4 Discussion

This chapter has presented the key discourses and soft power strategies that GHPs deploy to influence policy and practice for M&E in the country. The presentation has been crucial in answering part of research question one:

How do GHP M&E discourses and soft power strategies shape and influence the policy and practices of public health M&E systems in Zimbabwe?

The current section discusses the results, theoretically juxtaposing them to the NPG theoretical models and the Critical Discourse Analysis (CDA) and comparative studies that reinforce or contradict them. The styles of discourse discussed are the dominant economic, the

participatory/partnership, the scientific, the technological, the results-based, the country-led, the human-rights-based, and the emergency and security discourse.

5.4.1 Dominant economic discourses in M&E policies

The study shows that the collaborative governance structures for M&E partnerships in Zimbabwe align with the key tenets of New Public Governance theory, whose theoretical roots borrow from organisational sociology and network theory. The data further reveal the crucial elements of the NPG theory, as illustrated by Osborne (2006), which include an attempt to create a pluralist state, a focus on inter-organisational governance, and an emphasis on neo-corporatist liberal service processes and outcomes. Drawing from the CDA framework, critical scholars such as Fairclough (2001b) and Van Dijk (2005) argue that discourse control represents power beyond linguistic characteristics. It is a tool for extending ideology, hegemony, and control. Based on this accurate characterisation, the study identified the topicalisation and foregrounding of pro-economic terms and phrases as an extension of neoliberal hegemony through collaborative health partnerships for M&E through local autonomy, self-awareness, and self-directed responsibility to apply neo-liberal ideas and managerial practices. The study upholds this view, given the strategic placement of the key pro-economic terms in the foreword of the reviewed M&E policy documents and the voices of the speakers, the Country's President, and the Minister of Health. According to Huckin (2002), topicalisation positions a sentence element at the beginning to ensure the foregrounding of key messages in the sentence. The topical aspects in all the M&E policy documents reviewed substantiate the argument. Thus, CDA provided a critical view to expose the hidden meaning and goals of the pro-economic discourse.

Likewise, the study's results also expose the limits of the NPG theory in practice as the pro-economic goals are driven by self-interest rather than Osborne's assumptions of trust and relational contracts (Osborne, 2006). Similarly, the emphasis on trust-building by Ansell and Gash (2008), on principled engagement by Emerson and Nabatchi (2015), on ideology by Vangen *et al.* (2015), and mutuality and organisational identity by Brinkerhoff (2002) do not comprehensively reflect collaboratives that have all the ingredients of hidden power games played through discourse. Scholars such as Cummings *et al.* (2018) find pro-economic discourse by global development partners in the final Sustainable Development Goals (SDGs) report "Transforming our world," which was adopted by the United Nations in September 2015. They observed the support for pluralist-participatory discourse in the policy planning stages and active financing of techno-scientific-economic discourse in policy implementation.

These contradictions support the current study's observations regarding the dominant economic discourse that supports a Selected Primary Health Care (SPHC) rather than a pro-social Primary Health Care (PHC) (Cueto, 2004). Another study by Barlow and Thow (2021), reveals a similar application of pro-economic discourse to draw policy attention to business approaches to nutrition programmes through the expert and legitimate influence of the World Trade Organization in countries such as Thailand, Chile, Indonesia, Peru, Ecuador, Bolivia and Uruguay.

Thus, the study argues that the collaborative partnership for health is not based on trust, as covert strategies are deployed to influence local policy. The practice reflects a lack of open communication, mutuality, and goal congruence.

5.4.2 Participatory discourse in M&E policies

The second finding regarding participatory discourse in national M&E policy documents scaffolds the first argument about neoliberal impulses in GHP support for M&E in Zimbabwe. The emphasis on the collaborative engagements of the private sector, the civic sector, academia, and local communities with government suggests a plural governance structure based on shared values, as proposed in the NPG theory and its allied models discussed earlier. However, a CDA lens provides better insights into the skewed arrangement favouring private sector interests in Zimbabwe's public health system. A quick synopsis of active GHPs in the country, such as the Global Fund, the World Bank, and PEPFAR, suggests that they are intricately connected organisations, if not an extension of the private sector. For example, the Gates Foundation and its private corporations established the Global Fund in 2001.

Similarly, the World Bank, a private global corporation, is one of the world's largest sources of funding and knowledge for developing countries, and its influence on M&E and health policy has been phenomenal. Likewise, academia and community partners receive financial and technical support from GHPs and private sector partners. Worse still, the study shows that the government is "indebted" to these organisations through financial and technical support for M&E collaborations. Based on this evidence, the study argues that the private sector controls all the partners, including the government. As a result, it is insincere to talk of collaborative partnerships in which one partner controls the financial and epistemic direction of the governance arrangement. The voice of Global Fund structures like the Country Coordinating Mechanism (CCM) has been louder and listened to by the government on HIV, TB, and malaria programmes. While the CCM has representation from community organisations and individuals like People Living with HIV, it remains unconvincing that a community voice has

equal influence with a corporate voice in instances that involve self-business interests. Scholars like LeBan (2011) have discussed the role of communities as social capital. However, the conversations have not been critical to exposing the role of GHP financing in silencing essential voices of the community. Thus, the influence of social capital has diminished due to the monetary effect.

Scholarly evidence by Cornwall and Eade (2010) substantiates the use of participatory discourse to aid pro-economic interests. For example, in an article by Cornwall and Eade (2010), Leal asserts that ‘the World Bank's calls for the local state’s withdrawal from the economy were never about a takeover by ordinary citizens but placing the resources in the “market,” where all citizens supposedly have equal access.’ Drawing from scholars like Mulderrig (2011), one can implicate advanced liberal governing strategies in participatory discourse that rely on the subject’s sense of responsibility, obedience, and personal responsibility on the part of the government in these policies. Similarly, the strategy invokes new forms of what Lilja and Baaz (2022) call *artepolitics* or the ‘governing through nongoverning.’ The approach relies on extorting subjects’ aspirations for improvement and creativity to control and profit from their social capital. Thus, the government’s foregrounding of its role in the policy process and the involvement of communities represent an advanced form of governmentality that works productively for GHPs. The NPG assumptions of transformative leadership and trust building, as suggested by Ansell and Gash (2008), or shared motivation, principled engagement, and joint capacity, as Emerson *et al.* (2012) suggest, aid rather than abate unequal partnerships. Likewise, Vangen et al. (2015) make assumptions about the absence of ideology to conceal and obfuscate the pro-business interests in partnership discourse.

5.4.3 Scientific discourse in M&E policies

The third finding of the study implicates the use of scientific discourse in GHP-supported M&E policies in Zimbabwe. Introducing the scientific approach into a low-resource setting such as Zimbabwe has far-reaching consequences on the government’s focus on primary health issues. For example, the proposal to establish the quinary tier in the Ministry of Health and Child Care suggests the GHP's desire to promote biomedical and pharmaceutical science and innovation through research and development. That observation substantiates the literature that indicates that GHPs play R&D, Access, financial, and advocacy roles (Rushton and Williams, 2011). The scientific discourse portrays scientific intervention as an ‘undisputed good,’ which conceals other interests. For example, the emphasis on quinary research is essential but diverts

the Ministry from addressing primary service delivery challenges that could produce quick wins before venturing into medical tourism and other high-end costly scientific pathways. The proposal for medical tourism and high-end research sounds medically appropriate until one senses the business interests driving such approaches. They ignore prevention and promotional interventions to facilitate profit-oriented biomedical processes. Medical tourism and biomedical interventions are valuable strategies, and Zimbabwe can benefit from such innovative approaches if effective governance systems are in place. However, the current challenges in the health system are essentially immediate primary health issues, so proposals for high-end costly medical tourism and biomedical approaches are more likely to bring benefits in the long run. As a result, the current recommendations will likely benefit private sector actors investing in the interventions in the short term.

However, CDA scholars implicate the use of discursive techniques like hedging and modalisation to reinforce the uncontested position of scientific discourse in understanding collaborative partnerships for health. For example, Abuzyarova and Takhtarova (2018) discuss the efficacy of hedging as an effective mitigating strategy in scientific discourse. This study observed the effects of assertive mitigation of scientific discourse in one of the responses by KII-IT regarding the use of scientific approaches such as HIV estimates in M&E. The participant's strong belief regarding Bayesian modelling and HIV estimates as standard and globally accepted techniques reflects what Abuzyarova and Takhtarova (2018) referred to as 'ritualized tactics of deictic depersonalization and modalization' hidden in the scientific discourse. These tactics achieved two goals - the subjective participant's dogmatic desire to show the scientific significance of a system he belongs to or his contribution to scientific research and the desire to portray a picture of objective facts and strong evidence from science in health. Both tendencies serve only to confirm the opposite. People and science are neither objective nor free from bias. Thus, scientific discourse conceals rather than reveals evidence. Similarly, epistemic modalisation portrays a positive attitude toward the scientific approaches, as reflected in the M&E policy documents reviewed. These observations provide comprehensive insight into the limits of NPG-oriented governance systems and the value of critical discourse analysis in post-colonial partnerships for policy.

Furthermore, Tichenor and Sridhar (2019) have shown that scientific approaches such as the DALY and Estimates applied in the Gates-funded Global Burden of Disease Report (GBD) provide data for quantifying health problems in units useful for economic appraisal. Similarly, Sastry and Dutta (2013) conducted a dialogical appraisal of the PEPFAR programmes in

countries such as Malawi and unearthed scientific and pro-economic discourses in the DALY approach. These approaches inform key public health policies in Zimbabwe, implying that GHPs shape and influence Zimbabwean policies.

5.4.4 Technological discourse as governing technologies

The study's findings on technological discourse reveal a problem regarding the unchallenged common sense conceptualisation of health technology as an 'undisputed good' intervention for improved public health decision-making. The notion of pragmatic-instrumental partnerships advanced by Brinkerhoff (2002) and Abrahamsen (2004) appears to persist in technological discourse. Stevens *et al.* (2018) observe that the conceptualisation of technological decision support systems receives favourable reviews as managerial problem-solving and decision-making tools in healthcare. The systems have not received comprehensive scrutiny, as have partnerships in general. However, this positivist perspective fails to recognise technology's political and social burden and its disruptive effects on health and social life. Thus, instead of leading to productive and empowering data-driven decision-making, data systems for monitoring and evaluation lead to the erosion of local autonomy, data drift, and data fragmentation. This observation of Bopp *et al.* (2017) resonates with the current study's results, which show the chaotic, contested, and conflict-ridden nature of ICT-enabled M&E systems in Zimbabwe. The study exposes technology's political nature, contrary to the technocratic reviews in official policy documents. Technological discourse is blind to the richness of post-constructivist epistemological feedback that provides comprehensive dialectical views of the system's end-users. Moreover, the unintended effect of the discourse is its tendency to legitimise pro-economic discourse in Zimbabwe. The discourse drives the sale of computer hardware and software in developing economies such as Zimbabwe.

The above view resonates with that of Weiss (2019), who asserts that public-private partnerships are strategies designed to serve a dual purpose: to improve health services throughout the sector and to commercialise these technologies by strengthening and supporting the health technologies industry. Moreover, the study's findings on supporting client-centred technological systems like EPMS and EHR provide helpful cues regarding the pro-private sector approaches to health. The design of technology that tracks individual health needs aligns with the neoliberal goal of health as being a personal responsibility rather than a government responsibility. Sastry and Dutta (2013) find neoliberal imperatives in personalizing HIV health programmes by PEPFAR in Malawi. They argued that discourse takes away the government responsibility to prepare the way for the private sector to take over.

Thus, technological systems like the EPMS and EHR indicate the GHP influence on government towards the individualisation and privatisation of health as the government rolls back its responsibility. The Zimbabwe government's policy approach to health reflects this shift. Based on this argument, the technological discourse has enabled the roll-back of the state in public health while promoting active private sector participation through health decision support systems. Based on the results of this study, and contrary to the stated goals of collaborative partnership, technological discourse facilitates the disempowerment of the health system through technological interventions.

5.4.5 Results-based discourse in policy and practice of M&E in Zimbabwe

The concept of results-based discourse invokes conversations that help demystify the unchallenged and the self-appropriating collaborative partnership goal. The taken-for-granted definition of 'results' often refers to the quantitative targets for indicators decided in boardrooms far from the beneficiaries represented through the results. Thus, results-based discourse creates reductionism in peoples' daily struggles, where people are reported as numbers or figures. The study has shown the partnership's (un)intended effects of quantitative measures, including falsifying statistics to facilitate access to further funding. These practical extraversion tactics reveal the lack of trust in collaborative partnerships and valuable feedback about the limits of this concept in policy theory and practice. Gautier *et al.* (2019) use a post-structural approach to explain the origins of essential elements of the political debate on PBF, emphasising problematic representations embedded in the discourse. Examining the strategies and motivations of GHPs in results-based financing through CDA was consistent with the recommendation of Gautier *et al.* to explore the belief systems, motivations, resources, and strategies of actors shaping global health discourses. For example, the literature confirms the neoliberal impulses in the results-based discourse. Scholars such as Erikson (2016) and the comprehensive editorial work by Adams (2016) problematise private sector-driven indicators and targets in global health programmes. They express concern about the valorisation of quantitative metrics that echoes that in the current study, in which KII-TC has characterised data as the "new oil." Thus, CDA provides a critical view that exposes the instrumental use of results as governing technology through numbers (Bartl *et al.*, 2019; Shore and Wright, 2015).

Similarly, Jablonka and Bergsten (2021) apply CDA to question the unchallenged adage 'numbers speak for themselves.' Using a post-structuralist discourse theory, they warn against policy evaluations that fail to take cognizance of the delicate relation between the information

that numbers represent and the policy decisions they support. Thus, this study concurs with Erikson, Adams, Jablonka and Bergsten (2021) that appropriating too much power to numbers in policy decisions may advance economic interests at the expense of informing public health decisions. Jablonka and Bergsten (2021) illustrate these experiences through quantitative reporting for SARS-CoV-2 during Germany's first epidemic wave of COVID-19. As Erikson (2015) aptly demonstrates, global health results are a site for mega profits. The new goal is 'to save a life while making money.'

Moreover, the RBF approach equates quantitative measures to service accessibility and quality. Yet recent studies have failed to find a causal link between service uptake and quality through RBF interventions (Gage and Bauhoff, 2021). As a result, RBF advances the politics of evidence more than facilitating transformative change. Thus, the study concurs with scholars such as Parkhurst (2017), who calls for a shift from evidence-based policy to the good governance of evidence. The focus should be on ensuring comprehensive mixed approaches that pay attention to the lived realities of the beneficiaries rather than on upward accountability to donors. The voice of street-level bureaucrats and communities should be integral in health policy and practices.

5.4.6 Country-led discourse in the policy and practice of M&E in Zimbabwe

The findings of this study concerning the country-led discourse offer exciting insights into ideational and discursive clues for understanding postcolonial and poststructural strategies of collaborative governance that use postconditional soft power approaches to maintain and perpetuate power imbalances in Zimbabwe. The data show the insidious effects of the discourse in a potentially explosive environment through false self-awareness and self-directed neoliberal values suggesting that the country is an equal player with a global health partner, despite known limitations due to the continued imposition of economic sanctions by Western countries on Zimbabwe since early 2000.

In an article in Cornwall and Eade (2010), Buiters reflects on the elusive concept of local autonomy. It could mean that the local authorities either agree with an externally proposed programme that achieves its objectives or that the country has designed and drafted the programme. Alternatively, it could mean that the government implements a programme and donors receive progress updates. The question of who constitutes the country or what the role of its citizens may be remains elusive. Coincidentally, Buiters asks a rhetorical question: What

would country ownership mean in Zimbabwe, the Democratic Republic of the Congo, and Sudan? The rhetoric in the text suggests that country ownership does not obtain in Zimbabwe due to its weak governance systems. However, the lack of definitional clarity above makes country-led discourse an ornamental tool designed to perform rather than deliver genuine local control in the partnership collaboration. Based on this argument, the partnership is false, being based as it is on a lack of trust, a lack of shared values, and plural decision-making platforms. The study results confirm the fear that the involvement of the OECD and the World Bank in the diffusion of country-led discourse is a means of governing and maintaining the privileged position of the West through false local autonomy and self-realisation. Thus, the critical-governmentality and critical-ideological perspectives of partnership illuminate this idea in the context of collaborative partnerships for health in Zimbabwe.

Thus, the study raises crucial questions about the discourse that foregrounds evidence-based policy-making through country-led monitoring and evaluation systems (Segone, 2009). The concerns raised about this discourse are that it largely obscures the profit interests of international financial institutions (IFIs). As a result, Buitter's characterisation of this concept as a 'pernicious example of politically correct IFI-speak' supports the current study's findings about the nature of this discourse. The discourse is (ab)used by international funding institutions (IFIs) to facilitate extending loans and other softer aid conditionalities in Zimbabwe.

5.4.7 Human rights-based discourse as technologies of power

The study finds that rights-based discourse is another effective strategy used instrumentally to influence and shape M&E policy and practice in the country. The results show that GHPs invoke UN human rights conventions to remind the government about its commitments and obligations to uphold the rights of every individual regardless of moral and cultural differences. Thus, the strategy involves policy framing of contentious issues like the LGBTQI challenges as human rights violations with implications for funding health programmes. In this case, the human rights discourse apportions obligations and silences oppositional religious, cultural, and political voices against same-sex marriages in Zimbabwe. Likewise, the study has identified the economic interests hidden in the discourse, where the private sector hopes to expand the market for medical and pharmaceutical commodities like ARVs and condoms.

Storeng *et al.* (2019) observe that in South Sudan and Malawi, NGOs Marie Stopes and Ipas apply human rights discourse to silence opposition to family planning and abortion policy

issues by providing financial and technical support to frame the contentious issues. The strategy also effaces a pro-economic agenda by advocating service provision through private clinics. Moreover, the strategy invokes local autonomy and self-realisation through 'behind-the-scenes' technical support as a governing technology. The NGOs used discourse framing and control to navigate the volatile policy environment in the two countries. For example, framing abortion as a human right 'pandemic' that needs redress to achieve maternal health MDG targets diffuses the moral issues and foregrounds the MDG agenda for the countries.

Similarly, Zimbabwe's current National Health Strategy frames HIV among key populations as a 'distinct sub-epidemic that requires targeted responses.' The framing of the 'epidemic' invokes urgency and a global emergency that justifies scientific evidence and external policy implementation support. Thus, a rights-based discourse intersects with the marginal and minority discourses to justify the urgent need for global support and intervention. This study observes that both parties to the collaboration functionally apply the human rights discourse, and the beneficiaries are the ultimate losers in the power games. The GHPs use the intervention to advance their pro-economic objectives, while the government uses the opportunity to raise funds to support public health. Globally, programmes such as the International Partnership for Planned Parenthood and Family Planning (IPPF) and Marie-Stopes (MSI), which also operate in Zimbabwe, commonly incorporate private clinics through non-profit or social franchising in their programmes.

Based on the above discussion, this study agrees with scholarly warnings on the need to avoid the tokenistic use of human rights discourse without holding governments, civil society, and the private sector accountable for meaningful implementation. Williams and Blaiklock (2016) warn that using the discourse of human rights without reflecting the full intent of human rights promotes 'a customary' or casual attitude to the use of the terms that undermine the real meaning of 'human rights.' Thus, the deterministic, instrumental, and performative use of human rights discourse sullies its idealism with the motive of pursuing profit. It weakens the accountability systems that monitor the actions that the private sector, the government, and civil society take against citizens. Such scholars further warn against the state's abdicating its legitimate authority to deliver health to the benevolence of the free market or what Alfred-Maurice de Zayas calls 'dogmas of market fundamentalism with a focus on profit rather than sustainable development.' The state should uphold the representative authority granted to it through its electoral processes to safeguard the population from the interests of the private and civic sectors.

5.4.8 Framing Health as an emergency and security issue

The final discourse identified in national M&E policy documents in Zimbabwe is framing health as an emergency and security issue. The strategy effectively influences the national policy timeframes and situates the provision of health services in an ongoing emergency mode in dealing with specific diseases. The rolling out of HIV treatment medicines in Zimbabwe is one example of the effects of emergency discourse in health. The strategy influenced the acceleration of ARV rollout to many people initially considered healthy but now require life-prolonging treatment. The process necessitated the review of national ART guidelines and policies to facilitate quicker turnaround periods between HIV testing and enrolment into care.

Similarly, the reaction to the current Covid-19 pandemic has placed the country in an emergency mode, resulting in debates about mandatory vaccinations. These two examples show the role M&E data play in justifying the activation of emergency and security discourses in global health. While scholars like Jablonka and Bergsten (2021) have used the Covid-19 pandemic to argue that ‘numbers don’t speak for themselves,’ the analysis further contends that the discourse has a performative effect on justifying emergency response. Meanwhile, discourses oppositional to emergency and security discourses are dismissed as ‘conspiracy theories.’ The modal attitude of IDI-AM when talking about conspiracy theories in HIV and Covid-19 was dismissive of voices oppositional to this narrative as devoid of science or as political talk. Likewise, security discourse activates an emergency security mode that inspires resource mobilisation and departs from the usual bureaucratic processes.

Storeng *et al.* (2019) note that local partners in Malawi sought alliances with global anti-abortion activists to counter the discourse and regulatory measures against the controversial abortion laws in that country. Ipas NGO's obfuscation and concealment strategies in dealing with the controversial political issues fed speculation and "conspiracy theories," which meant that the organization could not effectively influence the intended policy changes. Thus, the study argues that strategic policy planning and implementation should consider conspiracy theories in planning. Moreover, the findings reveal the relational nature of power in partnerships, as local partners successfully mobilised around the conspiracy theory to counter GHPs' local influence despite their legitimate, expert, financial and epistemic power over local partners. Thus, the study shows the limits of the discursive institutionalist approach to policy and that no single partner has absolute control of partnership processes.

5.5. Soft Power Strategies

The previous section addressed the first part of the research question discussing the discourses shaping and influencing policy and practice for M&E. The current section discusses the soft power strategies identified in the findings in chronological order: M&E artefacts as governing technologies, the provision of M&E policy advisory and consultancy services, and support for M&E champions.

5.5.1 Monitoring and evaluation artefacts as governing technologies

The study's findings reveal that M&E artefacts such as policies, plans, and strategies are important sources of policy influence in collaborative partnerships for M&E in Zimbabwe. The conversations with IDI-AM and KII-TC illustrated how the PEPFAR and the Global Fund M&E planning artefacts are integrated into the Ministry of Health planning and policy frameworks. The respondents suggested co-option rather than coercion in the incorporation of the artefacts. The use of monetary and persuasive strategies by GHPs to influence and shape M&E planning and policies confirms similar findings regarding the role of such artefacts in shaping and influencing local policies. Duval *et al.* (2015) observe that funders use discursive power and artefacts to exert a certain degree of control over NGOs' representation by restricting the physical space needed to provide personal information in application templates and guidelines. Duval *et al.* use the Canadian International Development Agency (CIDA)'s funding application system to reveal how donor templates relay meaning that influences the recipient NGOs through the organisation of the application forms, the order of titles, paragraphs, the use of colourful frames and hyperlinks, among other discursive markers on the application forms. As the responses by KII-TC show regarding the Global Fund, the application forms have a linguistic influence on the local partner that responds to the call for proposals. Similarly, the logical framework which forms part of Zimbabwe's M&E artefacts for strategic planning and design instruments has an imported language of its own. The GHP's influence through the logical framework is pervasive in the M&E Policy, 2015 and the ZimASSET, which has a government-wide M&E framework. Its weaknesses include its reductionist approach to complex health, economic, political, and social problems in Zimbabwe. Whereas the tool provides a systematic approach to programme implementation in stable environments, it has not helped to provide predictable planning and implementation in health programmes in Zimbabwe.

Scholars such as Makuwira (2018) and Gasper (2000) point out the limitations of the LFA concept in situations similar to Zimbabwe. They call the approach illogical, "lack-frame," and

"lock-frame" because it does not provide space for a careful consideration of the social dynamics of health. Moreover, the focus is on reporting the positive aspects or performance of the intervention logic with little room for adverse reporting. As a result, the approach leads to missed learning opportunities from negative feedback and mistakes in the project implementation. Thus, the pressure to report positively to funding partners results in the M&E system providing information relevant to global rather than local systems decision-making and programme learning. Moreover, GHPs ensure local control through prescribing guidelines for funding, leaving no room for local partner input to the quantitative data collection rituals to reify the power imbalance between donor demands and project implementation reality. Thus, M&E artefacts play an essential role in M&E partnerships as they include and exclude, visibilise or invisibilise local health issues in the broader conversations and agenda-setting for health policies in Zimbabwe.

5.5.2 Provision of M&E policy advisory and consultancy services

The study highlights critical issues about the role of consultants in shaping and influencing public health M&E policy and practices in Zimbabwe. The evidence from the thematic analysis of the policy documents reveals that consultants and policy advisors play a crucial role in conceptualising, drafting, and the diffusion of policy ideas in the country. The study notes that apart from the financial and technical support facilitating the recruitment of appropriately qualified and experienced consultants, consultants and policy advisors represent a new private sector logic of outsourcing key government processes to the private sector. Thus, their involvement exerts a broader policy influence that introduces pro-business values into public governance.

Similarly, the involvement of private financial advisors like KPMG in the Global Fund has the same effect. These global corporates provide financial advisory services that emphasise value for donor funds through recommendations for more private sector involvement in public service provision. This resonates well with the tenets of the NPG Theory, which advocates inter-governmental relations that prioritise corporate concerns that focus on service delivery. The study data reveal that policy consultants in Zimbabwe have a discursive influence on policy processes through the collection and arrangement of information which involves discretionary choices on the types of information gathered through organising and classification. The findings resonate with observations by Duval *et al.* (2015) that consultants use linguistic and visual processes to select, discard, manipulate, couple, label, highlight, and

edit policy information. As a result, the categorisation, linkages, and other formal features result in the construction of a policy representation rather than a simple reflection of the policy issues under scrutiny.

Similarly, a more recent study by Bortz (2019) acknowledges the influence of consultants on public policy by introducing private-sector ideas to assist public-sector managers in resolving challenging organisational and social problems. As this study does, Bortz notes the dearth of scholarly work on the discursive aspects of the influence of consultants. Current scholarship, however, tends to downplay the more discursive elements of that influence. Based on a selection of discursive mechanisms and ideas, the Bortz study draw the conclusion that consultants' power is not unidirectional, as other actors are capable of resisting the concepts, narratives, metaphors, and discourses that consultants supply. Bortz further argues that consultants would be more influential on a coalition when their discursive repertoire may establish a rapport with the interpretive frame of the policy coalition. According to this scholar, an interpretive frame is a collection of pre-conceived ideas, interests, and identities that a policy coalition uses to understand and interpret the world around it.

Similarly, Howlett and Migone (2013) raise concerns over the high costs to governments of hiring consultants (they refer to those hired in this manner the 'consultocracy') and the erosion of democratic virtues through active private sector participation in public policy and organisational development, while the value derived from the investment remains inconclusive. No adequate data and methodological approaches exist to explore consultants' merits fully. Suffice it to say that the line between elected officials and outside consultants blurs over time in policy making. This discussion points to governance systems skewed in favour of private and civic players benefiting from government contracts through policy shifts allowing less government and more private sector involvement.

5.5.3 Support for monitoring and evaluation champions

The final soft power strategy shaping and influencing M&E policy and practice is the concept of M&E champions. The approach relates closely to hiring consultants and advisory services discussed above, except that in Zimbabwe, the champions influence and shape policies internally. Contrary to most recent literature on M&E champions, the study successfully identified practical challenges in the execution of their duties in the Ministry. Rogers and Gullickson (2018) observe that the limited literature suggests that the contribution of champions is highly valued but not recognised as much as it should be. Similarly, Silliman *et*

al. (2016) describe champions as catalysts for building evaluation capacity in an organisation, as advocates for the importance of programme evaluation, as role models for good evaluation behaviours, and as mentors to their peers in programme evaluation skills and competencies.

However, unlike this study, these studies could not further reflect on these champions' bi-directional unintended practical effects in their varied work environments. The evidence suggests that champions influence policy and practice positively and negatively but also face resistance or pushback from the Ministry's system. That finding resonates with the study's Foucauldian governmentality framework which states that policy influence and power in the Ministry is relational rather than unidirectional. Thus, claims by World Bank scholars such as Mackay in Lopez-Acevedo and Krause (2012) suggest that champions are indispensable in building M&E systems and require contextualisation. In contexts such as Zimbabwe, the good intentions of GHPs sometimes face resistance due to the salary discrepancies between the champions and low-salaried government employees. As a result, the issues that engage champions have limited relevance to the work they were hired for. KII-TC elaborated on the reverse 'othering' effects of GHP support for champions in the country. Reverse "othering" refers to the negative attitudes that champions experience as higher-earning ministry employees. Based on these findings, the study maintains that champions influence and shape M&E policies despite the operational challenges they face in the system in Zimbabwe.

Matrix 5:2 summarises the discussion on the discourses and strategies GHPs use to influence and shape local health M&E policies and practice in Zimbabwe.

Matrix 5 2 Discussions on key discourses and soft power strategies shaping and influencing the policy and practice of M&E in Zimbabwe

Research question /s	Emergent theme/s	Interaction with literature	Sources
How do GHP M&E discourses and soft power strategies shape and influence the policy and practices of public health M&E systems in Zimbabwe?	Dominant economic discourses in M&E policies	<ul style="list-style-type: none"> The influence of discourse control through topicalisation, lexicalisation of key terms in sentences, paragraphs Dominant economic discourse that supports a Selected Primary Health Care (SPHC) rather than pro-social Primary Health Care (PHC) Pro-economic discourse drawing policy attention to business approaches to nutrition programmes through expert and legitimate influence of the World Trade Organization in countries like Thailand, Chile, Indonesia, Peru, Ecuador, Bolivia, and Uruguay Implicated pro-economic discourses by global development partners in the final Sustainable Development Goals (SDGs) report “Transforming our world.” 	Huckin (2002), (Cueto, 2004) Barlow and Thow (2021) Cummings <i>et al.</i> (2018)
	Participatory discourse in M&E policies	<ul style="list-style-type: none"> Participatory discourse facilitates the local state’s withdrawal from the economy and takeover by the private sector. Participatory discourse is implicated as advanced liberal governing strategies that rely on the subject’s sense of responsibility, obedience, and personal responsibility on the part of the government in these policies. Governing through non-governing-arteopolitics Role of social capital in collaborative partnerships 	(Cornwall and Eade, 2010) Mulderrig (2011) Lilja and Baaz (2022) LeBan (2011)
	Scientific discourse in M&E policies	<ul style="list-style-type: none"> Role of GHPs in R&D, access, financial, and advocacy roles and the influence of scientific approaches like the DALY and HIV Estimates, Global Burden of Disease Report (GBD) The use of hedging techniques to improve the acceptability of science as an effective mitigating strategy in scientific discourse. 	(Rushton and Williams, 2011) (Tichenor and Sridhar, 2019)
	Technological discourse as governing technologies	<ul style="list-style-type: none"> Instead of leading to productive and empowering data-driven decision-making, data systems for monitoring and evaluation work lead to the erosion of local autonomy, data drift, and data fragmentation. Public-private partnerships are strategies designed to improve health services and commercialise these technologies by strengthening and supporting the health technologies industry. 	Bopp <i>et al.</i> (2017) Weiss (2019)
	Results-based discourse in the policy and practice of M&E in Zimbabwe	<ul style="list-style-type: none"> Used post-structural approach explaining the origins of essential elements of the political debate on PBF, emphasising problem representations embedded in the discourse. Applied CDA to question the unchallenged adage ‘numbers speak for themselves.’ Applying a post-structuralist discourse theory exposing the delicate relation between the information that numbers represent and the policy decisions they support. Failed to provide a nuance between service uptake and quality through RBF interventions 	Gautier <i>et al.</i> (2019) Jablonka and Bergsten (2021) (Gage and Bauhoff, 2021)
	Country-led discourse in the policy and practice of M&E in Zimbabwe	<ul style="list-style-type: none"> Country-led discourse is characterised as a pernicious example of politically correct IFI-speak. Evidence-based policymaking through country-led monitoring and evaluation systems 	Cornwall and Eade (2010), Buiter (Segone, 2009)
	Human rights-based discourses as technologies of power	<ul style="list-style-type: none"> NGOs applied human rights discourses to silence opposition to family planning and abortion policy issues by providing financial and technical support to frame the issues 	Storeng <i>et al.</i> (2019)
	Monitoring and evaluation artefacts as governing technologies	<ul style="list-style-type: none"> Discussed the use of discursive power and artefacts to exert a certain degree of control over NGOs’ representation by restricting the physical space needed to provide personal information in application templates and guidelines. The scholars dismissed the logical framework approach as ‘logic-less, a lack-frame, and a lock-frame’ due to its limits in providing space to address the social dynamics of health comprehensively. 	Duval <i>et al.</i> (2015) Makuwira (2018)
	Provision of M&E policy advisory and consultancy services	<ul style="list-style-type: none"> Consultants use linguistic and visual processes to select, discard, manipulate, couple, label, highlight, and edit policy information. Acknowledged the influence of consultants on public policy by introducing private-sector ideas to assist public sector managers in resolving organisational and social challenges. 	Duval <i>et al.</i> (2015) Bortz (2019)
Support for monitoring and evaluation champions	<ul style="list-style-type: none"> Observed that the limited literature suggests that the contribution of champions is highly valued but not recognised as much as it should be. Described champions as catalysts for building evaluation capacity within an organisation. Suggesting that champions are indispensable in building M&E systems requires contextualisation. 	Rogers and Gullickson (2018), Silliman <i>et al.</i> (2016) Mackay in Lopez-Acevedo and Krause (2012)	

5.6 Chapter Conclusion

This chapter has addressed the research objectives and questions by identifying the discursive and soft power strategies and mechanisms that influenced and shaped M&E policy and practice in the health M&E system in Zimbabwe. Through the qualitative analysis of the four official M&E policy documents and interviews with

crucial M&E staff from the Ministry of Health and the National AIDS Council, the study applied the CDA, Governance of Collaborative partnership, and NPG frameworks and provided helpful insights into the extent to which GHPs apply common discourses and sustain neoliberal pro-business ideas through the health system. In the process, the study successfully addressed the hypothetical assumption that the challenges experienced in the health M&E system directly result from GHP ideational strategies (ideological and epistemological) designed to sustain neoliberal values in the health system in Zimbabwe. The study concluded that all GHP-supported discourses advance a neoliberal ideology to support a common sense capitalist view that promotes free markets' primacy to determine future public health service delivery. The discursive themes such as partnership/participatory, technological, scientific, country-led, human rights, health emergencies, and results-based discourses advance a dominant pro-economic discourse through public health M&E policies in the country.

Moreover, using attractiveness and persuasion rather than coercion is the principal strategy for shaping and influencing policy and practice for M&E in health. Through a Foucauldian conceptualisation of power as governmentality or governing from a distance, the study concluded that GHPs govern public health policy processes from afar through ideational and ideological persuasion. However, the study also found that power relations in the partnership are not unidirectional as the Government of Zimbabwe instrumentalises discourse to resist some of the policy influences.

CHAPTER SIX: LOCAL M&E PARTNER RESOURCE AND POWER RATIONALISATION MECHANISMS AND STRATEGIES IN THE PARTNERSHIP FOR HEALTH IN ZIMBABWE

6.1 Introduction

The previous chapter discussed the M&E discourses and soft power strategies GHPs use to influence the policy and practice of M&E in Zimbabwe. The chapter examined the dominant economic, scientific, technological, country-led, results-based, participatory, and human rights discourses as the common mechanisms used in the country. In addition, the chapter discussed how the GHPs use policy consultants, M&E champions, M&E artefacts, health emergencies, and false conspiracy theories as soft power strategies to influence policy and practice. The emphasis of this chapter is to answer the second research question by addressing the mechanisms and strategies the Ministry of Health, as the local health M&E partner, deploys to rationalise the resource and power imbalance in the partnership for health in Zimbabwe. The chapter looks explicitly at the recourse to constitutional and sovereignty power, the availability and enforcement of clear policies and guidelines, the use of memoranda of understanding (MoUs), the instrumental use of bureaucratic power, victimisation and polarisation, extraversion, and obfuscation as some of the strategies that the Ministry of Health uses to counter GHP influence and maintain its leadership role in the partnership for M&E.

6.2 Mechanisms and strategies for rationalising power imbalances in partnerships

This study has identified six strategies that the government of Zimbabwe, as an under-resourced partner, has deployed to counterbalance its position in the partnership for M&E. The specific mechanisms and strategies identified and discussed include the recourse to constitutional and sovereignty power, the availability and enforcement of clear policies and guidelines, the use of memoranda of understanding (MoUs), the instrumental use of bureaucratic power, victimisation and polarisation, extraversion, and obfuscation. Matrix 6:1 is a summary of the findings

Matrix 6 1 Summary of findings on mechanisms and strategies by the Ministry of Health to rationalise resource and power imbalances in partnerships

Sub-theme/sub question	Participants' responses	Source/s
Recourse to constitutional and sovereignty power	<i>The State must adopt and implement policies and legislation to develop efficiency, competence, accountability, transparency, personal integrity and financial probity in all institutions and agencies of Government at every level and in every public institution</i>	Constitutional Amendment No 20 of 2013
	<i>So, if you have sovereignty, you can demand accountability. But if there is no sovereignty, you cannot demand accountability; the decision-making power has been usurped and taken from you. So, you cannot demand accountability.</i>	KII-TC
	<i>In such a collaboration, the government provides the labour and the infrastructure, for example. The labour is good and educated enough to do statistics, operations research, and even Ph.D. studies. All the people who staff the clinics, the hospitals, and the facilities are Zimbabweans. They are all locally trained and competent enough. So, the government is providing human resources. It is also providing the infrastructure</i>	(IDI-CN).
Enforcement of clear policies and guidelines	<i>So, in terms of power dynamics, I realised that where there are clear policies, regulations, and guidelines on the government side, usually the government is in control.</i>	KII-LM
	<i>All stakeholders shall comply with the National Monitoring and Evaluation Policy to ensure the effective implementation of Government policies, programmes, and projects. Compliance in this policy is adhering to guidelines, standards, operating procedures, and regulations.</i>	National M&E Policy, 2015
Use of memoranda of understanding (MoUs) as government source of power in partnerships	<i>It's like the funding partner and the Ministry have got some memorandum of understanding. So, as much as the Ministry has its interests, the funding partner also has its interests.</i>	IDI-AM
	<i>They want to control the information, they want to control the data, they come through the formal structures, and formal structures also direct them to formal data storage. And when they want this data, they must ask (for it) from the Permanent Secretary, which they don't want to do.</i>	KII-TC
Bureaucratic power as procedure and orderliness	<i>Why should they beg for data, they want to get the data as and when they want it without the government's consent? So, they want to avoid, in a nutshell, I can say, bureaucracy with the government. They see the bureaucracy, but we see it as procedure. And we see it as, you know, orderliness.</i>	KII-TC
	<i>When she (politician) was around in a certain district, many resources were pushed to that district. So that when she is available, it appears like the district is well resourced.</i>	IDI-AM
Victimisation and polarization as a strategy	<i>However, since the introduction of RBM in 2005, the Public Sector performance moderately improved despite both external and internal factors. The external factors were mostly influenced by the illegal sanctions imposed on Zimbabwe by Western Countries.</i>	National M&E Policy, 2015
Extraversion and obfuscation Strategies	<i>Working closely with the other essential units such as the Health Management Information System, this platform will meet all the data needs of the country and allow progress towards attaining the goals and objectives specified in the NHS, as well as national, regional, and international commitments such as the SDGs.</i>	National Health Strategy for Zimbabwe, (2021-2025).

6.2.1 Recourse to constitutional and sovereignty power

In alignment with the NPG and governmentality and the CDA theoretical framework, the study found that partnerships for M&E in Zimbabwe involved relational power dynamics among the tripartite partners, the government, civil society, and the private sector. The study further observed that while the GHPs and private sector partners applied various soft power strategies, including financial and technocratic approaches, the Government of Zimbabwe (GoZ) invoked its sovereignty and constitutional power to counter the influence in the partnership for M&E. The government applied the topicalisation of the health system as a Constitutional provision in all the M&E policies reviewed. In line with the CDA framework, topicalisation in discourse analysis is a communication strategy that foregrounds key messages that a speaker wishes to communicate to the audience. Thus, the Government of Zimbabwe's reference to Constitutional health provisions in all the M&E policies is a tactic aimed at reminding the partners in the NPG framework to respect the sovereign authority of the government regardless of its financial and technical deficiencies in the partnership. An excerpt from the National M&E Policy, 2015, illustrates the strategy aligned to the RBM framework. In terms of Chapter 2, Section 9(1) of the Constitution of Zimbabwe:

The State must adopt and implement policies and legislation to develop efficiency, competence, accountability, transparency, personal integrity and financial probity in all institutions and agencies of Government at every level and in every public institution....

What is striking in the excerpt is the Government's clarion call to promote systems that facilitate delivering public health services in the best interests of Zimbabwe's citizens by all partners involved. Thus, the government has legitimate and legal authority to lead the process in the public interest of all citizens of Zimbabwe. Despite the financial constraints the Government of Zimbabwe faces, well-resourced GHPs and the private sector still rely on express approval from the government to implement proposed public health programmes in line with the Constitutional provisions.

Some of the M&E respondents felt that the government provided other crucial sovereign resources like human resources and health infrastructure in the partnership for M&E. Take, for example, an excerpt from IDI-CD when responding to a question on the government's contributions to the partnership for M&E in the country:

In such a collaboration, the government provides the labour and the infrastructure, for example. The labour is good and educated enough to do statistics, operations research, and even Ph.D. studies. All the people who staff the clinics, the hospitals, and the facilities are Zimbabweans. They are all locally trained and competent enough. So, the government is providing the human resources. It is also providing the infrastructure. (Participant IDI-CN)

The exciting response above shows that no matter how the GHPs may be financially or technically equipped, they still rely on the government to provide the human resources and infrastructure that the GHPs require for their programmes to succeed. Thus, the Zimbabwe government uses its human resources and infrastructure as sovereign resources to contribute to the partnership. The response further illustrates the limits of financial and

other soft forms of power in partnerships for M&E that ultimately require express authority and support from the under-resourced government. Sovereignty power is taken seriously by the government of Zimbabwe, given the sanctions imposed against the country since the early 2000s. An excerpt from another participant illustrates the importance of this concept among bureaucrats. While responding to the kind of partnership existing between the government and GHPs and implications for sovereignty, he remarked that:

So, when you talk of sovereignty, you are saying as the father of the house, I want to be consulted, if there are visitors that are going to come, I want to be consulted, if the visitors are going to come and take x, y, z, children from me, I want to be consulted when they do ABC when they give you something in this household, I want to know what are they giving us for and why? So, if you have sovereignty, you can demand accountability. But if there is no sovereignty, you cannot demand accountability; the decision-making power has been usurped, it has been taken from you. So, you cannot demand accountability (Participant KII-TC).

It is interesting how the respondent topicalises consultation and the demand for accountability by the government from the GHPs and the private sector, in the absence of a financial contribution to the partnership. The response is interesting, considering that usually GHPs demand accountability of the government. Thus, the government has the sovereign power to hold GHPs accountable for the resources they bring into the country and the results they help bring about.

However, sustaining the authority to counter GHP's influence in the M&E partnerships has been difficult. The GHPs continue to use technology and other strategies to circumvent the limits of sovereignty power in partnerships for M&E. While illustrating the challenges GHPs pose with regard to sovereign rights in partnerships for M&E, KII-TC expressed exasperation due to the sophisticated methods applied by GHPs to circumvent the Ministry's systems as they access health data from the system, illegally so. He remarked that Zimbabwe's sovereignty is under threat from GHPs:

I say so because the data mining activities, the real ones that matter, are not Superintendent(overseen) by our M&E director, you know, that they are mediated through technology that external partners provide. The technology otherwise is not approved to be used in the country; otherwise, the technology excludes the decision-makers, as opposed to being included as part of that technology matrix (Participant KII-TC).

The response highlights crucial practical challenges that limit the government's ability to effectively counter the financial and technical resources of GHPs in partnerships for M&E. The response further questions the role of sovereign power in global governance, given the proliferation of technology and the advent of a virtual reality, a metaverse that presents opportunities and threats for Zimbabwe. The data mining metaphor expresses the extractive nature of GHPs dealing with health data in Zimbabwe. It portrays nefarious activities contrary to the requirement of mutual trust expected in partnerships for M&E. Additionally, such approaches do not

consider local needs, instead prioritising foreign economic needs for GHP proxies in Western capitals who use the data for epidemiological, economic, and strategic purposes.

6.2.2 Enforcement of clear policies and guidelines

Apart from the constitutional and sovereignty provisions, the study found opportunities for the government to use the availability and enforcement of GHP-supported M&E policies and guidelines as instruments of power in partnerships for health. National policies and guidelines provide a systematic, structured and conceptual mechanism through which the government holds its partners accountable in providing financial and technical support to its public health programmes in the country. The policies might take the form of law or regulatory frameworks governing the conduct of GHPs and the private sector in partnerships for health M&E systems. The availability and enforcement of these policies and guidelines constitute a hybridisation of conceptual and material power that holds GHPs accountable in Zimbabwe. An interview response by KII-LM provides insights into the agency of policy availability and enforcement as a source of power in partnerships for M&E in Zimbabwe. While responding to a question on how the government can optimise policy processes to uphold its values and national priorities, KII-LM remarked that:

So, in terms of power dynamics, I realised that where there are clear policies, regulations, and guidelines on the government side, usually the government is in control. However, where there are gaps in the regulations, policies, and guidelines, I've realized that the partners usually take advantage of that and try to dominate in those areas because they're saying you have no capacity, you have no clear way of doing these things. But, where there are clearly outlined policies and guidelines, the government is usually on top of the situation (Participant KIILM).

The availability and enforcement of policies and guidelines is therefore an opportunity to align GHPs to government policy which the GHPs participated in drafting. In this process, the government and local civil society organisations ensure the effective and efficient implementation of the policies as set out in the government gazette. The government of Zimbabwe made this clear intention in its national M&E policy. An excerpt from the policy clearly illustrates the point above:

All stakeholders shall comply with the National Monitoring and Evaluation Policy to ensure the effective implementation of Government policies, programmes, and projects. Compliance in this Policy is adhering to guidelines, standards, operating procedures, and regulations. All Public Sector Institutions, Civil Society and Private Organisations that are registered with Government and handle public funds will be required to comply with the provisions of this National Monitoring and Evaluation Policy. Standards set out in this Policy document that guides the monitoring and evaluation processes shall be applicable across the Government structures (National M&E policy, 2015:35).

The policy guideline is clear in ensuring all partners play according to the laid down rules. Thus, the government normatively highlights its role in ensuring accountability for all public funds, including those

received through civil society organisations such as GHPs. To this extent, the M&E policy and guidelines represent a powerful artefact that aligns all key public health stakeholders with accounting for public funds flowing into Zimbabwe. Implementing this policy requirement promotes bottom-up accountability mechanisms that benefit the government, the donors, and the beneficiary populations. However, the extent to which the Government of Zimbabwe has applied this resource remains unclear. As alluded to earlier, the lack of control over the sovereign responsibility due to financial and other resource constraints severely limits the government's ability to enforce policy guidelines and recommendations in the health sector.

6.2.3 Use of memoranda of understanding as a government source of power in partnerships

Signing a memorandum of understanding is another mechanism and strategy the government deploys to counter-balance M&E partnerships for health in Zimbabwe. Drawing from the Governance of Collaborative Partnership Framework, MoUs are among the artefacts that the government uses to guide the implementation of mutually agreed programmes to transform the M&E system for health. MoUs are non-legally binding agreements between two or more parties with a common objective. Similarly, viewing MoUs through a CDA framework reveals the partnership discourse as a depoliticised space in which partners advance mutual interests driven by trust and common purpose. The discourse conceals the power imbalances inherent in the government-GHP and private sector partnerships in volatile policy environments like Zimbabwe. It is interesting to note that all the participants in the study mentioned MoUs as one mechanism and strategy used by the government to hold GHPs accountable in the partnership for M&E. The participants highlighted partner commitment to mutual interests, trust, equity and organisational identity, and independence as some of the issues that MoUs address. They also lay out the operational rules for the partners and agreements on M&E artefacts, such as reporting templates, indicators, and targets for joint programmes. Thus, at the policy planning level, MoUs promote win-win situations for the partners. Take, for example, an excerpt from one of the respondents below:

It's like the funding partner and the Ministry have got some memorandum of understanding. So, as much as the Ministry has its interests, the funding partner also has its interests. So, you find some templates, as per the norm, are developed jointly considering the interests of the various players. So, for example, if you look at the RBF template, it was developed by the Ministry in collaboration with Cordaid and Crown Agents. If you look at the Reporting Template for TB, it was developed by USAID in collaboration with the Ministry of Health, so those collaborations through technical working groups, and the other platforms, I think, work in favour of coming up with the templates, which are representative of the interests of each other part (Participant IDI-AM).

The above text provides a normative view of MoUs as facilitators of partnerships. It aligns with the pragmatic-instrumental epistemology advanced by scholars like Brinkerhoff (2002), who views partnerships as helpful in advancing national development and implementable in practice. As the response shows, it

unproblematically suggests that the government and GHPs collaboratively design tools because they have an existing MoU. Moreover, lexical analysis of the response further illustrates that the collaborative design of M&E artefacts such as templates is normative rather than practical. His aspirational mode shows that what ought to happen is not happening. The statement ‘So you find some templates as per the norm are, developed jointly’ substantiates the normative argument. Likewise, drawing from Fairclough’s three-dimensional CDA framework provides insight into helpful interpretations and explanations of the response's textual and contextual aspects that reflect the external influence of GHPs in MoU partnerships. Cordaid, Crown Agency, and USAID are global leaders in those programmes, and most of the Ministry's M&E tools align with the GHPs' global M&E programmes.

However, some participants highlighted practical challenges in MoU partnerships despite describing them as a strategy and mechanism by the government to counter GHP's influence on M&E policy and practice. While illustrating the practical challenges the government faces in implementing MoUs, KII-TC became ballistic about the bullying tactics of the well-resourced GHPs against the provisions of the agreements. He remarked that:

They want to control the information, they want to control the data, they come through the formal structures, and formal structures also direct them to formal data storage. And when they want this data, they must ask (for it) from the Permanent Secretary, which they don't want to do. They are partners; they have the money. Why should they beg for data? They want to get the data as and when they want it without the government's consent (Participant KII-TC).

The above rhetorical response depicts the political instability and fragility that MoUs are exposed to in practice, far from the depoliticised mutual interests and win-win discourse at the policy planning and strategic level. Thus, it is unconvincing to suggest that the government has the power to hold GHPs accountable through non-binding MoUs. The response shows that GHPs apply soft and material power to get the data they want at any time. They do not rely on official processes to access the data. As noted earlier, the government’s failure to address sovereign responsibilities limits its ability to hold the GHPs to account through non-binding agreements like MoUs. As a result, the GHPs continue to engage in extractive data practices outside the agreed framework. Thus, MoUs do not provide adequate safeguards for the government to hold GHPs accountable.

6.2.4 Bureaucratic power as procedure and orderliness

Another interesting finding of this study is that government officials sometimes instrumentate bureaucratic tendencies to exert their bureaucratic authority in partnerships for health. Thus, insistence on hierarchical processes is not always about inefficiencies or negative stigma around bureaucracy. It serves as a governing technology to counter GHP influences in partnerships for health M&E systems. The strategy has currency, considering that the government has the ultimate decision on whether a GHP-funded project can go ahead

within the sovereign boundaries of the state. To this extent, bureaucracy remains a potent weapon available to the government in complex partnership arrangements like Zimbabwe's. To illustrate this finding, an excerpt from KII-TC shows the conceptual variations between GHPs and the government as it tries to resist too much external influence in partnerships for M&E. In response to the reasons given by GHPs for parallel data collection and reporting systems, KII-TC rhetorically remarked that:

Why should they beg for data, they want to get the data as and when they want it without the government's consent? So, they want to avoid, in a nutshell, I can say, bureaucracy with the government. They see the bureaucracy, but we see it as procedure. And we see it as, you know, orderliness (Participant KII-TC).

The above text shows two parallel worldviews concerning the slow pace of data sharing between the partners, perhaps driven by mistrust and a lack of goal congruence, contrary to the values of an ideal partnership. Moreover, the views reflect conceptual discrepancies between Western and African public governance knowledge systems over concepts like bureaucracy. As the response suggests, the century-old common sense negative conceptualisation of bureaucracy does not apply in Zimbabwe. It has regained its original Weberian sense of 'orderliness' and 'procedure.' Government processes cannot escape the need for thoroughness and order if governments are to exercise their legitimate authority to serve their citizens. However, the procedural 'rituals' that sometimes accompany these processes have acquired negative connotations that imply slow decision-making processes and fuel mistrust in partnerships.

In some cases, bureaucratic practices embody corrupt tendencies disguised as order and procedure. As a result, government officials take advantage of GHP partners by requiring bribes to fast-track processes driven by short-term goals and targets. Thus, M&E practices invite reflections on the power of street-level staff for the success of GHP-supported programmes in Zimbabwe. This raised the issue of the contestation between bureaucracy and international socialisation. Whereas international NGOs have the financial and technical resources, their influence does not automatically change perceptions and processes at local levels.

Similarly, local-level hierarchies experience the same street-level bureaucratic influence in policy practice. An excerpt from IDI-AM below shows how lower-level staff makes discretionary decisions on issues based on local experience, sometimes in deceptive ways. When commending non-scientific bureaucratic decision-making processes in health M&E, IDI-AM gave an exciting example of manipulative processes when politicians visit health projects. He remarked that:

When she (a politician) was around in a certain district, many resources were pushed to that district. So that when she is available, it appears like the district is well-resourced. So you are pushing resources not because of any numbers but because some political force is pushing those resources there (Participant IDI-AM).

The above response reveals the discretionary and political nature of decision-making in the underfunded bureaucratic environment in Zimbabwe. These experiences also present opportunities for street-level government officials to exercise their power against GHPs during project site visits. They decide which site should be visited and which beneficiaries should meet the visitors. Similarly, GHPs working with slow government processes get absorbed into bureaucratic socialisation, so that bureaucratic traits, inefficiencies, and even corruption become part of their *modus operandi*.

The study thus shows the immense positive and negative influence the government has at its disposal through the bureaucratic execution of its functions in a partnership. The study also suggests that bureaucracy is not always damaging but can act as a mode of resistance against abuse by external partners. In addition, GHP's influence on M&E processes in Zimbabwe faces matching resistance through bureaucratic socialization when GHPs adopt bureaucratic traits like slow funds disbursements and sometimes corruption.

6.2.5 Victimhood as a strategy

Another surprising finding in this study relates to the government's pragmatic and instrumental use of international victimhood as a resource in partnerships for health. Critical discursive analysis and policy review provide evidence of agentive reflexivity by transforming the mantra of sanctions into a resource mobilisation tool for health financing M&E. The government embraced the negative effects of sanctions and used them as a source of funding by playing the victim and appealing to sympathetic and friendly countries for financial support. As discussed earlier, the issue of sovereign rights remains part of Zimbabwe's discourse as it resists perceived domination by Western countries, resulting in a lack of external support in other critical aspects of the economy. However, the government uses discourse to depoliticise and access health financing from the same countries that have imposed sanctions. While this arrangement is functional for both sides of the partnership, it works particularly for the Zimbabwean government, considering its financial constraints. An extract from the National M&E policy illustrates how the government perceives and uses the sanctions mantra to its benefit:

However, since the introduction of RBM in 2005, the Public Sector performance moderately improved despite both external and internal factors. The external factors were mostly influenced by the illegal sanctions imposed on Zimbabwe by Western Countries.

The phrase 'illegal sanctions' used here has a different connotation when used at a political rally. Considering the broad target audience for the policy document, it is an instrumental call to sympathetic donors from the left and right to support Zimbabwe's health M&E system, which is under attack from its enemies. Another interpretation could be that the message is directed to Western countries, asking them to remove their sanctions if they want to achieve their objectives through the government. In other words, the government says, 'remove the sanctions so that we can use your money effectively.' Cognizant of their strategic and moral responsibility to deliver on behalf of their funders, GHPs become advocates for the government against sanctions through

lobbying neutral institutions like WHO and the UN, in the context of their moral responsibility to save lives. Thus, the government uses victimhood and polarization through sanctions discourse to mobilise financial support and counter opposition. In October 2021, the government took the opportunity of a visit by a UN Special Rapporteur to reiterate this position, and the central message from the official was a call for consideration by Western countries to lift their sanctions for the sake of the health system. Some European countries have relaxed some of the conditions following the recommendations. To this extent, the argument is that the government succeeded in instrumentally applying the sanctions discourse to foreground its victimhood as the reason for its shortcomings in policy and practice.

The discourse of victimhood has worked for the government to influence global powers to feel the moral responsibility to support its health system-strengthening initiatives. The sanctions mantra is a call to the world for support, a strategy that has worked in the health sector. The health sector is the Zimbabwean institution most freely financed by Western and multilateral institutions.

6.2.6 Extraversion and obfuscation strategies

Another interesting finding of this study is the use of covert extraversion and obfuscation strategies by the government to access financial and technical support from the GHPs. The strategy links closely to victimhood and involves the government's acceptance and embracing of contemporary global health strategies and approaches as a primary strategy to attract global funding available through the programmes. In this process, the government uses contemporary global health discourse and rhetoric to obfuscate its shortcomings and project its commitment to supporting the global programmes targeted at resource-constrained countries such as Zimbabwe. Take, for example, an excerpt from the National Health Strategy, 2021-2025, that embraces the concept of country-led M&E and gives an assurance of commitment to regional and global commitments such as the Sustainable Development Goals (SDGs). The extract below illustrates this point:

Working closely with the other essential units, such as the Health Management Information System, this platform will meet all the data needs of the country and allow progress towards attaining the goals and objectives specified in the NHS, as well as national, regional, and international commitments such as the SDGs. The health sector, including development partners and CSOs, is expected to unite under this single M&E platform (National Health Strategy for Zimbabwe, 2021-2025).

This shows how the government reproduces the GHP discourse of country-led M&E, and Results-Based M&E discussed in the previous chapter as part of the Paris Declaration on Aid Effectiveness in 2005 and the Millennium Development Goals (MDGs). The MDGs and the Paris Declaration, like the SDGs, advance partnership discourses based on mutual trust and commitment to common global goals. The commitment to Universal Health Care (UHC) and SDGs was supported at the highest policy level through the Minister's Foreword. It is a strategic indication of the government's intention to participate in the partnerships in which the GHPs have a moral commitment and an obligation to help countries with national plans to comply with

the global plans, regardless of other factors like sanctions. As a result, the Government has since 2001 been a recipient of Global Fund and PEPFAR resources aimed at strengthening the M&E system in the country. The Zimbabwean government has used global platforms like the United Nations General Assembly to advocate for financing its HIV and AIDS programmes, considering its dire financial situation due to sanctions. The strategy involves highlighting universal international humanitarian laws that apply, regardless of the status of a country. The reference to conventional programmes such as the SDGs makes the argument more telling as a challenge to the Western countries that champion them. The strategy deploys partnership rhetoric to depoliticise health programmes while challenging the developed countries to act on their promise ‘to leave no one behind’ on the road toward Universal Health Coverage by 2030. Thus, the developed countries are held responsible for acting on their promise, even in countries considered risky from a political point of view.

In concluding this finding, the government uses contemporary GHP-led discourses to depoliticise health programmes aligned to the Sustainable Development Goals (SDGs) to get the necessary buy-in from potential funding partners with moral and partnership responsibility to support health programmes in countries considered despotic and under sanctions. The findings reveal how the government aligns its plans and rhetoric to demonstrate its commitment to the global goal of achieving universal health care. Thus, the government carefully and tactfully use partnership rhetoric and universal obligations to health care to depoliticise health and as justification for the call to the international community to support its health system and its health M&E programmes regardless of its shortcomings in the political arena. To this extent, the thesis argues that the government of Zimbabwe has successfully applied extraversion and obfuscation strategies to access global resources to support M&E systems.

6.3 Discussion

This study seeks to establish the mechanisms and strategies the Ministry, as a local health M&E partner, deploys to rationalise its resource and the power imbalance in the partnership for health in Zimbabwe. In addressing this issue, the study has identified and discussed six legal, paralegal, and ideational mechanisms and strategies the government applies to rationalise its resource and power imbalances in the partnership for health with GHPs. The study has applied the Foucauldian Critical Discourse Analytic framework of power as a relational process to illuminate valuable insights into understanding the government’s use of soft power strategies and instruments to assert its leadership role in the partnership. The supremacy of the Constitution and the need to respect the sovereignty of Zimbabwe was the first strategy identified and discussed. The study concludes that government uses constitutional provisions reminding GHPs about its supremacy and the need for respect as its custodian.

6.3.1 Constitutional and sovereign power

The study has shown the limits of Zimbabwe’s reliance on the Westphalian sovereign principles of 1648 in partnerships for M&E in the 21st century. Technological developments are putting into question the conventional conceptualisation of sovereignty based on state-centred boundaries and machinery to protect its

citizens. The Zimbabwean experience shows the urgent need for a shift to a post-structuralist understanding of conceptual boundaries to effectively extend knowledge frontiers on this subject. Thus, conversations on sovereignty should be cognizant of the virtual and metaverse environment in which health data and information are collected, analysed, and disseminated. This argument aligns with the digital governance framework proposed as part of the broader New Public Governance (NPG) partnership with M&E in Zimbabwe. In the digital era, sovereignty is under threat from what I call ‘technomentality’ or governing from afar through technology.

Moreover, the Zimbabwean experience brings to the fore a less explored governance concept, sovereign responsibility, given the unavoidable encroachment of digital governance on domestic affairs. Brown (2015) provides helpful insights into the concept, describing it as “the space that lies between the sovereign and the citizen, where states and nongovernmental or foreign governmental organizations organize the transfer of resources.” Drawing from Foucault's governmentality framework, this study shows that GHPs exploit the sovereign conceptual boundaries and technology to fill the empty sovereign responsibility due to the government’s inability to fulfil basic health needs in Zimbabwe. The extractive data mining activities reflect the gaps in the government health system that GHPs believe the citizens have the right to know. Thus, applying the NPG-digital governance framework, sovereign responsibility is no longer a preserved space for the government but a contested one involving civil society and the private sector. In an earlier conversation about sovereignty, KII-TC referred to Zimbabwe as a father who deserves to know what outsiders (GHPs) are giving to his poor family. This metaphor illustrates the country's sovereign vulnerability due to its inability to fulfil the sovereign responsibilities of its citizens. The gap has opened opportunities for GHPs to intervene. In real life, the government has the moral and legal duty to take over the welfare of children in cases where the biological father fails to provide for his family. Thus, GHPs believe they have a moral and legitimate responsibility to intervene in local health systems. This finding concurs with that of Brown (2015), that sovereign responsibility is an important concept to theorise extended and transnational governance in the health policy process. Thus, the government’s ability to maintain sovereign power depends on its ability to fulfil sovereign responsibility, and its failure is a source of conflict and instability.

The observation aligns with Van Dijk (2005)’s critical discourse analysis model, which identifies a reference to authority as a discursive strategy to mobilise support. The scholar’s reference to authority as a person, a book, or an organisation provides a helpful post-structuralist and discursive institutionalist perspective in illuminating constitutionalism's effects on GHP interventions in policy and practice for M&E in Zimbabwe. In this case, the Constitutional authority wields power to exert control, enforce obedience, or give orders in any order. Furthermore, it represents a social construct that influences the conduct of GHPs in policy and practice for M&E. Thus; the Constitution embodies a discursive instrument or tool with legitimate and sovereign power that affects the partnership for M&E.

However, the influence through recourse to Constitutional provisions becomes clearer when viewing knowledge creation in partnerships for M&E as a dialogical discursive process involving the author of the document (the government) and the intended audience (government officials, the researcher, and GHPs). The argument draws strength from critical scholarly views that policy problems or solutions are not pre-determined experiences but active constructs through discourse by the policy actors themselves (Swinkels, 2020). This argument implies that the effects of GHP on M&E policy and practice are situated or interpretive encounters, contrary to the positivist perspective. There are no absolute truth or policy positions and implementation modalities, making it difficult to pin down the effects of the government's constitutional power. GHPs also refer to the same provisions to hold the government accountable to their rules and regulations. Consequently, conceptualising ideas as tools relies on the partner's ability to deploy ideational entrepreneurship or craftsmanship in the partnership for M&E.

Nevertheless, the above analysis does not make the government completely helpless in partnerships for M&E. Drawing from the Foucauldian governmentality framework, we still identify the bi-directional and relational flow of power between the government, on the one hand, and its civic and private sector partners. Using examples from global NGO partnerships in Sierra Leone, Herrick (2018) observed the dramatically unequal and uneven power relations involving GHPs, drawing our attention to the precarity of power that the GHPs lay claim to in partnerships. Herrick makes further arguments that substantiate this thesis, drawing attention to the reliance of multiple international donors in Sierra Leone on local resources like trained hospital referral coordinators and the availability of functioning and fuelled ambulances to transport patients to tertiary sites. Drawing parallels with IDI-CD's exciting observations about qualified local staff and health infrastructure as a resource in Zimbabwe, the success of GHP support to Sierra Leone depended on local resources. The system, which mimics the Zimbabwean experience, showed that GHPs still relied on the poorly funded and weak health system to ensure their programme's facilitated accountability to their funders. Thus, the sustainability of the well-intentioned work of GHP projects in Sierra Leone, as in Zimbabwe, is ultimately a question of national, regional, and local capacities and politics. Yet, the 'medicalised' GHP and government project teams continue to lead processes that require transdisciplinary reflexivity to navigate the legal, sociological and political challenges that militate against partnerships for health M&E. These challenges dovetail with other political problems in partnerships.

In summarising the power relations in partnerships for M&E, the study maintains that local bureaucrats and politicians still hold the keys to successful partnerships even in resource-constrained environments such as Zimbabwe and Sierra Leone. The study has shown in the Sierra Leone example that achieving GHP impact requires sustained reliance on the willingness of those at the top of the national government to implement new or existing health policies based on evidence generated by GHP projects. Thus, absolute power ultimately rests with local decision-makers regardless of their lack of financial and technical resources. Hence reliance on conceptual and soft power has limits in unstable policy environments like Zimbabwe. GHPs ultimately

apply both soft and material power to achieve their objectives. Other strategies involve providing incentives and sometimes bribing local bureaucrats to facilitate project implementation. These factors contradict the spirit of trust and mutual interests in conventional partnerships.

6.3.2 Enforcement of policies and guidelines

The study has shown that the availability and enforcement of policies and guidelines is an essential source of power in partnerships for health in Zimbabwe. Its normative function is to apply legitimate authority ascribed to the government through representative electoral power to promote accountability and transparency for all publicly financed health programmes in Zimbabwe. Unlike civil society and private partners, the government has the legitimate representational power to represent citizens in distributing these public funds. However, the current relationship between Zimbabwe and its civil society partners for health does not auger well for the conventional Governance of Collaborative Partnership framework, as trust issues always interfere with the government's ability to execute its legitimate roles (Vangen *et al.*, 2015). Apart from the GHP's mistrust of how the government manages its public funds, contextual issues justify the discourse around poor public funds management in Zimbabwe.

In 2008 the Global Fund placed the country under additional safeguard measures following allegations of donor funds mismanagement. As a result, the more significant chunk of external donor funds is handled through the United Nations Development Program (UNDP), with GHPs like PEPFAR, USAID, and DFID channeling funds through international and local NGOs for health. Similarly, the repeated disputed electoral process every five years makes it difficult for GHPs to trust the government with significant direct financial disbursements through the government financial system. As a result, a lack of trust, mutual interest, and organisational identity diminish the government's legitimate authority to hold GHPs and the private sector to account, as the Collaborative Governance framework by Ansell and Gash (2008) requires.

Likewise, the three-dimensional CDA framework of Fairclough (1989) provides valuable insight into the government's inability to use accountability and transparency discourse to justify its legitimate and moral responsibility to hold GHPs accountable using policies and regulations. Fairclough argues that we can use discourse as description, interpretation, and explanation to counter the domination and sustainability of unequal power relations in partnerships. However, this framework appears more appropriate in a linguistic framework than in a global digital governance system driven by technology and the neoliberal impulse to dominate others. While the Zimbabwean government has outstanding governance issues that compromise its moral standing to hold GHPs accountable through policy and guidelines, GHPs appear to instrumentally apply discourse to their advantage against citizens' wishes, even in advanced societies. The debates around vaccination illustrate how hegemonic discourses have remained difficult to oppose, even in advanced societies. Thus, scholars like Van Dijk (2005) argue that CDA can be an instrument to deploy text and talk to counter social power abuse. Dominance in the social and political context has practical limitations in weak

states with compromised legitimacy such as Zimbabwe. Discursive and hybrid instruments like policies and regulations remain instruments that work to the advantage of powerful GHPs and countries that control the discourse around applying the policies and regulations. Thus, soft and material power is instrumental in successfully deploying discourse and ideational instruments like policies and guidelines in partnerships for health.

However, in countries with relatively more robust governance systems such as Botswana, the governments have been successfully ambivalent to neoliberal cash transfer programmes, insisting on traditional non-financial social support policies for its vulnerable children (Chinyoka and Ulriksen, 2020). However, in the Zimbabwean situation the dependence on donors for technical and financial resources for M&E makes it challenging to establish the government's ability to control its policy agenda and goals.

In concluding the discussion on the importance of government enforcing policies and procedures, the study argues that the ability to meet legitimate citizen expectations through the fulfilment of sovereign responsibility is an essential step toward the government's ability to play its leadership role in partnerships for M&E. The Botswana example gives hope to African countries that partnerships involving Western partners can still be established on an equal basis, with each party holding on to the normative values of its national interest. The discussion has also highlighted the importance of discourse analysis in identifying and challenging domination in partnerships, this being the main challenge associated with partnerships in weak governance systems.

6.3.3 MoUs as a government source of power in partnerships for health

The Memorandum of Understanding (MoU) findings clarify essential aspects of partnerships in practice. The practical challenges in Zimbabwe cast doubt on the sincerity of such partnerships. The evidence shows that MoUs do not have the legal standing to facilitate transformation in partnerships, as GHPs continue to find ways to justify actions contrary to the prescribed and agreed framework. The partnerships fail to play what Vangen *et al.* (2015) calls the 'governance of collaborative partnerships,' meaning a partnership that focuses on post-structural aspects like the vision and mission of partnership rather than hierarchical structural aspects of power. Vangen *et al.* raise an essential point about the need to focus on post-structural aspects of leadership, like vision and mission, to direct efforts towards transformation, but their focus on leadership perhaps ignores an essential element of power relations in partnerships. As the response from KII-TC shows, adopting a discursive institutionalist approach that ignores power relations, as Vangen *et al.* (2015) do, perhaps fails to illuminate the practical contextual challenges that negatively impact health partnerships. The transformation of Zimbabwe's volatile health policy framework may not happen without addressing the structural and post-structural aspects of power.

Furthermore, the strong language that KII-TC uses to describe the partnership arrangement suggests a simmering conflict between the GHPs and the government that may have gone unresolved for longer than

necessary. The language reflects a lack of patience, perhaps due to a lack of action from the Ministry's highest decision-making officers. What worsens the situation is the arrogance of GHPs who consider the request to follow laid-down MoU rules as a 'begging' process. Regardless of the GHP's financial and technical assistance, they must still respect the rules. However, their actions are a departure from the provisions of the MoU; hence KII-TC's harsh language is a departure from the partnership language of mutual respect and trust. The response further exposes the depoliticisation discourse in partnerships, and official policy documents conceal the reality of partnerships for health. The foregrounding of mutual respect and trust while backgrounding the contested issues in the partnerships delays taking opportunities for transformative change.

Similarly, the complaints by the GHPs about the slow implementation of MoU requests by the Ministry suggest that a lack of trust and mutual expectations in the partnership drives parallel processes. In conventional partnerships, it should not be difficult to access data. This finding corroborates similar findings by Cheng (2019), who observes the practical use of MoUs in integrative partnerships involving government and conservation NGOs in the United States of America. Cheng's observations hold in stable policy environments like the USA but may not apply in volatile policy environments like Zimbabwe. The issues of power imbalances, mistrust, and divergent interests negatively impact the partnership. The context is different, and findings such as Cheng's are less helpful.

All participants acknowledged that MoUs are a strategy and mechanism that the government uses to hold GHPs accountable in the partnership for health. However, the practical aspects of the partnership show that the GHPs are impatient with the slow pace of government's response to data requests, and hence apply soft and material power strategies to circumvent the MoU guidelines. Thus, the GHPs continue negatively influencing the Ministry's M&E system, creating conflict and mistrust. Until the Ministry can address its sovereign responsibility to make health data accessible, the GHPs will continue to pose a challenge to the Ministry.

6.3.4 Bureaucratic power as procedure and orderliness socialisation

The findings on bureaucracy as power and procedure in Zimbabwe's health M&E system revive and resurrect age-old crucial conversations on this concept. While the concept has become synonymous with negative discourses over the years, its original Weberian sense remains true decades later. As shown in the findings, procedure and orderliness are crucial aspects of any functioning governance system. They safeguard vital government information arrived at through meticulous verification. However, the same process is also prone to abuse as it opens windows for corruption and underhand activities involving GHPs with tight deadlines and targets to report to their funding partners. These revelations highlight the effects of external funding on national processes. For example, the parallel reporting systems that go against partnership values result from demands for results driven by private sector discourses aligned to profiteering through health services.

However, its disruptive implications run deep; hence, the government sometimes takes time to approve some processes to prevent such disorderly conduct.

In addition, the findings reflect the importance of comprehensive policy analysis focusing on structural and post-structural discursive approaches to knowledge creation. Sadly, the pragmatic-instrumental partnership conceptualisation of GHPs in Zimbabwe conceals the importance of structural and discursive processes that perpetuate power imbalances through health M&E systems. Scholars like Schmidt (2011) have demonstrated the explanatory and reconciliatory power of post-structural and discursive institutionalist approaches to policy and practice. While this approach is helpful in established democracies due to the blurring of juridical government and conceptualisation under the New Digital governance, the concept ignores the basic building blocks that make partnerships work in volatile and resource-constrained environments such as Zimbabwe. The example of data unavailability or slow reporting may be a rare incident in established systems, but it is a daily occurrence in Zimbabwe. Hence GHPs should focus on the needs of government rather than promoting superfluous ideas when the basic structures are absent. Discursive institutionalist approaches assume and build on the availability of functional systems.

Another vital discussion point relates to the under-theorised and under-discussed concepts of street-level bureaucracy and bureaucratic socialisation in public health governance. The works of Lipsky (2010) highlighting the dilemmas of public servants provide valuable insight into the soft approaches that characterise some of the GHP influences in partnerships, as highlighted in the findings of this study. While these findings show the perverse effects of street-level bureaucracy on policy practice, its contribution to knowledge remains valuable in the country. Moreover, recent studies by Zarychta *et al.* (2020) have made a positive contribution to the concept from a behavioural public administration and governance perspective as a motivation for lower-level public health staff in the decentralized health sector in Honduras. Similarly, Zhang *et al.* (2021) reflect on how the Chinese bureaucracy enables street-level bureaucrats to be policy entrepreneurs, stimulating and initiating valuable policy discussions. Thus, the Zimbabwean experience, perverse as it appears to be, provides helpful policy insights. According to Zhang *et al.*, accountability and effective communication are essential to the success of street-level entrepreneurship. Zimbabwe's health system would need to address these issues to harness the benefits of this concept. Experiences similar to those in Zimbabwe are discussed by Walker and Gilson (2004) and (Erasmus, 2014), who discuss the implementation challenges of free health care policy by nurses in South Africa and various other similar types of research in LMICs, respectively.

The concept of bureaucratic socialisation needs further exploration as it remains under-studied and theorised. This thesis argues that the government's bureaucratic processes have conditioned GHPs such as the Global Fund to act inefficiently in the same way government processes operate. The slow disbursement of funds, the insistency on procedures, and sometimes the accusations of corruption all indicate the assimilation of GHP staff into practices that civil servants are accused of by GHPs. The conclusion is that the government influences GHPs through bureaucratic socialisation, which is a source of partnership influence.

6.3.5 Victimhood and polarisation as a strategy

There are surprising findings on the government's instrumental use of its victimhood in the sanctions discourse. The findings are consistent with similar scholarly findings that some developing countries play on their victimhood as a strategy by presenting themselves to potential external funders as weak, impoverished victims of global structures (Patterson, 2018). Patterson (2018) discusses adopting a similar strategy by President Museveni, who deployed Uganda's victimhood and polarising nationalist strategies by blaming the World Bank and IMF for disrupting its programmes through neoliberal structural adjustment programmes, seeking global sympathy and financial assistance from friendly countries. The government invoked sovereignty and respect for international law to remind hostile countries about their responsibilities in international relations and health. As a result, any threats to these established norms instrumentally perpetuate the state's victimhood and shame the perpetrators while downplaying the government's shortcomings in discharging its legitimate sovereign responsibility for the health of its citizens.

The use of the sanctions mantra in Zimbabwe fits well with Uganda's diversionary discourse, aiming to influence how the GHPs interact with health financing. From a critical constructivist partnership perspective, the study shows that local partners have agentive reflexivity or street-level discretionary power to counter GHP influence through polarisation tactics. Thus, the Critical Discourse analytic framework helps understand the partnership as a dialogical reflection of the nature of each partner. However, from a Collaborative of the Governance framework, the partnership fails to meet the critical tenets of trust and mutual interest due to the concealed and effaced nature of some aspects of the relationship.. Consistent with this partnership within a digital governance framework and a global post-truth framework for health, GHPs sometimes allow local partners to "do nothing" with donor funds, which is a strategic policy option. For example, GHPs can enable local partners to play polarisation and victimisation strategies as part of the GHP strategy so that the country can continuously rely on their support for other strategic reasons. For example, GHPs may be complicit in financing corrupt practices in the health sector to gain access to additional resources like information. As a result, the study suggests that Zimbabwe and Uganda benefit from their victimhood and polarisation strategies only if their benefits are greater than those the GHPs get from the partnership.

6.3.6 Extraversion and obfuscation

The study's findings on the government's use of extraversion and obfuscation strategies are interesting, considering the economic and political challenges the government has been facing due to the confrontational approach it has adopted against sanctions since 2001. Scholars like Jean-Francois Bayart (2000) conceptualise extraversion as explaining a phenomenon whereby developing countries' response to global programmes and institutions with weak governance systems allows them to manipulate the support for their benefit. While some scholars have referred to similar responses as a critical constructionist agency, Jean-Francois Bayart's characterisation of this behaviour by developing countries concurs with this study's findings of perverse reflexivity. As argued in the previous chapter, perverse reflexivity is a phenomenon whereby deliberate

decisions are made conveniently for corrupt or personal benefit based on informed choices in a post-truth global health environment. Similarly, Patterson (2018) observes in his study that developing countries practise ‘performances of compliance’ as a strategy to remain within the global frameworks that create opportunities for further financial and technical support for M&E. Thus, Bayart and Scott's observations concur with this researcher's concept of perverse reflexivity in global health programmes. The weakness of governance in GHPs such as GFATM allows countries such as Zimbabwe to apply extraversion and ‘performance of compliance’ as a strategy to access more funding for health M&E systems. Moreover, these findings substantiate previous observations on bureaucratic socialisation as part of assimilating GHP operations in Zimbabwe.

Thus, this study cautions against the conventional view attributing constructivist agentive reflexivity without questioning the objectives of local partners in a post-truth governance system. As a result, the study agrees with Patterson (2018), calling for exploring how African states are agentic actors in these governance processes. Patterson acknowledges the use of rhetoric and covert actions in shaping global health policies and how norms, state interests, and identities drive them. Patterson identifies three approaches to the region's involvement with global health governance: acceptance, challenge, and ambivalence. They all speak to extraversion and obfuscation as they involve normative rhetoric and actions shaping the making of global health policies. Developing countries also challenge or attempt to reframe the narrative underlying policy design, implementation, and covert resistance through developing projects and programmes that counter public health practices (Patterson, 2018). Ambivalence involves the redesigning and uneven implementation of agreed-upon global agenda, which may be contrary to national norms and expectations. The experience of GHP support for M&E in Zimbabwe reflects all three approaches applicable in the unfinished MDG business and the current SDGs, particularly on key populations. Matrix 6:2 is a summary of the findings.

Research Question	Emergent Theme	Interaction with literature	Sources
What mechanisms and strategies do local health M&E partners deploy to rationalise their resource and power imbalance in the partnership for health in Zimbabwe?	Constitution and sovereign power	<ul style="list-style-type: none"> • Draws attention to the precarity of power that the GHPs lay claim to in partnerships. • Authority as a discursive tool, reference to a person, a book, or an organisation • Contests to control sovereign responsibility- space between the sovereign and the citizen. 	Herrick (2018) Brown (2015)
	Enforcement of policies and guidelines	<ul style="list-style-type: none"> • The Botswana government has been successfully ambivalent to neoliberal cash transfer programmes insisting on traditional non-financial social support policies for its vulnerable children 	(Chinyoka and Ulriksen, 2020).
	MoUs as government source of power in partnerships for health	<ul style="list-style-type: none"> • Observes the practical use of MoUs in integrative partnerships involving government and conservation NGOs in the United States of America. 	Cheng (2019)
	Bureaucratic power as procedure and orderliness socialisation	<ul style="list-style-type: none"> • Highlights the dilemmas of public servants at the shop-floor level, which provides useful policy insights • Reflects on how the Chinese bureaucracy enables street-level bureaucrats as policy entrepreneurs, stimulating and initiating valuable policy discussions. • Uses the example of Honduras to demonstrate the positive contribution of the concept from a behavioural public administration and governance perspective as motivation for lower-level public health staff in the decentralised health sector. • Discusses the implementation challenges of free health care policy by nurses in South Africa and various other similar types of research in LMICs 	Lipsky (2010) Zhang <i>et al.</i> (2021) (Zarychta <i>et al.</i> , 2020) Walker and Gilson (2004) and (Erasmus, 2014),
	Victimization and Polarisation as a strategy	<ul style="list-style-type: none"> • Discusses strategies by President Museveni, who deployed victimisation and nationalist strategies by blaming the World Bank and IMF for disrupting its programmes through neoliberal structural adjustment programmes seeking global sympathy 	Patterson (2018)
	Extraversion and obfuscation	<ul style="list-style-type: none"> • Developing countries practise “performances of compliance” as a strategy to remain within the global frameworks, creating opportunities for further financial and technical support for M&E. 	Patterson (2018)

6.4 Conclusion

The study has sought to establish the mechanisms and strategies the Ministry, as a local health M&E partner, deploys to rationalise the resource and power imbalance in the partnership for health in Zimbabwe. In answering addressing this topic, the study identified and discussed six legal, paralegal, and ideational mechanisms and strategies the government applies to rationalise the resource and power imbalances in the partnership for health with GHPs. The study applied the Foucauldian Critical Discourse Analytic framework of power as a relational process to reach valuable insights into the government's use of soft power strategies and instruments to assert its leadership role in the partnership. Reminding partners of the supremacy of the Constitution of Zimbabwe and the need to respect the state's sovereignty is the first strategy identified and discussed. The study has demonstrated how the government refers to the Constitutional provisions in all its M&E policies as a reminder to GHPs of their constitutional health obligations within the provisions of Zimbabwe's supreme law.

Similarly, the study has identified paralegal strategies like the availability and enforcement of clear M&E policies and guidelines and discusses them as another vital strategy that helps government enforcement of policies and regulations. The study has identified the government's ability to meet the legitimate health expectations of citizens and effective governance systems as essential contributory factors to effectively enforcing health M&E policies and regulations. Likewise, the Memorandum of Understanding was another critical mechanism the government used to hold GHPs accountable, insisting on its implementation according to agreed frameworks. However, its non-legal status compromised its efficacy as an instrument of compliance in the partnership.

Moreover, the study has identified the recourse to bureaucratic power as an unexpected source of government power in the partnership. The study has concluded that the slow pace of government processes is not always the result of inefficiency but can be instrumental in achieving the partnership's goals. As a result, the study has observed that the pathological connotations of bureaucracy are not always accurate unless one dialogically interacts with government officials. As KII-TC remarked, what GHPs call bureaucracy represents a positive reference to procedure and orderliness. Likewise, the government instrumentally deploys its victimhood and polarisation to provoke a feeling of moral responsibility among global funding partners to persuade them to fulfil their international humanitarian obligations to protect people from health disasters, given the economic sanctions and global epidemics of HIV and TB.

Similarly, the government applies extraversion and obfuscation strategies through acceptance, resistance, and ambivalent responses to global programmes such as the MDG and SDGs by aligning its national health M&E policies to these global programmes. The rhetoric showed commitment by the government to these programmes, thereby putting global funding partners in a difficult situation if they ignored the cry for help. These strategies provided valuable insights into understanding the positive and negative covert effects of GHPs on local health M&E systems rarely discussed in conventional partnership discourses.

CHAPTER SEVEN: THE IMPACT OF THE GOVERNMENT- GHP COLLABORATIVE GOVERNANCE SYSTEM ON THE PUBLIC HEALTH ADMINISTRATION AND M&E SYSTEM IN ZIMBABWE

7.1 Introduction

The previous chapter answered the second research question addressing the mechanisms and strategies the Ministry of Health, as the local health M&E partner, deployed to rationalise its resource and power imbalance in the partnership for health in Zimbabwe. The chapter looked explicitly at the recourse to constitutional and sovereign power, the availability and enforcement of clear policies and guidelines, the use of memoranda of understanding (MoUs), the instrumental use of bureaucratic power, victimhood and polarisation, extraversion and obfuscation as some of the strategies that the Ministry of Health used to counter the influence of GHPs and maintain its leadership role in the partnership for M&E in the country. The current chapter addresses the third research question, seeking insight into the impact of the government-GHP collaboration on the public governance system in Zimbabwe. The specific findings and discussions focus on effects such as the normalisation of parallel M&E systems, digital disruptions of existing M&E systems, the source of conflicts and contestations, the facilitation of patron-client relations, threats to national sovereignty, the brain drain, the promotion of mute and perverse practices, digital exclusion, threats to regular employment, perverse conceptual boundaries, and competitive behaviour for visibility and leadership. The following section provides detailed discussions on the issues identified.

7.2 Global Health Partnership impacts on governance and public health M&E system

The specific discussions in this section draw from the study's finding that GHP support for M&E facilitates adverse effects that include the normalisation of parallel M&E systems, digital disruptions for local partners, the source of conflicts and contestations, the facilitation of patron-client relations, threats to national sovereignty, the brain drain, mute and perverse practices, digital exclusion, threats to regular employment, conceptual boundaries, and competitive behaviour for visibility and leadership. The following section provides detailed discussion of the issues identified. The following Matrix 7:1 provides a summary of the findings.

Matrix 7 1: Summary of the results on GHPs' impacts on the governance and M&E system in Zimbabwe

Sub-theme/sub-question	Respondent responses	Source/s
GHP supported M&E leads to digital exclusion	<i>I will give you one very good example: the young girls and adolescents in their programme code-named DREAMS. They had to develop their customisation of DHIS2 because the Ministry DHIS2 was not providing what they wanted. So those are excluded, I can say, from the Ministry's programming. It's called digital exclusion.</i>	KII-TC
Normalisation of parallel M&E systems	<i>You know, an organisation like OPHID is an established entity with its culture and way of doing things. But only that it is coming to complement Ministry? Yeah, so you would not expect the NGO to be a replica of the Ministry. If we meet to provide services for the same client and generate and identify the same data, I'm sure we are okay.</i>	IDI-AM
	<i>So, in the short term, you allow such to happen, parallel systems to happen, but you have to coordinate those parallel systems. It's my philosophy; I'm now telling you my views</i>	KII-TC
Digital disruption of M&E data capture and reporting	<i>One of the challenges is that you need to be continuously connected, and your gadgets should be continuously functional to discharge your duties. In one way or another, if, for example, your gadgets experienced a technical challenge for you, the electricity is not there, and you don't have a backup. It means everything will come to a standstill, and you won't be able to continue offering services just because a gadget malfunctioned.</i>	KII-IC
GHP funding of M&E as a source of contestation and a conflict	<i>Because data is so highly contested, data is the new oil in this world, and as such most data collection systems are propelled by ICT. ... So, ICT is at the centre stage, and it is a conflict-ridden domain, especially in Zimbabwe.</i>	KII-TC
	<i>My issue is access to the Ministry database. Do you know this database is confidential? You know, it is a security item. Data is a security item; if you want someone in the USA to start reading how many clients have this kind of disease, you will be vulnerable. They know how to attack you.</i>	IDI-AM
Partnerships for M&E as threats to national sovereignty	<i>Yeah, there may be different schools of thought around sovereignty. But remember, we have case-based surveillance, which has patient-level data, right? So, if the whole of your battalion (military battalion) at Mbizo barracks is found to be contracting STIs, that's translating into security issues.</i>	IDI-AM
GHP M&E funding and patron-clientelism	<i>They can even finance or pay salaries or level of effort for big guys in government. --- There are other guys in the C-suite of decision-making, and those are the guys who are ignorant of ICTs, and when they are told that we give you a level of effort, can we have this technology implemented, they say, yes. And as such, you don't find meaningful, you know, development.</i>	KII-TC
GHP capacity building facilitating brain drain in the health sector	<i>The Global Fund should also build the capacity of the M&E of the host country M&E, including capacity (on) internationally recognised M&E skills like data science, the issues that have to do with DHIS 2, data storage, DHIS 2 academy so that they (local staff) can do the modelling and have access to global opportunities for professional growth</i>	KII-IT
	<i>I see a potential for growth as a country in terms of analysis and even research because we may use this secondary data; you may not need to go to the facility collecting data because most of these data points will be in there. But I think that expertise will be limited; that also allows for personal growth</i>	KII-IC
Promoting mute and perverse practices	<i>So, the difference between RBF with VMMC is that the ownership was with the facility and if these incentives were to benefit a facility and benefit everyone rather than a few individuals. So, this is one of the differences, and why falsification is not evident within the RBF system as compared to the VMMC system</i>	KII-IC
	<i>But at the end of it all, you realise that we need to meet the partners' targets and ensure that the reporting deadlines are met. So, in the process, we have been sacrificing the quality, and our attempts have been compromised because of the need to meet the targets of the donor.</i>	KII-TF
Threats to employment opportunities	<i>I think all systems, once you advance in technology, also have social harm. So, once you go electronic, it means minimum work will be required, and it becomes a threat to some employees.</i>	KII-IC
Promoting conceptual boundaries	<i>When we joined the Ministry, monitoring and evaluation was not understood in the name of monitoring and evaluation. Of course, they had their information officers at the provincial, district, and national levels performing quasi-monitoring and evaluation roles</i>	IDI-AM

Coordination challenges	<i>You know, blockchain technology was resisted outright. Because it did not come through CDC, it came through the World Bank. So, as we speak, the technology has been shelved, and the partner has been outclassed because it arms the government to know what is happening in their area in their districts (CDC-supported districts).</i>	KII-TC
-------------------------	---	--------

7.2.1 GHP-supported M&E leads to digital exclusion

One of the surprising findings on GHP-government M&E collaborations was that GHP-supported systems like Electronic Health Records (EHR) lead to the digital exclusion of small partner NGOs and some Ministry departments. The partnership for M&E involving the GFATM and PEPFAR made financial and technical investments into the electronic M&E data collection and reporting platforms like the Electronic Patient Monitoring System (EPMS) and the Electronic Health Records (EHR) mainly to facilitate reporting for the HIV, TB, and malaria programmes in Zimbabwe. The systems created high expectations for integrated and near real-time reporting for HIV, TB, Malaria, and related programme indicators. However, interview data from information technology-savvy M&E staff reveal that the initiatives have created unintended effects as they excluded small NGOs that are important in feeding M&E data into the mainstream system. While responding to a question on M&E challenges that affect sub-sub-recipients (SSRs) of GFATM M&E finances to collect and report M&E data to the Ministry of Health and Child Care, KII-TC, an M&E specialist with an IT background, highlighted how the digital health platforms such as EHR and DHIS2 digitally exclude the key populations and the DREAMS projects and create parallel reporting systems. His remarks below illustrate this argument:

I will give you one very good example: the young girls and adolescents in their programme code-named DREAMS. They had to develop their customisation of DHIS2 because the Ministry DHIS2 was not providing what they wanted. OK, another programme is the Key Populations one. Yes, they have also had to develop their customisation of DHIS2 to collect the data they want. So those are excluded, I can say, from the Ministry's programming. It's called digital exclusion. So, they must make do with what they have (Participant KII-TC).

The above excerpt appears to challenge the pragmatic instrumental view of partnerships that focus on the positive influence of technological advancements in health M&E systems. In Zimbabwe, HIV, TB, and malaria, funded through the Global Fund, constitute the most predictable source of donor funds for public health interventions. The programme is progressive due to its perceived country-led, inclusive, and bottom-up approach, in acknowledging the role of previously disadvantaged community organisations such as People Living with HIV and the LGBTQI community, among other community groups, as sub-sub-recipients of the grant. However, these organisations often lack the relevant technological

infrastructural and technical skills required to host big projects like EHR and DHIS2 that require colossal infrastructure and technical capacities. As a result, the systems remain restricted within the Ministry's HIV, TB, and Malaria departments with little connectivity and interoperability capacity with other departments in the Ministry and other Global Fund partners which are vital to the success of the M&E reporting system.

Similarly, digital exclusion creates another challenge for parallel digital and reporting systems as the SSRs and SRs try to find an organised way of documenting their health information in the health system. One of the participants from an NGO Sub-Recipient confirmed non-integration of their health information system into the Ministry of Health M&E system. Thus, the lack of a formal framework for integrating the civil society and private sectors not only provides fertile ground for exclusion but also justifies parallel M&E reporting systems. Likewise, the unavailability of the infrastructure connecting the civic and private sector players makes it challenging in cases where the partners are ready to participate but have no electronic means to connect into the partnership for M&E, as indicated in the NGO-recipient case above.

To conclude this conversation, the findings of the study confirm that GHP-supported electronic systems like EPMS, DHIS2, and EHR can potentially integrate civic and private sector players into the Ministry of Health M&E system. To that extent they represent opportunities for comparative advantages of the private and civic sectors to generate consolidated M&E information for evidence-based reporting. However, due to weak coordination and infrastructure challenges, civic and private sector players remain excluded from the current electronic reporting system, justifying the establishment of parallel reporting systems.

7.2.2 Normalisation of Parallel M&E systems

Another surprising finding of the study is that local staff justified the GHP-supported parallel reporting systems created due to the lack of interoperability of existing electronic systems. The systems are not available to all partners who require them, resulting in digital exclusion and coordination challenges between the Ministry of Health and small NGOs and other Ministry departments that require their use. These findings contradict the conventional scholarly findings that view parallel M&E systems as some of the negative effects of GHPs on local health M&E systems. In a dialogue with KII-TC, an expert on electronic systems, he suggested allowing parallel systems to run parallel to each other as an interim solution, arguing that it

enables the availability and comparison of data from the different streams into the Ministry reporting channels. An excerpt from his conversation below illustrates his argument:

So, in the short term, you allow such to happen, parallel systems to happen, but you have to control those parallel systems. It's my philosophy; I'm now telling you my views. Yes, you can allow those to happen because they are there for a purpose; they are helping the M&E, they're helping to programme, but you then coordinate and make sure that you have standardisation across the board (Participant KII-TC).

The above remark reflects pragmatic street-level solutions rarely acknowledged in the existing literature on collaborative partnerships for health. The general views about parallel systems focus on their pathological effects on the system. This interesting argument refers to the possibility of data triangulation as one unintended positive result of having parallel GHP electronic systems in the country. He emphasises the importance of leadership to ensure the effective coordination of the processes rather than complaining about their existence. Thus, KII-TC sees opportunities rather than threats arising from the existing parallel processes. The use of deontic modalisation or obligatory discourse strengthens his argument. For example, his use of technological lexical terms such as 'standardisation,' 'cross-platform data sharing' and coordination illustrates his honest and professional technical views about practical solutions to the situation.

Furthermore, his views confirm the findings in Chapter Five about the pragmatic-instrumental technological discourse in existing national policy documents. Interestingly, the pragmatic-functional view about parallel M&E systems appears to be widely shared by the participants in this study. An M&E specialist at the provincial level, IDI-AM, shared similar sentiments, as illustrated in the excerpt below:

You know, an organisation like OPHID is an established entity with its culture and way of doing things. But only that it is coming to complement Ministry? Yeah, so you would not expect the NGO to be a replica of the Ministry. They are different in their operations. And in their requirements. If we meet to provide services for the same client and generate and identify the same data, I'm sure we are OK (Participant IDI-AM).

In the above excerpt the participant defends and justifies the GHP-funded local NGO's parallel M&E system, which acknowledges and normalizes the parallel reporting system. These views were widely shared by the participants, emphasising the need to coordinate the systems rather than to wish one of them away. Thus, the study shows unintended positive effects of having parallel electronic M&E systems, which facilitate data triangulation for the Ministry. IDI-AM's

views concur with those of another national M&E specialist, KII-IC, who observed that GHPs sometimes have access to updated data from the health facilities, which the Ministry's head office might find challenging to collect on its own. They concurred on the need for effective coordination to ensure the availability of all the data sets for triangulation purposes.

7.2.3 Digital disruption of M&E data capture and reporting

Despite the normalisation of the digital M&E systems, as observed in the previous finding, the respondents acknowledged the disruptive digital effects of GHP-supported M&E systems in clinical data collection and reporting systems due to the weak infrastructure supporting the digital migration process. The pragmatic-instrumental technological discourses appear to emphasise and justify the adoption of technologies without fully appraising local contexts. The mechanistic and positive regard for electronic systems such as DHIS2 and EHR often ignores their political and social context in practice. In the absence of a full contextual appraisal, these systems create unintended results, as illustrated in the excerpt from KII-IC below:

One of the challenges is that you need to be continuously connected, and your gadgets should be continuously functional to discharge your duties. In one way or another, if, for example, your gadgets experienced a technical challenge for you, the electricity is not there, and you don't have a backup. It means everything will come to a standstill, and you won't be able to continue offering services just because a gadget malfunctioned (Participant KII-IC).

The above observation shows that there can be unexpected disruptions from a well-intentioned GHP-supported programme without a full contextual appraisal. This finding reflects the gap between pragmatic-instrumental, predictable, good policy intentions and the chaotic constructionist perspectives of street-level policy bureaucrats who struggle with the policy's practical implementation. The chaotic balance between decommissioning the paper-based system of registers and the potential misrepresentation of missed and incomplete data sets makes digital M&E systems disruptive and counter-developmental in volatile policy environments such as that of Zimbabwe. Moreover, the parallel system requires additional commitment from the demotivated staff who have to capture the clinical and programme data twice over. Furthermore, the need always to have the electronic gadgets plugged into a power supply makes the sustainability of this intervention questionable. The practical views of KII-IC take cognizance of the erratic power supply in a country, whose access to alternative renewable energy sources remains dependent on the will of external donors. Based on these

findings, the study concludes that GHP-supported M&E systems contribute to clinical data disruptions that compromise the data availability and completeness necessary to informed decision-making.

7.2.4 GHP M&E funding as a source of contests and conflicts

This study notes that GHP's support for M&E partnerships has surprisingly led to contestation and conflict at the M&E policy implementation level in Zimbabwe. This observation contrasts with the partnership discourse of mutual interests and trust in collaborative governance, substantiating the findings from the M&E policy reviews in Chapter Five. The study, therefore, confirms from the primary data collected that trust and mutual interest are rarely in practice at the heart of collaborative partnerships, as the excerpt from KII-TC below illustrates:

Because data is so highly contested, data is the new oil in this world, and as such most data collection systems are propelled by ICT. I think ICT is strategically positioned in the government and NGOs. It ushers in methods of collecting data and helps in the efficiency and speed at which data is collected and utilised. So, ICT is at the centre stage, and it is a conflict-ridden domain, especially in Zimbabwe.

As far as I am concerned, CDC is the Ministry of Health of the Government of America. And then you find a Ministry of Health of another country interested in another country's data. You can say that Zimbabwe is occupied or Zimbabwe is colonised in the information space, because they know exactly what Zimbabwe has and is in control of that machinery. It means if it was physical war, we could say that Zimbabwe is under occupation, just like what Afghanistan was a few months ago; it was under occupation by the United States of America (Participant KII-TC).

These surprising remarks form part of a frank conversation regarding the possible motives and effects of GHP funding for electronic M&E partnerships in Zimbabwe. The tone in the above two excerpts reveals the tensions and mistrust that characterise partnerships for M&E in practice, contrary to the carefully depoliticised and mutual language of official partnership policy discourses. The respondent accurately describes health data as the 'new oil' and hence 'conflict-ridden.' The reference to data as oil is a graphic reminder of GHP-supported M&E practices synonymous with conflict-ridden oil zones in the Middle East and some parts of Africa. The use of this image is a powerful example of emphatic discourse control, showing conviction and undisputed logic of a (un)common nature. Thus, the strength of the expression of the participant's views compels the researcher to agree with him. Using phrases like 'highly

contested' and 'conflict-ridden' exposes the deficiency and limits of technocratic, participatory, scientific approaches to M&E policy in the context of the chaotic, contested political terrain of M&E policy implementation. Thus, a gulf exists between policy and practice for M&E in Zimbabwe.

The strong views about contests and conflicts in GHP-supported partnerships for M&E appear to be shared widely among the respondents. For example, IDI-AM expressed fears regarding the collection, analysis, and utilisation of confidential national M&E data by GHPs. The views expressed below illustrate the argument:

My issue is access to the Ministry database. Do you know this database is confidential? You know, it is a security item. Data is a security item; if you want someone in the USA to start reading how many clients have this kind of disease, you will be vulnerable. They know how to attack you. So, to share a database with a partner headquartered in America, I think that's a security threat that exposes you. So, there could be some trust issues between partners and the government?(Participant IDI AM).

This exposes the lack of trust and mutuality that the partnership discourse imposes on decidedly political contexts in practice. The rhetorical question '*Do you know this database is confidential?*', like the previous participant's statements, employs two critical strategies in discourse analysis: epistemic modalisation and presupposition. As discussed in Chapter Five, these discursive mechanisms show the participant's expectation that the researcher will be aware of what, after all, is common knowledge - that sharing confidential data poses a security risk to the country. The strategy strengthens the argument by suggesting that the statement is obvious and does not require elaboration. The discourse strategy is to emphasise the point by not saying much. The participant is essentially reminding the interviewer of something he expects the interviewer to already know, hence mobilizing support against the arrangement. In addition, IDI-AM's reference to data as a 'security item' concurs with KII-TC's characterisation of data as 'the new oil.'

Based on these findings, the study concludes that the strong views about 'vulnerability,' 'attacks,' 'security threats' and reference to the USA by the two participants reflect and expose the contested and conflicted collaborative space in which partnership discourses strives to depoliticise and silence, without success. The spectacular evidence of these unspectacular effects is manifested through failed or incomplete projects like the various ICT-enabled M&E

systems in the Ministry. Ultimately, the mistrust and lack of goal congruence reduce the partnership discourse to mere rhetoric.

7.2.5 Partnerships for M&E as threats to national sovereignty

A finding corresponding to those above and in Chapter Six shows that GHP-supported technology not only disrupts M&E systems but also poses threats to national sovereignty in the partnership for M&E. The technological mediation role facilitating GHP access to sensitive personal information raises crucial questions about the partnership values involving unequal partners and the partnership's implications for sovereign rights. Take, for example, the responses by KII-TC and IDI-AM expressing counter-discourses to the pragmatic-instrumental views about technological mediation role in M&E systems and potential threats to the country's sovereignty below:

So, if you have sovereignty, you can demand accountability. But you cannot demand accountability without sovereignty; the decision-making power has been usurped and taken from you. So, you cannot demand accountability. I say so because of the data mining activities, the real ones that matter. Our M&E director does not superintend them, you know, but is mediated through technology provided by external partners (Participant KII-TC).

Yeah, there may be different schools of thought around sovereignty. But remember, we have case-based surveillance, which has patient-level data, right? So, if the whole of your battalion at Mbizo barracks is contracting STIs, that translates into security issues. Remember, the database of the Ministry also contains information from the uniformed forces. Access to such information means they can pull this information and use it against you in case of a disagreement (Participant IDI-AM).

As in Chapter Five, the above excerpts raise crucial points about the nexus between health and security. Moreover, the role of technology in this conversation contradicts its instrumental value emphasised in technological discourses. In this case, it represents threats to national security through the external partners' access to sensitive health data. These dialogical views raise another crucial point about simplified versions of trust and mutuality in partnership policy, contrasting with the counter-discourses at policy implementation levels. These concerns reflect the pragmatics of mistrust and incongruent goals in unequal partnerships glossed over through discursive rhetoric. The discussions on the power of sovereignty in Chapters Five and Six highlighted its role as a legitimately appropriated source of government authority to enforce

leadership in collaborative partnerships. The GHP technology-mediated systems create instabilities in government, representing the public and giving too much power to private or external partners in collaborative partnerships for M&E. The observation by KII-TC that Zimbabwe no longer owns its data due to the unintended effects of technological mediation depicts the situation as dire and requires home-grown strategies and systems to avoid its reliance on external systems that expose the country to unsanctioned access to sensitive data. As argued earlier, the statement has far-reaching implications. The observations also question the conceptual relevance of classical Westphalian sovereignty in an evolving 21st-century governance system. To what extent are the physical state boundaries and coercive power emphasised in 1648 relevant to the 21st century with its soft metaphysical boundaries based on technological and ideational power? These are crucial questions that countries like Zimbabwe should reflect on through critical policy analysis using approaches such as CDA. The collaborative partnerships should ensure that the street-level policy feedback finds its way into mainstream policy planning and implementation processes.

In conclusion, this study makes crucial points about balancing national security, sovereign rights, and externally supported electronic systems for health M&E. The study reiterates the political and contested nature of the public health policy process, contrary to the depoliticisation effects of the technocratic, scientific, and participatory partnership discourse in official policy documents. The issue of national sovereignty and security rarely finds its way onto the official policy agenda, but the street-level dialogical feedback has raised this crucial issue, and national policy should respond appropriately.

7.2.6 GHP M&E funding and patron-clientelism

The results of the current study raise crucial issues about home-grown Zimbabwean leadership and governance systems imbued with patriotic values based on ‘ubuntu’, and putting national interests ahead of individual interests. The observed trend of external influence over senior bureaucrats through the dissemination of soft power incentives brings into question the value of government leadership (the people’s representatives) in collaborative M&E partnerships for M&E in Zimbabwe. The use of CDA should help unearth the real meanings behind GHP discourses like support for ‘Human Resources for Health’ and support for the ‘level of effort’ and expose the unspectacular effects of these GHP-specific interventions in government policy in public health. The insights derived from KII-TC reflect the human resources challenges that countries with weak governance systems face in dealing with well-resourced GHPs. The excerpt below exposes the ideational and monetary influence:

They can even finance or pay salaries or level of effort for big guys in government. --- There are other guys in the C-suite of decision-making, and those are the guys who are ignorant of ICTs, and when they are told that we give you a level of effort, can we have this technology implemented, they say, yes. And as such, you don't find meaningful, you know, development (Participant KII-TC).

The above excerpt shows a worrying use of financial incentives to influence decisions such as adopting new health technologies based on ignorance rather than information. However, ignorance in the C-suite invokes sentiments by Alvesson and Spicer (2012) on the concept of functional stupidity. Their idea suggests that the managers' narrow and circumspect interests may be driving their apparent inability and unwillingness to apply their minds to the situation rather than a genuine failure to appreciate what is in the country's best interest. It is difficult to assume that executives in the C-suite (the Chief Executive, Chief Finance Officer, and Chief Operating Officer) would fail to make patriotic, country-centred decisions unless motivated by personal gain. The participant's response suggests a direct link between the lack of executive reflection on critical decisions and the payment of GHP incentives to some senior government officials for the level of effort.

However, as the results of the study show, the offer of partnerships has exposed government staff to rent-seeking behaviour requiring the making of patron-client-based decisions affecting national priorities and interests. Thus, the government's inability to fully address the salary and work-related incentives have exposed the health system to counter-productive patron-client relations in the country. These findings raise crucial points about the need for the government to prioritise adequate support for the human resource needs of all its critical civil servants, particularly in the health sector. The observation calls for accountable and ethical leadership that shuns corruption and patron-client relations at political and collaborative governance levels.

7.2.7 GHP Capacity building facilitating the brain drain in the health sector

Another finding related to those in the preceding section concerns the unintended effects of GHP support for programs like capacity building for M&E in Zimbabwe. The study reveals that the GHP support for M&E international training programme and capacity-building initiatives has equipped government M&E staff for personal and professional growth and opportunities for local and international assignments with GHPs. This observation contradicts the official policy discourse on GHP-supported M&E systems that justifies capacity building

as an ‘undisputed’ good intervention. The GHP support for M&E skills development appears to aid in the internal and external brain drain from the Ministry to GHPs locally and internationally. Take, for example, the excerpts from KII-IT and KII-IC below. The responses addressed things that GHPs, such as Global Fund, could do to improve M&E capacity in Zimbabwe:

The Global Fund should also build the capacity of the M&E of the host country M&E, including capacity [on] internationally recognised M&E skills like data science, the issues that have to do with DHIS2, data storage, DHIS 2 academy so that local staff can do the modelling and have access to global opportunities for professional growth. It also creates opportunities for personal development (Participant KII-IT).

So, Excel may be limited to some extent, even maybe STATA [statistical software] may be limited, but you may need other software that may give you results even running some models using that data. I see a potential for growth as a country in terms of analysis and even research because we may use this secondary data; you may not need to go to the facility collecting data because most of these data points will be in there. But I think that expertise will be limited; that also allows for personal growth (Participant KII-IC).

The above two responses look like initiatives that would benefit Zimbabwe’s health system, but the reality shows that this training has exposed most key experienced and qualified staff to GHPs who eventually hire them for their new skills. As a result, the internal and external brain drain has primarily been from the Ministry to the GHPs. This creates the impression that the actual beneficiaries of these capacity-building initiatives are individuals and GHPs rather than the national health system. Thus, a critical view of the above excerpts reveals that personal ambitions are presented as being beneficial to the system. When explicitly asked for opinions concerning the brain drain from the Ministry to GHPs, another respondent, KII-LN, remarked that he does not consider local staff movement from the Ministry to GHPs as strengthening the health system. International training programmes present opportunities for personal and professional growth to get out of the system. The dialogical reflections by the three respondents bring out crucial issues about the national benefits of international M&E training for key staff members. The participants attest to the high staff turnover from the Ministry to local and international NGOs. This study problematises the increasingly global and technocratic

approaches to M&E that appear to prepare systems for global epidemiological reporting rather than local reporting.

Thus, the effects of the scientific discourse and training in techniques like HIV estimates, DALY, and RCTs, among others raised in Chapter Five, are implicated in this current discussion as facilitating the brain drain from the Ministry of Health and Child Care. The reference to modelling, STATA, and ‘big data’ systems often serve the interests of GHPs more than the government, as many experienced staff members trek out of the Ministry to pursue better-remunerated careers with the GHPs and other civic partners. The skills also make them more expensive to keep in government, as the private sector may also require modelling and Big data skills. Thus, capacity building creates competition between the government and its collaborative partners. This finding calls for the government to consider a home-grown strategy to cater to critical staff development to arrest the scourge of the brain drain.

7.2.8 Promoting mute and perverse practices

The findings of this study about the unintended benefits of GHP support for M&E provides to local M&E staff lead to insight into similar practices by health staff who remain in the Ministry and look for illicit financial and other material support from GHPs. The findings relate to GHP-influenced malpractices among staff who implement the GHP-supported M&E systems. These include reporting inflated figures or using unethical means of reporting programme data to achieve high GHP programme targets. The World Bank and the Global Fund are examples of programmes that use the achievement of set results to justify continued financial and technical support. Most private civic and corporate funding partners finance these initiatives, such as the Bill and Melinda Gates Foundation, the Crown Agency, and Cordaid. While the intended objective is to promote the accurate and timely collection, analysis, and reporting of M&E data on HIV, TB, reproductive health, and voluntary medical male circumcision (VMMC), the study reveals the perverse effects of such policy at street-bureaucratic levels. While commenting on the challenges associated with data quality in the VMMC program, KII-LN asserted that “*the pressure to meet set targets and person-centred incentives compromised the integrity and quality of data and information for M&E.*” His views are widely shared, as corroborated by another respondent, KII-IC, who remarked that the Results Based Fund (RBF), unlike the voluntary medical male circumcision (VMMC) programme, provided better results. The excerpt below illuminates the issue:

So, the difference between RBF with VMMC is that the ownership was with the facility and these incentives were to benefit a facility and benefit everyone rather than a few

individuals. So, this is one of the differences and why falsification is not evident within the RBF system as compared to the VMMC system, and even the reporting, the RBF system uses the national database. There is no parallel system hence the issues of discrepancies between the two systems were not being pronounced compared to the VMMC one because, if you notice, there were two reporting systems, and these systems were not in sync; there were discrepancies for the same indicator, the same period, and same facilities (Participant KII-IC).

This response highlights a few crucial points, including the perverse practices of data falsification and the issue of the parallel M&E systems justified by other participants in previous discussions. Both programmes provided monetary incentives that created and reinforced the perverse falsification of M&E data to create an impression of the achievement of the set results to access the funds. IDI-AM raised similar sentiments about the RBF's tendency to promote tempting collusion on the provincial, district, and facility levels to falsify performance data and facilitate access to the financial incentives attached to the programme. His views appear to contradict those of KII-IC, but they concur on the effects of results-based funding mechanisms on their unintended consequences. Mute program reporting occurs when local partners tacitly or passively comply with donor reporting requirements instead of producing reports that inform local planning and learning. Local health partners suffer the same experiences, as illustrated in the response by KII-TF below:

It's very difficult; it seems like there is a need to strike a balance. But in the end, you realise that we need to meet the partners' targets and ensure that the reporting deadlines are met. In the process, we are sacrificing quality, and our attempts have been compromised because of the need to meet the targets of the donor (Participant KII-TF).

The above response shows the real struggles that force local partners to compromise quality through mute reporting to the donors regardless of their intention to do the right thing. Thus, the pressure to meet donor targets creates perverse reflexivity as the local partners focus on reporting according to the donor's requirements, which may not make a meaningful contribution to their work. However, due to the desire for monetary incentives and to secure further funding, they deliver as per the donor's expectations. The conclusion drawn from the above data is that the partnership is based on mistrust and goal incongruence.

7.2.9 Threats to employment opportunities

The reported results highlighted perverse and mute practices in partnerships for M&E in Zimbabwe. That feeds into the result registered here, which is that there is a fear of job losses linked to the electronic GHP-supported M&E systems in the country. There is a measure of incongruity in the call for electronic systems and the professionalisation of M&E in an environment of high unemployment and economic underperformance that has persisted for over two decades. The study finds that the push for technocracy is a source of anxiety for staff in the health information department, which are not qualified and are not among those required to perform health information and M&E functions. As a result, the migration to algorithmic and fully electronic M&E systems creates justified anxiety among this category of employees. An extract from KII-IC below illustrates the mentality of M&E staff regarding the GHP-Supported electronic M&E systems:

I think all systems, once you advance in technology, also have social harm. So, once you go electronic, minimum work is required, and it becomes a threat to some employees. If we compare the thrust of the EHR against the paper-based system, this paper-based system was supported by more staff than this current setup. So, if we are saying let's embrace technology, let's go E-First [a full electronic system], what it means is we no longer need all these extra hands, yet these extra hands were also having their livelihoods from that system [the paper-based system](Participant KII-IC).

The above response shows the conflict between future technology and the present reality in Zimbabwe in the context of high formal unemployment rates. It further highlights the importance of considering the social life of M&E contrary to the aspirational clamour for a virtual metaverse in the under-resourced health M&E system. Moreover, it shows the potential social cost of technocracy in collaborative governance in high unemployment environments such as Zimbabwe. Thus, the technology faces resistance if not introduced through participatory processes. Its failure to capture the social realities of local people, regardless of the good intentions behind the introduction, becomes disruptive, as observed earlier.

In conclusion, considering local realities and fears becomes crucial in policy planning and implementation. The concerns raised may appear insignificant but could be the site of resistance to policy through its non-implementation or outright sabotage unless a complete context analysis and engagement is performed.

7.2.10 Promoting conceptual boundaries and “othering” effects

The threat of electronic GHP-supported monitoring and evaluation systems formed the basis of the previous section. This section builds on the previous by discussing related challenges in which GHP-supported M&E systems raise the alarm and create M&E conceptual boundaries among M&E and health information staff in Zimbabwe. Some unintended adverse effects include the “othering” problem resulting from creating an exclusive M&E epistemic professional community. Take, for example, an excerpt from IDI-JK and IDI-AM below substantiating the thinking observed among the M&E community:

*The other gap we have is that during recruitment, most of the organisations or even the Ministry of Health are recruiting what they call M&E officers, but with some other qualifications linked to the M and E function. Yes, this was happening because we had no cadres specifically trained for M&E in Zimbabwe earlier on, but now we have Lupane University training cadres in M&E. So that gap is still in the Ministry and on the partner side. They are recruiting someone with a statistical background, for example, in our development courses, something like that, not specifically linked to M&E but has some part of the curriculum with an M&E function. But we would like to say that for **us** to speak with the same understanding as M&E Officers, we need a cadre well aligned to M&E in its wholesome state, not in part. Yes, but currently, **we** have those guys (Participant IDI-JK).*

When we joined the Ministry, monitoring and evaluation were not understood in the name of monitoring and evaluation. Of course, they had their information officers at the provincial, district, and national levels performing quasi-monitoring and evaluation roles that were not properly defined within the spectrum of monitoring and evaluation. So, when myself and colleagues joined, I think we were the first, we were the pioneers, to come on board as real monitoring practitioners. And now, there is a need to streamline monitoring and evaluation (Participant IDI-AM).

The two responses concur in their exclusive discourse that separates ‘them’ as a unique group from others within the system. The use of modal phrases like ‘us,’ ‘them,’ ‘those guys,’ ‘they,’ and ‘we’ constitute a common reference point reinforcing the professional boundaries in a system that requires integrated and coordinated processes to compensate for the limited resources in the system. The impression gained from the two responses is that Provincial M&E systems started when they joined the Ministry in 2015, yet health information officers performed the functions in the past. However, the respondents considered the M&E role only

from entering the Ministry. The lexicalisation of M&E as new terminology and practice is emphasised through the nature of the language describing the previous M&E activities. The use of phrases such as ‘quasi-monitoring,’ ‘not_properly defined,’ and ‘monitoring and evaluation were not understood in the name of monitoring and evaluation’ is indicative. These terms show the dismissive attitude of the new M&E staff to the staff in M&E in the period before they joined.

On the other hand, the participants used terms that foreground the current phase as the actual period of M&E. Phrases like ‘we were the first, we were the pioneers,’ and ‘real monitoring practitioners’ substantiate the study’s argument that GHP support for M&E has resulted in an ‘othering’ challenge in the Ministry. The challenge is linked to the lexicalisation or conceptualisation that recreates health information processes as M&E. This includes the use of terms such as strategic information, knowledge management, Strategic Information Officer (SIE), monitoring, evaluation, and evaluation Learning (MEAL), among others. These functions are closely related, but the changes often reflect semantic gymnastics.

In conclusion, the GHP-supported M&E systems have been instrumental at the policy planning level by establishing the M&E procedures and structures at provincial and national levels. However, at the policy execution level, the divisions and conflicts involving M&E staff and departments, such as those in Health Information, have not been helpful in a system that requires coordinated and integrated implementation of programmes. The conceptual cracks among the staff are not conducive to partnership relations.

7.2.11 Coordination challenges due to competition for visibility and leadership

The previous discussion addressed the effects of conceptual boundaries among local M&E and health information staff in M&E in the Ministry. In the current conversation, the study draws explicit evidence of how GHP's lack of harmonisation and competitive practices for leadership amongst themselves negatively impacted coordination efforts by the Ministry. In discussing inter-coordination challenges among GHPs in supporting the Ministry of Health, KII-TC expressed frustration with the political maneuvering between the World Bank (WB) and the Centre for Disease Control (CDC) Atlanta over a proposed blockchain programme to improve the M&E of public health pharmaceutical and medicines database management in the country. An excerpt from the conversation illustrates the challenges:

You know, blockchain technology was resisted outright. Because it did not come through CDC, it came through the World Bank. So, as we speak, the technology has

been shelved, and the partner has been outclassed because it arms the government to know what is happening in their area in their districts [CDC-supported districts] (Participant KII-TC).

The quotation reveals two key aspects. Firstly, excluding the Ministry from the decisional processes for the technology supposed to benefit it reveals the exclusive decision-making process of the CDC, contrary to the cooperative perspectives of collaborative governance. Secondly, it shows that some GHPs (ab)use or withhold technologies that expose or give the government too much decisional and knowledge power. Thus, the issue of visibility has negative and positive implications for GHPs. In the current conversation, CDC perceived the World Bank as exposing its poor performance and asserting its influence on crucial matters in the country.

Moreover, the observations raise issues of GHP accountability and transparency in the partnership for health M&E. Trust is a central value proposition in partnerships, and it reflects insincerity when GHPs conceal information, as reported in the quotation. As a result, this substantiates earlier findings and arguments over the mediation role of technology and its threat to national sovereignty. In this case, the partner wants to deny the government information about its activities but demands access to Ministry databases to have access to government information. The lack of reciprocity is counterintuitive to partnership values.

Based on the above excerpt, the study concludes that GHPs are not homogenous groups pursuing home-grown humanitarian objectives but heterogeneous organisations with varying interests. Their competition points to these hidden interests through their partnership discourses. Technology is the new medium that hides GHP's interests from local partners. Such practices negatively impact the core values of partnerships, such as trust, transparency, and accountability.

7.3 Discussion

This section provides critical discussion points highlighting the GHP effects on governance processes and M&E in the public health system. The discussion focuses on GHP support for M&E as facilitating the normalisation of the existence of parallel M&E systems, digital disruptions for local partners, conflicts and contestations, patron-client relations, threats to national sovereignty, the brain drain, mute and perverse practices, digital exclusion, threats to regular employment, conceptual boundaries, and competition for visibility and leadership. The following section provides a detailed discussion of the issues identified.

7.3.1 GHPs-supported M&E facilitating digital exclusion

The GHP support for electronic M&E systems should facilitate the coordinated and integrated collection and reporting of patient-level and consolidated programme data to inform clinical and management decision-making. The collaborative governance process should facilitate mutuality, organisational identity, and joint decision-making among the partners. The New Public Governance (NPG) theory emphasises trust-building and relational contracts that enable inter-organisational governance, services, and outputs underwritten by a corporatist value-based system (Osborne, 2006). This study's findings about the exclusion of core members of the collaborative partnership for M&E appear to suggest that the ideals of the NPG theory do not automatically apply to unstable economic environments like Zimbabwe, where basic infrastructure to complement GHP support is inadequate. As a result, the well-intended intervention led to the exclusion of core partners, including community NGOs that provide social capital and the beneficiaries that makes the programmes implementable. A study by Bopp *et al.* (2017) identified the comparable effects of electronic M&E systems. Bopp *et al.* observed that instead of leading to productivity and empowerment, the introduction of the systems led to the erosion of autonomy, data drift, and data fragmentation.

Similarly, the experience in Zimbabwe has led to increased disempowerment of the local partners, contrary to planned goals. This finding suggests that NPG and the discourse of integrated collaborative models appear to overemphasise and overestimate the role of trust-building and plural processes that seldom occur in partnerships involving parties with different capacities and motivations. Vangen *et al.* (2015) also appear to rely more on the partners' transformative leadership, which seems to be lacking in the Zimbabwean scenario. As a result, the envisaged mutual benefits were not realisable, and the system produced unintended effects. The electronic systems, the DHIS2, the EPMS, and the current EHR systems created challenges for the subnational partners who provide the Ministry's primary data. The study results, therefore, substantiate the fears noted in Chapter Five about GHPs supporting higher-level quinary scientific processes at the expense of investing in the primary health levels. As a result, the system relies on population-based estimates and surveys for crucial M&E data. The Zimbabwean situation resembles that observed by Kanyamuna *et al.* (2020). They assert that international NGOs avoided supporting the Zambian Whole of Government M&E system due to the slow response by the government to embrace new technologies to track indicators and targets and manage databases. The Zimbabwean government cannot afford some of the electrical equipment that would facilitate GHP-supported systems at selected health facilities

and departments. As a result, international NGOs maintained their parallel M&E systems to ensure reporting to their donors.

The study concludes that the NPG and related collaborative governance models that rely on trust-building and mutual interest may perhaps function adequately in stable economies where the governments facilitate the other partners to contribute effectively in a plural decision-making process, but not in situations such as that in Zimbabwe. Cheng (2019) tries to provide another more informed framework for multiple case design government-non-profit partnerships, proposing the institution of mechanisms like government representation on the non-profit board, formal agreements, building relationships, and building leadership capacity. While these could work in a Western governance environment, this study has revealed the shortcomings of such organisations in Chapter Six, as the government cannot fully exercise its responsibility to hold GHPs to account. Thus, the NPG theory and governance models appear to perpetuate power imbalances by relying on discourses of mutuality and trust, which do not exist in practice in developing countries. This is why this study has applied the CDA - to expose the limits of NPG and comprehensively explain the challenges in the M&E system in Zimbabwe.

7.3.2 Normalisation of Parallel M&E systems

The existence of parallel M&E systems revealed by this study suggests the need for the public health system to adopt CDA as its established policy analysis approach. The study highlights the importance of considering street-level bureaucratic views as an essential feedback loop in public health policy-making processes. As discussed in Chapter Six, street-level bureaucrats may provide effective feedback into the policy process for informed joint decision-making in collaborative governance for M&E. There has been interest in this concept, as articulated initially by (Lipsky, 2010). Studies of actor interfaces and practices of power in a community health worker programme in South Africa by Lehmann and Gilson (2013) find that the existence of parallel M&E systems in that country has been normalised. The programme identified unintended policy outcomes that were critical to reprogramming similar activities. The new trend focuses on street-level entrepreneurship, a concept that instrumentalises street-level innovations for learning and improvement (Gofen and Lotta, 2021; Zarychta *et al.*, 2020; Zhang *et al.*, 2021). Thus, the acknowledgment and defence of the existence of parallel GHP systems suggest that it has crucial positive and negative effects that help policymakers to make informed decisions.

However, such pragmatic feedback contradicts the conventional views of Jain and Zorzi (2017) and Craveiro and Dussault (2016), who see parallel reporting M&E systems as a coordination challenge. KII-IC also highlights the issue as a challenge. These views are understandable through the NPG theory. The existence of parallel systems implies parallel rather than shared beliefs, joint capacity, and a lack of principled engagement. However, based on IDI-AM's explanation, there is a need for clarity on what constitutes parallel systems.

According to IDI-AM the fact that the Ministry and partners like OPHID implement separate reporting systems does not mean that they have parallel systems. He argues that the objective is the same, and the Ministry does not expect GHPs to operate like departments of the Ministry. The argument holds if we apply the government-NGO collaborative framework for partnerships, according to Brinkerhoff (2002), which emphasises organizational identity and mutuality as key to partnerships. As KII-TC argues, GHPs should maintain their organizational identity as ministry partners by retaining their reporting systems. This process will allow for individual, organizational plans that complement efforts to provide program data. These two responses provide fresh perspectives on the parallel M&E systems against the generally negative view. They may arise from a lack of coordination, but they play a functional role in allowing the triangulation of various data sets. The outcome is positive as the goal has always been systems harmonisation. KII-TC's view that the Ministry should ensure effective coordination concurs with that of Vangen *et al.* (2015), who emphasise that any of the partners may lead and coordinate resources for effective joint decision-making and the achievement of the goal of transformation. The focus is on heterarchical rather than hierarchical relations.

In conclusion, the public policy processes should ensure the use of CDA as a central approach to policy making, incorporating street-level feedback that provides different but practical approaches to policy issues often missed in boardrooms. This study finds that the alternative reporting systems constitute complementary systems useful to achieving Ministry goals while maintaining individual partnership identities.

7.3.3 Digital disruptions in M&E

The study's findings about digital disruptions are surprising revelations about the collaborative partnership for M&E. The term 'digitalisation' has acquired a positive and affirmative meaning to represent the future way of doing business, but discourse around leadership and technology represents the positive lexicalisation of a destructive process. Public administration scholars have developed an interest in concepts like digital governance discourse, the fourth industrial governance revolution, or public administration by algorithms (Veale and Brass, 2019) as

governance paradigms (Bunasim, 2020), but adopting these approaches to administration has been unproductive in Zimbabwe. The lack of appropriate infrastructure to support the continuous electronic data capturing and reporting necessary for the management of parallel data management processes for clinical staff has resulted in the deleterious disruption of the health system. While the GHPs intended to facilitate smooth data collection and reporting, the intervention has had the opposite effect. Gimbel *et al.* (2018) illustrate the “data vacuuming” practice, with clinical staff in Tanzania spending more time preparing reports than focusing on their core business.

Moreover, the data challenges reinforce the findings of the study reported in Chapter Five about the limits of the pragmatic-instrumental views of technological discourse in Zimbabwe. At the practice level, M&E is chaotic and disruptive due to power outages that literally switch off the digital M&E systems and negatively impact policy implementation. In addition, framing the experience of the government-GHP partnership through the Governance of Collaborative theory of Vangen *et al.* (2015) and the concept of hybrid governance systems as articulated by Koppenjan *et al.* (2019) shows the absence of the goal congruency and trust that define successful partnerships and hybrid forms of governance.

In conclusion, the study results show that the government-GHP collaboration has led to unintended effects that have necessitated the maintenance of two parallel systems and created additional workloads for understaffed departments and overworked clinical staff. This result is at odds with the positive views of technological discourse and debates, which focus on technology's positive contributions to public administration that apply to functioning and stable government systems.

7.3.4 Contested nature of GHP-supported M&E

The study results on this issue confirm the initial argument that partnerships are contested sites, contrary to the technocratic and apolitical discourse found in official policy documents. KII-TC and IDI-AM illustrate as they express their views concerning the potential threats inherent in collaborative partnerships. The specific reference to the mediation role of ICTs and sovereignty highlights crucial aspects of technology and ideas in extending knowledge about the fluid boundaries of sovereignty. The issues raised by the participants question the relevance of classical Westphalian sovereignty of 1648 in the digitalised twenty-first century.

Through CDA, the study observed the use of rhetorical framing, epistemic modalisation, and presuppositions as discursive tools by the participants to drive home their arguments about the

threats to sovereignty posed by technological mediation in collaborative partnerships. These strategies add emphasis through their non-emphasis. For example, they drive home the point by framing an issue as common sense that does not require elaboration. That means that the issue is not negotiable and requires action. Huckin (1997) elaborates on the effects of presupposition as a discursive strategy involving language that takes specific ideas for granted and excludes alternative views. As a result, it is known for its manipulative force and resistance to opposing views. In the above example, the participant manipulatively challenged the interviewer on the ground that he should have known that databases are confidential. Thus, the dialogical experience confirms the critical constructivist epistemology of this study.

Similarly, rhetorical phrases like *'Do you know this database is confidential?'* are an affirmation by IDI-AM that the government should address this situation. Likewise, modalisation phrases are linguistic expressions of possibility and necessity. In this case, the participants applied epistemic and deontic modal phrases to express the urgent need for the government to reflect and act on the issues.

Another critical discussion point is the extractive nature of the partnership for M&E, which breeds mistrust and chaos. Herrick (2018) and Okeke (2018) discuss similar experiences and limits and the precarity of GHP data extraction practices in higher learning research collaborations involving universities from developed and developing countries. Correspondingly, Kenworth and Crane (2018) reflect on Boum's interesting observation about Western institutional partners tending to provide the financial and technical expertise in research partnerships and African partners often being called upon to provide 'sites, patients, samples, and data.' While Boum's analysis reflects negatively on the sovereign contributions of African states, the current study has observed that they play functional roles in collaborative partnerships in Zimbabwe. In Chapter Six, IDI-CN asserted that the Ministry provided the human resources and infrastructure like clinics as its contribution and as a power source in the partnership.

However, the challenge with most of these collaborations is the creation of conceptual boundaries, which reduces local experts to the role of assistants roles in research. Kenworth and Crane (2018) argue that the material flow of research funds and equipment (un)intentionally echoes and reinforces neo-colonial extraction economies. They further highlight the problematic extraction of raw material for global health work from Africa, which Western scientists, experts, and institutions transform into more valuable products; and then

return and market in African states as essential health interventions or products. These assertions reflect practices counter-productive to the trust and mutual respect expected in conventional partnerships. Gimbel *et al.* (2018) describe the data extractive practices by GHPs as ‘data vacuuming,’ whereby GHPs and their local and international partners engage in audit-like extensive data extraction processes from health systems in which data is the ‘new oil.’ The figurative description of data as the ‘new oil’ by KII-TC accurately denigrates the post-colonial soft power strategies affecting local health systems in Zimbabwe, Tanzania, and Mozambique, as Gimbel *et al.* (2018) confirm. Thus, the paternalistic tendencies of the GHPs perpetuate mistrust and a lack of goal congruence, contrary to the expectations of partnerships for M&E. The lexicalisation of this aspect of monitoring as ‘data mining’ or ‘new oil’ could be described as the creation of a counter-discourse to the post-conditionality discourses of partnerships through CDA. Critical scholars such as Youde (2016) accurately describe global health as ‘high politics,’ in contrast to the depoliticisation agenda of partnership discourse. Likewise, Segone (2008) reminds us that public policies are developed and delivered through power; hence, tensions between power and knowledge exist in shaping policy. Segone warns against the cynical emphasis on knowledge and expertise and the naivety of emphasising coercive power at the expense of co-optive soft power like knowledge. Thus, it is possible to conclude that there is a need for multi-disciplinary public health policy teams to handle the complex issues raised here.

7.3.5 GHPs as threats to national sovereignty

The results of this study on the mediation role emphasise similar sentiments as those raised in the preceding section concerning access to sensitive health information outside conventional partnership agreements. The key issues are the limits of applying the NPG and the centrality of critical discourse analysis in unstable collaborative governance contexts such as Zimbabwe. The role of champions invokes the social science concept of boundary spanning, in which individuals within an innovation system take on the task of connecting the organisation's internal networks with external sources of information. From another perspective, boundary-spanning roles emerge because champions are local collaborators who balance national and donor interests. As a result, KII-TC views are personal rather than official or organisational. Thus, sensitive issues around sovereignty, stability, and security remain shadow discourses that may not make it onto the official policy agenda due to the silencing effect of partnership discourse. As a result, the dialogic reflections of KII-TC offer insight into the silencing effects of official partnership discourses that aim to preserve relationships rather than disrupt them.

Thus, relying on frameworks like the NPG helps to subvert rather than affirm the collaborative governance for partnerships in Zimbabwe. CDA provides the critical perspective required in dealing with discrete processes like partnerships and makes it possible to question the preparedness of Zimbabwe to function in meta-governance systems that advocate Governance 4.0 or what others call Administration by Algorithms (Veale and Brass, 2019). Thus, technological mediation in unequal partnerships poses threats to under-resourced partners.

Similarly, Larsson (2013) raises crucial questions about blurring socially and politically constructed boundaries between the public and private sectors, which he calls the ‘politics of politics.’ In the process, he exposes the precarious position of classical sovereignty as a concept, acknowledging the limits of physical attributes and incorporating sovereignty's social and performative characteristics to show that meta-governance through networks has failed to contribute to public value as anticipated. While collaborative governance failures are spectacular in developing countries, they also have occurred in advanced economies. The global anger against the shortcomings of the market-driven health and food distribution systems has seen widespread riots and governments retreating towards centralised control for health and energy systems. In conclusion, global shocks like Covid-19 and the Russia-Ukraine war have exposed the limits of collaborative governance systems as governments shield themselves from the outfall, sometimes even bailing out failing private corporations.

7.3.6 Patron-clientelism

The study suggests that GHPs apply discursive and material strategies to influence the making of M&E policies at the C-Suite level by offering co-optive and monetary incentives to senior bureaucrats in Zimbabwe. The targeting of decision makers at this level is effective as their influence improves the chances of GHP proposals translating into official plans and policies. Using terminology such as ‘Human Resources for Health’ or ‘level of effort’ is identified as justifying GHP financial support for senior staff salaries. However, as KII-TC argued, the support has strings attached that translate into patron-client relations in collaborative partnerships in Zimbabwe. The study also observes that financial incentives negatively influence functional ignorance, or what Alvesson and Spicer (2012) describe as functional stupidity. The concept describes the making of questionable decisions, presumably out of ignorance. The process sometimes involves deciding not to decide or not to act on critical issues one ordinarily expects management in the C-Suite to appreciate fully. Thus, patron-client relations limit the bureaucrats to act in the national interests in partnerships for health M&E policy and practice in the country.

It destabilises the partnership by compromising the government's representatives by offering them material incentives, including salaries. The primary concern is that this leads to outsourcing electoral and bureaucratic sovereign and legitimate authority to unelected civic and private players who account to their shareholders. This study confirms similar observations by Patterson (2018). Applying the neo-patrimonial model, Patterson asserts that because state elites seek rents, they look to benefit from donor health resources. He observes that patron-client relations occur through the payment of per diems for donor-funded workshops, health projects placed in their voting constituencies, and salaries from donor projects. Thus, these resources influence and benefit elites and their clients to make specific decisions in their patronage networks.

The literature and this study's results highlight the capture of senior bureaucrats, sometimes of leaders in the private and civic sectors. Thus, all locals involved in the collaboration are susceptible to monetary co-option by a few influential corporates and may be persuaded to vote for or advocate specific policy positions. However, patron-client relations are not all as bad and linear as the neo-patrimonial model or conventional literature suggests. The general belief assumes capture without acknowledging the possibility of agentive reflexivity by the local bureaucrats, who may instrumentally appropriate the GHP resources for the greater good as one of the obfuscation and extraversion strategies discussed in Chapter Six. Herrick (2018) and Okeke (2018) address the precarity of GHPs at the intersection with bureaucrats. The buck stops with the government in all collaborative governance partnerships.

In conclusion, this study has revealed the negative influence of patron-client relations on partnerships for M&E in Zimbabwe. Its existence reflects the unequal relations characterising the partnerships and the precarious threats to core values like trust and organisational identity. However, there is a need to acknowledge the role of local agency as locals can appropriate and channel the resources positively through soft power strategies like extraversion and obfuscation for the greater good of the local people. In these collaborations, the hunter sometimes becomes the hunted.

[7.3.7 GHP support as a facilitator of the M&E brain drain in the health sector](#)

Apart from patron-client relations, GHPs facilitate a skills flight away from government to GHPs, NGOs, and the private sector through M&E local and international skills building and training programmes. This study observed that the request for international skills training in highly coveted areas like HIV, estimates, modelling, and big data resonates with the scientific discourse discussed in Chapter Five and has underlying personal skills and professional

interests. Thus, the study concludes that M&E staff in Zimbabwe hold a pragmatic-instrumental view about scientific discourse, which benefits them as part of skill sets that facilitate their coveted transition to global careers, especially with the GHPs as funding agencies. Capacity building is considered an undisputed good by the GHPs and the beneficiary M&E staff, but the government is the biggest loser as the skilled and experienced staff leave critical government positions to coordinate narrow disease-specific assignments.

Working in Sierra Leone, Herrick and Brooks (2018) observed that capacity building was generally thought of as an undisputed good intervention that GHPs use to justify various training programmes that benefit GHP programme-specific projects rather than the Ministry of Health. The Zimbabwean experience shows that there are (un)intended positive impacts for the GHPs and the individual beneficiaries who get skills and opportunities for better-paying jobs. The objectives of GHPs in supporting capacity building to individual ministry staff is to strengthen the system, not improve personal opportunities for career advancement with the GHPs. Similarly, Shukla (2013) discusses the improvement of individual CVs as one of the (un)intended positive impacts of individuals working for global NGOs in India. Consistent with the findings in the current study, Shukla observes that working for celebrity NGOs is an ambition for most local staff as it boosts their professional profiles. The goal for most of the ministry M&E staff is to work for the donor GHPs. The findings of this study show that the capacity-building programmes that KII-IT and KII-IC proposed appear to be more globally relevant than locally relevant. Thus, the attractive power of GHPs negatively influences local M&E policy and practice by encouraging a brain drain to better-paying collaborative partners, including the private sector. These developments raise crucial aspects of current neoliberal debates about the implications of GHPs' support for human health resources for M&E. For example, Lilja and Baaz (2022) discuss an increasing form of governance in which human resource subjects' desires for career professional improvement and creativity are extorted to control and profit from them. The concept Lilja and Baaz refer to as "artepolitics" is a particular form of governance technology that seeks to regulate individual behaviour in terms of self-realization and the distribution of "freedom" to control the labour situation of the employees. The reflections of KII-IT and KII-IC regarding GHPs' support for internationally recognised capacity building trainings for M&E demonstrate the influence of arte politics in Zimbabwe's public health M&E system. As indicated in Chapter Five, the shift from GHP support for primary level to quinary level M&E programmes in a country still struggling to get basic M&E processes right suggests the negative effects of the attractive power of GHP capacity-building

initiatives that are more relevant at the global than at the local level. At the same time, the study does not oppose capacity-building initiatives for M&E in Zimbabwe. Instead, the study aims to elevate the critical reflection on issues rarely discussed in collaborative governance discourse. The results highlight the need for reflection on Zimbabwe's capacity-building priorities. The rush to join global modelling and big data initiatives should not occur before Zimbabwe's primary-level data capacity needs have been met. The earlier neoliberal arguments in Chapter Five appear to drive the courses provided by private consultant firms. Pro-economic discourse also drives demand for courses focused on econometrics and health economic modelling. The findings are consistent with similar scholarly work by Erikson (2016), Adams (2016), and Tichenor (2020), who highlights increasing practises in global health metrics that promote the financialization and commercialization of M&E data and processes such as capacity-building programmes for pro-economic purposes. While health economic models help assess the need for health investments, their preoccupation with return on investment sometimes takes precedence over equitable access to affordable care for all.

7.3.8 Promoting mute and perverse practices

This study has revealed the mute and perverse effects of the incentives offered by GHPs, which are counterintuitive to the goals of collaborative governance. Scholars such as Makuwira (2018), Shukla (2013), and Storeng *et al.* (2019) share experiences of GHP-driven mute and perverse practices and their effects in Malawi, India, and South Sudan. The deployment of extraversion and obfuscation strategies includes some less-than-admirable strategies, such as falsifying data to compensate for missed collaborative partnership targets. This shows a lack of open and transparent communication based on trust and mutual interest in the functioning of GHPs. Moreover, a lack of joint decision-making is evident in the collaboration, as the targets and indicators set appear to be an imposition from the GHPs rather than the outcome of consultation. The unintended effects of the data falsification further illustrate the GHP's problematic focus on quantitative results.

Moreover, their approach neglects qualitative data, which provides contextual information that makes sense of the quantitative data and is relatively difficult to manipulate. The pressure to attain consolidated results and the desire to access the monetary incentives motivate the cheating and the perverse reflexivity in which local partners falsely produce programme reports to fulfil the donors' requirements. While these practices negatively impact the M&E policy practice, they draw our attention to critical epistemological issues about the chaotic nature of M&E practice, contrary to the predictable and friendly modicum of the partnership discourse

in official policy documents. As illustrated in Chapter Six, local partners adopt coping strategies to deal with street-level problems, as shown by the findings of this study.

IDI-AM indicated that the collusion among the provincial-, district- and facility-based staff to qualify for monetary incentives under the RBF programme represents a perverse agentive reflexive coping mechanism in an under-resourced health system. While the practice is pathological, it highlights the counterbalancing strategies by local partners, as discussed in Chapter Six. It highlights the need for GHPs to consider local circumstances when conceptualising programmes. The results provide negative lessons contrary to the partnership's ideals. Moreover, the results reveal the importance of factoring street-level feedback into policy-making processes. Street-level bureaucratic practices could provide information to inform policy and practice in the broader Zimbabwean partnership context. The negative feedback could provide valuable information on the need to avail appropriate monitoring mechanisms beyond merely reporting statistics. Therefore, mute and perverse practices are vital policy feedback loops for improved design and implementation. Thus, this study has chosen to draw positive feedback from negative practices.

The above discussion draws interesting conclusions illuminating the need to consider dialogical views of street-level bureaucrats in managing relational power dynamics in the partnership. Thus, the perverse practices that include data gaming [manipulation of M&E data] and mute reporting [reporting for the sake of reporting] are functional reflexive processes that are part of the survival strategies of the underfunded health centres in Zimbabwe. These practices are not random events but are based on broader extraversion and obfuscation strategies that reflect desperate coping mechanisms rather than habitual dishonesty by local partners in collaborative partnerships. Just as GHPs deploy discourse and other soft power strategies to conceal their objectives, local partners apply mute and perverse strategies to counter the power imbalance in the relationship. Note that this conclusion does not condone cheating and the falsification of M&E data. It simply draws attention to the need for policymakers to be conscious of these practices and to understand their motivation.

7.3.9 GHP-supported M&E as a threat to employment

The perceived threat to employment emanating from GHP-supported electronic M&E systems perhaps reflects a lack of collaborative processes and consultations among the partners. The concern highlights the importance of street-level feedback in policy and decision-making processes. The circumstances reveal technology's unintended adverse social effects, which are crucial for consideration in evidence-based policy and decision-making processes. Moreover,

resistance to technological change suggests the need to consult shop-floor-level staff and the incremental introduction of potentially disruptive programmes directly impacting people's livelihoods. Resistance sometimes emanates from inadequate information about the goals of the GHP programmes. In the Zimbabwean context, GHP-supported programmes created additional jobs due to the need to back up the two systems. It created more jobs rather than facilitating unemployment. This argument does not ignore the genuine concerns of the workers, but opportunities also arise out of negative circumstances. As a result, transformative leadership is essential to sensitising all stakeholders to changes that potentially impact people. Another strategy is to co-opt support by promoting self-realization and encouraging existing staff to enroll in courses that prepare them for the new roles. For example, some Health Information staff successfully joined the M&E department based on their new qualifications and the recognition of prior learning.

7.3.10 “Othering” and conceptual boundaries

The major issue arising from the study on the topic of M&E conceptual boundaries is the unintended effect of “othering” among the Ministry staff due to the better GHP working conditions, the exclusive view of the M&E function, and the need for higher qualifications as prerequisites for employment. While staff is engaged as champions to play catalytic roles in institutionalising M&E, the GHP initiative has had unintended negative effects. The Zimbabwean results contradict the favourable reviews of the employment of M&E champions elsewhere in Africa in the extensive literature on the topic (Mackay, 2007; Mackay, 2008; Zall Kusek and Rist, 2004; Lopez-Acevedo and Krause, 2012). The ‘othering’ tendencies compromise the anticipated role of champions as boundary-spanners [knowledge diffusion entrepreneurs] against them in the Ministry. Thus, personality and perception issues in the M&E department need to be managed to promote collaboration and teamwork.

The results of this study of the “othering” effects of GHP-supported M&E staff are consistent with findings by Peters (2016) and Mueller-Hirth (2012), who identify adverse effects of professional M&E boundaries involving expatriates, local M&E, and programme staff in Angola and South Africa respectively. Strand (2018) discusses the “othering” concept as distancing through space, time, and knowledge production. Othering is a concept derived from the notion that there is an ‘us’ and a ‘them’ and that they are in opposition to one another. A false distinction is drawn between the ‘us’ and the ‘them’ to subjugate one group to the other (Strand, 2018). The Zimbabwean example reveals ‘othering’ in terms of knowledge and experience. The use of phrases such as *‘we were the first, we were the pioneers’* reflects

‘othering’ through experience, and othering through knowledge is reflected in phrases like ‘*quasi-monitoring,*’ ‘*not_properly defined,*’ and ‘*monitoring and evaluation were not understood in the name of monitoring and evaluation.*’

The effect of the intervention of the GHP is therefore to create a superior M&E ‘us’ and a subaltern Health Information ‘them’ in the health partnership for M&E in the country. However, as the results in Chapter 8 show, this study also found what might be called ‘reverse othering,’ a process in which the privileged group becomes isolated. The current study adds to the interesting discussions of Peters, Mueller, and Strand by introducing the concept of ‘reverse othering’ observed in the dialogic analysis of bidirectional power flow in M&E partnerships.

In conclusion, the current study argues that GHP-supported M&E systems in the health sector perpetuate conceptual boundaries rather than facilitating knowledge diffusion for innovative and functional disruptive governance of M&E partnerships in the country. The ‘othering’ practices of GHP-supported M&E staff create and perpetuate power imbalances that resemble the paternalistic behaviour of its funders in the partnership with M&E in Zimbabwe. These practices are counter-productive and contrary to the core partnership values of trust and mutual interest.

7.3.11 Weakened coordination due to competition for visibility and leadership

The previous section addressed the effects of conceptual boundaries on M&E partnerships for health involving local and expatriate staff and the impact of the partnership on the health M&E system in the country. Similarly, this discussion highlights the effects on the country of GHPs’ competitive practices and lack of harmonisation among themselves, which run counter to the progressive narrative of the pragmatic-instrumental and critical-ideological partnership literature and networked governance that present civil society partners like GHPs as a homogenous group complementing the government in serving humanitarian objectives. The observations are consistent with Barnes (2011), who asserted that GHP intentions among themselves are unclear and involve contradictory and inconsistent expressions. Barnes noted donor practices are often more contested, complicated, and “dirtier” than the critical-ideological literature suggests. However, this observation does not indicate the absence of neoliberal intentions among the GHPs as they differ in approaches or competition for visibility. They may vary in the means or techniques, but the end is the same. The common goal converges toward rebranding and sustaining paternalistic control of public health systems through post-conditionality discursive soft power strategies.

Consistent with the findings on the competitive practices and lack of harmonization among GHPs, Craveiro and Dussault (2016) observed a similar pattern among Global Health Initiatives (GHIs) in the Angolan health system. The scholars observed that GHPs acted in parallel, non-synergistic or complementary ways and always competed to see who was ‘ahead of the chariot’ despite Global Fund’s efforts to harmonise the interventions (Craveiro and Dussault, 2016). In conclusion, the lack of harmonisation and the competition among GHPs reveals the non-homogenous, political, and contested nature of GHP interests and the limits of critical-ideological perspectives on partnerships that give too much coherence to GHP goals in partnerships. Matrix 7:2 is a summary of the findings

Matrix 7 2: Summary of the discussion on the impacts of government-GHP collaborative partnerships for M&E on the public health governance system in Zimbabwe

Research question	Emerging themes	Interaction with literature	Sources
What impacts does the government-GHP collaborative partnership for M&E have on the public governance system in Zimbabwe?	GHPs-supported M&E facilitating digital exclusion	<ul style="list-style-type: none"> International NGOs avoided supporting the Zambian Whole of Government M&E system due to the slow response by the government to embrace new technologies to track indicators and targets and manage databases. Instead of leading to productive and empowering data-driven intervention, it led to the erosion of autonomy, data drift, and data fragmentation. 	Kanyamuna <i>et al.</i> (2020). (Bopp <i>et al.</i> , 2017)
	Normalisation of parallel M&E systems	<ul style="list-style-type: none"> The scholars problematise parallel reporting M&E systems as a coordination challenge. 	Jain and Zorzi (2017) Craveiro and Dussault (2016),
	Digital disruptions in M&E	<ul style="list-style-type: none"> Digital governance discourse, fourth industrial governance 4.0 or public administration by algorithms Disruptive governance paradigms. Illustrated “data vacuuming” practices, with clinical staff spending more time preparing reports than focusing on their core business. 	(Veale and Brass, 2019) (Bunasim, 2020) Gimbel <i>et al.</i> (2018)
	Contested nature of GHP-supported M&E	<ul style="list-style-type: none"> Discussed presupposition as an established discursive strategy involving the use of language that takes specific ideas for granted and excludes alternative views. Discussed similar experiences, limits, and the precarity of GHP data extraction practices in higher learning research collaborations involving universities from developed and developing countries. Observed that Western institutional partners tend to provide the financial and technical expertise in research partnerships, while African partners are often called upon to provide ‘sites, patients, samples, and data.’ Described the data extractive practices of GHPs as ‘data vacuuming,’ audit-like extensive data extraction processes from health systems in which data is the ‘new oil.’ 	Huckin (1997) Herrick (2018) Okeke (2018) Kenworth and Crane (2018) Gimbel <i>et al.</i> (2018)
	GHP as a threat to national sovereignty	<ul style="list-style-type: none"> Raised crucial questions about the precarious position of classical sovereignty, blurring socially and politically constructed boundaries between the public and private sector, which he called ‘politics of politics.’ 	Larsson (2013)
	Patron-clientelism	<ul style="list-style-type: none"> Applied the neo-patrimonial model. Asserted that because state elites seek rents, they look to benefit from donor health resources. Discussed the concept of functional stupidity or questionable decisions made presumably out of ignorance. 	Patterson (2018). Alvesson and Spicer (2012)
	GHP support as a facilitator for the M&E brain drain in the health sector	<ul style="list-style-type: none"> Capacity building is generally (ab)used as an ‘undisputed’ good intervention that GHPs use to justify various training programmes that in most cases benefit GHP programme-specific projects rather than the Ministry of Health. 	Herrick and Brooks (2018)
	Promoting mute and perverse practices	<ul style="list-style-type: none"> Experiences of NGO influences from South Africa, Malawi, and South Sudan. 	Makuwira (2018), Storeng <i>et al.</i> (2019)
	Othering and conceptual boundaries	<ul style="list-style-type: none"> Othering is a conceptual creation of the notion of ‘us’ and ‘them’ and the distinction between the two, designed to perpetuate the subjugation the other to the one. The ‘othering’ attitudes of GHP-supported M&E staff are consistent with findings by, Peters (2016) and Coultas (2020) who identified the adverse effects of professional M&E boundaries involving expatriates, local M&E, and programme staff in Angola and South Africa, 	(Strand, 2018),(Coultas, 2020); Peters (2016) Mueller-Hirth (2012)
Weakened coordination due to competition for visibility and leadership	<ul style="list-style-type: none"> GHPs acted in parallel, non-synergistic or complementary ways and always competed to see who was ‘ahead of the chariot’ despite Global Fund’s efforts to harmonise the interventions 	(Craveiro and Dussault, 2016)	

7.4 Chapter conclusion

This chapter has presented the impacts of the government-GHP collaborative partnership for M&E on the public governance system to answer the research objective and question three of the study. The adverse effects identified and discussed include the normalisation of M&E parallel systems, digital disruptions of systems, conflicts and contestations, patron-client relations, threats to national sovereignty, the brain drain, mute and perverse practices, digital exclusion, threats to regular employment, ‘othering’ and conceptual boundaries, and competitive behaviour for visibility and leadership.

The study has revealed that government-GHP collaborations for M&E partnerships result in the exclusion of small local NGOs and other government departments from the digital network for the Ministry’s major electronic health systems like the DHIS2, EHR, and EPMS. As a result, primary health facilities do not report data through the electronic system. The current system favours facilities in urban areas and provincial and district capitals. Moreover, the study reveals that the collaboratives are sites for contestation and conflict due to the complicit patron-client relations and the technologically mediated access to classified health data sponsored through GHPs. Likewise, there is an unintended brain drain with equipped and qualified Ministry of Health staff joining GHPs and the private sector due to GHP capacity-building initiatives and networks. Consequently, the capacity-building initiatives benefit the GHPs and individuals rather than the Ministry. Thus, GHP capacity-building programmes pose threats to the health M&E systems collaboration and pose threats of instability to the Ministry.

Other adverse effects include threats to employment, the ‘othering’ of members of staff, and erection of conceptual boundaries of M&E, digital disruptions, and weakened coordination due to competitive behaviours among GHPs. These revelations highlight the unanticipated chaotic effects of government-GHP collaboration in practice, contrary to the mutual and friendly picture reflected in official policy discourse and national policy documents. The study reveals the efficacy of constructivist dialogical knowledge creation that acknowledges street-level experiences in policy analysis through CDA. The “othering” and conceptual boundaries between M&E and health information staff are apparent through a CDA lens. The conceptual boundaries widened the gap between M&E and health information officers, limiting the opportunities to foster an integrated system. Likewise, the study identified digital disruptions and threats to employment discussed through dialogical conversations foregrounding critical issues that conventional NPG approaches overlook. Based on these results and their discussion,

the study concludes that collaborations for health M&E in Zimbabwe do not meet the criteria for collaborative partnerships based on mutuality, organisational identity, and trust. The NPG theory also limits the ability to address the post-structural, ideational, and discursive effects of the collaborations identified as the significant GHP negative influence on the M&E policy and practice in Zimbabwe.

CHAPTER EIGHT: IMPACT OF GHP GLOBAL M&E TECHNICAL AND FINANCIAL ASSISTANCE ON WIDER PUBLIC HEALTH M&E SYSTEM-STRENGTHENING INITIATIVES IN ZIMBABWE

8.1 Introduction

The previous chapter discussed the impacts of the government-GHP collaborative partnership for M&E on Zimbabwe's public health governance system. The preceding chapter specifically identified the following factors: digital exclusion, normalisation of parallel M&E reporting, digital disruption of M&E systems, contestations and conflicts, threats to sovereignty, patron-clientelism, the focus on personal and professional growth, mute and perverse incentives, conceptual boundaries, and GHP competitive practices for visibility as contributory to the challenges imported through GHP-support to HIV, TB, and malaria programmes in Zimbabwe. The current discussion specifically applies CDA and the Governance of Collaborative Partnership framework to address the fourth research question interrogating the extent to which GHP-government M&E partner power relations influenced the broader M&E system beyond the HIV, TB, and malaria programmes. Based on the World Health Organization (WHO) building blocks for effective health systems, the discussion focuses on the GHP-government partnership in the health information system, human resources for health, finance for health, pharmaceutical and medical technologies, service delivery, governance, and leadership for health on the broader health system in the country.

8.2 Effects of GHP support on broader health M&E systems in Zimbabwe

This section presents the findings on the effects of GHP-government partnerships based on the WHO's six building blocks: human resources for health, health information system, finance for health, pharmaceutical and medical technologies, service delivery, governance, and leadership for health on the broader health system in the country. Matrix 8:1 summarises the findings for the chapter.

Matrix 8 1 :Summary of findings for GHP and Ministry of Health power strategies' impact on broader M&E system in Zimbabwe

Sub-theme/sub-question	Participants' responses	Source(s)
Support for human resources for health in the health system	<ul style="list-style-type: none"> • <i>So, sitting in the Provincial Office, you don't only do M&E for Global Fund-supported activities.</i> • <i>The data entry clerks cover all diseases, and PCs also provide counselling beyond HIV and backup documentation when needed.</i> 	IDI-AM IDI-CN
GHP support health information systems in the country	<ul style="list-style-type: none"> • <i>We do have support for people within the Health Information Systems. We also, as I said, contribute to other systems. We also have other programmes that work hand in hand, like ante-natal care (ANC) and malaria, that share some indicators with the ANC programme.</i> • <i>We have a database that cuts across all programmes and a robust information system that collects all the data throughout the country. And this has been through the Global Fund, and other programmes benefit significantly</i> 	KII-TT KII-LM
Support for governance and leadership in the health system	<ul style="list-style-type: none"> • <i>It also supported the development of the M&E policies and guidelines that cut across the Ministry.</i> 	KII-LM
Finance for health and contributions to national financial accountability systems	<ul style="list-style-type: none"> • <i>Yeah, I think they've done better because their systems are watertight, i.e., they are very risk averse.</i> • <i>So, in terms of accountability, you are supposed to keep accommodation receipts when you attend a workshop. Receipts of how you have spent your money on food etc. It is frustrating in an economy where you have limited choices on how to spend money and where you have no options on where and how to spend money</i> 	KII-PZ IDI-AM
Monitoring and evaluation of pharmaceutical and medical technologies	<ul style="list-style-type: none"> • <i>As a country, we have some programmes that may not be a priority from the implementing partner's side but maybe a priority on our side. Yes. But for them now to procure medicines outside what they are supporting, it may be difficult from their end. So, I think this is also one of the challenges in medicine.</i> • <i>I think we have a system though it's not electronic, the Microsoft Access database business system. For example, suppose the medicines are delivered at the facility. In that case, everything is captured, what was installed and delivered electronically, and the balance to the end.</i> 	KII-IC
Support for health service delivery	<ul style="list-style-type: none"> • <i>When the data comes now when it is with village health workers, it may be reported according to partners supporting the programme, but when it comes to the Ministry now, there is no way you would see that this data is from which partner.</i> 	KII-STHE

8.2.1 Support for human resources for health in the health system

The support for human resources for health is one of the most critical inputs into the Zimbabwe health system due to the systemic and structural challenges currently being experienced in the country. The previous chapter provided insights into the unintended instability and dire situation that GHPs have contributed to the system in the form of threats to employment due to the introduction of electronic systems and conflicts due to the higher salaries paid to M&E and other GHP-supported officers in the Ministry. However, this support has made significant contributions, despite causing unintended effects in some spheres of the Ministry's HIV, TB, and Malaria programmes. While responding to a question on the impact of GHP support beyond the three diseases, participants had this to say:

So, sitting in the Provincial Office, you don't only do M&E for Global Fund-supported activities. So, there are some spill-over benefits across all other programmes because you also do nutrition, Extended Programme of Immunisation (EPI), Non-Communicable Diseases (NCDs), and any other general monitoring and evaluation activities, like generic reports, the Governors reports. So, my services are not limited to the grants, which global fund is supporting (Participant IDI-AM).

I think the global funding impacted a lot and in a big way. Because if you look at data entry clerks and the primary counsellors (PCs) in clinics play essential roles. The data entry clerks cover all diseases, and PCs also provide counselling beyond HIV and backup documentation when needed. Data entry clerks also enter data for pharmacy and medicine into the health centre database for all diseases, not just HIV, TB, and Malaria (Participant IDI-CN).

The two excerpts above reflect the fact that the GHP support for M&E partnerships has permeated beyond the proximate spheres of the Ministry's HIV, TB, and Malaria programmes to support the broader government systems, including reports for the Provincial Governor's Office. Similarly, the generic report covers all disease conditions of interest, administrative, financial, human resources, and coordination issues that require management attention based on M&E evidence. Likewise, reports like the Extended Program of Immunization (EPI) are critical instruments for local and national response systems covering several childhood diseases that require emergency responses in the country. As IDI-AM remarked, all these reports are coordinated and produced by the Provincial M&E Officer, a deployed M&E Champion under the Global Fund support programme in the country. Correspondingly, IDI-CN reveals that the Global Fund-supported positions like the data entry clerks and primary counsellors based at

the health centre level play crucial roles that include data entry for all diseases into a health centre database. At the same time, PCs also provide counselling services and documentation of other illnesses beyond HIV, TB, and malaria at the health facilities. With the increase in non-communicable diseases (NCDs), PCs also provide counselling on alcohol abuse and various types of cancer as part of the Ministry's response to increasing NCDs. Thus, the GHP support provides extra human resources that play a catalytic role in the health system in the country.

However, as alluded to in the previous chapter, the GHP-supported remuneration of these staff in foreign currency is a source of street-level conflicts between health facility supervisors and the supported staff at health facilities. When converted into local currency, modest salaries translate to salaries higher than their supervisors, creating a salary scale mismatch in the health system. As a result, the intervention has become a source of unintended destabilisation at some health facilities, with reported cases of supervisors overloading responsibilities onto the supported staff. While it is not government policy to undermine a GHP-supported initiative to strengthen the system, these street-level insights provide cues to some of the unintended effects of GHP-government collaborative partnerships for health in the country. Thus, a Governance of Collaborative approach to partnerships for M&E becomes essential to educate street-level managers on the importance of focusing on the partnership goals rather than personal benefits. Other non-monetary incentives may be conducive to motivating the supervisors at that level.

8.2.2 GHP support of Health Information systems

The previous discussion addressed the benefits and challenges of human resources for health in the Partnerships for Health M&E. The availability of a human resources health information system is one component that health information systems should address. As a result, the current conversation focuses on health information as another critical building block for sound health systems. According to the WHO, sound and reliable information forms the basis for evidence-based decision-making across all health system components. The cross-cutting functionality of the health information system is essential for policy development and implementation, governance and regulation, health research, human resources development, health education and training, service delivery, and financing. The significant functions underpinning its decision-support roles include facilitating data generation, compilation, analysis, synthesis, communication, and use (WHO, 2010). The health information system enables the data collection from all health departments and GHPs, analyses its overall quality, relevance, and timeliness, and converts the data into information for health-related decision-

making, including human resources for health, as discussed in the previous section. As a result, GHP support for health information systems is one of the oldest interventions that GHPs consistently provide to the Ministry, and the support for M&E processes is one such contemporary intervention. The two excerpts below illustrate the type of support and the perceptions of the M&E staff:

We do have support for people within the Health Information Systems. We also, as I said, contribute to other systems. We also have other programmes that work hand in hand, like ante-natal care (ANC) and malaria, that share some indicators with the ANC programme (Participant KII-TT).

The Global Fund played a significant role in helping us have a sound M&E system within the Ministry of Health and Child Care and beyond the funded areas. Remember, I pointed out the issue of their support for health information. We have a database that cuts across all programmes and a robust information system that collects all the data throughout the country. And this has been through the Global Fund, and other programmes benefit significantly (Respondent KII-LM).

The above responses exemplify the pragmatic-instrumental and technological discourse highlighting the positive effects of GHP-supported M&E systems through providing computer and electronic hardware and software data to facilitate reporting across programmes like ANC and malaria. The responses identify the Health Information Department as one of the primary beneficiaries of the HIV/TB and malaria GHP support. The Health Information Department is separate from the HIV/TB and Malaria departments, and its functions cross-cut the Ministry departments. As a result, the respondents accurately describe the GHP support as benefitting all Ministry Departments, including the administrative functions.

However, as noted in Chapters Five and Seven, the well-intentioned GHP support has had unintended adverse effects on the Partnership for Health. The previous section on human resources for health also provided insight into the challenges that seconded GHP staff face in the Ministry due to their privileged access to monetary and electronic equipment support. Tension and conflict arise due to this support, apart from the benefits of the ICT equipment. A critical juxtaposition of the responses in Chapters Five and Seven reveals a thin line between the positive and negative effects of the GHP support for health information. The contestations in distributing these electronic resources and the disruptive effects on existing manual systems at the street level contrast sharply with the predictable and functional discourse in official

partnership policy documents. This study concludes that GHP support for the health information system has significantly influenced the M&E system beyond the HIV/TB and malaria programmes but cautions on the unintended adverse effects on the system.

8.2.3 Support for governance and leadership in the health system

The previous section addressed the role of health information in the health system and its cross-cutting influence, including policy formulation and implementation. The discussion in this section explicitly interrogates the role of GHPs in supporting governance and leadership for health through National M&E policies and strategies. The production of policies and strategies is among the critical functions of national leadership and the governance structures in the health sector. The study data show GHP-supported national health M&E policies and strategies that guide the whole health system in the country. All the participants highlighted the critical role that GHPs play in financing and technical support in the drafting and implementing M&E policy and strategies. To illustrate the prevalent views, two excerpts from KII-IC and KII-LM follow:

We used to have separate policy documents, but for M&E, we have developed this strategic policy document involving Ministry managers from all departments and GHP partners (Participant KII-IC).

It also supported the development of the M&E policies and guidelines that cut across the Ministry. This has been through support from the Global Fund. And currently, it also supports the data sharing policy, which we have come up with, which will also affect the entire health sector (Participant KII-LM).

The above excerpts reflect a collaborative approach involving the government and GHPs in drafting crucial M&E policies, including a data-sharing policy underway during the data collection. An important finding answering the research question is the cross-cutting nature of these national M&E policies and strategies that benefit the whole system beyond the HIV, TB, and malaria programmes that provided the resources. The Global Fund supported the establishment of the M&E Directorate, Policy, and Planning Department in the Ministry, which guides all policies and plans. Moreover, governance structures that exclusively focus on the Global Fund, such as the Country Coordinating Mechanism (CCM) and the Program Coordinating Unit (PCU), exist to provide strategic guidance and coordinate programme implementation. The CCM is a multi-sectoral and transdisciplinary governance structure with representation from the private sector, civil society, and the government. Its involvement in

strengthening accountability and transparency in the HIV, TB, and Malaria programmes through the Public Finance Management System (PFMS) has supported the government's ability to manage government and other donor resources beyond the three disease budgets. Similarly, the Health Centre Committees are GHP-supported street-level committees selected by communities to provide leadership and governance support at local health facilities.

However, the positive reflections by the local M&E staff on GHPs' support for leadership and governance show a pragmatic-instrumental conceptualisation of the partnership for M&E. As the discussion section will elaborate, the GHP- support has unplanned adverse effects when scrutinised through the Critical Discourse Analysis lens. One could view the establishment of the CCM and PCU as facilitating parallel governance and implementation structures in a system where other structures like the Parliamentary Portfolio on Health and the National Research, Monitoring, and Evaluation Advisory Group (NRMEAG) exist. These structures took over the coordination of HIV, TB, and malaria from conventional government control. In conclusion, the GHP's support for leadership and governance has significantly impacted M&E policy and strategy development with spill-over benefits across all departments in the Ministry. However, a critical reflection of this support's positive and negative effects perhaps provides balanced insight into the effects of GHP interventions on the whole M&E system in the country.

8.2.4 Finance for health and contributions to the national financial accountability systems

As stated in the previous section, GHPs' support for M&E has strengthened the Public Finance Management system (PFMS), encouraging electronic financial records management for government and donor resources in the country. According to WHO, one of the goals of health systems financing is to raise sufficient health funds in sustainable ways to avoid the risk of severe financial hardship for the citizens. This objective involves raising adequate funds and providing financial risk protection to the population. Tied to these objectives is the need for efficiency in financial resource utilisation. As a result, the focus of the financing system is on revenue collection, fund pooling, and the procurement of services. However, the research data suggests that GHPs' support for finance for health has generated mixed views about its contributions to the country. Some view GHP systems as promoting accountability and transparency in the revenue collection, funds pooling, and procurement processes. Others have had frustrating experiences and perceive the system as a set of rigid procedures driven by mistrust and the control of the government of Zimbabwe by GHPs. Excerpts from the statements of two participants provide insight into these perceptions:

Yeah, I think they've done better because their systems are watertight, i.e., they are very risk averse. So you imagine what happens when we're dealing with the government? From what you've heard from people like the Auditor General, there have been a lot of grey areas. And I can imagine what could have happened if these systems had not been set in place, and more so now that we have the Local Funding Agency (LFA) in Zimbabwe, which is looking at Global Fund because UNDP works with the LFA, the local funding agency, that is looking at issues to do with accountability, and due diligence in terms of use. So very important, I think, even it's pushing the Ministry of Health to be more accountable than it used to be in terms of resources (Participant KII-PZ).

So, in terms of accountability, you are supposed to keep accommodation receipts when you attend a workshop. Receipts of how you have spent your money on food etc. It is frustrating in an economy where you have limited choices on how to spend money and where you have no options on where and how to spend money (Participant IDI-AM).

The above texts show the two contrasting views of the comparative advantages of the governance of the collaborative approach: that the system involves civil society and the private sector in playing boundary-spanning [knowledge diffusion] roles that strengthen accountability mechanisms for the partnership; and that the system is frustrating micro-management of government spending processes driven by mistrust extending even to very small amounts of money spent on food and accommodation. The coordination between the government's Auditor General, the Local Fund Agent, an international accounting firm KPMG, the United Nations Development Program (UNDP), and the local NGOs plays a vital role in the peer review of critical financial and procurement management systems in the country.

However, the first respondent's message also exposes the mistrust in the partnership for M&E, confirmed by the second respondent, as the GHPs pay more attention to accountability and due diligence issues than other crucial partnership values. The first respondent uses presupposition, an essential strategy in Critical Discourse Analysis, projecting the government as a non-accountable partner that requires constant oversight from the Auditor General, the Local Fund Agent, and the UNDP to be prevented from misusing funds. Statements such as '*So you imagine what happens when we are dealing with the government?*' presupposes that the researcher knows or ought to know about the government as an untrustworthy partner that needs policing from the other partners in the tripartite governance framework. As will be

elaborated in the discussions section, the presupposition technique is a crucial covert strategy in Critical Discourse Analysis that provides cues on the problematic nature of the unspoken but loud messages in the partnership. The attitude provides helpful insights into the problem of mistrust at the policy practice level that official M&E policy discourse fails to capture.

Moreover, the use of modal verbs like ‘watertight,’ ‘risk averse,’ ‘grey areas,’ and ‘due diligence’ in the excerpt highlights the reproduction of GHPs’ mistrustful attitude towards government financial systems and processes. The discussion section will also juxtapose lexicalization and modalization techniques to problematise GHP’s discursive power that conceals mistrust and the adverse effects of such power relations in the partnerships for M&E in health in the country. Despite these issues, GHPs such as the Global Fund has contributed to establishing the Public Finance Management System (PFMS) and integrated the HIV, TB, and Malaria grant financial management into the system. The system provides real-time interoperability with the Ministry of Finance and other government finance departments. Thus, the GHP support has influenced improved financial management systems in the Whole Government M&E system (WGM&E) for financial management. The intervention has facilitated financial disbursements and procurement processes through an electronic platform providing financial trails for audit and accountability purposes.

In conclusion, the GHP’s support of financial management systems for health in Zimbabwe has contributed to improved interoperability between the Ministry of Health and Child Care and the Ministry of Finance systems in ways that facilitate electronic disbursements and the tracking of transactions across departments and ministries. However, the study data reveal crucial partnership issues of mistrust that official M&E policies rarely anticipate or discuss. The discussion identifies otherwise elided issues to provide helpful insights into the covert processes that negatively impact the GHPS partnerships for health M&E.

8.2.5 Monitoring and evaluation of pharmaceutical and medical technologies

The previous discussions have highlighted the contributions and associated challenges of the GHP’s support to the health system in the country. Similarly, the current discussion provides evidence of the GHP’s contributions and challenges in the country’s pharmaceutical and medical technologies. The significant contribution of the GHPs closely relates to other building blocks for health systems, such as human resources for health, finance for health, governance, leadership, and health information systems. Likewise, the results show related challenges identified in Chapter Five regarding the GHP’s proposed support for a pro-private sector strategy to strengthen procurement and logistical support systems linking national, regional,

and global systems at the implementation level. While responding to the GHP's contributions to pharmaceutical and medical technologies in Zimbabwe, all the respondents acknowledged the positive contributions that provincial and district pharmacy managers supported through the Global Fund had made in harmonising the pharmacy management system across all disease components. Similarly, respondents commended the Global Fund for supporting the data entry clerks for consolidating health facility pharmacy databases for disease components beyond HIV, TB, and malaria. The excerpts from KII-IC and IDI-CN below illustrate the perceptions of the M&E staff at national and provincial levels regarding GHP's contributions on the subject:

I think the global funding impacted a lot and in a big way. Because if you look at data entry clerks and the primary counsellors in clinics play essential roles. The data entry clerks cover all diseases, and PCs also provide counselling beyond HIV. Data entry clerks also enter data for pharmacy and medicine into the health centre database for all diseases, not just HIV, TB, and malaria. Pharmacy managers also compile the Programme Update Disbursement and Request reports (Participant IDI-CN).

I think we have a system though it's not electronic, the Microsoft Access database business system. For example, suppose the medicines are delivered at the facility. In that case, everything is captured, what was installed and delivered electronically, and the balance at the end. With the coming in of this EHR, it is also taking on board all the medicines to timely report on what was dispensed. Of course, it will be implemented at all the facilities (Participant KII-IC).

The two excerpts confirm the integrated support for human resources, health information, leadership, and governance to ensure effective service delivery for Zimbabwean citizens beyond the Global Fund's three disease components. The intervention has had positive effects cascading down to the health facility level, the type of support lacking in most other GHP interventions. While the current database system is not electronic, it has successfully integrated all the pharmaceutical needs of all the disease components ready for electronic systems like the EHR. As anticipated by KII-IC in his response above, the electronic systems have the added advantage of integrating the reports in real-time to facilitate quantifications, re-ordering, and reduced pilfering of medicines.

Such perceptions substantiate the technological and pragmatic-instrumental views about technology as a panacea for health systems challenges in the country. It is, therefore, unsurprising that none of the participants had negative feedback about the GHP interventions on this building block for health. They saw nothing sinister about the increasing involvement of private sector players, including the conversion of the parastatal National Pharmaceutical Company of Zimbabwe (Nat Pharm) into a private entity. These developments confirm the findings in Chapter Five, linking GHP support to pro-private sector discourses that project the private sector as more efficient than the public system and as the solution to current bottlenecks in the health system. Yet these significant changes to the governance architecture have lasting adverse effects on the Ministry's mandate to deliver affordable health to all citizens.

Thus, this study observes that the Ministry of Health M&E staff has a technocratic view of pharmaceutical and medical technologies with a limited appreciation of the social life of pharmaceutical and medical technologies. As IDI-CN acknowledges, the pharmacy manager compiles the pharmacy and medicines sections of the Program Update and Disbursement Request (PUDR) reports, and he does not comment on it as he relies on the honesty and efficiency of the technical managers who understand the process thoroughly. These issues do not reflect negatively on the individual staff member but are perhaps a cue to the need to address the technocratic bubbles characterising the system in most departments with limited focus on the common-sense aspects of health.

On the topic of medical procurements, the study observes a bias towards GHP support for specific medicines, regardless of the evidence to support other basic, more pressing needs. Though the support positively influences the availability of some out-of-reach medical products for the country, it neglects and excludes essential and critical avoidable conditions that burden the health system daily, as the GHPs insist on procuring specific medicines for diseases like HIV, TB, and malaria. The excerpt from KII-IC below illustrates the challenge referred to above:

As a country, we have some programmes that may not be a priority from the implementing partner's side but may be a priority on our side. Yes. But for them now to procure medicines outside what they are supporting, it may be difficult from their end. So, I think this is also one of the challenges in medicine. For example, we may have some medicines that may be procured to address, for example, avoidable deaths; we can say a dog bite. Isn't the dog bite death avoidable if the medicine is administered on

time? Yes, but these implementing partners are rigid. Sometimes, it does not help to have an overstock of donor-supported programmes and a lack of essential daily medicines or supply of adequate lubricants for condoms when emergency drugs for dog bites are unavailable (Participant KII-IC).

The above excerpt suggests that there are cracks in the partnership for pharmaceutical and medical supplies, as procurement decisions remain driven by the interests of one partner rather than by evidence and common goals. Thus, GHPs influence local health systems to ignore available evidence and local needs as they prepare processes to procure, warehouse, and distribute disease-specific medicines. The arrangement creates an awkward shortage of essential life-saving drugs and an oversupply of advanced top-of-the-shelf medications. This observation does not diminish the GHPs' contribution to combatting HIV, TB, and malaria but highlights this issue to ensure balanced and evidence-based interventions. The awkward pharmaceutical and medical supply system does not serve the partnership's interests as it fails to meet the beneficiary's basic medical needs. As highlighted above, having an overstock of GHP-supported condom lubricants without essential drugs like rabies vaccines does not align well with GHP support for strengthening health systems. Thus, the rigid GHP interventions create missed opportunities for M&E data use to transform the health system at minimal costs. As the respondent KII-IC rightly observed, the moral of supporting the availability of medicines for stable conditions like HIV against emergencies like rabies dents the good intentions of GHP-supported programmes in the country.

In concluding the discussion on the above findings, GHPs have crucially contributed to pharmaceutical and medical technologies beyond the Global Fund's three disease components by supporting pharmacy managers and data entry clerks who manage the databases at the facility, district, and provincial levels. However, the pragmatic-instrumental and technological views accompanying GHP support for health suggest the need for caution to develop a comprehensive understanding of GHPs' unintended effects on the system. The unspectacular indicators hidden in partnership discourse have deep-rooted effects on the system; identifying them is one step toward addressing them. The failure to identify and confront these challenges perpetuates the power imbalances that manifest in the procurement and oversupply of high-end medicines amid the country's lack of essential medicines.

[8.2.6 Support for health service delivery](#)

Service delivery monitoring and evaluation have immediate relevance for all the other building blocks of the health system. The previous discussion has shown that medicines, good

leadership and governance, electronic information management systems, and appropriate human resources are essential to service management. Much of the GHP support for health service delivery came through the Global Fund and other international NGOs. They provide human resources, support for electronic systems, medical and pharmaceutical supplies, and financial support through Results-Based Funding models to improve service availability and uptake at the lowest service delivery levels beyond the Global Fund-supported HIV, TB, and malaria programmes. The interventions include supporting sub-health centre community structures such as the Village Health Workers and Community Volunteers. The interventions seek to reduce the distance people walk to access essential health services by establishing health centre posts and activating the Village Health Worker Programme.

However, the study finds that these GHP-supported decentralised service delivery models (DSMs) introduce unintended adverse effects on the monitoring and evaluation systems at the health and sub-health centre levels. There are significant challenges related to data collection, collation, and reporting from the Village Health Worker Programme and the health centres, which are ill-staffed and sometimes ill-equipped with M&E skills. They remain uncoordinated, operate in silos, and sometimes involve competitive practices. The response from KII-STHE below illustrates the challenges that street-level staff face when dealing with GHP-supported sub-national M&E interventions at health facility level:

So, as I said, when the data comes now, when it is with village health workers, it may be reported according to partners supporting the programme, but when it comes to the Ministry now, there is no way you would see that this data is from which partner when they submitted the statistics since its aggregated in the DHIS according by the programme, not organisation reporting. So, but the Global Fund, I understand it is supporting the community-based monitoring, you know, the component supporting decentralised service models is part of the Global Fund supporting the Village Health Workers to monitor activities of Community AIDS Refill Groups for delivery and distribution of Anti-Retroviral Drugs. So, in a way, they also contribute to the monitoring system when they collect the data and submit. That's part of the monitoring at the community level. The clinics also have health centre committees that provide oversight, leadership, and governance for services at that level (Participant KII-STHE).

An important observation from the above quotation is the non-integrated nature of the collaborative partnerships for community health service delivery at the sub-health centre level.

KII-STHE notes that Village Health Workers produce separate reports that are partner-specific rather than goal-oriented. Similarly, the study found that NGOs supported under GHPs like PEPFAR recruit and deploy staff at health centres and communities, collecting and reporting specific patient-level data for PEPFAR indicators and targets under the Direct Service Delivery (DSD) model. This model's parallel GHP structures provide direct clinical HIV and TB services, resulting in additional person-centred M&E data. The reference to CARGs is one source of patient-level decentralised health service delivery systems designed to facilitate the delivery of ARVs at the client's doorstep. While the strategy has successfully decongested the health centres, it has created unforeseen data collection and reporting challenges for the staff. Correspondingly, the community-led M&E systems should facilitate data collection and reporting for community-based health service delivery initiatives.

However, the well-intentioned GHP interventions create pressure on the understaffed and ill-equipped health centre nurses, who face challenges in consolidating and submitting the numerous NGO reports. The GHPs rely on the health centre staff to consolidate, harmonise and report community and health centre reports, creating a work overload for the lean staff. Equally, the interventions create a coordination conundrum for monitoring the sub-health centre service delivery, making additional work demands on under-resourced nurses to check the quality of M&E data and the storage of medicines. As the discussion section elaborates further, the interventions in Zimbabwe focus on increased medicines uptake through private-sector-driven technological innovations in delivering these medicines to the client's doorsteps.

The study concludes that GHP support for health service delivery has successfully facilitated the decentralisation of services beyond the three Global Fund-supported diseases to sub-health centre structures such as Village Health Workers and health centre posts. The process also introduced additional staff to manage the community-led M&E systems. However, uncoordinated data collection and reporting systems have created additional workload and coordination challenges for under-resourced nurses. This conclusion does not discount the positive spin-offs for communities that struggle to access distant health centres. However, it alerts scholars and policymakers to the unintended effects of such well-intentioned interventions to ensure balanced and evidence-based decision-making and improve the monitoring and evaluation of the decentralised health service.

8.3 Discussion

The previous section presented the chief findings on the effects of GHPs on the wider Ministry of Health and Child Care system beyond HIV, TB, and malaria. The results focused on the

GHPs' effects on human resources for health, health information systems, governance and leadership, finance for health, pharmaceutical and medical technologies, and service delivery. The current section discusses these issues through a Critical Discourse Analysis (CDA) and the Governing Collaboration framework. The discussion also relates to similar arguments and findings in previous chapters and similar experiences in other developing countries.

8.3.1 Human resources for health

The study reveals mixed outcomes of the GHP-supported human resources programme for health regarding human resources. The findings raise critical conceptual discussion points about the partnerships for health that include the role of M&E champions in knowledge diffusion and skills transfer in the health sector in Zimbabwe. The WHO considers the health workforce as one of the six building blocks for sustainable health systems. As a result, the GHPs' support of this building block contributes to the WHO vision for a sustainable health system in Zimbabwe. The intervention has significantly helped to fill gaps in the system due to the sector's internal and external brain drain.

However, a critical analysis of the GHP discourse about the collaborative partnership framework in this respect may provide helpful cues as to the partnership challenges for M&E in Zimbabwe. As alluded to in Chapters Five to Seven, support for human resources is one of the most common sources of M&E partnership instabilities, contrary to the pragmatic-instrumental discourse that views human resource support as an 'undisputable' good intervention in the partnership for health. It is not surprising that most participants praised the GHP support, with IDI-AM and KII-TC highlighting only a few challenges. Therefore, the unintended adverse effects of GHP support for human resources for health require further scrutiny, as highlighted in the findings. The current conversations on GHP support for human resources for health have not adequately discussed the challenges that GHP-supported staff encounter at work and their impacts on the broader partnership for health in the country.

The payment of salaries in foreign currency helped to counter the brain drain but also led to other street-level work-related conflicts and to supervisors overworking the supported staff because they believed the staff should do more work to justify their inflated salaries. There is a thinning line between work overload and the positive spin-off of providing better health services beyond the HIV, TB, and malaria programmes. Some GHPs have also offered additional health staff through the Direct Service Delivery (DSD) model to ensure improved service delivery and the accurate capture of M&E data. Most of these staff are hired from the Ministry staff complements and suffer the work overload that seconded clinical and support

staff like data entry clerks and M&E staff experience. This discussion does not intend to criticise the GHP's for providing such support. It only aims to generate informed knowledge that will make it possible to deal appropriately with the underlying issues as they affect the efficacy of the partnerships for M&E.

The study's findings raise crucial points about street-level bureaucratic entrepreneurship and public service motivation from a behavioural public governance perspective. Given the centrality of GHP support for human resources under the current conditions, the Governance of Collaborative partnerships and behavioural public governance provide helpful clues as to what the government and GHPs could do to achieve their broader goals. Zarychta *et al.* (2020) discuss the role of Public Service Motivation (PSM) in the Honduras health sector, highlighting the role of staff motivation through decentralised and deconcentrated health systems to promote trust and street-level decision-making. Zarychta *et al.*'s behavioural public governance approach borrow concepts from psychology and economics to provide insights into government interventions that could address staff morale in the health sector. The model references altruism, trust, mistrust, and intrinsic and extrinsic factors and aligns favourably with the Governance of Collaborative framework, which focuses on transformative strategies that get the job done based on trust and the comparative advantages of partners' hierarchical structures.

As in the Zimbabwean findings, Zarychta *et al.* warned against the moral hazards of the market model approach through extrinsic monetary performance-based incentive systems that potentially change the overall organisation culture in a resource-constrained public sector. Decentralised management decisions helped to balance street-level motivation, moral hazard opportunism, and agency problems arising from the approach. The Zimbabwean market-based performance-based funding could learn from this experience to make the best out of its GHP-supported human resource schemes and limit the harmful effects of neoliberalism on the health care system. Similarly, GHPs could also take a cue from this experience to identify how to support governments in ways that maximise value for donor investments.

8.3.2 Support for health information

The findings on GHP support for health information reveal the common-sense influence of market-driven technological discourse that presents ICT support as an undisputed good intervention in health systems. As argued in Chapter Seven, the pertinent 'technomentalities' or technology governing rationalities have trickled down to all departments in the Ministry of Health. Despite the disruptive adverse effects of this, related to inconsistent power supplies,

incompatibility, and the inoperability of systems like the EHR, EPMS, and DHIS2, the supply collaborative efforts for the partnership. The positive and negative voices from participants such as IDI-AM and KII-TC on the GHP support for health information provide helpful insights into the country's dialogical and critical constructivist nature of health information systems. This study's qualitative and interpretive inquiry, viewed through Fairclough's (1989) three-dimensional CDA framework, helped uncover the unintended effects of GHP support for electronic health information systems. Similarly, the conversations between the interviewer and participants provided insights into how M&E personnel construct and understand their world concerning the negative effects of GHP support for digital health information systems

8.3.3 Support for leadership and governance for M&E

The study has identified the contributions of GHPs in developing policy and strategy documents as one of the critical contributions to the partnership for health in the country. However, in Chapter Five, the study disclosed the harmful effects of GHP support on the formulation of health policy and strategies in the country. Through critical discourse analysis the study argued against 'consultocracy' or the use of policy consultancy as limiting the opportunities for skills transfers through knowledge diffusion activities. Similarly, the study observed the use of discursive and soft power strategies, including inter-sectoral technical and financial leverage, to influence the M&E policies towards indicators and targets relevant to private business and away from the social aspects of M&E. When viewed through a Governance of Collaborative partnerships framework, these effects contrast sharply to the declared partnership objectives for health system strengthening based on mutual trust and organisational identity. As the data have revealed, structures like the CCM and health centre committees have positively contributed to strengthening governance and leadership systems at national and sub-national levels. However, they also threaten the organisational identity of the Ministry of Health as the legitimate coordinator of the HIV, TB, and malaria programmes. As a result, leaving the coordination of such significant programmes under the direction of a civic board like CCM devolves a constitutional, sovereign, and legitimate government responsibility to unelected individuals who are permitted to make crucial decisions on the Ministry's policy direction. This argument does not discount the comparative value of civic and private sectors in strengthening governance systems for the Ministry. However, it is the government's sovereign and constitutional mandate to regulate private sector interests and protect citizens through pro-poor policies.

Craveiro and Dussault (2016) register similar concerns about GHPs directing government health policies in Angola, despite their positive role in stimulating policy and strategy formulations in the health sector in the country. Similarly, Khan *et al.* (2018) observe that GHPs in Cambodia and Pakistan use inter-sectoral leverage and proximity to global organisations like the WHO to influence policies toward global goals like the triple 90 targets for HIV. Inter-sectoral leverage involves capitalizing on the cross-cutting influence of GHPs like the Global Fund and their global operations implemented through close coordination with multilateral institutions like the WHO. Member countries of the WHO are expected to abide by international health treaties and conventions. In this process, GHPs act as the local knowledge diffusion partners of the specific treaties and conventions to ensure their implementation. As a result, they use intersectoral leverage as an effective strategy, riding on multilateral organizations' legitimate and epistemic authority to influence local policy positions. In Zimbabwe, the increasing NCD challenge appears to receive less attention despite the decreasing menace of TB and malaria and the containment of HIV. Thus, GHPs' exclusive support might be more effectively applied to the new threats rather than relying on the policy framework's trickle-down effect. Direct support for emerging challenges like NCDs should become a priority in the future GHP support to the country.

In conclusion, GHP's support for leadership and governance through policy and strategy formulation significantly contributed to providing strategic direction for health M&E partnerships in the country. Accountability and transparency mechanisms have been established and have helped strengthen the HIV, TB, and Malaria programmes with trickle-down effects in all departments in the Ministry. However, the same accountability structures as the CCM pose challenges to the sovereignty, legitimacy, and constitutional mandate of government when unelected civic and private sector partners take leadership roles in policy and strategy on behalf of the Ministry. The partnership discourse conceals the challenges that inevitably impact negatively on the efficacy of collaborative governance for health M&E in the country.

8.3.4 Finance for health

The study's findings have provided helpful feedback on the positive and negative effects of GHP support on health financing in the country. The most significant contribution has been establishing and sustaining the Public Finance Management System in line with the Public Finance Management Act, Chapter 22:19, the objective of which is to secure transparency, accountability, and the sound management of the revenues, expenditure, assets, and liabilities

of government entities like Ministries, designated corporate bodies, public and constitutional entities, and statutory funds. However, juxtaposing this finding with the Governance of Collaborative Partnerships and critical discourse analysis provides useful insights into the problematic power relations that characterise the practice of M&E partnerships through the financing of the health system. Similarly, the discussion on human resources for health revealed the tensions that come with funding M&E salaries and electronic equipment for health information systems. The current discussion uses the CDA to problematise the partnerships for M&E through finance for health as a primary tool for accountability and transparency in ways that betray the values of trust and organisational identity.

As illustrated in the findings, the use of presupposition and lexical and modal phrases hidden in the partnership's official discourse and depicting the Ministry as an untrustworthy partner creates tension and resistance in practice. From a critical constructivist perspective, discourse as a dialogical or dialectical construction invites textual and contextual interpretation and explanation in a social context. The use of CDA helped the researcher identify the use of discursive strategies such as presupposition, lexicalisation, and modalisation as a conceptual interface and medium for understanding and interpreting participants' feedback in partnership discourse and the broader social structures of conversation. As illustrated in earlier discussions, Huckin (1997) reminded us that writers could also manipulate readers through presupposition. The strategy involves using taken-for-granted language in ways that exclude alternative views. Back to the responses of KII-PZ, the respondent spoke in ways that assumed that researcher knew or ought to know that the government lacks accountability and transparency, which require policing. The presupposition is a compelling strategy with the oxymoronic potency of an 'objective' view such as that found in news reports and notoriously 'subjective' discourse which resists critique due to its impenetrable nature. This premise is consistent with previous arguments about the neoliberal influence of the GHP in that it uses ideas and discourse to exclude alternative views. This renders potentially contentious issues unchallengeable and gives them the status of common sense or generally acceptable understanding of the topic under discussion.

Similarly, Hastings (1998) reveals how the lexicalisation or the wording of specific paragraphs or texts creates a phenomenon that provides insight into the subject under study. In the current discussion, modal phrases like 'watertight', 'risk averse', 'grey areas' and 'due diligence' give an impression or presupposes the existence of a government partner who requires close monitoring and policing at every turn. Likewise, modalisation in discourse marks the rhetorical

attitude of the speakers as reflected in the presupposition of a government that lacks accountability and the frustrating and controlling attitudes reflected in KII-PZ and IDI-AM's responses. These discursive techniques reveal the problematic nature of GHPs-supported M&E partnerships viewed through a Governance of Collaborative partnerships lens, where success depends on partnership goal congruence and trust.

In conclusion, the study has highlighted the positive and adverse effects of GHP support for M&E partnerships through the CDA and Governance of Collaborative partnership frameworks. More importantly, it reveals the hidden and under-discussed partnership power issues that undermine its effective implementation and practice. Analysing discursive strategies like modalisation, lexicalisation and presupposition helps lift the corporate veil of pro-private sector partnership discourse to flag the issues for further discussion.

8.3.5 Pharmaceutical and medical technologies

The previous discussions have highlighted the positive contributions and associated challenges of GHP's support to the health M&E system in the country. The current debate explicitly focuses on GHPs' influence on the M&E of the country's pharmaceutical and medical technologies. The monitoring of access to the building block of essential medicines is closely intertwined with that of all the other building blocks: service delivery, health information, finance for health, and governance. In Chapter Five, the study identified and flagged potential challenges regarding GHPs' proposed support for a pro-private sector strategy to strengthen procurement and logistical support, linking national, regional, and global systems. The National Health Strategy 2021-2025 provided detailed guidance on quantification, warehousing, and distribution plans involving the private sector working with the quasi-government company, the National Pharmaceutical company of Zimbabwe. An interesting issue that substantiates earlier arguments on the primacy of pro-private sector discourse in the government's policies is the conversion of Nat Pharm from a parastatal to a company. The paradigm shift perhaps aligns with the government's move from the pro-social primary health-focused policies of the 1980s-1990s to the liberal pro-market policies of the mid-1990s.

The GHP support for district and provincial pharmacy managers and data entry clerks is one example of the positive outcomes of partnerships in the country. Consistent with Vangen et al. (2015) conceptualisation of the Governance of Collaborative framework, the partners focused on mobilising member organisations' resources toward achieving joint goals. The partners' goals were congruent, thus providing the impetus for collaboration, considering the challenges linked to the potential pilferage of medicines, as alluded to in KII-IC's response. As a result,

the Governance of Partnership between the Ministry of Health and the Global Fund focused on achieving a collaborative advantage to strengthen the M&E of pharmaceutical and medical supplies, given the resource constraints that Zimbabwe's health system faces.

Moreover, collaboration governance facilitated knowledge and skills transfer in pharmacy management by establishing medical databases to account for the supplies appropriately. The skills of pharmacy managers and data entry clerks were instrumental in ensuring accountability and leadership in the management of the medicines. The smooth implementation of this function has implications for service delivery, which depends on the availability of the medicines. However, the GHP interventions have all the ingredients of liberal pro-market-driven policy hidden in the partnership discourse. Similarly, KII-IC's call for electronic systems for accounting pharmaceutical and medical technologies appears to foster pragmatic instrumental epistemologies that underestimate the disruptive nature of ICT-driven systems in a resource-constrained environment such as Zimbabwe. Likewise, the current National Health Strategy calls for integrated electronic procurement and logistics systems linking national, regional, and global systems. While these proposals are reasonable, the partners still have a long way to go to ensure their success, given the current state of the infrastructure required to facilitate this intervention. Interventions in electronic systems for medical and pharmaceuticals certainly go a long way towards preparing the Ministry for electronic governance systems (Veale and Brass, 2019). However, the Ministry is still required to address primary-level systems of administering the pharmacies and medical procedures like the stock card system before undertaking extensive interventions that may face sustainability challenges along the way. The experience in Health Information systems will provide valuable lessons as most interventions have not delivered value for investment, making it possible that most of these systems could implicate business interests to sell ICT software rather than to solve problems.

In conclusion, the GHP support for the M&E of pharmaceutical and medical supplies provided the skill sets needed to establish and manage pharmacy databases for the Ministry. The Governance of Collaboration between the Ministry and the Global Fund focused on the required resources to improve the leadership and governance needed to administer the scarce resources. However, the pragmatic-instrumental view of the interventions draws attention to the need to focus on the current practical needs of the system. The focus may give better returns on investment through adequately managing primary-level systems while the Ministry is preparing to embark on electronic systems.

8.3.6 Health Service Delivery

The study's findings on health service delivery have provided helpful insight into the positive contributions and challenges posed by GHP support for M&E in the health system. These include extending service delivery to sub-national structures and across various disease programmes. However, juxtaposing the findings through the governance of collaborative and critical discourse analysis frameworks reveals helpful clues to unspectacular challenges often omitted from key official partnerships for M&E policy discourse. The study has revealed the positive contributions of decentralised service provision through the provision of additional human resources and skills through the PEPFAR Direct Service Delivery Models (DSD) and the Global Fund-supported Village Health Worker programmes. The models help the Ministry to attain most of the global standards for health service delivery according to the WHO: service comprehensiveness, accessibility, coverage, continuity, quality, person-centredness, coordination, accountability, and efficiency (WHO, 2010). However, nurses' weak coordination and work overload were counter-productive to the pragmatic-instrumental expectations of Governance of Collaborative partnerships for M&E of health service delivery. These findings are consistent with similar results by Gimbel *et al.* (2018) in one Tanzanian district, where health clinicians spent one-third of their time compiling and submitting reports to PEPFAR-supported NGOs. Thus, the capacity building for the M&E of health service delivery is counter-productive to the partnership's goals.

However, unlike similar work by Baptiste *et al.* (2020) and Grimsrud *et al.* (2017), who focused on clinical and operational aspects of GHP-supported decentralised and community-led M&E systems, the current study looked at the effects of this support on the local health system's ability to collect, analyse and report the M&E data from the interventions. The clinical and operational focus perhaps substantiates earlier arguments on the technocratic and pro-private sector interests of decentralised health models in current discourses. The insightful primary discussion points made by Baptiste and Grimsrud relate to costs and the improvement of services without addressing the associated data collection and reporting challenges. Similarly, the concept of citizen-led M&E remains elusive as most of the initiatives are bottom-up on paper but top-down in practice. As the study data reveals, the GHP-driven initiatives provide financial and human resources with limited evidence of street-level participation, let alone of street-level staff leading the process.

Similarly, collaborations involving partners remain top-down with tokenistic involvement of village health workers and nurses, who cooperate in data collection and report for GHP

programmes. There is little evidence to suggest intimate interaction between the nurses/Village Health Workers with the data. Thus, the mechanistic involvement of Ministry staff in data collection and reporting at the community level contradicts the pragmatic-instrumental commendation of community-led monitoring in official policy and plans, with limited practical application in the country. Thus, these programmes lack the insights into critical constructivist-dialogical views central to discursive community-led M&E policy and programme planning. Similarly, the health service models rely on top-down quantitative M&E indicators and targets at the community level. For example, the village health workers and GHP-supported DSD staff primarily provide quantitative reports that do not address the social aspects of M&E. To illustrate this gap, one of the acclaimed differentiated service delivery (DSD) models in Zimbabwe, the AFRICAID Zvandiri Adolescent and Youth Project, admitted to the need to address the qualitative aspects of its M&E system, including mental health measurement and service provision quality (Willis *et al.*, 2018). Like most differentiated service models, the focus has been on promoting clinical service uptake.

In conclusion, the study has revealed the GHPs' influence on health service delivery through support for human resources and clinical processes with a limited focus on initiatives to strengthen data collection, analysis, and reporting. The GHP interventions have further contributed to added M&E coordination and work overload for the under-resourced and ill-equipped nurses who consolidate multiple M&E reports for sub-health centre health delivery activities. These challenges are counter-productive to the Governance of Collaborative partnership framework, and the pragmatic-instrumental approaches viewing the partnership as helpful have missed the chance to reveal the relational power imbalances impacting negatively on the collaboration.

Matrix 8 2 :Summary of discussions on GHP and Ministry power strategies' impact on broader M&E systems in Zimbabwe

Research question	Emergent theme/s	Interaction with the literature	Sources
To what extent do the GHP and local health M&E partner power strategies impact on the broader M&E system beyond Zimbabwe's disease and donor-specific M&E systems?	Human Resources for Health	<ul style="list-style-type: none"> Discussed the role of public service motivation in the Honduras health sector, highlighting the role of staff motivation through decentralised and deconcentrated health systems to promote trust and street-level decision-making. 	Zarychta <i>et al.</i> (2020)
	Support for health information	<ul style="list-style-type: none"> CDA helped to reveal the unintended covert effects of GHP support for electronic health information systems. 	Fairclough (1989)
	Support for leadership and governance of M&E	<ul style="list-style-type: none"> In Angola, GHPs directed government health policies despite their role in stimulating policy and strategy formulations in the health sector. 	Craveiro and Dussault (2016)
	Finance for Health	<ul style="list-style-type: none"> The use of presupposition as a manipulative tool. Reveals how the wording of specific paragraphs or texts creates a phenomenon that provides insight into the subject under study. 	Huckin (1997), Hastings (1998)
		<ul style="list-style-type: none"> Current studies focused on clinical and operational aspects of GHP-supported decentralised and community-led M&E systems. Admitted to the need to address the qualitative aspects of its M&E system, including mental health measurement and service provision quality 	Baptiste <i>et al.</i> (2020) and Grimsrud <i>et al.</i> (2017); (Willis <i>et al.</i> , 2018)

8.4 Chapter conclusion

This chapter has provided a summary of the key findings in Matrix 8:1 and an overview of the discussions in Matrix 8:2. The chapter has focused on answering the fourth question of the study regarding the impact of GHPs on broader local public health M&E beyond HIV, TB, and malaria in Zimbabwe. The chapter has explicitly focused on the effects of GHPs on health human resources, health financing, health information systems, pharmaceutical and medical technologies, leadership and governance, and service delivery. The WHO health systems strengthening framework helped identify the impact of GHPs in these strategic areas.

The chapter has identified and discussed GHP support for additional staff such as nurses, pharmacists, managers, data collectors, and village health workers as valuable contributors to the ministry's understaffed health centres and coordination structures at the facility, district, provincial, and national levels. Such staff provides M&E, clinical, and pharmacy management services critical to efficient and effective service delivery. However, the study also found that the GHP's financial support of these staff has led to a problem of 'forward and reverse

othering.’ ‘Forward othering’ occurs when supported staff feel superior to lower-paid staff, as was observed among higher-paid M&E officers and unsupported health information officers. Reverse ‘othering’ occurs when better-paid staff, such as M&E officers, are overloaded with work by their supervisors or sabotaged by their subordinates because they believe the better-paid staff should do all the work. The clinical staff also faced a huge data stream from community-based interventions supported by GHPs, which impacted on their ability to consolidate and analyse data for decision-making. Similarly, the study noted the valuable contributions made to the ministry's broader health information system, providing insights beyond HIV/TB and malaria programmes, but pointed to the uncoordinated nature of the data collection processes feeding into local health centre systems. Linking financial management systems between the Ministry of Health and the Ministry of Finance is an example of linking health information and health financing.

Similarly, leadership and governance support through structures such as health centre committees, RBF incentives for health facilities, and other GHP interventions strengthened M&E, procurement, and clinical functions at the local level. Monetary incentives, however, led to perverse reflexivity as desperate staff manipulated M&E performance data to continue receiving performance-based incentives. As a result, GHP contributions have created a money-driven culture that motivates dishonesty and may be difficult to sustain beyond GHP support. The unintended consequences are that health care workers need incentives to perform their duties.

This chapter has also discussed the unintended challenges of establishing parallel accountability structures, such as CCM, at the national and sub-national levels that transfer the government’s sovereignty, legitimacy, and constitutional mandate to unelected civil society structures and private sector partners that provide leadership in ministry policy and strategy. Likewise, the public financial management system's emphasis on accountability and transparency suggested distrust rather than a desire to build capacity for the Ministry. The emphasis on upward accountability and transparency would seem to be the product of self-centred values as against partnership values. As a result, the chapter has concluded that despite its positive contributions, GHPs' financial and technical support across the six WHO building blocks has created unanticipated and unfortunate outcomes that require policy and management attention.

CHAPTER NINE: SUMMARY, RECOMMENDATIONS, AND CONCLUSION

9.1 Introduction

This study has aimed to establish the effects of GHPs on local health M&E systems in Zimbabwe. This chapter seeks to outline the study's objectives and reach conclusions concerning the study's objectives. The study has specifically sought to understand the influence of GHPs on the Ministry's M&E policy and practice, focusing on the unspectacular or hidden mechanisms. Thus, the current chapter discusses the results and implications based on the conclusions drawn from the thematic and discourse analysis of key M&E policy documents and responses from key informants.

9.2 Summary of Research Objectives and Research Questions

There are four specific research objectives, as elaborated in Chapter One of the study. The table below summarises the research objectives and questions.

	Research Objectives	Research Questions
1	To investigate the M&E discourses and soft power strategies that shape and influence the policy and practice of public health M&E systems in Zimbabwe.	How do GHP M&E discourses and soft power strategies shape and influence the policy and practices of public health M&E systems in Zimbabwe?
2	To analyse the mechanisms and strategies that the Ministry of Health deploys to rationalise the resource and power imbalance in the partnership for health in Zimbabwe.	What are the mechanisms and strategies the Ministry of Health and Child Care, deploy to rationalise the resource and power imbalance in the partnership for health in Zimbabwe?
3	To unpack the impact of the government-GHP collaborative partnership on the public governance system in Zimbabwe	What impacts does the government-GHP collaborative partnership for M&E have on the public governance system in Zimbabwe?
4	To examine how GHP and local health partnerships impact on the broader M&E system beyond the disease and donor-specific M&E systems in Zimbabwe	To what extent do the GHP and local health M&E partnerships impact on the broader M&E system beyond Zimbabwe's disease and donor-specific M&E systems?

Table 9 1 : Summary of research objectives and questions

9.3 Overview of the study

This section presents an overview of the significant findings and discussions from Chapter One to Chapter Eight. The details of each chapter are explained below:

9.3.1 Chapter One: Background and outline of the research problem

The purpose of the first chapter was to present the background to the study, outline the problem statement, the objectives of the study, the research goals, the research questions, the scoping, and the delineation of the study. The chapter laid the foundation for the thesis by providing a summary of the key issues that would be addressed in subsequent chapters regarding the impact of collaborative GHP on the local health M&E system in Zimbabwe. Finally, the structure and flow of the chapters were outlined.

9.3.2 Chapter Two: Theoretical understanding of the impacts of GHPs on local health M&E systems in Zimbabwe

In Chapter Two, the theoretical frameworks for collaborative governance were presented. The New Public Governance (NPG) is the overarching theoretical framework for the study and its various collaborative models, such as the Integrated framework for collaboratives by (Emerson and Nabatchi, 2015), the model of collaborative governance by (Ansell and Gash, 2008), the governance of collaboratives by (Vangen et al., 2015), the Government-NGO Partnership by (Brinkerhoff, 2002) and the CDA by (Fairclough, 1989; Fairclough, 2001b) were presented. The chapter demonstrated how these models complement one another to provide a comprehensive understanding of the effects of GHPs on the local health M&E system. The individual strengths and weaknesses and the justification for selecting these models were presented. The chapter also reviewed relevant literature, demonstrating the various critical approaches to the subject of Global Health Partnerships. The chapter chronologically introspected on the current debates and discussions on what constitutes ‘Global Health’ and ‘partnerships,’ providing appropriate examples in the context of the theoretical frameworks identified. Likewise, the concept of monitoring and evaluation was also interrogated, addressing its political and technocratic aspects. The chapter also provides the terminology used to define M&E and brief discussions on the World Bank and the Global Fund M&E systems.

9.3.3 Chapter Three: Research methodology and methods

Chapter Three described the research methodology and methods, foregrounding the philosophical interpretivism paradigm, qualitative design, case study research strategy, key informant interview data collection instruments, in-depth interviews, and documentation review processes. The chapter also examined the research population and the research approach

chosen. The sampling methods discussed are purposive sampling and snowball sampling, which are aligned with the non-probabilistic nature of the technical topic of GHPs and M&E. These methods also fit well with the qualitative nature of the study. In addition, the chapter outlined the issues of ethics, the protection of research subjects, voluntary participation, ensuring the quality of the data management, and ensuring the use of the data only for approved purposes. The chapter also reviewed the four selected key national M&E documents. These are the National M&E Policy of 2015, the Health Sector Performance, Monitoring and Evaluation Guidelines and Strategy of 2018, the National Health Strategy 2021-2025, and the National HIV Strategic Plan for M&E in Zimbabwe of 2015-2020. The chapter concluded by highlighting some of the limitations encountered.

9.3.4 Chapter Four: Global Health Partnerships, Monitoring, and Evaluation in Zimbabwe

This chapter examined the country's current M&E system. The chapter presented M&E developments chronologically, highlighting critical interactions between the system and GHPs since the decades of ESAP in the early 1990s. Similarly, it discussed the roles of key actors in the M&E system and the impacts of these GHP interventions as identified in the literature.

9.3.5 Chapter Five: Soft power strategies, M&E discourses, and their impacts on public health monitoring and evaluation policy and practice in Zimbabwe

This chapter addressed the research objective and questions by identifying the discursive and soft power strategies and mechanisms that influenced and shaped M&E policy and practice in the health M&E system in Zimbabwe. Through qualitative analysis of the four official M&E policy documents and interviews with key M&E staff from the Ministry of Health and the National Council AIDS, the study applied the CDA, Governance of Collaborative Partnership, and NPG frameworks and provided helpful insights into the shared discourses that GHPs employ to achieve the extent and perpetuation of neoliberal, pro-business ideas through the health system in the country. In this process, the study addressed the hypothesised assumption that challenges in the health M&E system resulted directly from GHP strategies (ideological and epistemological) aimed at perpetuating the neoliberal values of Western countries in the health system of Zimbabwe. The study concluded that all discourses supported by the GHP advance a neoliberal ideology to support a commonly understood capitalist view that promotes the primacy of free markets to determine the delivery of public health services in the future. The discursive themes of partnership/participation, technology, science, country leadership, human rights, health emergencies, and outcome-based discourses promoted a dominant pro-economic discourse on health M&E policies.

The use of attraction and persuasion rather than coercion is the main strategy and mechanism for shaping and influencing policy and practice for M&E in health. Through a Foucauldian conceptualisation of power as governmentality or governing from afar, the chapter concluded that GHPs control health policy processes from afar through ideational and ideological persuasion. However, the chapter also found that power relations in the partnership are not unidirectional, as the government of Zimbabwe instrumentalises discourse to resist some of the policy influences.

9.3.6 Chapter Six: Local M&E Partner Resource and power rationalization Mechanisms and Strategies in the Partnership for Health in Zimbabwe

The focus of Chapter Six was to carefully analyse and identify the mechanisms and strategies that the Ministry, as a local health M&E partner, uses to rationalise its resource and power imbalance in the Partnership for Health. In addressing this issue, the study identified and discussed six legal, paralegal, and ideational mechanisms and strategies that the government uses to do so. The chapter applied the Foucauldian framework of the critical discourse analysis of power as a relational process to gain valuable insights into understanding the government's use of soft power strategies and instruments to assert its leadership role in the partnership. The supremacy of the constitution and the need to respect the sovereignty of Zimbabwe was the first strategy identified and discussed. The chapter showed how the government refers to constitutional provisions in all its M&E strategies to remind GHPs of their obligations under the provisions of the supreme law of Zimbabwe.

Similarly, paralegal strategies such as the availability and enforcement of clear M&E policies and guidelines were identified and discussed as essential to help the government ensure that GHPs operate within the confines of the policies and regulations. The government's ability to meet citizens' legitimate health expectations and provide effective administrative systems were identified as factors essential to enforcing health M&E policies and regulations. Similarly, the Memorandum of Understanding (MoU) was another important mechanism for the government to hold GHPs accountable and implement according to the agreed framework. However, its extra-legal status compromised its effectiveness as a compliance tool under the partnership.

In addition, soft power strategies in the form of recourse to bureaucratic power were identified as an unexpected source of government power in the partnership. The chapter concluded that the slowness of government processes is not always related to inefficiency but is sometimes instrumentalised in achieving partnership goals. Consequently, the negative connotations of bureaucracy in this study proved false, as one respondent described it as procedure and order.

It was also noted that the government used victimhood and polarisation as strategies to evoke moral responsibility from global funding partners to fulfill international humanitarian obligations to protect citizens from health disasters in the face of economic sanctions and global epidemics such as HIV and TB. Similarly, the government employed strategies of extraversion and obfuscation by accepting, resisting, and responding ambivalently to global programmes such as the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs) and aligning its national health M&E policies with these programmes. The government used rhetoric to show its willingness and commitment to implement global programs while citing sanctions as one of the main reasons for failure to achieve goals. In doing so, rhetoric was used to shift blame to the GHPs and the countries supporting them rather than to hold the government accountable. These strategies provided valuable insight into understanding the positive and negative hidden impacts of GHPs on local health M&E systems that are rarely discussed in traditional partnership discourses.

9.3.7 Chapter Seven: The Impact of the government-GHP collaborative governance system on the public health administration and M&E system in Zimbabwe

This chapter presented the impact of the government-GHP collaborative partnership for M&E on the public health management system to address the research objective and answer the third question of the study. Negative impacts identified and discussed included the normalisation of the existence of parallel M&E systems, the digital disruption of systems, conflict and contestation, patronage relations, threats to national sovereignty, the brain drain, silent and perverse practices, digital exclusion, threats to regular employment, othering and conceptual boundaries, competitive behaviour for visibility, and leadership.

The chapter found that government-GHP collaboration on M&E partnerships resulted in the exclusion of small local NGOs and other government agencies that are not digitally connected to the Department's large electronic health systems such as DHIS2, EHR, and EPMS. As a result, primary healthcare facilities where primary data are generated are unable to submit electronic reports to the system. The current system favours facilities in urban areas and provincial and district capitals. In addition, the chapter showed that collaborations are sites of contestation and conflict due to the complicated clientele relationships and technologically mediated access to classified health data promoted by GHPs. Similarly, the unintended consequences of GHP training and capacity-building initiatives leading to the exodus of qualified Ministry of Health staff to GHPs and the private sector were discussed. The training provides Ministry staff with enhanced skills and networking opportunities for better-paying

jobs with GHPs and in the private sector. As a result, capacity-building initiatives benefit GHPs and individuals rather than the Ministry. Thus, GHP capacity-building programmes pose a threat to collaboration among health M&E systems and to the stability of the ministry.

Other negative impacts included threats to jobs, ‘othering’ and the conceptual limitations of M&E, digital disruption, and weakened coordination due to competitive behaviour among GHPs. These revelations highlighted the unexpected, chaotic effects of government-GHP collaboration in practice, contrasting with the mutual and friendly picture painted in official policy discourse and national policy documents. The study's findings demonstrate the effectiveness of constructivist, dialogic knowledge-building that acknowledges street-level experiences in policy analysis through CDA. The ‘othering’ and conceptual boundaries between M&E and health information workers are clearly articulated through CDA. The chapter discusses conceptual boundaries between M&E and health information officers and limited opportunities to create an integrated system. In addition, the chapter identified digital disruptions and threats to employment discussed in dialogic conversations and raised critical issues that are overlooked in traditional NPG approaches. Based on these findings and discussions, the chapter concluded that health and M&E collaboration in Zimbabwe does not meet the criteria for collaborative partnerships based on reciprocity, organisational identity, and trust. NPG theory also limits the ability to account for the post-structural, ideational, and discursive effects of collaboration, which have been identified as the key mechanisms of GHP influence on M&E policy and practice in Zimbabwe.

9.3.8 Chapter Eight: The impact of GHP global M&E technical and financial assistance on wider public health M&E system-strengthening initiatives in Zimbabwe

This chapter presented findings highlighting the unspectacular implications of the collaborative partnership between the government and GHP for M&E, which are rarely found in conventional and official discourse on partnership policy in Zimbabwe. The public governance of the collaborative partnership and the critical discourse analysis framework provided helpful insights into the positive and negative impacts of GHPs on M&E of service delivery models in the country. In addition, the six building blocks of the World Health Organization health system provided another valuable perspective making it possible to adequately answer the fourth research question, which aimed to understand the extent to which power relationships between GHPs and government M&E partners influence the broader M&E system beyond the Global Fund-supported HIV, TB, and malaria programmes. The discussion was presented in terms of the six building blocks: health information system, human resources for health, finance for

health, pharmaceutical and medical technologies, service delivery, governance, and leadership for health.

The chapter observed positive impacts on human health resources by supporting additional staff such as nurses, pharmacists, managers, data collectors, and village health workers who took on useful clinical and M&E roles in the health system. However, the intervention resulted in unintended coordination and work overload for clinical staff, who now needed to write various GHP reports and consolidate them with additional granular data collected outside of the Ministry's traditional reporting systems. Surprisingly, most of the available literature on service delivery models focused on clinical service utilisation and cost containment strategies without addressing the processes that generate the data needed for evidence-based decision-making. The chapter also noted the valuable contributions made to the Department's broader health information system, providing insights beyond the HIV/TB and malaria programmes.

GHP-supported health centre committees and village health workers also contributed to community leadership and monitoring by facilitating policy implementation and feedback on the health delivery system. Accountability and transparency mechanisms established under the HIV, TB, and malaria programmes had significantly strengthened child-focused programmes such as the Ministry's Expanded Immunisation Programme (EPI). However, in contrast to the pragmatic partnership perspectives in official policy documents, the chapter found that accountability structures such as CCM were challenged by the creation of parallel structures at the national and sub-national levels that subordinate and outsource the sovereign, legitimate, and constitutional mandate of the government to unelected civilian and private sector partner structures for leadership in ministry policy and strategy.

In addition, the interoperability of the public sector financial management system (PFMS), which links the Department of Health and Children's Services with the systems of the Department of the Treasury, represents another positive impact of the GHP on the nation's broader government systems beyond health care. As a result, electronic financial disbursements and the tracking of transactions between departments and ministries have become more efficient and faster. However, the chapter noted and cautioned that the GHP financial management system's emphasis on accountability and transparency betrayed distrust rather than a desire to build capacity for the ministry. The focus on upward accountability and transparency to donors betrayed partnership values that were driven by individual rather than partnership goals. A critical discourse analysis provided insight into the hidden interests behind

the emphasis on accountability and transparency that run counter to the values of the partnership. Moreover, the use of electronic financial systems is consistent with private sector discourses on efficiency and effectiveness that inform governance approaches to public service delivery.

The pharmaceutical and medical technologies introduced positively impacted all disease components as GHP employed pharmacy managers and data collectors who organized pharmacy management systems by establishing and maintaining medical and pharmaceutical databases from village health workers to the national level. The additional staff also provided the necessary leadership and oversight of medical and pharmaceutical needs at various levels. However, the chapter cautioned against an overly pragmatic instrumental and technological view that ignores the unspectacular adverse effects of this support that are hidden beneath the discourse of technology and partnership. The GHP's insistence on procuring drugs for HIV, TB, and malaria is a challenge that reflects the GHP's slow response to new evidence, such as the proliferation of non-communicable diseases (NCDs).

In terms of health service delivery, GHP support for decentralised service delivery models has provided additional human resources for clinical and support staff to ensure that services beyond HIV, TB, and malaria reach the most neglected communities. However, uncoordinated data collection and reporting systems have created additional workload and coordination challenges for under-resourced nurses. Initiatives to improve data collection, analysis, and reporting were not a priority, as the focus shifted to clinical service utilisation and cost considerations. However, decisions in this regard depend on the availability of accurate and complete M&E data. Similarly, the additional coordination and M&E functions required of nurses resulted in work overload with negative impacts on clinical and M&E outcomes, which is at odds with the Governance of Collaborative Partnership Framework and the pragmatic-instrumental partnership perspective, which ignore these more nuanced challenges.

The following section summarises the key findings for each of the four research objectives and questions in chronological order.

9.4 Summary of Findings

The objective of this study was to determine the impact of cooperative GHPs on M&E systems in Zimbabwe. The particular interest of the study was to identify and shed light on the unspectacular mechanisms and strategies that GHPs use to influence local M&E systems. The study had four broad research objectives and questions that guided the poststructuralist,

ideational, and discursive soft power mechanisms and strategies that are the focus of this study's critical discussions.

The next section presents the main conclusions drawn from the main findings for each objective.

9.4.1 Research Objective One and Research Question One

- **Research Objective:** To broaden knowledge on how GHP-supported M&E discourses and soft power strategies shape and influence local M&E policy and practices in Zimbabwe.

- **Research Question:** How do GHP M&E discourses and soft power strategies shape and influence the policy and practices of public health M&E systems in Zimbabwe?

9.4.1.1 Soft power strategies, M&E discourses, and impacts on public health monitoring and evaluation policy and practices in Zimbabwe

The first objective of this study was to advance knowledge on how GHP-supported M&E discourses and soft power strategies shape and influence local M&E policies and practices in Zimbabwe. The study identified seven key M&E discourses and three soft power strategies that GHPs use to influence and shape local M&E policy and practice. The key finding of the study is that support for monitoring and evaluation has neoliberal objectives and that its function in government has specific linguistic codes that guide and influence its effective use in global development. The study applied thematic text and context analysis and critical discourse analysis (CDA) to identify key discursive terms in four national M&E policy documents. Through dialogic conversations with key informants from the Ministry of Health, the National Council AIDS, and a local NGO, key thematic patterns were identified that helped to identify the discourses of business, participation/partnership, technology, science, outcomes, human rights, country leadership, and emergency/security as central to shaping and influencing local health M&E policy and practice. Similarly, the use of M&E champions, policy advice, consultant services, and M&E artefacts are some of the soft power strategies identified as influencing local health M&E policy.

The overarching finding of the study refers to the prolific use of pro-economic or business-oriented language or discourse in all major M&E documents of the Ministry, indicating a neoliberal impulse influencing and shaping national health policy - from pro-social primary health care (PHC) to pro-economic selected primary health care (SPHA). The study identified several discursive cues and strategies, such as framing policies, presuppositions, rhetoric, modalisation, topicalisation, foregrounding, and backgrounding, among other linguistic cues

prevalent in the policy documents studied. Similarly, the study identified participatory discourse as another discourse that emphasises pluralistic and hierarchical policy-making processes that focus on service delivery rather than organisational power hierarchies in the collaborative partnership. The partnership and participatory language enabled GHPs and their private partners to advocate policies that promote greater private sector and civil society participation in policy planning and implementation in Zimbabwe.

In addition, the technological and scientific discourses were identified as two complementary discourses that exert scientific and technological influence on policy decisions and view them as key to public health service delivery. The study found that these two discourses, despite their undisputed positive contribution to efficient and effective policy making and implementation, instrumentally and productively implicate underlying neoliberal objectives. As a result, this study has highlighted their unintended consequences to shed light on the little discussed and unspectacular discursive strategies in policy and practice for M&E. Hardware and software procurement is one of the acknowledged positive contributions of the health sector technology discourse, even if it obscures the role of the facilitator in the collaborative partnership. The uncoordinated way GHPs implement ICT-enabled M&E systems betrays business interests in the interventions that lead to the disruption of current manual systems.

On the other hand, the scientific discourse silenced opposition to the M&E policies and depoliticised GHPs' business and political interests in collaborative partnerships. The undeniable and unquestionable good intentions of science appropriated this motivation to influence and shape local M&E policy. As a result, the appeal of science influenced local M&E staff and engaged them in global training programmes that emphasised scientific approaches such as randomised control trials, HIV estimation, modelling, etc. Similarly, the technocratic use of outcome-based discourse and M&E artefacts such as log frames influenced local M&E policies and practices. The study found that the ministry defined outcomes narrowly in statistical/quantitative ways, omitting opportunities for qualitative data collection and analysis.

Similarly, country-led discourses on human rights and health as an emergency represent another layer of soft power strategies and mechanisms that GHPs use to influence and shape local health M&E systems. The study found that country-led discourse represents GHPs' remote influence on the policy process through local accountability and autonomy. Local catalytic agencies such as M&E champions, policy advisors and consultants are some of the identified mechanisms and tools of GHPs' local influence. Similarly, GHPs used their

proximity to UN and other legitimate global agencies to influence and shape local M&E policy by citing the need to implement global commitments to Zimbabwe. In this way, GHPs used the legitimacy and expert power of the UN to influence and shape M&E policy and address contentious local public health issues, particularly access to health for the LGBTQI community. The framing and lexicalisation of contested LGBTQI issues silenced moral and religious opposition to the universal human rights discourse. The lexical use of terms such as key populations to broadly categorise LGBTQI issues is a strategy that silenced opposition voices, particularly on policies targeting men who have sex with men (MSM) in local M&E policy documents. Overall, these unspectacular GHP strategies have successfully influenced and shaped the local health M&E system in spectacular ways.

4.4.1.2 Conclusion

The study concludes that GHPs have successfully shaped and influenced the structure and direction of M&E policy using ideational and discursive soft power strategies, from the pro-social primary health care of the 1980s to the early 1990s to the current neoliberal, pro-business selective primary health care (PSHC) targeting specific diseases and financial and technical assistance programmes. The preceding discussion has provided a solid foundation for this conclusion, based on secondary and primary evidence that traces all identified discourses and soft power strategies to pro-business interests. For example, the use of private policy advisors and consultants reflects the tendency toward private contracts suggested by NPG theory. The study found that NPG theory has limited ability to capture the realities of collaborative partnerships involving technically equipped GHPs with expert knowledge and attractive influence due to their global reach and experience, while local learning systems are under-resourced. Based on these findings, the assumptions of NPG theory do not adequately address the lived reality of unequal collaborations that requires CDA support for comprehensive insights. Thus, the hybrid theoretical framework has expanded the boundaries of knowledge about the influence of unspectacular discursive and soft power strategies on health M&E policy in Zimbabwe.

9.4.2 Research Objective Two and Research Question Two

• **Research Objective:** To broaden scholarly insight into the mechanisms and strategies local M&E partners deploy to rationalise the resource and power imbalance in the partnership for health in Zimbabwe

• **Research Question:** What mechanisms and strategies do local health M&E partners deploy to rationalise the resource and power imbalance in the partnership for health in Zimbabwe?

9.4.2.1: Local M&E partner resource and power rationalisation mechanisms and strategies in the Partnership for Health in Zimbabwe

The second objective of this study was to extend scientific knowledge about the mechanisms and strategies that local M&E partners use to rationalise the imbalance of resources and power in the Partnership for Health in Zimbabwe. The goal of the study recognises the relational nature of power in collaborative partnerships, so there is a need to counterbalance the discussion to gain comprehensive insights into the topic. The six strategies identified as rationalisation strategies of the underfunded Ministry of Health and local partners include recourse to legal, paralegal, and ideational strategies, including recourse to constitutional and sovereign power, the enforcement of clear policies and guidelines, the use of memoranda of understanding (MoUs), the instrumental use of bureaucratic power, victimhood and polarisation, extraversion and obfuscation.

The study shows that the Ministry of Health and Child Welfare remains strong in the partnership with GHPs, despite being the local and less resourced partner. The application of NPG theory and the CDA framework provided a critical lens for the Department's ideology and co-option strategies. Recourse to constitutional authority is one of the key strategies identified through the thematic and CDA documents of the national M&E policy. The study shows that all the key M&E policy documents refer to the constitutional health provisions in Chapter Four, Section 76 of the Constitution, which provide for health as a right. The study also found that the reference in the first chapters or preface of the policy documents is a tactical reminder of the GHPs' moral and sovereign obligation to respect national laws and support local health priorities as a moral responsibility. The government uses theming and foreground discourse as strategies to proclaim its position and direction through the Constitution. Thus, the Constitution, as the supreme law of Zimbabwe, is a source of power in the collaborative partnership for health. The thematisation of constitutional and statutory health provisions in all national M&E policies is a reminder to GHPs to ensure the implementation of policies and practices in accordance with the existing legal framework.

Similarly, national policies and guidelines are other systematic, (post)structural, and ideational artefacts through which the government holds accountable its partners in the collaborative partnership for health. While GHPs influence policies and guidelines, the government uses these same mechanisms and tools to hold them accountable for their promises. One way in which the government uses this strategy is to refer to the policy and guidelines when making financial proposals to fund GHPs. Similarly, the government uses memoranda of understanding

as another mechanism to hold GHPs accountable for meeting established agreements for collaborative partnerships for M&E. While such instruments are not legally binding, this demonstrates the government's intention to delineate the influence of GHPs on M&E policy and practice in the country.

In addition, the study found that what is described in the literature as bureaucratic pathology may be a misunderstanding of the local appropriation of the bureaucracy as a reflexive body to stamp local authority on issues where the government does not readily agree with GHPs. Responses from KII-TC on this topic provided helpful insights that the GHPs view the government as bureaucratic when it comes to authorising access to health data through MoUs, while the government views this as 'due process and procedure.' These revelations are consistent with other scientific findings that remind us that regardless of the monetary and ideational power of GHPs, the government the buck stops with the government. Thus, the insistence on hierarchical processes is not always pathological but is sometimes a balancing act and a control technique in unstable partnerships.

Another surprising finding of this study relates to the pragmatic and instrumental appropriation of international victimhood by the government as a resource in the partnerships for health. Evidence from the critical thematic discursive analysis of national M&E policy documents and interviewee feedback provided dialogic evidence of the government transforming the sanctions mantra into a resource mobilisation strategy for M&E health financing. The government used this dual strategy of polarising Western sanctions as unwarranted victimisation and calling on friendly and sympathetic countries to intervene in health underfunding caused by the sanctions. The thematisation of moral health and international responsibility is among the strategies used by the government to justify global public health support through M&E cooperation.

The national M&E policy categorically states that the government has not met M&E targets because of sanctions. The message of this statement is "Lift the sanctions if donor funds are to achieve the desired effects." Polarisation, then, allays legitimate Western concerns about the government's radical policies as interference in sovereign affairs. The three-part strategy of sovereignty, victimhood, and polarisation is thus successfully employed as a resource mobilisation strategy. The government addresses Western governments with messages aimed at arousing moral rather than political and economic responsibility for intervening in the HIV, TB and malaria situation.

Similarly, the government reflexively used covert extraversion and obfuscation strategies to obtain financial and technical support from GHPs. The strategy is for the government to accept and embrace modern global health strategies and approaches, such as the SDGs, as the primary strategy to attract global funding available through the programmes. The focus on these programmes masks its shortcomings in other areas such as human rights.

9.4.2.2 Conclusion

Based on these study findings, the conclusion is that collaborative governance for M&E partnerships in Zimbabwe is based on power games, contrary to the trust and mutuality seemingly espoused in conventional and official policy documents. The strategies identified, combined with the findings described in the previous section, reveal elements of mistrust and competition counterintuitive to partnerships' plural and collaborative objectives. The NPG theory and CDA frameworks helped provide the lens through which the shortcomings of the collaborative governance approaches were exposed. Thus, CDA is an integral tool of critical policy analysis to uncover the influence of partnership discourse that appears to normalize and maintain power imbalances between former colonial masters and developing countries through postcolonial soft power strategies that promote responsible autonomy and self-discipline as mechanisms of GHP control from afar.

9.4.3 Research Objective Three and Research Question Three

- **Research Objective:** To provide insights into the impact of the government-GHP collaborative partnership on the public governance system in Zimbabwe.
- **Research Question:** What impacts does the government-GHP collaborative partnership for M&E have on the public governance system in Zimbabwe?

9.4.3.1 The impact of the Government-GHP collaborative governance system on the public health administration and M&E system in Zimbabwe

The third research objective and question sought insights into the impact of the government-GHP collaborative partnership on the public governance system in Zimbabwe. The specific findings include the normalisation of the parallel M&E systems, the digital disruption of the existing M&E governance systems, the fuelling of conflicts and contestations, the facilitation of patron-client relations, threats to national sovereignty, the brain drain, the promotion of mute and perverse practices, digital exclusion, threats to regular employment, the creation of conceptual boundaries, and the fuelling of competitive behaviour for visibility and leadership among GHPs.

The study revealed that GHP-government collaborative partnerships for digital M&E systems led to the digital exclusion of small local NGOs and other government departments that were not networked. Similarly, more prominent NGOs with electronic systems had standalone systems which are not interoperable with the government system. Moreover, sub-national government departments at district and health facility levels are not connected to the network, thereby excluding the primary data sources from the M&E system. The study concluded that the well-intended electronic systems created uncoordinated systems and stalled progress toward integrating the M&E system with lower-level health facilities. Another surprising finding was that the GHPs parallel M&E systems were justified as helping with data triangulation and as falling within the collaborative partnership framework.

Likewise, the study provided a varied view of the pragmatic-instrumental perspective on electronic systems such as DHIS2 and HER. The mechanistic impression of technological benefits for health systems as being impervious to the social and political life of M&E is judged to be inaccurate, as the electronic systems introduced have unintended deleterious effects on the Zimbabwean health system. This observation contradicts the conventional policy discourse that views electronic M&E systems as progressive and enhancing managerial decision-making. This rarely discussed aspect of introducing technology requires policy reconsideration, as the technology is disruptive and poses threats to gainful employment for some staff. Moreover, managing backup systems in unstable environments like Zimbabwe remains challenging for the M&E system. These extra demands require more resources and create more work for overworked and underpaid staff members. It is acknowledged that the introduction of the digital reporting system is well-meaning, but it has created chaos and strife in the local health system. Thus, the pragmatic-instrumental view of the contribution of technology in health M&E systems is problematic because it conceals politics and topicalises the science.

The threat to national sovereignty due to the granting of technologically mediated access to classified health data is an issue that is not on the agenda of GHP collaborations, yet the study found it to be a matter of concern for all the participants. Their strong language in talking about sovereignty shows that it is an issue that needs policy and management attention, yet the partnership discourse occludes the matter. The discussions raised crucial points regarding our understanding of the Westphalian concept of sovereignty as originally theorized in 1648. This is due to the influence of technology, which renders physical boundaries ineffective in establishing state sovereignty. The discussion reveals how technology can facilitate the cyber-invasion of states even as they secure their physical borders.

Moreover, the issue of patron-client relations was of urgent concern as a lack of proper human resources motivation for staff in the ministry was highlighted as another area that GHPs exploit to get the information they require from the Ministry. The process threatens national sovereignty and involves supporting senior bureaucrats with financial increments in their salaries to facilitate access to otherwise unavailable health information.

The study also found that M&E staff appropriate GHP training programmes and experience to their personal benefit, improving their opportunities to find employment with the GHPs. The attractive power of collaborating with GHPs for individual staff is an instance of the new 'governing technology through non-governing' described by Lilja and Baaz (2022) as 'artepolitics'. The strategy (ab)uses the desire of underpaid M&E employees of the Ministry of Health for continuous professional self-improvement, better salaries, and working conditions as "distributed freedom" to control and regulate their individual behaviour, which includes their desire and ambition to work for the GHPs. Thus, at the state level, the GHPs influence the behaviour of the Ministry's M&E staff by supporting internationally recognised capacity-building programmes that equip them professionally and open up employment opportunities with the GHPs for the staff. The participants' reference to the need for capacity building provides clues to the importance of specific skills in areas such as HIV estimates, key population size estimates, and modelling techniques for public health. Possession of these skills opens global opportunities for the local M&E staff. Thus, the GHP intervention unintendedly contributes to the brain drain from the underpaying Ministry to the better paying GHPs.

Similarly, mute and perverse incentives like data falsification and dependency on monetary incentives are unintended negative effects that the Ministry will find difficult to correct without GHPs support. Paying monetary incentives is not a suitable intervention in a fragile health environment. Perhaps focusing on integrated and structured support for the whole M&E system would bring sustainable results.

Another finding related to the above is the unintended 'othering' effect of GHP support for M&E systems staff. The support creates conceptual boundaries between M&E and 'other' Ministry staff. The Ministry's evolution from being health information-focused to relying on the knowledge and strategic M&E system has resulted in rearranging the Ministry's structure to create a directorate for M&E, which is better supported than others. As a result, M&E staff view themselves as better than other staff, and the 'other' staff expect them to perform most of

the Ministry tasks. These developments have created silent wars particularly between the M&E and Health Information Departments.

Finally, the issue of competition among GHPs like the CDC and the World Bank on the proposed blockchain intervention indicates that GHPs are not homogenous and are driven by self-interest rather than by altruistic humanitarianism. These are crucial issues for policy and managerial consideration in collaborative partnerships.

9.4.3.2 Conclusion

Based on the findings discussed here, the study acknowledges that GHPs are an integral part of Zimbabwe's public health M&E system. Their contributions to the establishment, development, and maintenance of the M&E system are acknowledged. However, the study also concludes that the intended interventions have led to numerous challenges that require further investigation and discussion. Focusing on the intended positive contributions of collaborative partnerships does not accomplish much, as celebrating the intended and obvious outcomes does not improve the system. The study concludes that the collaborative partnership should focus on the negative, local lessons presented here rather than on 'international best practise.' The focus should also extend to 'bad practises' to learn rather than punish. Therefore, the unspectacular impact of GHP support to M&E in Zimbabwe requires careful consideration before successes are celebrated. Lessons learned from unspectacular strategies should be an integral part of policy discussions between the government and the GHPs so that labour relations may be improved from a position of trust. The issues raised in this study, such as clientelism, extraversion, obfuscation, data manipulation in performance-based funding, the brain drain, and competitive behaviour among GHPs, represent realpolitik that is part of the global health conversation. The medical approach to public health needs reconsideration in Zimbabwe, where the focus is now on disease, death, and high politics.

9.4.4 Research Objective Four and Research Question Four

- **Research Objective:** To gain new insight into the extent of GHP and local health partner power strategies on the broader M&E system beyond Zimbabwe's disease and donor-specific M&E systems.

- **Research Question:** To what extent do the GHP and local health M&E partner power strategies impact on the broader M&E system beyond Zimbabwe's disease and donor-specific M&E systems?

9.4.4.1 Impact of GHP global M&E technical and financial assistance on wider public health M&E system-strengthening initiatives in Zimbabwe

The fourth research objective and question examine the impact of GHP support on broader initiatives to strengthen M&E in health systems. The chapter examined the impact of GHP support for the HIV, TB, and malaria programmes on the M&E system beyond these three diseases. The discussion of the six building blocks for health (WHO) helped to provide a comprehensive baseline assessment of the impact of the GHP, covering essential aspects for strengthening systems. Thus, the study's findings and discussions focus on the impact of the GHP on the health information system, health human resources, health finance, pharmaceutical and medical technologies, service delivery, governance, and health leadership. The results of the study show that the ministry's human resources have benefited significantly from GHP support to M&E partnerships in Zimbabwe. The hiring of GHP-supported staff such as M&E officers, pharmacy managers and data entry clerks provided additional health data collection, analysis, and reporting staff to enable informed health decision-making. The staff responsibilities were not limited to HIV, TB, and malaria as the staff processed data and information for all diseases and administrative components. For example, human resources, drug, medical, and programme databases such as DHIS2 manage health information for ministry-wide decision support systems. However, the study noted the existence of unforeseen challenges such as 'reverse othering.' In Chapter Five GHP-supported staff were found to look down on others as poorly paid and qualified health information staff. In this case, the 'othered' non-GHP team, including health facility management, assigned more work to GHP-supported staff beyond their scope of duties to justify the fact that they were earning better salaries. In addition, the health information system facilitated the integration of clinical and nonclinical data at selected health centres. Although this process excluded unconnected rural health centres, the system provided insight into the capabilities of electronic health systems when fully operational. Systems such as the DHIS2 and the EHR provided the opportunity to integrate the Department's data products from all disease areas as well as finance, human resources, management, and service delivery into one system. The operation thus facilitated the interconnection of the Department's various functions, although the lack of coordination and interoperability among the systems remains a challenge. For example, the DHIS2 and the EHR remain separate systems with different capabilities but the same goals. Overall, however, the health information system has improved and facilitates communication among the Department's six building blocks. The primary benefit of GHP support for health information is the provision of hardware and software products.

Similarly, GHP interventions under the Global Fund provided leadership and governance support through establishing structural and post-structural support, such as procurement committees for medical and pharmaceutical products at the health facility level and the Country Coordinating Mechanism (CCM) at the national level. Also, support for policy development and review and the printing and distribution of key national guidelines are some of the valuable contributions of GHPs to strengthening M&E beyond the country's HIV, TB, and malaria programmes. However, structures such as CCM exercise too much decision-making power outside of government, sometimes duplicating or replacing other government platforms for decision-making. For example, decisions about the Global Fund are made exclusively by CCM. Parliamentary oversight is barely involved, leaving the process under the influence of an unelected structure with influential civilian and private partners. As a result, unelected representatives ultimately make decisions for the country.

The contributions to health care funding are substantial, although GHPs are overly concerned with accountability and transparency in their dealings with the government. The 'witch hunt' that thwarts accountability has resulted in M&E collaboration being based on mistrust. GHPs' indirect financial disbursements through the United Nations Development Program confirm the mistrust that delays programme implementation, as HIV grant procurement is handled through GHP outside Zimbabwe. Other adverse effects of health financing include the silent and perverse effects of results-based funding discussed in Chapter Seven. The desperate drive to achieve quantities as programme outcomes have led to falsifying statistics in some facilities. Some GHP-supported management systems, such as the Health Centre Committee have not been able to stop these practices because they, too, desperately need the funds to develop health centres. However, the Global Fund played a critical role in establishing the Public Sector Finance Management System (PFMS) in the ministries of health and finance, linking headquarters and subnational offices.

Finally, GHP support has had a cross-cutting positive impact on service delivery by supporting subnational healthcare delivery models such as community AIDS refill groups (CARGs), which led to a significant reduction in stigma and discrimination, as well as a reduction in out-of-pocket spending for stable patients in Zimbabwe. Capacity building for community or village health workers was also improved through GHP support for education and training, resulting in improved service delivery at the community and household levels. However, negative externalities include uncoordinated M&E systems in communities and the increased workload for underpaid and overworked government staff in health facilities and at the district

level. As a result, the hard work of village health workers sometimes does not find its way into the general reporting system, even though their information is some of the most pertinent to stopping outbreaks before they become pandemics. In addition, M&E data collection systems are largely quantitative in nature and do not provide an opportunity to capture the social lives of M&E.

9.4.4.2 Conclusion

The study findings and the discussion from them suggest that the Partnership for Health is an unstable partnership based on mistrust, goal incongruence, and challenging organizational identities. Despite the positive contributions of GHPs to the Department's support of the six building blocks for health, the study draws particular attention to the unspectacular, unexpected, and under-discussed impacts of GHPs on the Ministry of Health's M&E system. The revelations make a strong case for considering CDA as an integral tool for analysing public policy in Zimbabwe. A multidisciplinary policy approach involving contributions from political science, law, sociology, international relations, communications, ICT, and other disciplines might make a balanced and effective contribution to public health policy in the existing unstable collaborative arrangement. Biomedical approaches to health have proven inadequate to deal with markedly intricate global health politics. Locally supported multidisciplinary teams might provide the necessary patriotism and leadership to ensure that vital national interests are preferred to individual interests.

Moreover, multidisciplinary teams can identify and counter ideological and discursive strategies using CDA and other linguistic tools to protect national interests. The multidisciplinary teams might give the government the leadership needed to engage in global governance arrangements for health effects. Based on the literature and research data reviewed, the study also concludes that frameworks such as NPG theory (un)intentionally perpetuate unequal partnerships in collaborative partnerships between former colonial and developing countries. The unrealistic assumptions about mutual interests, organisational identity, and trust building in interest-laden collaborations with seemingly unequal capacities make for the continued dominance of unequal partnerships in GHPs. The analysis and discussion of the NPGs and other models of collaborative governance have helped illuminate the limits of collaborative partnerships in theory and practice. Their limitations are important research findings that show that their positive perception in the current discourse on collaborative partnerships could be an extension of pedagogical, ideational, and discursive strategies to maintain the status quo. Likewise, the findings related to contestation, 'othering,' distrust, and

competition, among other identified unintended pathological effects, justify the conclusion that the nature of these partnerships needs to be reconsidered.

9.5 Contributions to public administration theory and public health governance

The contributions of this study to theory and governance are discussed in this section. The following contributions are noted to improve understanding public governance theory and practice in Zimbabwe.

9.5.1 Contributions to the theory

Drawing on New Public Governance theory and the framework of Critical Discourse Analysis (CDA), a post-constructivist paradigm, this study uses the example of the Ministry of Health and Child Welfare to show that collaborative governance for M&E partnerships is an initiative of global health development partners that include private, civil and corporate enterprises. At the policy and planning level, the study identified all the key features of NPG according to the concept of Osborne (2006) in the government-GHP collaborative partnership. The study identifies the influence of the GHP on a pluralistic decision-making state, the role of intergovernmental governance, the emphasis on service outcomes, the role of private service providers, trust, and a neo-corporatist value system as evidence of NPG theory in practice in Zimbabwe. Similarly, the GHP's noted influence on discourse and soft power strategies suggests that they use language and semiotics to maintain and expand their power and influence through the postcolonial and post-conditionality strategy that appears to break with the colonial past. However, the evidence points to a postcolonial continuation of governance through local autonomy and accountability. This process of 'governing by not governing' is illustrated in this study by the key discourses identified, which provide useful evidence of the neoliberal and corporatist influence of GHPs in local M&E policies shifting from primary health care to selective primary health care. The emphasis on pro-business, participatory, human rights, scientific, technological and country-led approaches in global programmes such as the Sustainable Development Goals (SDGs) confirms the local influence of global collaborative governance partnerships involving UN agencies in Zimbabwe. These observations substantiate the methodological and earlier study findings by Cueto (2004), who identified the role played by the World Health Organization and UNICEF in the emergence and diffusion of the concept of primary health care during the late 1970s and early 1980s. That study, which drew on archival materials, analysed the political context of these organizations, their leaders, and their methodological and discursive techniques to determine the role that civil society and corporate

partners have played in shifting the emphasis on primary health care to an emphasis on selected primary health care in Latin America.

However, through the application of CDA to the gap between theory and practice it is found that NPG theory is a tool to disseminate neoliberal and neo-corporatist values that promote the commodification of illness and disease. The study observes that the assumptions of trust by Osborne (2006), of trust-building by Ansell and Gash (2008), and of principled engagement by Emerson *et al.* (2012) are difficult to accept as applying to collaborative partnerships that involve unequal partners with colonial histories and operating in different geographic contexts. Thus, proponents of the NPG and network approaches to pluralistic government systems may be sincere in their desire to propose government systems that deliver efficient and effective public services, but in their Western context they may not understand the local realities that stand in the way of this approach in LMICs. The dialogic post-structuralist approach used in this study shows that pragmatic-instrumentalist views of collaborative partnerships have led to exclusions, chaos, service disruptions, mistrust, dependencies, missed learning opportunities for government staff, brain drain, and mute and perverse practices in the M&E system. This observation does not diminish the immense contribution of NPG theory in more favourable environments, but highlight its shortcomings in unstable environments such as Zimbabwe.

Therefore, the study suggests continuing dialogic research on collaborative governance systems in fragile states and conflict countries, focusing more on street-level beneficiaries than on GHPs and senior bureaucrats. The latter are often unaware of the contentious and messy effects of street-level bureaucratic partnerships in practice.

9.5.2 Contributions to public health governance

The literature review has demonstrated the pragmatic-instrumental value of collaborative governance partnerships for strengthening health systems. However, very few of the studies reviewed have explicitly addressed street-level struggles and the unintended negative consequences of charitable interventions in unstable settings such as Zimbabwe. The studies that attempted to address this gap have failed to capture the real-world experiences of collaborative partnerships at this level because they focused on high-level bureaucrats and GHP representatives. The problem with this approach is that it provides the higher-level perspectives consistent with global views on the issue. As a result, the findings reflect a positive bias toward partnerships as a panacea for global governance challenges. This study therefore recommends the adoption of a critical approach to policy analysis to promote strong local multidisciplinary leadership and governance structures for health partnerships. This recommendation is

underpinned by global political dynamics in which proponents of these approaches are consolidating nationalist policies that contradict global health principles for addressing 'wicked' challenges. For example, Western governments' recruitment of health workers is at odds with the notion that collaborative governance partnerships strengthen health systems because it results in the outflow of skilled and experienced health workers from Zimbabwe. To address this challenge, the government should work out home-grown commitments to reforming its governance system, focusing on national values that reject corruption and promote adherence to the constitutional provisions for health care and better working conditions for civil servants, especially health workers. These changes require a new political and bureaucratic ethic that puts the country's interests above personal interests.

9.6 Overall Recommendation of the Thesis

The overall recommendations of the thesis are drawn from the results and aim to provide new insights for informed and evidence-based public health policy and practice in Zimbabwe. The recommendations apply to the government and GHPs to ensure a return to partnership values driven by mutual trust and respect for organisational identity and genuine autonomy in Zimbabwe.

9.6.1 Government should consider Critical Discourse Analysis as an integral part of public health policy analysis

In line with the research objective and the answer to the first question, the study recommends CDA as an essential component of health policy processes involving collaborative governance in Zimbabwe. The critical role of discourse as a governance technology observed in the study makes it imperative for the government to adopt the critical approach in public health policy formulation and implementation. Adopting this approach would give the government the skills necessary to negotiate complex global collaborations. A critical approach to health policy analysis enables the government to identify and combat neocolonial health policies that promote responsible local autonomy, where the government (un)consciously contributes to implementing policies that have little relevance to solving local health problems. Failure to recognise and interpret the politics of spoken language, texts, and semiotics leads to inconsistent local public health decision-making processes that may not benefit local populations. The involvement of multidisciplinary teams from linguistics, politics, law, humanities, international relations, sociology, economics, and health would provide an opportunity to promote balanced policy processes in the Department.

9.6.2 The government should invest in strong, locally driven leadership and governance programmes to ensure effective representation in collaborative partnerships

The success of collaborative partnerships in global health depends on mutuality, organisational identity, and trust, conditions that are present when the parties have comparable leadership and governance capabilities. Based on the findings, the study recommends that locally focused governance and leadership programmes be guided by the values and virtues of "Ubuntu" in public health. The use of discourse and educational soft power strategies has produced the unintended negative effect of not adequately preparing local bureaucrats to lead and govern in the national interest. The programmes have helped maintain and expand the remote control of local health programmes in the name of GHPs. Therefore, the government should work closely with GHPs to co-produce and co-implement programmes that uphold local patriotic values and interests. Partners could be allowed to contribute based on national acceptability, and the contribution should be limited to program funding, excluding implementation. The government should limit external funding of specific public health programmes and encourage structured and pooled funding through the government's Treasury. On the other hand, the government should adhere to transparency and accountability standards to ensure that external funds are accounted for through a transparent government process to avoid GHPs becoming directly involved in the ministry's implementation and management activities. Facilitating trust-building and principled engagement depends on sound local leadership and governance structures.

9.6.3 Global Health Partners should consider, respect, and acknowledge the power of local system partners for effective collaborative partnership results

The study results show that money, technology, and superior ideas do not solve all practical problems. The literature and the primary data suggest that external partners need to consider local knowledge and value systems to derive total value from the donor funds invested. They should act as 'unknowing' experts to learn about the dynamics of local politics that facilitate or hinder the implementation progress of the programmes they support. The ability of local partners to use gaps in the collaboration to their advantage has shown that GHPs should invest in processes that promote policy dialogue rather than relying on their knowledge of global 'best practice.' Thus, an accurate local context assessment should inform GHPs' interventions. Collaborative governance programmes should facilitate knowledge encounters and integration rather than impose global knowledge systems.

9.6.4 The government and GHPs should adhere to a clear collaborative partnership policy direction to avoid covert contests

Zimbabwe's covert contestations and policy disagreements result from a lack of clear policy positions on either side of the partnerships. On the one hand, the government does not fully commit to pro-business or pro-social policies. On the other hand, the GHPs do not openly call for the privatisation of the public health care system. As a result, both partners use soft power strategies to influence policy in their preferred direction, depending on the circumstances. The government should therefore provide leadership and take a health policy position to clarify the technical assistance needed to achieve policy goals. The current hybrid policy is a moving target, and it is difficult to assess its value and contribution to promoting equitable and affordable public health care for the people of Zimbabwe. Therefore, the study recommends that government and the GHPs, as collaborating partners, agree on a clear policy for public health governance.

9.6.5 Government should consider investments in locally initiated electronic health systems

The study shows that the electronic M&E systems supported by the GHPs' are mostly program-specific and uncoordinated. These arrangements have resulted in digital exclusion and the disruption of paper-based systems that provide minimal data for M&E reporting and local decision-making. The current, unsustainable electronic systems create a silent competition among GHPs and jeopardize the country's ability to fully transition to functional electronic systems. The study, therefore, recommends that a locally conceived and designed whole-of-government electronic public health M&E system be mandated, with all healthcare providers pooling resources if they wish to support the measure. As recommended earlier, the government should take a strong leadership role in this area. The system should collect and report quantitative and qualitative data for informed reporting on critical, locally agreed-upon indicators and targets.

9.6.6 Collaborative partnerships should focus on the whole health sector rather than selected interventions

The study recommends that GHPs consider pluralistic collaboration by supporting whole-of-government M&E initiatives that include all diseases and all ministry programmes aligned with the WHO Six Building Blocks for Sound Health Systems. For example, service delivery, human resources, finance for health, pharmacy, and medical technology systems, leadership, and health information systems should integrate all ministry processes to facilitate informed, evidence-based, and timely decisions. The current pattern resembles selective health care and is not cost-effective for the government and GHPs. The findings have also shown that the

current partnership arrangement is suboptimal for the intended beneficiaries and the donors, as none receives value for money. Therefore, it is in the interest of all stakeholders to insist on implementing coordinated, collaborative health governance partnerships that positively influence health policy and practice in Zimbabwe. It is difficult for the government to justify continued GHP funding due to the failure of GHP-supported programmes. Such a situation is untenable given the current budgetary constraints of the Ministry of Health in an environment where the Zimbabwean public is more informed and demanding public services from the government. Therefore, the government must strengthen cooperation with the GHPs to ensure effective utilization of the available resources to avoid political instability that could necessitate a change of government. Implementing successful integrated programmes could lead to a win-win situation for true partnerships.

9.7 Limitations

The major limitation of this study is that it was impossible to obtain all identified employees' full cooperation to participate in key informant interviews. Restrictions due to the Covid 19 pandemic limited the ability to speak with the proposed interviewees physically. Although some organisations gave their consent to performance of the interviews, some selected participants were unable to be available on the agreed-upon day and time, while others requested a reduction in the standard interview time for various reasons. Network connectivity disruptions were among the regularly cited reasons for the shortened interview time slots.

Despite these challenges, the researcher ensured that the respondents who made themselves available provided quality input into the dialogic process to ensure the coverage of all critical aspects of the study. Considering that qualitative studies do not depend on sample size, the responses from the staff who participated saturated the discussions with rich feedback incorporated into the study. Also, the original plan to interview local GHP representatives could not be implemented because other targeted GHPs gave various excuses for not participating in the study. However, the shift did not significantly change the study's focus since the perspectives of government M&E staff addressed their experiences with GHPs in coordinating externally supported programmes. While obtaining their views could have enriched the study in some ways, their non-participation did not significantly impact the study, as the study's interest was on the post-constructivist dialogic experiences of the government staff dealing with GHPs in policy planning and implementation.

In addition, most of the GHPs' views on partnerships which forms part of the publicly available literature was used to complement the primary data from the participant interviews. Consequently, the study's findings, conclusions, and recommendations relied on credible data based on participants' actual experiences. One area for further study is to examine public health M&E processes as high stakes politics. The study found that some participants suggested that GHPs use M&E technologies to gather information beyond health. In this study, these political topics were carefully limited to conversations that did not delve too deeply into international politics and security away from public health partnerships. Detailed politics and security topics were beyond the scope of the current study, so it is proposed that more researches that apply CDA be used to explore these topics.

9.8 Conclusion

This chapter has attempted to provide a summary of the study's findings, discussion, conclusions, recommendations on the study's objectives and research questions, and recommendations for further research to explore the impact of GHPs on local health M&E systems in Zimbabwe. The study's findings suggest that GHPs actively use pro-economic, participatory, technological, scientific, human rights, results-based and country-led discourses, and soft power strategies to influence policy and practice for M&E. The study also found that collaborative governance for M&E was based on relational power dynamics in which local partners also employed subtle forms of resistance and counter influence to GHP initiatives. As a result, the covert power plays led to the disruption of the M&E processes, the digital exclusion of some partners, mistrust, and conflict, a brain drain, and compromised governance and management structures. In addition, the study recognised the positive impact of interventions beyond disease-specific M&E support in the six building blocks for health. The study applied the New Public Governance and the Critical Discourse Analysis to shed light on the unexpected and unspectacular impacts of GHPs that are rarely discussed in policy and practice in Zimbabwe. It recommended CDA as an integral critical policy approach, the strengthening of local multidisciplinary leadership for public health policymaking, the development of indigenous electronic health M&E systems, recommended policy clarity for collaborative integrated health systems, and noted the need for GHPs to invest in understanding local knowledge systems to facilitate the provision of evidence-based support to the government. Addressing all these issues would strengthen government involvement in effective collaboration for the benefit of all Zimbabweans.

REFERENCES

- Abrahamsen R. (2004) The power of partnerships in global governance. *Third World Quarterly* 25: 1453-1467: Taylor&Francis Group Ltd, Available from: <https://www.jstor.org/stable/3993796> (accessed 21/2/2021)
- Abuzyarova D and Takhtarova S. (2018) Mitigation in the Scientific Discourse. Vol. 7, No. 4, 223-229 ; Karabuk: Journal of History Culture and Art Research, Available from <https://pdfs.semanticscholar.org/1ba9/2ea9c9afc150c15c5a78e11c8564fed191d0.pdf>(Accessed on 6/4.2022)
- Adams V. (2016) *Metrics: What counts in global health*: Durham London : Duke University Press, available on <https://read.dukeupress.edu/books/book/78/MetricsWhat-Counts-in-Global-Health> (Accessed 27/2/2021)
- Aggarwal GJEQ. (2016) Understanding discourse; from theory to method . Volume : 7, Issue : 3, New Delhi: New Delhi Publishers, Available from <https://www.indianjournals.com/ijor.aspx?target=ijor:eq&volume=7&issue=3&article=010>(accessed on 28/11/2021)
- Alpi KM and Evans JJ. (2019) Distinguishing case study as a research method from case reports as a publication type. *JMLA* 107: 1: Pittsburgh, USA: *Journal of the Medical Library Association*, Available from <https://www.semanticscholar.org/paper/Distinguishing-case-study-as-a-research-method-from-Alpi-Evans/f0e3f4f139a880f3b19e6cd00b9e7df242399c02>, (accessed on 25/5/2020).
- Altheide DL. (2013) *Qualitative Media Analysis*. 2nd Edition, Arizona State University, USA:Sage Publishers.
- Alvesson M and Spicer A. (2012) A Stupidity-Based theory of organizations. *Journal of management studies* 49:7 1194-1220. Oxford, UK: Blackwell Publishing , Available on <https://doi.org/10.1111/j.1467-6486.2012.01072.x>. (accessed on 13/3/2020)
- Amisi M, Masvaure S, Dlakavu A, et al. (2021) Strengthening VOPEs into Pillars of M&E Ecosystem. Johannesburg: University of Witswatersrand, Available on https://www.google.com/search?q=STRENGTHENING+VOPES+INTO+PILLARS+OF+M%26+E+ECOSYSTEMS&rlz=1C1CHBD_enZA891ZA891&oq=STRENGTHENING+VOPES+INTO+PILLARS+OF+M%26+E+ECOSYSTEMS&aqs=chrome..69i57.1388j0j15&sourceid=chrome&ie=UTF-8(Accessed 26/7/2021)
- Ansell C, Doberstein C, Henderson H, et al. (2020) Understanding inclusion in collaborative governance: a mixed methods approach. *Policy and Society* 39: 570-591, UK: Taylor and Francis, Available from: <https://doi.org/10.1080/14494035.2020.1785726> (Accessed on 13/6/2021).
- Ansell C and Gash A. (2008) Collaborative governance in theory and practice. *Journal of Public Administration Research and Theory* 18: 543-571, Berkeley: University of California, Available from <https://academic.oup.com/jpart/article/18/4/543/1090370> by California Digital Library (accessed on 13 /6/ 2021)
- Armstrong R, White AC, Chinyamuchiko P, et al. (2019) Inclusive engagement for health and development or 'political theatre': results from case studies examining mechanisms for country ownership in Global Fund processes in Malawi, Tanzania and Zimbabwe. *Globalization and health* 15: 34: BMC, Available from <https://doi.org/10.1186/s12992-019-0475-9> (accessed on 20/3/2020)
- Arnold G. (2020) Distinguishing the street-level policy entrepreneur. *Public Administration*. California, USA, University of California Davis: John Wiley & Sons Ltd, Available from <https://doi.org/10.1111/padm.12703>(Accessed on 13/6/2021)
- Aveling E-L and Jovchelovitch S. (2014) Partnerships as knowledge encounters: a psychosocial theory of partnerships for health and community development. *Journal of Health Psychology* Vol 19(1) : 34-45, Available on <https://doi.org/10.1177/1359105313509733> (Accessed 12/7/2020)

- Baaz ME. (2005) *The paternalism of partnership: A postcolonial reading of identity in development aid*: Zed Books.
- Babbie ER. (2016) *The Basics of Social Research*. Boston: Cengage Learning EMEA, Available from <https://www.perlego.com/book/2728565/the-basics-of-social-research-pdf> (Accessed on 3/6/2021) .
- Bano M. (2019) Partnerships and the good-governance agenda: Improving service delivery through state–NGO collaborations. *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations* 30: 1270-1283. Springer, Available on <https://doi.org/10.1007/s11266-017-9937-y>(Accessed on 4/1/2020)
- Baptiste S, Manouan A, Garcia P, et al. (2020) Community-Led Monitoring: When Community Data Drives Implementation Strategies. *Current HIV/AIDS Reports*: 17:415–421. Springer, Available on <https://doi.org/10.1007/s11904-020-00521-2>(Accessed on 11/8/2022).
- Barlow P and Thow AM. (2021) Neoliberal discourse, actor power, and the politics of nutrition policy: A qualitative analysis of informal challenges to nutrition labelling regulations at the World Trade Organization, 2007–2019. *Social science & medicine* 273: 113761: Elsevier ,Available on <https://doi.org/10.1016/j.socscimed.2021.113761> (Accessed on 24/2/2022).
- Barnes A. (2011) *The Politics of the Idea of Partnership: From contemporary aid policy to local health governance in practice in Zambia*. Sheffield,UK: University of Sheffield. Available on <https://etheses.whiterose.ac.uk> (Accessed on 3/3/2020).
- Bartl W, Papilloud C and Terracher-Lipinski AJHSRHS. (2019) Governing by Numbers-Key Indicators and the Politics of Expectations. An Introduction. *Historical Social Research / Historische Sozialforschung* , Vol. 44, Nos. 2 (168): Berlin, GESIS - Leibniz Institute for the Social Sciences in collaboration with JSTOR. Available on <https://www.jstor.org/stable/10.2307/26604897> (Accessed on 4/6/2022)
- Beran D, Aebischer Perone S, Alcoba G, et al. (2016) Partnerships in global health and collaborative governance: lessons learnt from the Division of Tropical and Humanitarian Medicine at the Geneva University Hospitals. *Globalization and Health* 12: 1-13. Geneva: BMC, Available on <https://www.DOI.10.1186/s12992-016-0156-x>
- Boas M and McNeill D. (2004) *Global institutions and development: framing the world?*. London:Routledge.
- Bopp C, Harmon E and Volda A. (2017) Disempowered by data: Nonprofits, social enterprises, and the consequences of data-driven work. *Proceedings of the 2017 CHI Conference on Human Factors in Computing Systems*. Denver, CO, USA, May 6–11, 2017, pp.3608-3619, Available on <https://www.DOI:http://dx.doi.org/10.1145/3025453.3025694> (Accessed on 1/2/2021).
- Bortz M. (2019) *We're all managers now: the discursive influence of management consultants*. Doctoral dissertation, School of Social and Political Sciences, University
- Briant C, Jane. (2017) Unheard voices: a critical discourse analysis of the Millennium Development Goals' evolution into the Sustainable Development Goals. *Third World Quarterly* Vol . 38, NO. 1, 16–41 . Routledge, Taylor and Francis Ltd, Available on <https://doi.org/10.1080/01436597.2016.1166944>, (Accessed on 31/5/2021).
- Brinkerhoff. (2002) Government–nonprofit partnership: a defining framework. *Public Administration and Development: The International Journal of Management Research and Practice* 22: 19-30. Washington DC: John Wiley & Sons, Ltd. Available on www.interscience.wiley.com DOI: 10.1002/pad.203 (Accessed on 30/6/2020).
- Brown H. (2015) Global health partnerships, governance, and sovereign responsibility in western Kenya. *American Ethnologist* Vol 42 Issue 2: 340-355. Available on <https://doi.org/10.1111/amet.12134>, (Accessed on 2/6/2021)
- Bunasim AS. (2020) Public administration 4.0: theoretical exploration of disruptive governance paradigm. Indonesian Association of Public Administration *Proceedings Conference*. p.15-43. Available on <https://journal.iapa.or.id>

- Buse K and Harmer AM. (2007) Seven habits of highly effective global public–private health partnerships: practice and potential. *Social science & medicine* 64: 259-271. Elsevier, Available on <https://doi:10.1016/j.socscimed.2006.09.001> (accessed on /3/2020).
- Buse K, Mays N and Walt G. (2012) *Making health policy*: Second edition, McGraw-hill education (UK): McGraw-Hill Global Education Holdings, LLC.
- Buse K and Walt G. (2000) Global public-private partnerships: part I-a new development in health? *Bulletin of the World Health Organization* 78: 549-561. Geneva: World Health Organization, Available on <https://apps.who.int/iris/handle/10665/268107> (accessed 16/6/2021)
- Campbell C. (2020) Social capital, social movements and global public health: Fighting for health-enabling contexts in marginalised settings. *Social science & medicine* 257: 112153. Elsevier, available on <https://doi.org/10.1016/j.socscimed.2019.02.004> (Accessed on 21/7/2021)
- Carlson C. (2004) Mapping global health partnerships. London: DFID Health Resource Centre, Available on https://www2.ohchr.org/english/issues/development/docs/who_1.pdf, (accessed on 11/8/2022)
- Cashin C. (2012) Comparison of the Monitoring and Evaluation Systems of the World Bank and the Global Fund. Independent Evaluation Group Working Paper 2012/1. Washington DC: World Bank Group, Available on <http://hdl.handle.net/10986/26678> (Accessed on 21/2/2021)
- Chakrabarty B and Kandpal PC. (2012) *Public Administration in a Globalizing World: Theories and Practices*: New Delhi: SAGE Publications.
- Cheng Y. (2019) Governing government-nonprofit partnerships: Linking governance mechanisms to collaboration stages. *Public Performance & Management Review* 42: 190-212. Available on <https://doi.org/10.1080/15309576.2018.1489294> ,(Accessed on 29/6/2020)
- Chinyoka I and Ulriksen MS. (2020) The Limits of the Influence of International Donors: Social Protection in Botswana. In Carina Schmitt (ed) *From Colonialism to International Aid*. Palgrave Macmillan, Cham, pp.245-271.
- Cohen L, Manion L and Morrison K. (2011) *Research Methods in Education*, London: Routledge.
- Comai A. (2014) Decision-making support: the role of data visualization in analyzing complex systems. *World Future Review* Vol. 6(4): 477-484. Sage: Available on <https://doi:10.1177/1946756715569233> (Accessed on 26/6/2021).
- Cornwall A and Eade D. (2010) *Deconstructing development discourse: Buzzwords and fuzzwords*: Warwickshire, UK, Oxfam GB.
- Coultas C. (2020) The performativity of monitoring and evaluation in international development interventions: Building a dialogical case study of evidence-making that situates ‘the general’. *Culture & Psychology* Vol. 26(1) : 96-116. Sage: Available on <https://doi:10.1177/1354067X19888192> (Accessed on 29/10/2021).
- Craveiro I and Dussault G. (2016) The impact of global health initiatives on the health system in Angola. *Global Public Health* 11: 475-495. Taylor and Francis, Available on <https://doi:10.1080/17441692.2015.1128957> (Accessed on 11/4/2020)
- Creswell JW. (2007) *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*, Thousand Oaks, California: Sage Publication.
- Cueto M. (2004) The origins of primary health care and selective primary health care. *American journal of public health* 94: 1864-1874. Available on <https://doi.org/10.2105/AJPH.94.11.1864> (Accessed on 26/7/2021)
- Cummings S, De Haan L and Seferiadis A-A. (2020a) How to use critical discourse analysis for policy analysis: a guideline for policymakers and other professionals. *Knowledge Management for Development Journal* 15: 99-108. Available on <https://www.km4journal.org/index.php/km4dj/article/view/473>, Accessed on 31/5/2021)
- Cummings S, Regeer B, De Haan L, et al. (2018) Critical discourse analysis of perspectives on knowledge and the knowledge society within the Sustainable Development Goals. *Development Policy Review* 36: 727-742. Willey: Available on <https://www.doi:10.1111/dpr.12296>, (Accessed on 31/5/2021).

- Cummings S, Seferiadis AA and de Haan LJS. (2020b) Getting down to business? Critical discourse analysis of perspectives on the private sector in sustainable development. 28: 759-771. Wiley:Available on DOI: 10.1002/sd.2026, (Accessed on 14/5/2022).
- D'Aquino L, Pyone T, Nigussie A, et al. (2019) Introducing a sector-wide pooled fund in a fragile context: mixed-methods evaluation of the health transition fund in Zimbabwe. 9: British Medical Journal, Available on ([http:// dx. doi. org/ 10. 1136/ bmjopen- 2018- 024516](http://dx.doi.org/10.1136/bmjopen-2018-024516)). (Accessed on 14/9/2022).
- Dolan A. (2011) The meaning of partnership in development: Lessons in development education. Center for Global Education:Available on <http://hdl.handle.net/10395/1916> (Accessed 4/8/2020).
- Duval A-M, Gendron Y and Roux-Dufort C. Exhibiting nongovernmental organizations: Reifying the performance discourse through framing power. *Critical Perspectives on Accounting* 29 (2015) 31–53 : Elsevier, Available on <http://dx.doi.org/10.1016/j.cpa.2015.01.003> (Accessed 27/6/2021).
- Eichbaum QG, Adams LV, Evert J, et al. (2021) Decolonizing Global Health Education: Rethinking Institutional Partnerships and Approaches. *Academic Medicine*, Vol. 96, No. 3: pp 329-335. Association of American Medical Colleges, Available on doi: 10.1097/ACM.0000000000003473, (Accessed on 7/8/2022).
- Emerson K and Nabatchi T. (2015) *Collaborative governance regimes*: Georgetown University Press.
- Emerson K, Nabatchi T and Balogh S. (2012) An integrative framework for collaborative governance. *Journal of Public Administration Research and Theory* 22: 1-29. Oxford University Press:Available at DOI:10.1093/JOPART/MUR011, (Accessed on 16/8/2022).
- Erasmus E. (2014) The use of street-level bureaucracy theory in health policy analysis in low-and middle-income countries: a meta-ethnographic synthesis. *Health Policy and Planning* 2014;29:iii70–iii78. Oxford University Press, Available at doi:10.1093/heapol/czu112, (Accessed 6/7/2022).
- Erikson S. (2015) Secrets from whom? Following the money in global health finance. *Current Anthropology* Volume 56, Supplement 12,: pp. S306-S316. Available at (Accessed 8/4/2021).
- Erikson S. (2016) Metrics and market logics of global health in Vincanne Adams: *Metrics: What counts in global health*: Durham London: Duke University Press: Available at <https://doi.org/10.1215/9780822374480>, (Accessed on 27/2/2021). pp. 147-162.
- Fairclough N. (1989) Language and power. *London and New York: Longman*.
- Fairclough N. (2001a) The dialectics of discourse. Available at <https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=75300d06ee03ce14b75007de6d256e2d58ee5279>, (Accessed on 21/9/2022)
- Fairclough N. (2001b) *Language and Power*:UK, Pearson Education.
- Frag M, Nandakumar A, Wallack SS, et al. (2009) Does funding from donors displace government spending for health in developing countries? *Health Affairs* 28: 1045-1055. Available at <https://doi.org/10.1377/hlthaff.28.4.1045>, (Accessed on 14/7/2021).
- Ferreira VdRS, Medeiros JJ, Bright CL, et al. (2020) Implementing social policy in Brazil: an inter-contextual exploration of the exercise of discretion by street-level bureaucrats. *International Public Management Journal*: 1-19. Routledge, Taylor and Francis Group, Available at <https://doi.org/10.1080/10967494.2019.1711474> (Accessed on 27/7/2021).
- Fridlund P. (2020) Post-truth politics, performatives and the force. *Jus Cogens* (2020) 2:215–235. Springer: Available at <https://doi.org/10.1007/s42439-020-00029-8> (Accessed on 4/7/2022)
- Fukuda-Parr S. (2016) From the Millennium Development Goals to the Sustainable Development Goals: shifts in purpose, concept, and politics of global goal setting for development. *Gender & Development* VOL. 24, NO. 1, 43–52. Routledge, Taylor and Francis Group, Available at <http://dx.doi.org/10.1080/13552074.2016.1145895> (Accessed on 29/6/2021)
- Fukuda-Parr S, Yamin AE and Greenstein J. (2014) The power of numbers: a critical review of millennium development goal targets for human development and human rights. *Journal of*

- Human Development and Capabilities Vol. 15, Nos. 2–3, Routledge, Taylor, and Francis, pp. 105–117. Available at <https://doi.org/10.1080/19452829.2013.864622> (Accessed on 30/5/2022)
- Gage A and Bauhoff S. (2021) The effects of performance-based financing on neonatal health outcomes in Burundi, Lesotho, Senegal, Zambia, and Zimbabwe. *Health policy and planning*. Oxford University Press, pp. 1-9 Available on <https://doi.org/10.1093/heapol/czaa191>, Accessed on 06/07/2022).
- Gautier L, De Allegri M and Ridde V. (2019) How is the discourse of performance-based financing shaped at the global level? A poststructural analysis. *Globalization and health* vol 15:6, pp 1-21. BioMedical Central journal, Available at <https://doi.org/10.1186/s12992-018-0443-9> (Accessed on 18/6/2021).
- Gimbel S, Chilundo B, Kenworthy N, et al. (2018) Donor data vacuuming Audit culture and the use of data in global health partnerships. *Global Health. Medicine Anthropology Theory* 5 (2): 79–99; Available at <https://doi.org/10.17157/mat.5.2.537>. (Accessed 7/4/2020).
- Gofen A and Lotta G. (2021) Street-Level Bureaucrats at the Forefront of Pandemic Response: A Comparative Perspective. *Journal of Comparative Policy Analysis: Research and Practice* Vol. 23, No. 1, pp.3–15. Routledge, Taylor, and Francis, Available at <https://doi.org/10.1080/13876988.2020.1861421> (Accessed on 27/7/2021).
- Gore R and Parker R. (2019) Analysing power and politics in health policies and systems. Taylor & Francis. Vol 14:4, pp 481-488, Available at <https://doi.org/10.1080/17441692.2019.1575446> (Accessed on 29/4/2020).
- Görgens M and Kusek JZ. (2010) *Making monitoring and evaluation systems work: A capacity development tool kit*: Washington DC: The World Bank.
- GoZ(a). (2015) National Monitoring and Evaluation Policy. HARARE. Available at <http://zdrh.ac.zw/xmlui/handle/123456789/1595>, (Accessed on 16/5/2018)
- GoZ(b). Government of Zimbabwe (2016) National Health Strategy for Zimbabwe,2016-2020. Harare: Available at worldbank.org/curated/en/364731563173429622/pdf/The-National-Health-Strategy-Equity-and-Quality-in-Health-Leaving-No-One-Behind-for-Zimbabwe-2016-2020.pdf Accessed on 6/7/2020).
- Grane DM. (2013) "*Indicatorism*": *The context, politics, and effects of monitoring and evaluation in the Kenya Education Sector Support Program*: Ph.D. Thesis, The University of Iowa. Available at <https://iro.uiowa.edu/esploro/outputs/9983777022702771>, (Accessed 12/8/2022)
- Gray J. (2020) 19. The data epic: Visualization practices for narrating life and death at a distance. *Data Visualization in Society*: 313. In Engebretsen, M. and H. Kennedy (eds.), *Data Visualization in Society*. Amsterdam: Amsterdam University Press. Available on <https://library.oapen.org/bitstream/id/da811a79-99fd-4ad7-b52e-45076a32beb4/9789048543137.pdf> (Accessed 27/7/2021). pp 314-328.
- Gray N. (2016) The role of boundary organizations in co-management: examining the politics of knowledge integration in a marine protected area in Belize. *International Journal of the Commons*. Vol. 10, no 2 2016, pp. 1013–1034. Uopen Journals, Available at <http://www.thecommonsjournal.org> (Accessed 27/7/2021).
- Grimsrud A, Barnabas RV, Ehrenkranz P, et al. (2017) Evidence for scale-up: the differentiated care research agenda. *Journal of the International AIDS Society* 2017, 20(Suppl 4):22024. Available at <http://dx.doi.org/10.7448/IAS.20.5.22024> (Accessed on 24/9/2021). pp 1-6.
- Grimsrud A, Bygrave H, Doherty M, et al. (2016) Reimagining HIV service delivery: the role of differentiated care from prevention to suppression. *Journal of the International AIDS Society* 19. Available at DOI: 10.7448/IAS.19.1.21484, (Accessed on 27/6/2020).
- Guest G, MacQueen KM, and Namey EE. (2011) *Applied thematic analysis*, London: Sage.
- Haque MS. (2020) A critique of the role of NGOs as partners in governance. *Asia Pacific Journal of Public Administration* 42:1 pp.17-32. Routledge, Taylor, and Francis, Available at <https://doi.org/10.1080/23276665.2020.1748960> (Accessed 30/6/2020).

- Hastings AJJoSP. (1998) Connecting linguistic structures and social practices: a discursive approach to social policy analysis. Vol 27:2. pp. 191-211. Available at <https://journals.cambridge.org/abstract/S0047279498005248>, (Accessed on 29/5/2022).
- Herrick C. (2018) The Power and Precarity of Global Health Partnerships. *Power. Science, Medicine, and Anthropology*: Available at <http://somatosphere.net/2018/06/power-and-precarity.html>, (Accessed on 31/3/2020).
- Herrick C and Brooks A. (2018) The binds of global health partnership: Working out working together in Sierra Leone. *Medical anthropology quarterly* Vol. 32, Issue 4, pp. 520–538, Available at DOI: 10.1111/maq.12462 (Accessed on 4/4/2020).
- Hill RL. (2020) What is at stake in data visualization? A feminist critique of the rhetorical power of data visualizations in the media. In Engebretsen, M. and H. Kennedy (eds.), *Data Visualization in Society*. Amsterdam: Amsterdam University Press. Available on <https://library.oapen.org/bitstream/id/da811a79-99fd-4ad7-b52e-45076a32beb4/9789048543137.pdf> (Accessed 27/7/2021), pp.391-405.
- Howlett M and Migone A. (2013) Policy advice through the market: The role of external consultants in contemporary policy advisory systems. Vol 32: 241-254. Elsevier, Available at <http://dx.doi.org/10.1016/j.polsoc.2013.07.005>, (Accessed on 23/6/2022).
- Huckin T. (1997) Critical discourse analysis. In Miller, Tom, (Ed.) *Functional Approaches to Written Text: Classroom Applications*. Washington, D.C: Available at <https://www.jstor.org/stable/23264919> (Accessed on 6/7/2021). pp 87-92
- Huckin T. (2002) Critical discourse analysis and the discourse of condescension. pp.155: 176. In E. Barton and G. Stygall (eds). *Discourse Studies in Composition*. Cresskill, New Jersey, USA, Hampton Press.
- Jablonka E and Bergsten CJESiM. (2021) Numbers don't speak for themselves: strategies of using numbers in public policy discourse. *Educational Studies in Mathematics*,108: pp. 579-596. Springer, Available at <https://doi.org/10.1007/s10649-021-10059-8> (Accessed on 24/2/2022).
- Jacob R. (2020) Visualising Global Pandemic: A Content Analysis of Infographics on Covid–19. *Journal of Content, Community & Communication* Vol. 11 Year 6, June - 2020: pp.116-123. Available at DOI: 10.31620/JCCC.06.20/09 (Accessed on 11/6/2021).
- Jain S and Zorzi N. (2017) Investing for impact: the Global Fund approach to measurement of AIDS response. *AIDS and Behavior* Vol 21, pp. 91-100. Springer, Available at DOI 10.1007/s10461-016-1620-6 (Accessed 3/4/2020).
- Jones A . (2016) Envisioning a global health partnership movement. BioMed Central, pp 1-3. Available at DOI 10.1186/s12992-015-0138-4 (Accessed on 1/11/2020).
- Kanyamuna V, Phiri M, Kanenga H, et al. (2020) Role of Actors Outside Government in Strengthening the Country Monitoring and Evaluation System in Zambia. *Journal of Humanities and Social Sciences World* 6: pp. 22-29. Available at DOI: 10.12691/wjssh-6-1-4, (Accessed on 28/6/2020).
- Kanyenze G and Kondo T. (2011) *Beyond the Enclave: Towards a Pro-Poor and Inclusive Development Strategy for Zimbabwe*. Harare, Weaver Press.
- Kelemen M and Rumens N. (2019) Re-asserting paradigm plurality: pragmatism and co-production in management and organisation studies. *Studi di Sociologia* 2019:1. Available at https://doi.org/10.26350/000309_000053 ,(Accessed 8/6/2020).
- Kelly E, Doyle V, Weakliam D, et al. (2015) A rapid evidence review on the effectiveness of institutional health partnerships. 11:48. pp. 1-10. BioMed Central, Available at DOI 10.1186/s12992-015-0133-9, (Accessed on 6/7/2021).
- Kenworth N and Crane J. (2018) Critical perspectives on US global health partnerships in Africa and beyond. *Medical Anthropology Theory* 5 (2): i–ix;. Available at <https://doi.org/10.17157/mat.3.1.168> (Accessed on 28/7/2021).

- Khan A, Rahman G and Iqbal S. (2020) A Critical Discourse Analysis of Discursive Reproduction of Ideologies in Pakistani and Indian Press Media in the Aftermath of Pulwama Attack. Vol. V, No. III, pp. 146 – 155, Available at [http://dx.doi.org/10.31703/gssr.2020\(V-III\).16](http://dx.doi.org/10.31703/gssr.2020(V-III).16) (Accessed on 20/1/2022).
- Khan MS, Meghani A, Liverani M, et al. (2018) How do external donors influence national health policy processes? Experiences of domestic policy actors in Cambodia and Pakistan. *Health policy and planning* 33(2018): pp.215-223. Available at doi: 10.1093/heapol/czx145 (Accessible on 20/5/2022).
- Kimaro JR and Fourie DJ. (2017) A roadmap, similarities, and lessons learnt from national monitoring and evaluation systems in Africa. *Administratio Publica* | Vol 25 No 4 December 2017. Available at <http://hdl.handle.net/2263/66285>, (Accessed 5/3/2020). pp. 193-211.
- Kislov R, Hyde P and McDonald R. (2017) New game, old rules? Mechanisms and consequences of legitimation in boundary spanning activities. *Organization Studies* Vol. 38(10) 1421–1444. Sage ,Available at DOI: 10.1177/0170840616679455 (Accessed 18/6/2021).
- Klecun E. (2016) Transforming healthcare: policy discourses of IT and patient-centred care. Volume 25, 2016 - Issue. pp. 64-76. Taylor and Francis, Available at <https://doi.org/10.1057/ejis.2014.40>, Accessed on 19/5/2021.
- Knack S, Parks BC, Harutyunyan A, et al. (2020) How Does the World Bank Influence the Development Policy Priorities of Low-Income and Lower-Middle Income Countries?: Policy Research Working Paper 9225. The World Bank. Available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3589886 , Accessed on (20/7/2021)
- Koplan JP, Bond TC, Merson MH, et al. (2009) Towards a common definition of global health. *The Lancet* 373: pp.1993-1995. Available at DOI:10.1016/S0140 (Accessed on 1/5/2021).
- Koppenjan J, Karré PM and Termeer K. (2019) New Governance Arrangements. Towards Hybrid and Smarter Government? In Koppenjan J, Philip Marcel Karré and Katrien Termeer (eds.) *SMART HYBRIDITY, Potentials and Challenges of New Governance Arrangements*: Netherlands, Eleven International Publishing.
- Kumar. (2019) *Research methodology: A step-by-step guide for beginners*: London: Sage Publications Limited.
- Kumar R. (2011) *Research Methodology: A Step by Step guide for beginners*. London:Sage Publications.
- Kwok H, Singh P and Heimans S. (2021) The regime of ‘post-truth’: COVID-19 and the politics of knowledge. *Discourse: Studies in the Cultural Politics of Education*: pp.1-15. Routledge, Taylor and Francis Group, Available at <https://doi.org/10.1080/01596306.2021.1965544> (Accessed 9/8/2022).
- Larson BA, Pascoe SJ, Huber A, et al. (2020) Will differentiated care for stable HIV patients reduce healthcare systems costs? *Journal of the International AIDS Society* 23: e25541. Accessible at <https://doi.org/10.1002/jia2.25541>, (Accessed on 28/7/2021).
- Larsson O. (2018) Advancing post-structural institutionalism: discourses, subjects, power asymmetries, and institutional change. 30: UK, Taylor & Francis Group, pp.325-346. Available at <https://doi.org/10.1080/08913811.2018.1567982> (Accessed on 30/7/2022).
- Larsson O. (2019) The Governmentality of Network Governance: Collaboration as a New Facet of the Liberal Art of Governing. *Constellations* 27: Early view. Wiley, Available at <https://doi.org/10.1111/1467-8675.12447> (Accessed on 30/5/2022)
- Larsson OL. (2013) Sovereign power beyond the state: a critical reappraisal of governance by networks. 7: 99-114. UK: Routledge, Taylor & Francis Group Available at <http://dx.doi.org/10.1080/19460171.2013.784624> (Accessed on 30/7/2021).
- LeBan K. (2011) How social capital in community systems strengthens health systems: people, structures, processes. *USAID, CORE Group, MCHIP*.

- Lehmann U and Gilson L. (2013) Actor interfaces and practices of power in a community health worker programme: a South African study of unintended policy outcomes. *Health policy and planning* 28: pp.358-366. Oxford University Press, Available at doi:10.1093/heapol/czs066 (Accessed 7/11/2019).
- Li TM. (2007) *The will to improve: Governmentality, development, and the practice of politics*: Duke University Press. Available at <http://www.jstor.com/stable/23820894> (Accessed 29/12/2021).
- Lilja M and Baaz MJJoPP. (2022) New forms of power in a neoliberal era: 'artepolitics' or the 'governing through non-governing'. *Journal of Political Power*, 15:2, 189-201, Routledge, Taylor, and Francis Group, Available at <https://doi.org/10.1080/2158379X.2022.2055278> (Accessed 30/7/2022).
- Lima V. (2021) Collaborative Governance for Sustainable Development. In: Peace, Justice and Strong Institutions. Encyclopaedia of the UN Sustainable Development Goals. Springer. Available at DOI: 10.1007/978-3-319-71066-2_2-1, (Accessed on 13/6/2021).
- Lipsky M. (2010) *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*, New York: Russell Sage Foundation.
- Liwanag HJ and Rhule EJBGH. (2021) Dialogical reflexivity towards collective action to transform global health. 6: e006825. *British Medical Journal*, Available at doi:10.1136/bmjgh-2021-006825 (Accessed on 4/7/2022)
- Lopez-Acevedo G and Krause P. (2012) *Building better policies: The nuts and bolts of monitoring and evaluation systems*: Washington DC: The World Bank.
- Lundkvist A, El-Khatib Z, Kalra N, et al. (2021) Policy-makers' views on translating burden of disease estimates in health policies: bridging the gap through data visualization. *Archives of Public Health* (2021) 79:17 pp. 1-11. BioMedical Central, Available at <https://doi.org/10.1186/s13690-021-00537-z> (Accessed 11/6/2021).
- Mackay K. (2007) *How to build M&E systems to support better government*: Washington DC: The World Bank.
- Mackay K. (2008) Helping countries build government monitoring and evaluation systems: World Bank Contribution to Evidence-based Policy Making. *The role of monitoring and evaluation in Evidence-based policy making* . Washington DC: The World Bank
- Makadzange PF. (2020) The study of institutionalisation of a national monitoring and evaluation system in Zimbabwe and Botswana. Ph.D. Thesis: Stellenbosch University. Accessible at <https://scholar.sun.ac.za/handle/10019.1/109097>, (Accessed on 6/7/2021).
- Makuwira J. (2018) Power and development in practice: NGOs and the development agenda setting. *Development in Practice* VOL. 28, NO. 3, 422–431. Available at <https://doi.org/10.1080/09614524.2018.1433816> (Accessed on 16/6/2023).
- Mapitsa CB, Tirivanhu P and Pophiwa N. (2019) *Evaluation Landscape in Africa Context, Methods and Capacity*: Johannesburg, Africa Sun Media
- Mararike M. (2019) *Zimbabwe Will Never be a Colony Again!: Sanctions and Anti-Imperialist Struggles in Zimbabwe*: Langaa RPCIG. Available at <https://doi.org/10.2307/j.ctvmd84jt>
- March JG and Olsen JP. (2004) The logic of appropriateness. *The Oxford handbook of political science*. Available at DOI: 10.1093/oxfordhb/9780199548453.003.0034
- Mendonça PMEd, Medeiros AKd and Araújo ETd. (2019) Models for government-nonprofits partnerships: a comparative analysis of policies for AIDS, social assistance and culture in Brazil. *Revista de Administração Pública* 53: pp. 802-820. Available at <http://dx.doi.org/10.1590/0034-761220180049x>, Accessed on 9/4/2021).
- Mercer T, Gardner A, Andama B, et al. (2018) Leveraging the power of partnerships: spreading the vision for a population health care delivery model in western Kenya. 14: 1-11. BioMedical Central, Available at <https://doi.org/10.1186/s12992-018-0366-5>, (Accessed on 3/6/2021).
- MoHCC. (2018) Zimbabwe Health Sector Performance, Monitoring, and Evaluation Policy Guidelines and Strategy. Harare. Ministry of Health and Child Care.

- Mounier-Jack S, Rudge JW, Phetsouvanh R, et al. (2010) Critical interactions between Global Fund-supported programmes and health systems: a case study in Lao People's Democratic Republic. *Health policy and planning* Vol 25: pp.i37-i42. Available at https://academic.oup.com/heapol/article/25/suppl_1/i37/626498 by University of California, San Francisco (Accessed 16/6/2021).
- Mueller-Hirth N. (2012) If you don't count, you don't count: Monitoring and evaluation in South African NGOs. *Development and Change* Vol 43: pp.649-670. Oxford, UK: Blackwell Publishing Available at DOI: 10.1111/j.1467-7660.2012.01776.x (Accessed on 25/9/2020)
- Mulderrig JJCS. (2011) The grammar of governance. Vol 8: pp.45-68. Available at DOI: 10.1080/17405904.2011.533570 (Accessed on 18/2/2022)
- Musemwa M. (2011) Zimbabwe's war veterans: from demobilisation to re-mobilisation. *Transformation: Critical Perspectives on Southern Africa* 75. Available at <http://muse.jhu.edu/journals/trn/summary/v075/75.musemwa.html> (Accessed on 23/7/2021)
- Nabukalu JB, Asamani JA and Nabyonga-Orem J. (2019) Monitoring Sustainable Development Goals 3: assessing the readiness of low-and middle-income countries. *International journal of health policy and management x(x)*, pp.1–12. Available at doi 10.15171/ijhpm.2019.134 (Accessed 4/4/2020).
- Nærland TU. (2020) 4. The political significance of data visualization: Four key perspectives. In Engebretsen, M. and H. Kennedy (eds.), *Data Visualization in Society*. Amsterdam: Amsterdam University Press. Available on <https://library.oapen.org/bitstream/id/da811a79-99fd-4ad7-b52e-45076a32beb4/9789048543137.pdf> (Accessed 27/7/2021),: pp.63-73.
- Nay O. (2014) International organisations and the production of hegemonic knowledge: How the World Bank and the OECD helped invent the fragile state concept. *Third World Quarterly* 35: pp.210-231. Taylor and Francis, Accessible at <https://doi.org/10.1080/01436597.2014.878128>, (Accessed on 7/5/2021).
- O'Connor S, Waite M, Duce D, et al. (2020) Data visualization in health care: The Florence effect. Wiley Online Library. Available at DOI: 10.1111/jan.14334, (Accessed on 12/6/2021).
- Oberfield ZW. (2014) *Becoming bureaucrats: Socialization at the front lines of government service*: Philadelphia, University of Pennsylvania Press.
- Okeke IN. (2018) Partnerships for now? Temporality, capacities, and the durability of outcomes from global health 'partnerships'. *Medicine Anthropology Theory* 5:2 pp.7-24. Available at <https://doi.org/10.17157/mat.5.2.535> (Accessed on 1/4/2020).
- World Health Organization (2009) *Monitoring and evaluation of health systems strengthening: An operational framework*. Geneva, Switzerland.
- Osborne SP. (2006) The New Public Governance? *Public Management Review* 8: pp.377-387. Routledge, Taylor and Francis, Available at <https://doi.org/10.1080/14719030600853022>, (Accessed on 2/9/2021).
- Osika J, Altman D, Ekblad L, et al. (2010) Zimbabwe health system assessment 2010. *Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc*. Available at https://www.hfgproject.org/wp-content/uploads/2015/02/Zimbabwe_Health_System_Assessment20101.pdf (Accessed on 12/2/2020).
- Parkhurst J. (2017) *The Politics of Evidence From evidence based policy to the good governance of evidence*.pdf. Oxford, Routledge, Taylor, and Francis.
- Patterson AS. (2018) *Africa and global health governance: domestic politics and international structures*: Baltimore, Johns Hopkins University Press.
- Peters RW. (2016) Participation Denied: The Professional Boundaries of Monitoring and Evaluation in International Development. *Human organization* 75(4): pp.315-325. Available at doi:10.17730/1938-3525-75.4.315, (Accessed 31/12/2020).

- Ramaswamy R, Kallam B, Kopic D, et al. (2016) Global health partnerships: building multi-national collaborations to achieve lasting improvements in maternal and neonatal health. 12: pp.1-8. BioMedical Central, Available at DOI 10.1186/s12992-016-0159-7, (Accessed on 2/5/2021).
- Rogers A and Gullickson A. (2018) Evaluation champions: A literature review. Vol. 14 No. 30 (2018) pp.46-63. Available at https://journals.sfu.ca/jmde/index.php/jmde_1/article/view/495, (Accessed on 8/4/2021)
- Roth W-M. (2013) Toward a post-constructivist ethics in/of teaching and learning. *Pedagogies: An International Journal* 8: 103-125. Taylor and Francis, Available at <https://doi.org/10.1080/1554480X.2013.767769>, Accessed on 2/9/2021)
- Rothman SB. (2011) Revising the soft power concept: what are the means and mechanisms of soft power? *Journal of Political Power* 4: pp.49-64. Available at <https://doi.org/10.1080/2158379X.2011.556346>, (Accessed on 20/10/2020).
- Rubin A and Babbie ER. (2016) *Empowerment series: Research methods for social work*: Cengage Learning.
- Rushton S and Williams O. (2011) *Partnerships and foundations in global health governance*: Springer. Palgrave Macmillan, UK Available on <https://link.springer.com/book/10.1057/9780230299474> (Accessed on 21/2/2021)
- Rushton S and Williams OD. (2012) Frames, Paradigms and Power: Global Health Policy-Making under Neoliberalism. *Global Society* 26: pp.147-167. Routledge, Taylor and Francis: Available at <https://doi.org/10.1080/13600826.2012.656266>, (Accessed on 25/11/2020).
- Sastry S and Dutta MJ. (2013) Global health interventions and the “common sense” of neoliberalism: A dialectical analysis of PEPFAR. *Journal of International and Intercultural Communication* 6: 21-39. Routledge, Taylor and Francis: Available at <https://doi.org/10.1080/17513057.2012.740682> (Accessed on 25/11/2020).
- Saunders R. (2020) The Politics of Resource Bargaining, Social Relations and Institutional Development in Zimbabwe Since Independence. In: Hujo K (ed) *The Politics of Domestic Resource Mobilization for Social Development*. Cham: Springer International Publishing, pp.371-403.
- Schmidt VA. (2011) Reconciling ideas and institutions through discursive institutionalism. 1: pp.76-95. Oxford: Oxford University Press, Available at DOI: 10.1093/acprof:oso/9780199736430.003.0003, (Accessed on 8/9/2021).
- Schnable A, DeMattee A, Sullivan Robinson R, et al. (2021) International Development Buzzwords: Understanding Their Use Among Donors, NGOs, and Academics. *The Journal of Development Studies* 57: 26-44. Routledge, Taylor and Francis: Available at <https://doi.org/10.1080/00220388.2020.1790532> (Accessed on 12/4/2022).
- Schulz M. (2014) Logic of consequences and logic of appropriateness. pp.1-17. Available at <http://www.palgraveconnect.com/esm/doi/10.1057/9781137294678.0377>
- Seekings J. (2020) The Effects of Colonialism on Social Protection in South Africa and Botswana. In Schmitt C: *From Colonialism to International Aid*. External Actors and Social Protection in the Global South , Palgrave Macmillan, Switzerland, pp.109-135.
- Segone M. (2008) Evidence-based policy making and the role of monitoring and evaluation within the new aid environment. *The role of monitoring and evaluation in Evidence-based policy making*: UNICEF: The Evaluation Working Papers (EWP) 16.
- Segone M. (2009) Enhancing evidence-based policy-making through country-led monitoring and evaluation systems. *Country-led monitoring and evaluation systems* UNICEF: The Evaluation Working Papers (EWP)17.
- Shaw SE. (2010) Reaching the parts that other theories and methods can't reach: How and why a policy-as-discourse approach can inform health-related policy. 14(2): pp.196-212. Sage Publishing: Available at <https://www.jstor.org/stable/26650017>, (Accessed on 30/1/2020)
- Shiffman J and Shawar YRJTL. (2022) Framing and the formation of global health priorities.

- Shore C and Wright S. (2015) Governing by numbers: audit culture, rankings, and the new world order. *Social Anthropology* 23: 22-28. Available at <https://www.jstor.org/stable/10.2307/26604897>, (accessed on 4 June 2022).
- Shukla. (2013) *Intended and unintended consequences of monitoring and evaluation in HIV programmes in India: discrepancy between pain and paper*. Ph.D Thesis, Glasgow Caledonian University. UK
- Shukla, Teedon P and Cornish F. (2016) Empty rituals? A qualitative study of users' experience of monitoring & evaluation systems in HIV interventions in western India. *Social science & medicine* :168 (2016) 7-15
- Silliman B, Crinion P, and Archibald T. (2016) Evaluation Champions: What They Do, Why They Do It, and Why It Matters to Organizations. *Journal of Human Sciences and Extension: Volume 4, Number 3, 2016* .
- Smith, G. J. (2018). Data doxa: The affective consequences of data practices. *Big Data & Society*. <https://doi.org/10.1177/2053951717751551>
- Ssempijja, V., Nason, M., Nakigozi, G., Ndyababo, A., Gray, R., Wawer, M., Chang, L. W., Gabriel, E., Quinn, T. C., Serwadda, D., & Reynolds, S. J. (2020). Adaptive Viral Load Monitoring Frequency to Facilitate Differentiated Care: A Modeling Study From Rakai, Uganda. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*, 71(4), 1017–1021. <https://doi.org/10.1093/cid/ciz880>.
- Stevens, M., Wehrens, R., & De Bont, A. (2018). Conceptualizations of Big Data and their epistemological claims in healthcare: A discourse analysis. *Big Data & Society*, 5(2), 2053951718816727.
- Storeng, K. T., & Béhague, D. P. (2014). "Playing the numbers game": evidence-based advocacy and the technocratic narrowing of the safe motherhood initiative. *Medical Anthropology Quarterly*, 28(2), 260-279.
- Storeng, K. T., Palmer, J., Daire, J., & Kloster, M. O. (2019). Behind the scenes: International NGOs' influence on reproductive health policy in Malawi and South Sudan. *Global public health*, 14(4), 555-569.
- Strand, M. (2018). From Development Aid to Development Partnerships—the End of Coloniality? Critical discourse analysis of DFID's development partnership with South Africa (Master's thesis, Faculty of Humanities).
- Suman AB. (2020) 25. Making visible politically masked risks: Inspecting unconventional data visualization of the Southeast Asian haze. *Data Visualization in Society*: 425.
- Swinkels, M. (2020). How ideas matter in public policy: a review of concepts, mechanisms, and methods. *International Review of Public Policy*, 2(2: 3), 281-316.
- Taylor, E. M., & Harper, I. (2014). The politics and anti-politics of the global fund experiment: understanding partnership and bureaucratic expansion in Uganda. *Medical Anthropology*, 33(3), 206-222.
- Tichenor M. (2020) Metrics. *Cambridge Encyclopedia of Anthropology*.
- Tichenor M and Sridhar D. (2019) Metric partnerships: global burden of disease estimates within the World Bank, the World Health Organisation, and the Institute for Health Metrics and Evaluation. *Wellcome Open Research* 4.
- Tracy S. (2013) *Qualitative Research methods: collecting evidence, crafting analysis communication impact*. Wiley Blackwell Publishers.
- Tracy S. (2019) *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*: John Wiley & Sons.
- Van Dijk TA. (2005) Critical discourse analysis. 349-371.
- Vangen, S., Hayes, J. P., & Cornforth, C. (2015). Governing cross-sector, inter-organizational collaborations. *Public Management Review*, 17(9), 1237-1260.

- Veale M and Brass I. (2019) Administration by algorithm. *Public management meets public sector machine learning*. In press K. Yeung & M. Lodge Eds. *Algorithmic regulation*. Oxford, UK: Oxford Press.
- Vernon G. (2020) Books: Reimagining Global Health: An Introduction: Is Global Health a Human Right? : British Journal of General Practice.
- Wagner C, Kawulich B and Garner M. (2012) *EBOOK: Doing social research: A global context*: McGraw Hill.
- Walker L and Gilson L. (2004) 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa. 59(2004): pp.1251-1261. Elsevier Ltd :Available at doi:10.1016/j.socscimed.2003.12.020 (Accessed on 6/7/2022)
- Weiss DJBph. (2019) Round hole, square peg: a discourse analysis of social inequalities and the political legitimization of health technology in Norway. 19: 1-15. BioMedical Central:Available at <https://doi.org/10.1186/s12889-019-8023-3>, (Accessed on 30/1/2022).
- WHO. (2010) *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*: World Health Organization. Geneva: Switzerland
- WHO. (2016) *Monitoring and evaluating digital health interventions: a practical guide to conducting research and assessment*. Geneva: Switzerland
- Wickremasinghe D, Gautham M, Umar N, et al. (2018) " It's About the Idea Hitting the Bull's Eye": How Aid Effectiveness Can Catalyse the Scale-up of Health Innovations. *International Journal of Health Policy and Management*, 2018;7(8):718–727. Available at doi:10.15171/ijhpm.2018.08 (Accessed 14/9/2022).
- Williams C and Blaiklock AJ. (2016) Human rights discourse in the sustainable development agenda avoids obligations and entitlements: Comment on " Rights language in the sustainable development agenda: has right to health discourse and norms shaped health goals?". 2016;5(6):387–390. *International Journal of Health Policy and Management*, Available at doi:10.15171/ijhpm.2016.29 ,(Accessed on 21/6/2022)
- Willis N, Napei T, Armstrong A, et al. (2018) Zvandiri—Bringing a Differentiated Service Delivery Program to Scale for Children, Adolescents, and Young People in Zimbabwe. *JAIDS Journal of Acquired Immune Deficiency Syndromes* 2018;78:S115–S123). Available at <https://journals.lww.com/jaids> by BhDMf5ePHKav1zEoum1tQfN4a+kJLhEZgbsIH04XMi0hCywCX1AWnYQp/IIQrHD3I7ttZ9b/VuL/bY2spoTx6y6fk4exxwBq7WWoYTc9PRyvV+rgzJubKg==, accessed on 24/4/2020
- Yam EA, Pulerwitz J, Almonte D, et al. (2020) Stigma among key populations living with HIV in the Dominican Republic: experiences of people of Haitian descent, MSM, and female sex workers. *LWW. Wolters Kluwer Health, Inc* , Available at <https://journals.lww.com/aidsonline> by BhDMf5ePHKav1zEoum1tQfN4a+kJLhEZgbsIH04XMi0hCywCX1AWnYQp/IIQrHD3K8lvHCABg h+sqwKq4B2bp/bBlhcu0MJ18IICF6TW/cutW1XPt+ausg== (Accessed on 28/9/2021)
- Yazdannik A, Yousefy A and Mohammadi S. (2017) Discourse analysis: A useful methodology for health-care system researches. *Journal of Education and Health Promotion* 6. *Journal of Education and Health Promotion* 2017;6:111. Wolters Kluwer, Available at DOI:10.4103/jehp_124_15
- Yin RK. (2011) *Applications of case study research*: Sage Publications, 3rd edition.
- Youde J. (2016) High Politics, Low Politics, and Global Health. *Journal of Global Security Studies* 1: pp.157-170. Available at <https://academic.oup.com/jogss/article/1/2/157/2579729> by University of California, San Francisco, (Accessed on 1/9/2021)
- Zall Kusek J and Rist R. (2004) *Ten steps to a results-based monitoring and evaluation system: a handbook for development practitioners*: Washington DC: The World Bank.
- Zarychta A, Grillos T, and Andersson KP. (2020) Public Sector Governance Reform and the Motivation of Street-Level Bureaucrats in Developing Countries. *Public administration review* Vol. 80,

- Iss. 1, pp. 75–91. The American Society for Public Administration: Available at DOI: 10.1111/puar.13132, (Accessed on 20/6/2021).
- Zeng W, Lannes L and Mutasa R. (2018) Utilization of Health Care and Burden of Out-of-Pocket Health Expenditure in Zimbabwe: Results From a National Household Survey. *Health Systems & Reform* 4. Taylor and Francis Group: Available at <https://doi.org/10.1080/23288604.2018.1513264> (Accessed on 8/4/2021).
- Zhang L, Zhao J and Dong W. (2021) Street-level bureaucrats as policy entrepreneurs: Action strategies for flexible community governance in China. *Public Administration*. Routledge, Taylor, and Francis, Available at <https://doi.org/10.1080/10967494.2019.1711474> (Accessed on 27/6/2021).
- Zimbabwe Go. (2015a) National Monitoring and Evaluation Policy. HARARE.
- Zimbabwe Go. (2015b) Zimbabwe National Monitoring and Evaluation Policy. HARARE.
- Zimbabwe Go. (2018) Zimbabwe Health Sector Performance, Monitoring and Evaluation Policy Guidelines and Strategy. In: Care MoHaC (ed). Harare.
- Zungura M. (2012) The Role Played By NGOs in Augmenting Government Efforts towards the Achievement of Millennium Development Goal of Combating HIV and AIDS in Zimbabwe. *Journal of Public Administration and Governance*, Available at DOI:10.5296/jpag.v2i4.2732,

List of Appendix

Appendix A: Provincial level Interview Questionnaire

1. Could you kindly share your experience in the Ministry's M&E system and its historical development to date?
2. Who are the major funding and technical partners for the Ministry's M&E system?
3. To what extent does the technical and financial support from GHPs align with Ministry's policy priorities, mission, vision, and goals for M&E?
4. How do the government (Ministry's) development ideology and the GFATM influence policy and practice of M&E in Zimbabwe?

M&E Discourses

1. Could you share your understanding of Results based M&E discourse and any unintended effects of such a system for policy and practice of M&E in Zimbabwe?
2. In the Ministry, what constitutes results? How do you measure and report results?
3. Could you share your understanding of evidence-based decision-making discourse and what constitutes evidence in the Ministry of Health and Child Care?
4. In your view, what is your understanding of the Strategic Information discourse and its impact on policy and practice of M&E in Zimbabwe?
5. What is your understanding of rights-based M&E discourse and its impact on policy and practice of M&E in Zimbabwe?
6. In your view, what has been the impact of global development discourses such as the MDGs and SDGs on local health M&E policy and practice in Zimbabwe?
7. What is your view and impact on framing HIV, TB, and malaria programs as global public goods, as global security, biomedical evidence, and as global emergencies?
8. What are the potential unintended impacts of GHP-supported biomedical M&E indicators and targets on local health policy and practice of M&E in Zimbabwe?
9. What are some of the unintended impacts of GHP-supported capacity-building initiatives on data analysis and visualization for M&E in Zimbabwe?
10. What has been the impact of framing GHP-supported programs on M&E indicators and targets for health initiatives in Zimbabwe?

Power Relationships in GHP-Local M&E Partner Relations

1. In your view, how do you describe your collaborative partnership for M&E with the Global Fund and other donors in Zimbabwe?
2. How are M&E priorities for the Ministry set? Who is involved in selecting key indicators and targets that you track?
3. Whom are the key partners involved in developing and reviewing the national M&E tools in Zimbabwe?
4. How have you influenced GHPs on policy and practice of M&E in Zimbabwe? What strategies do you apply to influence donors on policy and practice of M&E?
5. What strategies do you apply to manage challenging donor M&E targets or expectations?
6. How is M&E evidence utilized in the health sector policy and practice? How much do funding partners rely on Ministry M&E evidence?
7. How much do the Ministry's sovereign power influence the policy and practice of M&E in Zimbabwe?

8. What are the significant impacts of GHP-supported M&E training and capacity building for M&E in Zimbabwe?
9. What are the donors' positive changes that have contributed to the M&E system? What challenges did the donor-supported system create since you started implementing it?
10. How do GHP guidelines and funding requests influence the policy and practice of M&E in Zimbabwe?

Impact of organization's contribution to health governance systems

1. What has been the overall impact of GHP support on human resources for M&E in Zimbabwe?
2. Could you share your impression of GHPs' impacts on the Ministry's health information systems?
3. What's your view on GHP support for service delivery M&E systems at sub-national or decentralized levels?
4. What is your organization's role in the M&E of medical supplies and pharmaceutical products in the GFATM project?
5. Could you share with me the impact of your M&E programs on financial accountability for the GFATM and other donor-funded programs?
6. What leadership and governance aspects have been impacted through GHP interventions in Zimbabwe?

Impact of M&E on wider health M&E system

1. What is your overall impression about the impact of GHP funding on the broader national public health M&E system, mainly the non-partner-funded programs in Zimbabwe?

END

Appendix B Ministry of Health Head Office Interview Questionnaire

Role in organization

1. What is your view about the impact of GHPs on the Ministry's historical development of the M&E system in Zimbabwe?
2. Who are the major GHPs (funding partners) for M&E in Zimbabwe? Which aspects of the M&E system do they assist?
3. How does the Ministry align its national health goals, mission, and vision with partner ideologies and global health goals? What is the impact of ideology on M&E policy and practice in Zimbabwe?

M&E Discourses

1. What is your view regarding implementing GHP commitments to promote country ownership, harmonization, alignment, managing for results, and mutual accountability for M&E systems in Zimbabwe?
2. What impacts do you attribute to Results based M&E in Zimbabwe? Could you share any unintended effects of Results Based M&E in the Ministry's M&E system?
3. Could you share with me your understanding of evidence-based decision-making? What would you want to be done differently to improve the utilization of M&E evidence for policy and practice in Zimbabwe?
4. Could you kindly share your experience using the Logical Framework Analysis as an M&E tool in your work? What are some of the challenges you faced using the Logical Framework Matrics(LFM)?
5. In your view, what are the implications of characterizing M&E as Strategic information? What is the implication of this terminology on policy and practice for M&E in Zimbabwe?
6. What are some unintended impacts of rights-based approaches to M&E policy and practice in Zimbabwe?
7. What is the impact of framing key program approaches on M&E policy and practice in Zimbabwe?
8. How do framing HIV, TB, and malaria programs as **global public goods, global security**, evidence-based medicine, biomedicalism, and global emergencies impact the policy and practice of M&E in Zimbabwe?
9. How does GHPs' emphasis on concepts like 'value for money, transparency, and accountability impact M&E policy and practice in Zimbabwe?
10. What are some unintended impacts of global development (health) programs such as the MDGs and SDGs for M&E policy and practice in Zimbabwe?
11. What have been some of the intended and unintended impacts of GHP support on skills development in data analysis and reporting areas?

Power Relationships in GHP-Local M&E Partner Relations

1. In your view, how do you describe your collaborative partnership for M&E with your donors?
2. What are the Ministry's and its partners' roles in setting national M&E priorities in Zimbabwe? How does each party influence the M&E agenda on indicators and targets?

3. How do the Ministry and its partners do rationalizes their powers in deciding national M&E priorities and targets?
4. What are the positive and unintended impacts of using M&E Champions in the Ministry (Staff supported in the Ministry)?
5. What is the role of the Zimbabwe Evaluation Association in shaping the policy and practice of M&E in Zimbabwe?
6. What strategies do the parties in the collaborative partnerships for M&E to manage its expectations?
7. Could you share some challenges associated with applying evidence in policy and practice for M&E in Zimbabwe? What would you want to be done differently?
8. How does the Ministry rationalize its sovereign power to influence the policy and practice of M&E in Zimbabwe?
9. What are some of the impacts of framing key health programs and indicators on M&E policy and practice in Zimbabwe?
10. What are some of the unintended impacts of funding partner guidelines and templates on policy and practice for M&E in Zimbabwe?
11. What have been some of the unintended impacts of GHP support on capacity building and skills development for M&E in Zimbabwe?

Impact of organization's contribution to health governance systems

12. How has GHP support for M&E human resources impacted M&E policy and practice for M&E in Zimbabwe?
13. What do you consider to be the significant contributions of GHPs to Zimbabwe's **health information systems**? What would you wish to be done differently?
14. What is the impact of decentralized service delivery on policy and practice for M&E in Zimbabwe?
15. How do you describe the impact of GHPs on the **M&E of medical supplies** and pharmaceutical products in the GFATM project?
16. How do GHPs' financial support and management systems impact on policy and practice of M&E in Zimbabwe?
17. What is your view on the impact of GHPs on leadership and governance in Zimbabwe? How does it impact on policy and practice of M&E in Zimbabwe?

Impact of M&E on wider health M&E system

1. What is your overall impression about the impact of funding partner support on non-donor-funded programs for the Ministry of Health and Child Care?

END

Appendix D: UKZN Ethics Clearance



27 June 2021

Mr Zacharia Grand (218087400)
School Of Man Info Tech & Gov
Westville Campus

Dear Mr Grand,

Protocol reference number: HSREC/00002455/2021
Project title: Exploring the effects of collaborative Global Health Partnerships on Local health Monitoring and Evaluation systems in Zimbabwe
Degree: PhD

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 08 February 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** with the following condition:

- Data can only be collected from those research sites where gatekeeper permission was granted.

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 27 June 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,



Professor Dipane Hlalele (Chair)

/dd

Humanities and Social Sciences Research Ethics Committee

Postal Address: Private Bag X54001, Durban, 4000, South Africa

Telephone: +27 (0)31 260 8350/4557/5587 Email: hssrec@ukzn.ac.za Website: <http://research.ukzn.ac.za/Research-Ethics>

Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

INSPIRING GREATNESS

Appendix E: Medical Research Council of Zimbabwe Ethics Clearance letter

Telephone: 791193/08644073772
E-mail: mrcz@mrcz.org.zw
Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe
Josiah Tongogara / Mazowe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

REF: MRCZ/A/2771

27 September, 2021

Zachariah Grand
4 Tatonga Road
Morningside
Mutare

RE: - Exploring the effects of collaborative Global Health Partnerships on Local health Monitoring and Evaluation systems in Zimbabwe Version 1.0 dated 16 March, 2021

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

1. Completed MRCZ 101 Application Form
2. Protocol Version 1.0 dated 16 March, 2021
3. English Informed Consent Form Version 2 dated 24 August, 2021
4. Senior Management Interview Guide version 1 dated 26 August, 2021
5. Middle Management Interview Guide Version 1 dated 26 August, 2021
6. FACT Questionnaire Version 1 dated 12 July, 2021
7. CCM Key Informant Interview version 1 dated 06 July, 2021

- **APPROVAL NUMBER** : MRCZ/A/2771
- This number should be used on all correspondence, consent forms and documents as appropriate.
- **TYPE OF MEETING** : Full Board
- **MEETING DATE** : 26 August, 2021
- **EFFECTIVE APPROVAL DATE** : 27 September, 2021
- **EXPIRATION DATE** : 26 September, 2022

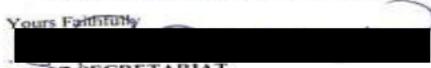
After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

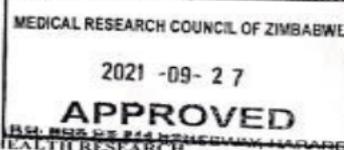
Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.
- In addition to this approval, all clinical trials involving drugs, devices and biologics (including other studies focusing on registered drugs) require approval of Medicines Control Authority of Zimbabwe (MCAZ) before commencement.

Yours Faithfully


MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH



MEDICAL RESEARCH COUNCIL OF ZIMBABWE

Page 1 [of 4]

MRCZ No.

INFORMED CONSENT FORM



PROJECT TITLE: Exploring the effects of collaborative Global Health Partnerships on Local health Monitoring and Evaluation systems in Zimbabwe

Principal Investigator: Zacharia Grand

Phone number(s): +263772714407 or +27710054047

ADD THE FOLLOWING PARAGRAPH TO ALL CONSENT FORMS

MORE THAN TWO (2) PAGES LONG (BEFORE ADDITION OF OTHER PARAGRAPHS)

What you should know about this research study:

- We give you this consent so that you may read about the purpose, risks, and benefits of this research study.
- You have the right to refuse to take part, or agree to take part now and change your mind later.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your participation is voluntary.

PURPOSE

You are being asked to participate in a research study of **“Exploring the effects of Global Health Partnerships on local health Monitoring and Evaluation systems in Zimbabwe”**. The purpose of the study is to **add scholarly knowledge on the power relations between GHPs and local health M&E partners and the impacts of this interaction on the policy and practice of M&E in Zimbabwe. The study focuses on the application of ‘soft ‘power strategies for influencing policy and practice of M&E which include the creation and deployment of knowledge.**

. You were selected as a possible participant in this study **because you are one of the key M&E specialist staff for the Global Fund program out of the targeted 27 participants for this study in Zimbabwe.]**

Page 2 [of 4]

MRCZ No.

PROCEDURES AND DURATION

If you decide to participate, the interview will take between 45 to 60 Min of your time.

RISKS AND DISCOMFORTS

The study acknowledges that any research has potential unforeseen psychological or work-related risks but all measures will be taken to ensure that individual responses are not linked to respondents. All respondents and their organizational identities will be coded to avoid potential identification of participants. **The researcher has put in place a data protection plan to ensure that all collected data is de-linked from respondents through use of anonymized codes and all data is kept in an Nvivo secured data base for the research project.**

BENEFITS AND/OR COMPENSATION

We cannot and do not guarantee or promise that you will receive any benefits from this study. However, the research team promises to reimbursement or refund of the actual expenses incurred during the interview particularly those linked to internet data for conducting the virtual interviews. The participants will receive at least USD10 for the internet data for the virtual interviews. Respondents are also free not to answer any questions they consider sensitive and free to stop the interview at any point.

CONFIDENTIALITY

If you indicate your willingness to participate in this study by signing this document, any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission. The information will only be accessible to the Principal Investigator and the Co-Principal Investigators for academic research purposes.

ADDITIONAL COSTS

Additional costs borne by the study include data for virtual meetings for 1 hour.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Medical Research Council of Zimbabwe (MRCZ) on telephone (0242)791792 or (0242) 791193 and cell phone lines 0784 956 128. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

Audio, Video Recording and Photography

Statement of Consent to be photographed, audiotaped or videotaped.

I understand that photographs / audio recordings / video recordings will be taken during the study. *(For each statement, please choose YES or NO by inserting your initials in the relevant box)*

- I agree to **being audio recorded** Yes

No

- I agree to having my **video recorded** Yes

No

- *I agree to have photographs taken* Yes

No

[delete the options that are not appropriate for this study]

Name of Participant (please print)	Signature	Date
Name of Witness(Please Print)	Signature	Date

Appendix G: Academic Editors letter

TO WHOM IT MAY CONCERN

5 [October](#), 2022

Kindly note that I have edited the text of a dissertation by Zacharia Grand titled “Exploring the effects of Collaborative Global Health Partnerships in the Ministry of Health and Childcare’s Monitoring and Evaluation systems in Zimbabwe”.

I am Professor Alan Brimer, DLitt (UPE), Professor Emeritus of UKZN.

Yours faithfully,
Alan Brimer

A black rectangular redaction box covers the signature of Alan Brimer. The box is positioned to the right of the typed name 'Alan Brimer'.