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Global health monitoring and evaluation partnerships as contested spaces in Zimbabwe

Authors:
Zacharia Grand[1]
Sybert Mutereko[1]

Affiliations:
[1]Department of Public Governance, School of Management Information Technology and Governance, University of KwaZulu-Natal, Durban, South Africa

Corresponding author:
Zacharia Grand,
zachariagrand@gmail.com

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Background: Global health partnerships (GHPs) have flourished across Africa as alternative governance mechanisms seeking to strengthen local health systems for effective national planning, implementation, monitoring, and evaluation. Mutual and trust-based relationships anticipate fostering relations that build weak systems for improved availability of data and information for local informed decision-making and programme learning.

Objectives: This article aims to explore and demonstrate how global health monitoring and evaluation partnerships (GHM&EPs) are contested spaces contrary to the pervasive collaborative discourse in official government policies.

Method: Data for this study were collected using content analysis of existing documents and key informant interviews for a qualitative case study. Furthermore, monitoring and evaluation (M&E) policy documents and key informant interviews with the M&E staff from the Ministry of Health and Child Care, Zimbabwe, were purposively selected. Ethics clearance was sought from the University of KwaZulu-Natal, HSREC/00002455/2021.

Results: The results show that GHM&EPs are contested spaces despite the expectation to foster mutual trust and improved availability of quality data and information for informed decision-making and learning. Evidence shows partner contests through unspectacular soft power strategies to counterbalance resource and power imbalances in partnerships.

Conclusion: The evidence of unspectacular soft power strategies suggests that collaboration for M&E conceals and prolongs opportunities for addressing practical and contested challenges, hence failing the test for ideal partnerships.

Contribution: The article contributes to a critical understanding of the limitations of the current theorisation of partnerships, which erroneously assumes trust, mutuality, and equality between resourced and under-resourced partners.

Keywords: global health partnerships; monitoring and evaluation; governance; collaboration; informed decision-making; discourse; evidence; mutual, trust; policies.

Introduction

Health partnerships constitute a potentially efficient and effective governance system to strengthen weak local M&E systems to successfully implement national development policies, programmes and projects, and ensure efficient and effective service delivery. Chapter Two, Section 9(1) of the Zimbabwean Constitution, mandates partnerships that facilitate systematic, coordinated, simplified, results-oriented, reliable, and effective policy processes through extensive research and external collaborative and consultative processes (Government of Zimbabwe, Office of the President and Cabinet), National Monitoring and Evaluation Policy (2015:2). According to New Public Governance (NPG) theory, partnership-based consultation processes enable interdependent stakeholders to participate in multiple policymaking and public service delivery processes (Osborne 2006). The NPG theory assumes effective service delivery and outcomes because of relational trust, mutual interests, and social capital, forming the basis of global health monitoring and evaluation partnerships (GHM&EPs) as inter-organisational governance mechanisms.

In the partnership process, mutually collaborative and trust-based collaboration for monitoring and evaluation (M&E) should foster alignment with local and global partnership principles that respect country ownership, harmonisation, and the alignment of external partner plans with national policy frameworks for development outcomes (Görgens & Kusek 2010; Lopez-Acevedo & Krause 2012; Wickremasinghe et al.). The neoliberal and market-driven approaches of global health partnerships

(GHPs), coupled with limited local resistance, have transformed partnerships for M&E into contentious spaces that contradict the principles of trust and mutuality. Ineffective M&E systems hinder evidence-based decision-making and programme learning. In Zimbabwe, the disputed electoral processes and inconsistent economic policies and sanctions since 2001 have led to weak, uncoordinated, donor-dependent, disruptive, and exclusionary public health M&E systems (Osika et al. 2010:7–9). These systems fail to generate, analyse, and report timely integrated national health information (Armstrong et al. 2019; D'Aquino et al. 2019; Jain & Zorzi 2017; Osika et al. 2010; Saunders 2020; Zeng et al. 2018; Zungura 2012).

Scholarly interest in partnerships for M&E at the local health system level in developing countries has grown, shedding light on the persistent challenges externally resourced and under-resourced local partners face. Nabukalu et al. (2019) reviewed health sector M&E challenges related to tracking Sustainable Development Goal (SDG) 3 on health and well-being in six countries. They identified weak institutional capacity, the fragmentation of M&E functions, inadequate domestic financing, insufficient data availability, weak dissemination, and the unsatisfactory utilisation of M&E outputs as some of the factors negatively impact the system. Similarly, Kanyamuna et al. (2020) conducted a study on the involvement of non-governmental actors in enhancing the M&E system in Zambia. Their findings align with previous research by Kimaro and Fourie (2017:206–207) highlighting the limited flexibility of donor support, which often prioritises externally driven interests.

However, the descriptive and prescriptive pragmatic-instrumental discourses that influence these studies erroneously assume partnerships as undisputed good governance mechanisms, thereby concealing the contestations in collaborative partnerships. Surprisingly, the current studies have not critically analysed contestations in the partnerships manifesting through the unspectacular display of soft power strategies contrary to the ideals of mutuality and trust. Consequently, little is known about the partnership contestations that disrupt local M&E systems failing to generate quality data and information for informed local decision-making and learning.

Following this introduction, the article begins with a brief description of the context and background of GHPs, drawing from (Osborne 2006) NPG theory and the Foucauldian Critical Discourse Analysis (CDA) as the conceptual frameworks. Next, the research methodology, data analysis procedures, ethical considerations, and study limitations are outlined. Subsequently, the results, discussions, and conclusions are presented sequentially.

Context, background, and concepts

A GHP is a governance arrangement involving non-state actors, emphasising the desire to achieve shared goals in specific areas of global health (Buse & Walt 2000). This arrangement includes global public-private partnerships (GPPPs). The definition of cooperation in this context specifically focusses on the collaborative interactions between actors, emphasising the scope of their engagement and the key factors that shape their relationship dynamics. Carlson (2004:5) defines GHPs as a collaborative relationship among multiple organisations sharing risks and benefits to achieve shared goals. Unlike Buse and Walt, Carlson's focus shifts towards the goals and formal structures rather than emphasising the actors involved. The emphasis is placed more on formal collaborative initiatives, encompassing a broader range of partnerships beyond just public-private partnerships (PPPs), although the latter still represent the majority of cases studied. For Buse and Harmer (2007:259), the focus is on 'relatively institutionalised initiatives, established to address 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 crucial in this perspective.

In the 2000s, new collaborative partners emerged to join the growing paradigm of NPG globally. These hybrid and networked organisations were initiatives of the United Nations (UN), Western governments, global corporations, and private foundations such as the Bill and Melinda Gates Foundation (BMGF). In Zimbabwe, these hybrid governance partners include the Global Fund to Fight AIDS, Tuberculosis (TB), and Malaria (GFATM 2001) and the Global Alliance for Vaccines and Immunization (GAVI 2000). In 2006, the American government President's Emergency Plan for AIDS Relief (PEPFAR) joined the partnership in Zimbabwe, providing similar bilateral support for HIV, TB, and Malaria. At the global level, PEPFAR was already an integral partner for GFATM and GAVI. The comparative advantage of these GHPs is that they can mobilise funding and technical support from Western governments and private companies, resulting in increased funding for the selected public health programmes. Hybrid GHPs emerged as the predominant global governance framework during the last decade of the millennium (Buse & Harmer 2007).

Despite the widespread proliferation of GHPs in Zimbabwe, the vision of establishing a partnership for M&E that can deliver high-quality data and information for informed decision-making and programme learning remains elusive (Armstrong et al. 2019; D'Aquino et al. 2019; Jain & Zorzi 2017; Osika et al. 2010; Saunders 2020; Zeng et al. 2018; Zungura 2012).

Conceptualising global health partnerships and monitoring and evaluation systems

The study employed the NPG theory to elucidate the practical implications of unequal partnerships between the resourced GHPs and the under-resourced Ministry of Health and Child Care in Zimbabwe. This article draws on four governance models, namely the Collaborative Governance Model (Ansell & Gash 2008), the Integrated Framework for

Collaborative Governance (Emerson, Nabatchi & Balogh 2012), the Collaborative Governance (Vangen, Hayes & Cornforth 2015), and the Government-Non-Profit Partnership Model (Brinkerhoff 2002). The collaborative and partnership conceptual frameworks help to illustrate the ideal partnership and its practical limitations in volatile governance systems such as Zimbabwe. The article also draws insights from CDA, effectively exposing the depoliticisation effects of partnership discourse and revealing the often unnoticed contestations in practice.

The Collaborative Governance framework by Ansell and Gash (2008:543) assumes that 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 model assumes a formalised forum where states participate directly and actively in consensus-oriented public policy planning and implementation decision-making processes. Similarly, according to Emerson et al. (2012:2), the integrated framework for collaborative governance applies knowledge and concepts from various fields beyond public administration, including conflict resolution and environmental management, among others, in collaborative governance. The framework also integrates collaborative public management, multi-partner governance, joined-up or network government, hybrid sectoral arrangements, co-management regimes, participatory governance, and civic engagement.

Furthermore, the Governance Collaborations by Vangen et al. (2015:1239–1240) focusses on any partner's transformative leadership role and power to initiate a shared agenda. The partner does not always have to be the government. The framework draws from the literature emphasising the governance, leadership, and management of cross-sector and inter-organisational relationships that maximise collaborative comparative advantage. Thus, the focus is on attaining goals beyond the capabilities of organisations acting alone. The post-structuralist model prioritises processes, actors, and structures to convert ideas into actions.

Likewise, the Government-Non-Profit Partnership model emphasises mutual dependence and organisational identity as key definitional dimensions (Brinkerhoff 2002:19). These factors differentiate it from other arrangements such as 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. However, the underlying shortcomings of the four models are their reliance on the erroneous assumption of mutual interests and trust in the partnership. As a result, the article further draws on the dynamism of CDA to unmask the subtle contestations in partnership practice.

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 & Thow 2021:2). Thus, the study uses the CDA to reveal the hidden meanings in collaborative governance arrangements in the interactive text (policies) and spoken words (interviews). According to Van Dijk (2005:352), discourse analysis aims to 'understand, expose, and ultimately resist social inequality'. Hence, this article draws on these strengths to reveal and expose the use of language to conceal the simmering contestations in partnership practice. The article also utilises Foucauldian discourse analysis to illustrate how power operates as a dialogic and relational force within the situated encounters of partnerships for M&E in Zimbabwe. This approach sheds light on the complex dynamics of power within these partnerships.

Research methods and design

The article is based on a qualitative research methodology, critical constructivist epistemology, and analysis of key informant interviews with Ministry of Health and Child Care M&E staff, and a document review of government M&E policy documents. The inductive qualitative research design provided an in-depth analysis of the partnership processes at the policy and practice level for a comprehensive contextual understanding of the contested terrain of GHPs. The article relies on the exploratory nature of this study to provide context-specific findings. Furthermore, it draws from the social constructivist understanding of the nature of reality – ontology, subjective and value-based knowledge creation – epistemology (Creswell 2007:16). The conversations in this article are grounded in the interpretivism paradigm, which posits that perception originates from a self-reflexive standpoint. The article highlights the significance of considering the social and historical dimensions of partnership contestations as a precursor to 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 practical questions about morality and values because of the dynamic changes in the landscape of GHPs. Contextual explanations and situated meanings of ongoing meaning-making are essential to understanding continuous change.

This study employed purposive sampling, a judgemental process of identifying Ministry of Health and Child Care M&E staff who could provide the best information to achieve the study's objectives. The technical nature of the topic under study required a deliberate and purposive selection of M&E staff as participants to elicit their views and experiences of working with key GHPs supporting the country's health system. The data collection instruments include Key Informant Interview Guides and questionnaires.

Data 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). The researcher used Otter Transcription software to convert the Zoom audio files into written text as part of data collation. Likewise, the software provided an integrated fact-checking system that allowed data cleaning by immediately comparing the oral and written data. Fact-checking was essential, in which the researcher reviewed the interview transcripts for accuracy. A qualitative data analysis NVIVO software was used to organise the transcript data into themes for further analysis. The interpretation of data was based on discourse analysis focussing on text and particular terms used in the policy documents and key informant responses. The data analysis ensured data quality control and improved data quality, credibility, and dependability for qualitative research in conformity with acceptable research findings (Kumar 2011).

Ethical considerations

The study formed part of the researcher's doctoral studies, and ethical clearance to conduct this study was obtained from the University of KwaZulu-Natal Human Research Ethics Committee (reference number: HSREC/00002455/2021).

Limitations

The study's critical constructivist and dialogical approach makes generalising the findings challenging. While the research methodology and design provide helpful context-specific insights, it remains a challenge to replicate the results, even in similar cited experiences from Africa.

Presentation of results

The upcoming section focusses on several key aspects, including the utilisation of constitutional and sovereignty power, the implementation and enforcement of government policies and guidelines, the use of a memorandum of understanding (MoU), the instrumental leveraging of bureaucratic power, instances of victimisation and polarisation, as well as the strategies of extraversion and obfuscation. These unspectacular yet significant soft power tactics lie at the heart of Zimbabwe's simmering and subtle contestations within GHM&EPs.

Recourse to constitutional and sovereign power

From the document review of M&E policy documents and key informant interviews, critical appraisal of the collected data shows that the Government of Zimbabwe (GoZ) draws its authority from topicalising constitutional provisions in all M&E policies. For example, the National Health Strategy 2021–2025 states:

> The obligation to ensure the provision of basic health services is spelt out in the constitution. This is supported by almost 20 pieces of legislation administered by the MoHCC and supplementary legislation administered through other sector Ministries. (National Health Strategy 2021–2025:38)

As reflected in many other official government policy documents, the given extract is not a random reference to the country's supreme law. The key text is strategically positioned in the foreword or other introductory sections of policy documents. It is argued in this article that the placement and reference to the constitution is a strategic reminder to all stakeholders, including GHPs, of where ultimate power lies in the M&E partnerships of health programmes. Furthermore, it is argued that this underscores a subtle counterbalance to GHPs' technocratic and financial power in partnerships to drafting and printing policy documents for stakeholder distribution. As a result, the authors argue that the Ministry's M&E policy documents not only communicate policy positions by the government but represent contested spaces. While the government does not have the financial and technical resources, it draws its power from constitutional and sovereign responsibilities as the custodian of citizen and sovereign power. While the government is the only partner in the tripartite governance arrangement with the constitutional and sovereign power to act on behalf of citizens, flexing its constitutional and sovereign muscles against partners providing technical and financial resources is counterproductive. However, typical of partnerships based on (mis)trust as argued in this article, it is not surprising that the government behaves in this manner.

However, the conceptual reliance on sovereign power has limits. The following interview extract metaphorically illustrates the sovereign insecurities when collaborating with GHPs such as PEPFAR:

> 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 and taken from you. So, you cannot demand accountability. (Key Informant IDI-TC)

As observed in the previous discussion, the above quotation from a senior M&E bureaucrat confirms the (mis)trust that characterises the partnership between the Zimbabwean government and foreign funding partners. The lack of consultation and feedback perhaps, signals mistrust, disrespect, and the contested nature of this collaboration as the public health system suffers from the sanctions-driven political and economic discourse and effects of contested elections since 2001. The contradiction is that the major GHP public health funding partner countries also lead the call for electoral reforms and imposed sanctions on Zimbabwe since 2001. However, through partnership discourse, the partners have (un)successfully projected health partnerships as politically neutral. Drawing from CDA, repeated words such as 'demand' used three times in the quotation are not

randomly chosen but are indicative of the frustrations that characterise partnerships in practice, contrary to the mutual and trust-based representations in official policy discourse and official policy documents. Similarly, the repetitive use of the word 'consulted' serves as a scaffold for the argument presented, highlighting the speaker's complaint regarding the perceived lack of consultation. This usage reveals the underlying subtle contestations within the discourse. Thus, the CDA framework reveals the subtle and simmering antagonism in the GHP with the Ministry, as illustrated in the figure of speech above.

Enforcement of policies and guidelines

The availability and enforcement of M&E policies and guidelines are identified as instruments of power in partnerships. The strategy, which closely relates to the constitutional and sovereignty provisions findings, is based on the realisation that M&E policies and guidelines provide a robust systematic, post-structured, and conceptual framework that wields authority and influence over GHPs when comprehensively implemented by the government. The effects of this approach are fully achieved when the government combines the conceptual and material power to hold GHPs accountable in Zimbabwe. Unlike civil society and private partners, the government has legitimate representational power to enforce policies and guidelines in ways that provide public value to its citizens. Extracts from key informants and policy documents illustrate the findings as follows:

> 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 realised 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. (Key Informant IDI-LM)

> 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. (National Monitoring and Evaluation Policy 2015:35)

The two given extracts, one from a key informant and the other from the National Monitoring and Evaluation Policy, demonstrate how policies and guidelines constitute a power source for a resource-constrained government when fully implemented. Drawing from the CDA framework, the deontic use of phrases such as 'All stakeholders shall …' reflects the influence of discursive modalisation or obligatory language associated with subtle confrontations and consequences for failing to adhere to the policy guidelines. The authors contend that although there is nothing wrong with obligatory language in official policy documents, a contextual analysis of such language within the political and economic context, as illustrated in previous discussions, reveals deeper implications beyond the conventional use in policy documents. As a result, its inclusion, positioning in the paragraphs, and emphasis suggest a subtle revelation of simmering contestations in the GHM&EPs collaboration in Zimbabwe. Thus, a critical reading and the positioning of the key deontic phrases and texts in the M&E policy expose the myth of partnership discourse in the Zimbabwean context. Consequently, policies and guidelines for M&E should be seen as a means to convey government positions on crucial policy matters and as a way to establish conceptual power boundaries within an increasingly contested global health landscape.

Memorandum of understanding as a government source of power in partnerships for health

Signing an MoU is another mechanism and strategy the government deploys to counterbalance M&E collaboration for the GHPs in Zimbabwe. Drawing from the Governance of the Collaborative Partnership Framework, MoUs are among the M&E artefacts that the government uses to guide the implementation of mutually agreed programmes to transform the M&E system for health. Memoranda of understandings 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 such as Zimbabwe. It is interesting to observe that all the participants in the study mentioned MoUs as one mechanism and strategy used by the government to hold global health partners accountable for M&E collaboration. The participants highlighted partner commitment to mutual interests, trust, equity and organisational identity, and independence as some of the issues that MoUs address. The power of an MoU lies in the conceptual laying out of the operational rules for the partners and agreements, including 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.

However, this article highlights the practical challenges of MoUs as instruments for holding global health partners accountable in Zimbabwe. The evidence shows that the government's lack of resources weakens its ability to enforce standing rules and regulations in MoUs. As a result, this tool does not have the legal standing to facilitate partnership transformation, as GHPs continue to find ways to justify actions contrary to the prescribed and agreed framework. Whereas arguments by Vangen et al. (2015:1243) through the 'governance of collaborative partnerships' call for attention to post-structural aspects of partnerships, such as the

programme goal, vision, and mission rather than hierarchical structural aspects of power, policy practice has shown that the approach has practical limitations. By adopting a discursive institutionalist approach, like GHM&EPs in Zimbabwe, it is possible to overlook the practical contextual challenges faced within the bureaucracy, which upholds hierarchical structures in its day-to-day operations. Consequently, the authors contend that the success of partnerships relies on recognising and addressing both the structural and post-structural dimensions of power.

While illustrating the practical challenges the government faces in implementing MoUs, a key respondent became most irate regarding the well-resourced GHPs' bullying tactics against the provisions within 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. (Key Informant IDI-TC)

The given 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. Despite the mention of 'formal structures' and 'the Permanent Secretary', which depict authority in the text, suggesting that the government has the power to hold GHPs accountable through non-binding MoUs is unconvincing. 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 noticed earlier, the government's failure to address sovereign responsibilities limits its ability to hold the GHPs to account through non-binding agreements such as MoUs. As a result, the GHPs continue to engage in extractive data practices outside the agreed framework. This practice continues despite the MoUs signed by the highest bureaucrat, the Permanent Secretary. Thus, MoUs do not provide adequate safeguards for the government to hold GHPs accountable.

Furthermore, the strong language in the interview suggests a simmering conflict between the global health partners and the government that may have gone unresolved for longer than necessary. The language reflects a lack of patience due to the inaction from the Ministry's highest decision-making officers. What worsens the situation is the arrogance of funding partners 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. In practice, their actions are a departure from the provisions of the MoU; hence, the harsh language in the interview quotation betrays the depoliticised partnership discourse of mutual respect and trust. Thus, the gap between official policy language and policy practice is a contested space reflecting the limits of discursive strategies of GHM&EPs to influence health policies in Zimbabwe. The partnership discourse foregrounds mutual respect and trust while backgrounding the contested issues in the partnership, delaying opportunities for transformative change.

Similarly, the interview extract shows that GHPs complain about the ministry's slow implementation of MoU requests, suggesting a lack of trust and mutual expectations in the partnership, which drives parallel processes. In conventional partnerships, it should not be difficult to access partner data. This finding corroborates similar discoveries by Cheng (2019:201), who observes the practical limitations of using MoUs in integrative partnerships involving government and conservation non-governmental organisations (NGOs) in the United States of America (US). Cheng observed that formal agreements such as MoUs might not be necessary for stable partnerships as they suggest a lack of trust and mutual understanding. Thus, true partnerships do not require formal agreements, including non-binding ones such as MoUs. However, if the interesting observation holds in stable governance systems and policy environments such as the US, it worsens in volatile policy environments such as Zimbabwe. The issues of power imbalances, mistrust, and divergent interests underlie the need to put the partnership agreements in writing.

In conclusion, MoUs are a strategy and mechanism that the government and GHPs use to hold each other accountable. However, the practical aspects of the partnership show that the GHPs are impatient with the slow pace of the government's response to data requests and, hence, apply soft and material power strategies to circumvent the MoU guidelines. Moreover, the (non-)availability of MoUs suggests (mis)trust and mutual understanding in partnerships for M&E. As a result, MoUs imply partnerships are a contested terrain.

Bureaucratic power as procedure and orderliness

Another interesting finding of this study is that government officials sometimes instrumentally use bureaucratic tendencies to exert their authority in health partnerships. Thus, insistence on hierarchical processes does not always depict inefficiencies and warrants the pathological stigma around the bureaucracy. The article argues that it is sometimes a governing technology to counter GHP's influence in health M&E systems. The argument holds, considering similar findings (Herrick 2018:2), 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 for the government in complex partnership arrangements like Zimbabwe's. To illustrate this finding, an excerpt from a key respondent shows the conceptual variations between GHPs and the government as it tries to resist too much external influence in GHM&EPs. In response to the reasons given by GHPs for parallel data collection and reporting systems, a respondent 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. (Key Informant IDI-TC)

The aforementioned text shows two parallel worldviews concerning the slow pace of data sharing between the partners, driven by mistrust and the 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 such as bureaucracy. As the response suggests, the century-old and common-sense negative conceptualisation of bureaucracy does not seem to mean the same in Zimbabwe. While the term has a pathological stigma in contemporary usage, it has regained its original Weberian meaning of 'orderliness' and 'procedure'. Government processes cannot escape the need for thoroughness and order 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, fuelling mistrust in partnerships.

In some cases, bureaucratic practices embody corrupt tendencies disguised as order and procedure. As a result, government officials take advantage of global health partners by requiring bribes to fast-track processes. These claims invoke the concept of street-level bureaucracy within the partnership between GHPs and the government in Zimbabwe (Lipsky 2010). The concept illustrates the contests between official policy positions and policy practice by shopfloor-level staff based on contextual situations. Similarly, bureaucracy is a contest between the local interpretation of practical struggles in government and the pathological international application of the idea. As the interview excerpt reflects, the concept means 'procedure and orderliness'. The findings show that procedure and orderliness are crucial to any functioning governance system. They safeguard vital government information through meticulous verification. The varied understanding of bureaucratic processes resonates with the dialogical constructivist epistemology of this article, which considers partnerships as situated encounters.

Furthermore, the findings underscore the significance of conducting thorough policy analysis that centres on structural and post-structural discursive approaches to knowledge creation. However, the current pragmatic-instrumental conceptualisation of partnerships in Zimbabwe poses a challenge in uncovering the GHP-driven post-structural and discursive strategies that conceal and perpetuate power imbalances within health M&E systems. Scholars such as 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 because of 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 the government rather than promoting superfluous ideas when the basic structures are absent. Discursive institutionalist approaches assume and build on the availability of functional systems.

Victimhood and polarisation as a strategy

Surprisingly, this study revealed the government's pragmatic and instrumental use of international victimhood and polarisation 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 partnerships. 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, especially in health. 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 Results Based Management (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. (National Monitoring and Evaluation policy 2015:3)

The phrase 'illegal sanctions imposed on Zimbabwe' depicts a forceful and unsuccessful contest in which external partners force the local partner to behave in a particular manner. 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 at shaming the Western countries and a call 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'. Whichever way one views the given analysis, it represents a contested space.

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. As a result, the health sector is the most freely financed by Western and multilateral institutions in the country.

The findings about victimhood are consistent with similar scholarly observations in countries like Uganda (Patterson 2018:12). The Ugandan President Museveni deployed 'victimhood and polarising nationalist strategies by blaming the World Bank and International Monetary Fund (IMF) for disrupting its programmes through neoliberal structural adjustment programmes'. He used this strategy to seek global sympathy and financial assistance from friendly countries. The government invoked sovereignty and respect for international law to remind hostile countries about their international relations and health responsibilities. 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 evidence suggests contestations as partners aim to outdo each other.

Extraversion and obfuscation

Interestingly, this study found that the government also uses covert extraversion and obfuscation strategies to access financial and technical support from the GHPs. The strategy links closely to victimhood and involves the government accepting and embracing 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 to project its commitment to supporting the global health programmes targeted at resource-constrained countries such as Zimbabwe. Take, for example, an excerpt from the National Health Strategy, 2021–2025. Despite the divergent ideological views of most Western countries, the national strategy embraces the concept of country-led M&E. It assures regional and global commitments such as the SDGs. The following extract 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 Sustainable Development Goals (SDGs). The health sector, including development partners and Civil Society Organizations(CSOs), is expected to unite under this single M&E platform. (National Health Strategy Zimbabwe 2021–2025:93)

Given the government's contested history with international funding partners and its poor record of implementing similar global commitments, the given excerpt's reference to regional and international commitments can be interpreted as an extraversion and obfuscation strategy. The SDGs advance partnership discourses based on mutual trust and commitment to common global goals. As a result, mentioning it in the policy signed by the minister is a strategic indication of the government's commitment to participate and adhere to global partnerships, regardless of other factors such as sanctions. As a result, since 2001, the government has been a recipient of the Global Fund and PEPFAR resources aimed at strengthening the health M&E system in the country. The authors of this article argue that the statement reflects the subtle conflict embedded in its emphasis. Patterson (2018:143) sheds light on these strategies employed by developing countries, which he refers to as 'performances of compliance', as a means to stay within global frameworks that offer opportunities for additional financial and technical support for M&E. The findings expose the prevalence of pragmatic-instrumental discourses that fail to recognise local partners' agency and constructivist reflexivity within a contested and post-truth global health system. Consequently, the study aligns with Patterson (2018) in advocating for exploring African states as agentic actors in these governance processes. Additionally, Patterson acknowledges rhetoric and covert actions evident in the ambiguous implementation of externally driven policies and the open challenge to the advice and acceptance of global health policies and norms as some of the strategies employed at the local health systems level.

Description of results

The findings articulated in this article make interesting analyses regarding the deployment of constitutional and sovereign provisions and related ideational soft power strategies in partnerships for M&E in Zimbabwe. The analyses highlight the theoretical contributions and limitations of the NPG theory and the dynamic revelation power of CDA in GHPs. For example, the sovereignty metaphor demonstrates that a partnership involving a disempowered father exposes (un)equal partnerships and subtle invasion from 'the good Samaritan' neighbour. The authors argue that the situation described reveals the limitations of collaborative NPG models, as put forward by proponents of this approach, which naively assume the presence of key tenets of mutual interests and trust in partnerships (Ansell & Gash 2008; Brinkerhoff 2002; Emerson et al. 2012; Vangen et al. 2015). Furthermore, the authors argue that in the same way, a government has the moral and legal duty to foster children from exposed and distressed parents, GHPs bring moral arguments to justify their interventions in unstable health systems. The observation highlights the concept of sovereign responsibility, which is often overlooked or not thoroughly discussed. Brown (2015:341) defines sovereign responsibility as 'the space between the sovereign and the citizen, where states and non-governmental or foreign governmental organisations organise the transfer of resources'. The concept helps to expose the shortcomings of relying on conceptual and ideational power alone as a partnership strategy for M&E. Brown (2015) elaborated on how GHPs combine citizenship and sovereignty to dilute local state power. For example, invoking global health moral norms or regulations supersedes local constitutional and sovereign rules regarding emergencies.

Similarly, Wintrup (2022:609) describes the concept of 'outsourcing sovereignty', in which global health partners believe they have the legitimate authority to take on tasks and responsibilities of government officials. Thus, the ministry's inability to meet the sovereign health demands of its people exposes it to this syndrome as GHPs invoke

overriding higher-order rules. From whichever perspective the sovereign contests are examined, the ideational contestations reinforce the argument presented in the article regarding GHM&EPs as contested spaces. The observation further exposes the limitations of the discursive power and concepts such as authority enshrined in artefacts such as the constitution.

Contrary to sound arguments by scholars such as Van Dijk (2005:352) who apportions power to talk and textual instruments such as policy regulations and Constitutions, the authors take a cautious approach since these instruments has limited force in less democratic systems like Zimbabwe. This explains why, despite textual instruments like MoUs with GHPs have not been effective despite having been signed by the Permanent Secretary for Health, the most senior bureaucrat in the health system.

Nevertheless, the aforesaid analysis does not make the government completely helpless in partnerships for M&E. The bi-directional and relational flow of power between the government, on the one hand, and its civic and private sector partners, on the other hand, is still identified when drawing from the Foucauldian governmentality framework.

The observations regarding policies and guidelines as wielding conceptual power further expose the shortcomings of relying on the NPG framework for conceptualising partnerships involving resourced and under-resourced government partners in unstable governance systems such as Zimbabwe. Thus, the assumptions of trust and mutual interests, as suggested by other scholars (Ansell & Gash 2008; Brinkerhoff 2002; Emerson et al. 2012; Vangen et al. 2015), have conceptual relevance in exposing their limited applicability in unstable governance systems rather than affirming partnerships as an instrumental approach to strengthening health systems. Similarly, the findings uncover the contextual limitations of relying on text and talk to counter social power abuse, as Van Dijk (2005) argues in his CDA framework. While discourse may counter social abuse in stable democracies, GHPs use technocratic asymmetries and access to information to (ab)use their local partners, such as in Zimbabwe. As argued earlier, discursive instruments such as policies and regulations are strategic tools that powerful GHPs use to control the discourse and frame policies and guidelines to their advantage. Thus, those who control the discourse and financial resources determine the content and interpretation of health partnership policies, regulations, and procedures. However, Botswana is an example of how perceived weaker partners can successfully resist neoliberal partnership discourses. The country's resistance to partnerships with powerful GHPs promoting cash transfer programmes insisting on traditional non-financial social support policies for its vulnerable populations is cited as one example of the relational nature of the resistance (Chinyoka & Ulriksen 2020). However, in the Zimbabwean context, the dependence on donors for technical and financial resources towards M&E exposes the government to the neoliberal impulses branded in partnership language and frames. As a result, the government loses its ability to control its policy agenda and goals. However, as argued earlier, GHPs still depend on government-expressed approval of all key health interventions. Hence, power continues to lie with the government despite the discursive and framing choreography that characterises partnerships in drafting policies and guidelines.

Another vital discussion point relates to the under-theorised and under-discussed concepts of street-level bureaucracy (Lipsky 2010) and bureaucratic socialisation (Oberfield 2014) in public health governance. Lipsky's (2010) work, which sheds light on the dilemmas faced by public servants, offers valuable insights into the soft approaches that characterise the influence of some partnerships within GHPs, as underscored by the findings of this study. Although these findings reveal the adverse effects of street-level bureaucracy on policy implementation, its contribution to knowledge remains valuable within the country. Moreover, a recent study by Zarychta, Grillos and Andersson (2020:82) has positively contributed to the concept from a behavioural public administration and governance perspective as a motivation for public health staff at the lower levels in the decentralised health sector in Honduras. Similarly, Zhang, Zhao and Dong (2021:11) reflect on 'street-level policy entrepreneurship' in the Chinese bureaucracy, stimulating and initiating valuable policy discussions. Thus, the Zimbabwean experience, perverse as it appears, provides helpful policy insights.

Furthermore, Zhang et al. (2021:1) assert that 'accountability and effective communication' are essential to the success of street-level policy 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 point to the implementation challenges of free health care policy by nurses in South Africa and various other low- and middle-income countries (LMICs), respectively.

Conclusion

The study sought to demonstrate with evidence the argument that GHM&EPs in Zimbabwe are contested spaces as local partners deploy strategies to rationalise their resources and power imbalances in collaborating. To address this, the authors have demonstrated how the government has (un) successfully deployed soft and ideational power strategies in GHM&EPs for health. The strategies include the recourse to constitutional and sovereignty power, the availability and enforcement of government policies and guidelines, the use of MoUs, the instrumental use of bureaucratic power, victimisation, polarisation, extraversion, and obfuscation in the GHM&EPs in Zimbabwe. As a result, it is concluded that the relationships involving the government and GHPs in Zimbabwe do not fit into the ideal partnership framework as the trust and mutuality test is not met. Consequently, questions about the current theorisation of partnerships are

raised, mistakenly assuming trust, mutuality, and equality between resourced and under-resourced partners. Thus, the approach conceals cracks in GHM&EPs and perpetuates opportunities to address practical and contested challenges within such unequal collaborations. Lessons are derived from these revelations, including applying multidisciplinary approaches to understanding critical public health and public administration concepts in a global and digital space and the need to (re)contextualise neoliberal concepts for a comprehensive understanding of GHM&EPs in Africa.

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Z.G. conceptualised the research design, data collection, analysis and drafted the article. S.M. guided the whole process providing feedback to Z.G. at each stage of the article writing.

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Data availability

The data that support the findings of this study are not openly available and are available from the corresponding author, Z.G.

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