

**Organisational change management framework for hospitals: A comparative case
of St Mary's, Marianhill, South Africa and St Joseph's, Adazi-Nnukwu, Nigeria**

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ABSTRACT

Change management in healthcare organisations is a complex task considering the continuous changes in global demography, technology, strategies, clinical communication, information transfer, and disease burden. The current global pandemic highlighted the need for healthcare organisations to continue implementing measures that adequately respond to health challenges towards patient satisfaction. Many organisations find it difficult to implement organisational change successfully. Unsuccessful change programmes can be attributed to the lack of employee training and development, poor leadership, inadequate communication, poor organisational culture and inadequate resources (Mosadeghrad & Ansarian, 2014). However, change programme implementation and its impact depend largely on the ability of managers to adopt and adapt the change programme techniques in their organisations. Agboola & Salawu's (2010) identified that the introduction of change produces a variety of reactions due to the intrinsic uncertainty or the alteration of employee behavioural patterns, including status quo, anxiety and lack of tolerance, amongst others. The greater the impact on the existing culture, the greater the amount of resistance likely to emerge and the more difficult it will be to implement change. The study of Organisational Development (OD) can serve as a learning paradigm for academic research by enhancing student knowledge about how change management can enable hospitals to create effective responses to changes. The main purpose of this study was to explore organisational change management practices in hospitals in Nigeria and South Africa and proposed a conceptual framework for the change management process for hospitals in a developing context. Employees are one of the most critical elements in any organisational change. Research objectives guided this study to determine the influence of driving forces of change on employee performance in St Mary's Hospital, Marianhill and St Joseph's Hospital, Adazi-Nnukwu; to examine the impact of organisation culture on the practical implementation of change in St Mary's Hospital, Marianhill and St Joseph's Hospital, Adazi-Nnukwu; to determine the influence of practical implementation of change on patient satisfaction in St Mary's Hospital, Marianhill and St Joseph's Hospital, Adazi-Nnukwu; and to establish if drivers of change

influence resistance to change during the implementation process in St Mary's Hospital, Marianhill and St Joseph's Hospital, Adazi-Nnukwu. This study provided information on resisting forces and stakeholder attitudes towards the change. And thus, assisted in restructuring the health system for greater efficiency through structural reforms that bring healthcare closer to the people, foster greater accountability and promote community participation. A case study research design was adopted for this study. An explanatory mixed-method approach was adopted with the observed hospitals. The target population and sampling frame were the employees and management from different organisational levels at both hospitals. The total number of employees and final sample size for the study was 132 for St Joseph's Hospital and 150 for St Mary's Hospital. The researcher designed two sets of questionnaires for all employees, a survey for quantitative and an open-ended questionnaire for qualitative. The Statistical Package for Social Sciences (SPSS) 28.0 and NVivo 12 were used to analyse the data. The analysis results for objectives one, two, three and four revealed a significant relationship between drivers of organisational change and employee performance. Organisational culture significantly impacted the practical implementation of change. Practical implementation of change showed a significant relationship with patient satisfaction. However, a non-significant association was found between drivers of change and resistance to change. The study found that both hospitals were successful in their change programmes. This can be attributed to proper employee training and development, good leadership, effective communication, strong organisational culture and adequate resources. Technology and organisational policy have been documented as key drivers of organisational change and performance. The study recommends that the management of the two healthcare organisations continue to implement technological changes with appropriate and required training. Management should continue to improve the adopted communication system, participative leadership and motivation system to enhance the implementation of change and promote team-building exercises to improve staff attitudes.

DECLARATION

I hereby declare that this work has not been previously submitted in substance for any Doctoral degree and has not been submitted in part or full for any other Doctoral Degree.

This submission results from my independent investigation, except where otherwise stated. Other sources are herein acknowledged giving explicit references. The bibliography is appended.

I hereby consent for my work to be photocopied and for the title and summary to be made available to outside organisations and future students.

Signed

Date 14- April -2022

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TABLE OF CONTENTS

ABSTRACT.....	ii
DECLARATION	iv
ACKNOWLEDGEMENTS	v
TABLE OF CONTENTS.....	vi
LIST OF FIGURES.....	xi
LIST OF TABLES.....	xii
CHAPTER ONE: INTRODUCTION AND BACKGROUND	1
1.1 Introduction	1
1.2 Background of the study.....	3
1.1.1 The South African health system	4
1.1.2 The Nigerian health system	6
1.2 Research problem	8
1.3 Aim of the study.....	10
1.4 Research questions	10
1.5 Objectives of the study	11
1.6 Significance of the study.....	11
1.7 Format of the Study	12
1.7.2 Chapter 2: The nature of hospitals in South Africa and Nigeria	12
1.7.3 Chapter 3: Extended literature	12
1.7.4 Chapter 4: Research Design and Methodology	13
1.7.5 Chapter 5: Data analysis and presentation	13
1.7.6 Chapter 6: Discussion of findings	13
1.7.7 Chapter 7: Summary, conclusions, and recommendation.....	13
1.8 Conclusion.....	13
CHAPTER TWO: THE NATURE OF HOSPITALS IN SOUTH AFRICA AND NIGERIA	14
2.1 Introduction	14
2.2 Hospitals.....	14
2.3 The hospital environment.....	17
2.3.1 The changing environment in hospitals.....	20
2.3.2 The Challenges to hospital changing environment.....	22
2.4 The Classification of Hospitals	24

2.5	Hospital support systems.....	26
2.6	Hospitals in South Africa	30
2.7	Hospitals in Nigeria	34
2.7.1	Challenges Faced by Hospitals in Nigeria.....	37
2.8	Theoretical framework	39
2.8.1	Kurt Lewin's Model of change.....	39
2.8.2	John Kotter – 8-step model.....	45
2.8.4	The ADKAR model	50
2.9	Organisation development (OD).....	51
2.10	The WHO systems framework	53
2.11	Proposed conceptual framework.....	55
2.12	Research hypotheses formulation	57
2.13	Conclusion.....	60
CHAPTER THREE: EXTENDED LITERATURE		61
3.1	Introduction	61
3.2	Change management	61
3.2.1	Change management in hospitals.....	64
3.3	The driving forces on resistance to change	68
3.4	Resistance to change	69
3.4.1	Strategies to reduce resistance.....	71
3.5	The role of culture in change management.....	73
3.6	Leadership and change management.....	77
3.7	The effect of change management on patient/ customer satisfaction and employee performance	78
3.8	Best practices in change management in hospitals.....	83
3.9	Continuous improvement processes	85
3.10	Conclusion.....	89
CHAPTER FOUR: RESEARCH DESIGN AND METHODOLOGY.....		90
4.1	Introduction	90
4.2	Research Philosophy- Pragmatism.....	91
4.3	Research Design.....	92
4.4	Mixed Methods.....	94
4.5	Target Population.....	97

4.6	Sampling.....	98
4.7	Data collection	100
4.7.1	Interview	102
4.7.2	Questionnaires.....	104
4.8	Data analysis	104
4.9	Statistical technique used in the study	106
4.9.1	The Kaiser-Meyer-Olkin (KMO)	106
4.9.2	Bartlett's test of Sphericity	107
4.9.3	Exploratory factor analysis (EFA)	107
4.9.4	Spearman's rank correlation.....	107
4.9.5	Analysis of variance (ANOVA)	108
4.9.6	Coefficient tables	108
4.10	Pilot study	108
4.10.1	Distributions of questionnaire	109
4.11	Limitation and delimitation of the study	110
4.11.1	Limitations.....	110
4.11.2	Delimitation	111
4.12	The principles of trustworthiness and authenticity.....	111
4.13	Reliability.....	112
4.14	Validity	113
4.15	Confidentiality and anonymity.....	114
4.16	Ethical considerations	114
4.17	Conclusion.....	116
CHAPTER FIVE: RESULTS AND INTERPRETATION OF FINDINGS		117
5.1	Introduction	117
5.2	Statistical analysis	117
5.2.1	Reliability.....	118
5.2.2	Research Instrument.....	118
5.3	Response rate	118
5.4	Presentation of findings.....	119
5.4.1	Biographical data	119
5.5	Exploratory factor analysis result	124
5.5.1	Exploratory factor analysis for use of technology	124

5.5.2	EFA for Patient Satisfaction.....	126
5.5.3	EFA for organisational policy.....	127
5.5.4	EFA for employee performance	129
5.5.5	EFA for organisational culture	131
5.5.6	EFA for Implementation of change	132
5.5.7	EFA for resistance to change.....	135
5.6	Correlation analysis for St. Joseph’s hospital Adazi-Nnukwu and St. Mary’s Marian Hill hospital	138
5.6.1	Objective one: Influence of driving forces of change on employees’ performance.....	138
5.6.2	Objective two: Impact of organisational culture on practical implementation of change	140
5.6.3	Objective three: Influence of practical implementation of change on patient satisfaction	141
5.6.4	Objective four: Impact of drivers of change on resistance to change	142
5.7	Regression analysis for St. Joseph’s hospital Adazi-Nnukwu and St. Mary’s Marian Hill hospital	144
5.7.1	Objective 1: To determine the influence of driving forces of change on employees’ performance	144
5.7.2	Objective 2: To examine the impact of organisational culture on practical implementation of change	148
5.7.3	Objective 3: To determine the influence of practical implementation of change on patient’s satisfaction.....	151
5.7.4	Objective four: to establish if drivers of change (Use of technology and organisational policy) influence resistance to change during the implementation process.....	153
5.8	Qualitative analysis findings	157
5.8.1	Sample characteristics	158
5.8.2	Core Themes	159
5.8.3	Objective one: Influence of drivers of change on employees’ performance	160
5.8.4.	Objective two: Impact of organisational culture on practical implementation of change	167
5.8.5	Objective three: Influence of practical implementation of change on patients satisfaction	174
5.8.6	Objective four: Impact of drivers of change on employee resistance to change	179
5.9	Chapter summary.....	184
CHAPTER SIX: DISCUSSION OF FINDINGS.....		186
6.1	Introduction	186

6.2	Discussion of research findings with regards to the research objectives and research questions	186
6.2.1	Influence of driving forces of change on employee performance.....	186
6.2.2	Impact of organisational culture on the practical implementation of change.....	189
6.2.3	The link between practical implementation of change and patient satisfaction	190
6.2.4	Impact of drivers of change on employee resistance to change	191
6.3	Nexus between quantitative and qualitative findings.....	193
6.3.1	Relationship between driving forces of change and employee performance.....	193
6.3.2	Impact of organisational culture on the practical implementation of change.....	194
6.3.3	Relationship between practical implementation of change and patient satisfaction.....	194
6.3.4	The link between drivers of change and resistance to change.....	195
CHAPTER SEVEN: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS.....		196
7.1	Introduction	196
7.2.1	Summary of findings from the quantitative data analysis.....	200
7.2.2	Summary of findings from the qualitative data analysis	202
7.2.3	General summary.....	205
7.3	Validation of proposed conceptual framework.....	205
7.4	Conclusion.....	208
7.4.1	General observation.....	209
7.5	Recommendations	210
7.6	Contribution to theory in change management.....	213
7.7	Limitations of the study	213
7.8	Area(s) for future research	214
7.9	Concluding remarks	215
Bibliography		216

LIST OF FIGURES

Figure: 2.1: Hospital Ownership, Booysens, 2009.	25
Figure 2.2: The Hospital system approach, Hayajneh, 2017	27
Figure 2.3: A health care systems framework, UCT, 2005	29
Figure 2.4: Kurt Lewin’s model of change, Lewin, 1946	40
Figure 2.5: Short-term win characteristics, Lewin, 1946	44
Figure 2.6: Short-term win characteristics, Lewin, 1946	48
Figure 2.7: Model representation ADKAR, Warrilow, 2019	50
Figure 2.8: Model for Organisational Change – Five Stages of OD, Brown, 2011	52
Figure 2.9: The WHO systems framework, WHO, 2007	54
Figure 2.10: Proposed conceptual framework of organisational change management for hospitals	56
Figure 3.1: Political, economic, social and technological factors that affect organisational change, Booysen, 2007	66
Figure 3.2: Positive Safety Culture, Muls et al. 2015	75
Figure 4.1: Research onions Saunder’s research onions, 2009	90
Figure 4.2: Research Design Badland, 2009	92
Figure 5.1: Clustered 3-D Bar Graph of the age, gender, marital status and occupation of the study’s participants	123
Figure 5.2: Clustered bar graph of job position by age and gender for participants	124
Figure 5.3: Project map for change management, NVivo 12	160
Figure 5.4: Influence of drivers of change on employees’ performance in St. Joseph’s hospital	161
Figure 5.5: Influence of drivers of change on employees’ performance in St. Mary’s hospital	164
Figure 5.6: Impact of organisational culture on practical implementation of change in St Joseph’s hospital	167
Figure 5.7: Impact of organisational culture on practical implementation of change in St Mary’s hospital	171
Figure 5.8: Influence of practical implementation of change on patient satisfaction	175
Figure 5.9: Influence of practical implementation of change on patients’ satisfaction in St Mary’s hospital	178
Figure 5.10: Impact of drivers of change on employees’ resistance to change in St Joseph’s hospital	180
Figure 5.11: Impact of drivers of change on employees’ resistance to change at St Mary’s Hospital	182
Figure 7.1 Proposed conceptual framework of organisational change management for hospitals	203

LIST OF TABLES

Table 4.1: Research Paradigms	95
Table 4.2: Target population	98
Table 4.3: Field survey, 2019.....	99
Table 5.1: KMO and Bartlett's Test.....	118
Table 5.2: Gender of participants	119
Table 5.3: Age of participants.....	120
Table 5.4: Educational qualifications of participants	120
Table 5.5: Marital status of the participants.....	121
Table 5.6: Race of the participants.....	121
Table 5.7: Department of the participants	122
Table 5.8: Job position of the participants.....	122
Table 5.9: Organisation of the participants.....	123
Table 5.10: Reliability statistics (use of technology).....	124
Table 5.11: KMO and Bartlett's Test (use of technology).....	125
Table 5.12: Use of Technology	125
Table 5.13: Reliability statistics (patient satisfaction)	126
Table 5.14: KMO and Bartlett's Test (patient's satisfaction)	126
Table 5.15: Patient's Satisfaction	126
Table 5.16: Reliability statistics (organisational policy).....	127
Table 5.17: KMO and Bartlett's Test (organisational policy)	128
Table 5.18: Organisational policy	128
Table 5.19: Reliability statistics (employee performance)	129
Table 5.20: KMO and Bartlett's Test (employee performance)	129
Table 5.21: Employee performance.....	130
Table 5.22: Reliability Statistics (organisational culture).....	131
Table 5.23: KMO and Bartlett's Test.....	131
Table 5.24: Organisational culture	132
Table 5.25: Reliability statistics (Implementation of change)	133
Table 5.26: KMO and Bartlett's Test (Implementation of change)	133
Table 5.27: Implementation of change	134
Table 5.28: Reliability statistics (resistance to change)	135
Table 5.29: KMO and Bartlett's Test (resistance to change).....	135
Table 5.30: Resistant to change management	136
Table 5.31: Kolmogorov-Smirnov and Shapiro Wilk Test of Normality	137
Table 5.32: Spearman's Rank correlation for drivers of change on employee performance at St Joseph's hospital	138
Table 5.33: Spearman's Rank Correlation for drivers of change on employee performance at St Mary's Hospital	139
Table 5.34: Spearman's Rank correlation for organisational culture and practical implementation of change in St Joseph's hospital.....	140
Table 5.35: Spearman's Rank correlation for organisational culture and practical implementation of change at St Mary's hospital	140

Table 5.36: Spearman's Rank correlation for patient satisfaction and practical implementation of change	141
Table 5.37: Spearman's Rank Correlation for patient satisfaction and practical implementation of change	142
Table 5.38: Spearman's Rank Correlation for drivers of change and resistance to change at St Joseph's Hospital.....	142
Table 5.39: Spearman's Rank Correlation drivers of change and resistance to change at St Mary's Hospital	143
Table 5.40: Model Summary for St Joseph's Hospital	144
Table 5.41: ANOVAa for St Joseph's Hospital	144
Table 5.42: Coefficientsa for St Joseph Hospital	145
Table 5.43: Model Summary for St Mary's Hospital Marianhill	146
Table 5.44: ANOVAa for St Mary's Hospital, Marianhill	146
Table 5.45: Coefficientsa for St Mary's Hospital, Marianhill.....	147
Table 5.46: Model Summary for St Joseph's Hospital, Adazi-Nnukwu.....	148
Table 5.47: ANOVAa for St Joseph Hospital, Adazi-Nnukwu	148
Table 5.48: Coefficientsa for St Joseph Hospital Adazi-Nnukwu.....	148
Table 5.49: Model Summary St for Mary's Hospital, Marianhill	149
Table 5.50: ANOVAa for St Mary's Hospital, Marianhill	149
Table 5.51: Coefficientsa for St Mary's hospital Marianhill	150
Table 5.52: Model Summary St Joseph's Hospital, Adazi-Nnukwu	151
Table 5.53: ANOVAa for St Joseph Hospital, Adazi-Nnukwu	151
Table 5.54: Coefficientsa for St Joseph Hospital, Adazi-Nnukwu.....	151
Table 5.55: Model Summary St Mary's Hospital, Marianhill	152
Table 5.56: ANOVAa for St Mary's Hospital, Marianhill	152
Table 5.57: Coefficientsa for St Mary's Hospital, Marianhill.....	153
Table 5.58: Model Summary for St Joseph's Hospital, Adazi-Nnukwu.....	153
Table 5.59: ANOVAa for St Joseph's Hospital, Adazi-Nnukwu.....	154
Table 5.60: Coefficients for St Joseph's Hospital, Adazi-Nnukwu.....	154
Table 5.61: Model summary for St Mary's Hospital, Marianhill	155
Table 5.62: ANOVAa for St Mary's Hospital, Marianhill	155
Table 5.63: Coefficients St Mary's hospital Marianhill	156
Table 7.1: Objectives, conclusions, and recommendations.....	197

LIST OF ACRONYMS AND ABBREVIATIONS

ADKAR	Awareness, Desire, Knowledge, Ability, and Reinforcement
ANOVA	Analysis of variance
ARV	Anti-retro viral
BPR	Business process re-engineering
CAQDAS	Computer-assisted qualitative data analysis software
CCMDD	Central chronic medicine dispensing and distribution
CBO	Community-based Organisation
DOH	Department of Health
EFA	Exploratory Factor Analysis
EMR	Electronic Medical Report
FBO	Faith-Based Organisation
FMOH	Federal Ministry of Health
HIT	Health information technology
HR	Human Resources
HRM	Human resources management
IMF	International Monetary Fund
KMO	Kaiser-Meyer-Olkin
KZN	KwaZulu-Natal
LGAs	Local Government Areas
M&As	Mergers and Acquisitions
MDGs	Millennium Development Goals
NIS	National insurance scheme
NHA	National Health Act
NHI	National Health Insurance
NHS	National Health Service
NPC	Nigeria Population Commission
NPHCDA	National Primary Health Care Development Agency
OD	Organisational Development
OECD	Organisation for Economic Co-operation and development
PHC	Primary Health Care

PMCC	Pearson Moment Correlation Coefficient
PRB	Population Reference Bureau
SA	South Africa
SDGs	Sustainable Development Goals
SPSS	Statistical package for the social science
TQM	Total quality management
UK	United Kingdom
UHC	Universal Health Coverage
USSR	Russia, the Union of Soviet Socialist Republic
WHO	World Health Organisation

CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1 Introduction

Change is a phenomenon that occurs daily in every organisation. For the past few decades, change in organisations, regardless of size or ownership, has been inevitable (Battilana et al., 2010). Trends of organisational change are increasing in complexity and turbulence under the current economic situation (Battilana et al., 2010). According to Battilana et al. (2010), “the purpose of change management for different organisations may differ. However, the ethos of change management is the same: ensuring that the organisation runs effectively and efficiently and is responsive to turbulent environmental changes. Andreasson et al. (2016) propose that changes in the environment are triggered by certain factors that may include:

- New government regulations and legislations;
- Technological innovations;
- The changing nature of the workforce;
- Increased global competition; and
- Customer and stakeholder expectations.

Governments today strive for more efficient, effective, and satisfactory health services for their citizenry. Quality healthcare delivery is the government's constitutional responsibility (Stuckler et al., 2011). In the developing world, change management has taken place in all public sector domains (Stuckler et al., 2011). Similarly, the South African Government has introduced health reform programmes to improve healthcare, efficiency, safety, and quality of delivery and access for all users to ensure compliance in delivering quality healthcare (Mogashoa & Pelser, 2014). Despite these commendable initiatives in the healthcare sector, the National Department of Health (2012) revealed that public health institutions were failing to meet basic standards of care and patient expectations.

Africa has had a turbulent change environment that has shaped the change management process in the health sector over the past half-century (Mogashoa & Pelser, 2014). One of the major challenges in African health systems is inadequate

human resources (HR). Africa is said to have less than one health worker per 1000 people compared to 10 per 1000 in Europe (Barron & Padarath, 2017). The lack of health workers leads to physical and mental exhaustion and even the deterioration of medical conditions (Barron & Padarath, 2017).

Many of the problems in the South African healthcare system can be traced to the apartheid era (1948–1993), in which the healthcare system was split between four different racial groups (Africans, Mixed-race, Indian and White) (Baker, 2010). This led to a deterioration in health system delivery due to a lack of resources, prolonged waiting times because of HR shortages, and poor hygiene - poor communities were more greatly affected (Chassin & Loeb, 2013). In Nigeria, despite the strategic position as the giant of Africa, the country is greatly underserved in its health care and poorly developed (Waweru et al., 2013). The health centres, personnel, and medical equipment are inadequate, especially in rural areas. Nigeria has experienced a series of major health sector reforms over the last two decades based on decentralisation, community participation and intersectoral collaboration (Waweru et al., 2013). Therefore, it can be said that change initiatives that are not implemented properly have implications for the organisation. The lack of clarity of roles and responsibilities among the different levels of healthcare workers leads to resistance to change. However, improving quality care means reduced delays in healthcare delivery, increased employee efficiency, higher productivity and lower costs.

This study explores the factors affecting change initiatives in two Sub-Saharan African hospitals. The relevance of a valid change management framework in St Mary's, Marianhill and St Joseph's, Adazi-Nnukwu was critical in ensuring that both organisations significantly contribute to the economy, enhance quality healthcare delivery, and increase productivity. In health care, change can be resisted when it is imposed on employees but may be better embraced when the employees are involved and adopt a sense of ownership. This introductory chapter outlines a brief background of the study, followed by an explanation of the statement of the research problem, the aim of the study, research questions, research objectives and the significance of the study.

1.2 Background of the study

Many organisations find it difficult to implement organisational change successfully. Unsuccessful change programmes can be attributed to a lack of employee training and development, poor leadership, inadequate communication, poor organisational culture and inadequate resources (Mosadeghrad & Ansarian, 2014). However, change programme implementation and its impact depend largely on the ability of managers to adopt and adapt the change programme techniques in their organisations (Mosadeghrad & Ansarian, 2014).

One of the key health concerns in healthcare management is the management of change and healthcare workers who are mandated to acquire and maintain their professional tasks. Organisational change is usually common in complex healthcare systems. Leadership, employees and reorganisation are reshaped in response to legislative change, and new technologies are introduced (Pomare et al., 2019). Agaboola & Salawu (2014) identify that the introduction of change produces a variety of reactions due to the intrinsic uncertainty of change or the alterations of employees' behavioural patterns, including status quo, anxiety and lack of tolerance. The greater the impact on the existing culture, the greater the amount of resistance likely to emerge and the more difficult it will be to implement change.

According to Lewis (2019), change in an organisation can serve as a means to address important challenges such as those related to policy, governance, dissemination of information and resources, lack of efficiency, effectiveness and competitiveness. Organisations are never completely static. Dynamic changes in the environment can leave employees unprepared to cope. The field of healthcare management has evolved into a dynamic and complex one with an ability to offer various opportunities as the industry continues to grow. The healthcare industry is quite diverse and is made up of small and large organisations, mainly hospitals. Hospitals are the most complex organisations and are constantly changing due to continuous politics, technology and scientific discoveries that significantly contribute to improving our community's health. Hospital managers are crucial as planners, organisers and leaders within the healthcare sector. Booyens (2008) connotes that the proportional link between the growth of the

healthcare sector, the incremental demand for healthcare and the significant role played by health employees in working towards quality delivery is quite evident.

1.1.1 The South African health system

The South African government has embarked on a health system transformation process since 1994 (post-apartheid), as outlined in the White Paper for the Transformation of the Health System in South Africa (1997). The significance of this healthcare reform process is that the primary healthcare approach is used as the platform for delivering healthcare from the National Health System via the District Health System. The White paper focuses on decentralising responsibility, accountability, power and authority to the lower levels of healthcare delivery. It also informs community involvement and decreases bureaucratic practices and the effective use of resources.

As explained by Booyens (2008), in line with the health system reform in South Africa, the department of public service and administration developed the Batho Pele (People First) principles, which apply to all public service employees. The transformation priorities in the implementation of the Batho Pele revitalisation and service delivery improvement initiatives are:

- Representativity and affirmative action.
- Human resource development and training;
- Employment conditions and labour relations;
- Rationalisation and restructuring;
- Transforming service delivery;
- Information technology;
- Promoting a professional service ethos;
- Institution-building and management, and
- Democratising the State

As defined by World Health Organisation (WHO) (2007), health systems comprise all the organisations, institutions and resources devoted to promoting improved health. Thus, health system strengthening refers to those activities employed to successfully improve a country's ability to perform essential functions described by WHO's six health

system building blocks: service delivery; health workforce; information; medical products; vaccines and technologies; financing; and leadership and governance.

The South African health system consists of the public and private health sectors. The former is managed by the provincial government health department and monitored by the Department of Health (DOH) (Abaerei & Ncayiyana, 2017). Poor funding in the public health system has negatively influenced the ability to exist health systems in African countries to respond to healthcare needs. Despite increased public health utilisation due to the high burden of disease and patient overload in South Africa, the public health sector fell from second to fourth on the list of spending priorities (Doherty et al., 2018).

Consequently, major challenges in this sector include; negative staff attitudes, long waiting periods, unclean facilities, medicine stock-outs, and compromised safety and security of both employees and patients. South Africa spends more than any other African country on health care; however, health outcomes are not always commensurate with spending. Therefore, there is a need to strengthen public health systems to enhance their overall performance and contribute immensely to improving the welfare and life expectancy of the population (Abaerei & Ncayiyana, 2017).

For over 100 years, St Mary's Hospital, Marianhill, located in KwaZulu-Natal (KZN), has provided quality healthcare services for communities around the area. The hospital was built by monks who arrived in South Africa in 1882. The 200-bed district hospital serves a population of approximately 3 million. In 2017, the DOH took over St Mary's hospital due to the financial difficulties encountered by the hospital. Fortunately, the DOH intervened when they did, as the closure of this hospital would have severely compromised access to healthcare services for the community and hampered efforts to reduce the burden of diseases in the province. The loss of jobs and skills would have also been a problem, as the hospital employees would have been out of employment.

Coates IV (2014) asserts that mergers and acquisitions (M & As) often face challenges. Inherently, many M&A deals have employee retention challenges resulting from a negative employee attitude. About St Mary's Hospital, this may include uncertainty about the hospital's future, job security, problems of integration, employee resistance to

change, perceptions of lack of leadership and feelings of confusion due to lack of communication. Hence, during this delicate process, it is imperative to keep employee turnover low. Recent research depicts that 30% of M&As fail within three years, the majority due to disparities in organisational culture (Bange, 2017). Communication challenges are one of the many factors that lead to failure in organisation M&As. Communicating with employees, empowering them and creating a strong culture is fundamental to integration.

1.1.2 The Nigerian health system

Agba (2010) stresses that the Nigeria health system is broad and heterogeneous, consisting of the public and private health sectors. The Nigerian health sector is one of the biggest sectors in the country. Welcome (2011) proposes that despite Nigeria's strategic position on the continent, the country is underserved in health care. Healthcare facilities like health centres, personnel, and medical equipment are inadequate. This makes it critical to understand how organisation frameworks impact the Nigerian health sector in the execution of its mandate (Welcome, 2011). Nigeria's three tiers of government are federal, state, and local. The local government areas (LGAs) manage the primary health care system, with support from their state health ministries. The Ministry of Health manages the secondary healthcare system at the state level.

According to the WHO (2000), Nigerian healthcare delivery has undergone tremendous policy changes. In post-colonial Nigeria, the health sector was subsidised. Although the major source of health care financing came through external funding like the World Bank, the International Monetary Fund (IMF) and many other multi-lateral donor agencies, there are other sources from the public sector, such as the government. The federal government launched its primary health care plan with the following objectives:

- Improve collection and monitoring of health data;
- Improve personnel development in health care;
- Ensure the availability of essential drugs;
- Improve immunisation programmes;
- Improve food supply and nutrition;

- Promote treatment of epidemic diseases;
- Improve maternal and child care; and
- Educate people on prevailing health problems and methods to prevent and control them (National Health Bill, 2008).

However, this healthcare plan did not impact the health sector. Unfortunately, the sector continued to suffer infrastructure and personnel deficits and poor management. The high burden of diseases (communicable) and rising prevalence of non-communicable diseases contribute to health system challenges, thus negatively impacting the quality of care.

The WHO (2006) contend that due to the rapid increase in the burden of disease and disability in the world, most especially the Sub-Saharan African countries, and the demand placed on the healthcare sector, which is often deprived of vital resources (personnel, financing, medical equipment, etc.), it is necessary to establish leaders and professionals that can apply modern management and organisational techniques to successfully deliver maximum benefits to the society (Andreasson et al., 2016). As healthcare delivery continues to change, healthcare managers, administrators and employees will play a key role in shaping the systems and processes of tomorrow. Hospitals need to adapt to changing market conditions and, at the same time, cope with the need for renewal rather than a reactive workforce (Brown, 2011).

St Joseph's Hospital, Adazi-Nnukwu, located in the Aniocha local government area of Anambra State, was initially built as an outstation clinic under the management of the Most Holy Rosary missionary sisters in 1938. The hospital under the care of the sisters was registered with 101 in 1939. It soon grew to 188 in recent years. The missionary sisters played an important role in forming the school of midwifery. The hospital continued to run and remained small in terms of structures until February 2012, when the administration of Governor Peter Obi decided to invest in the hospital and midwifery school. Hence, major transformations took place.

St Mary's, Marianhill, South Africa and St Joseph's, Adazi-Nnukwu, Nigeria, were established by missionaries before the relevant governments intervened. The

uncertainty resulting from acquisition and restructuring can increase employees' stress levels if not handled effectively. The perspectives of hospital workforces during a redevelopment have been poorly explored. Hospital redevelopment is often considered a physical action rather than an organisational one.

Pomare et al., (2019) posit that organisational change in hospitals does not require only the physical environment to change, but also the behavioural operations, structural relationships and roles, and the organisational culture may transform at large. According to Lady Cilento Children's Hospital Clinical Review (2015), in a recent example of a new hospital opening in Australia (the Children's Health Queensland hospital), employees' attitudes shifted from excitement during the early stages of change to frustration as the development progressed. The role and support of frontline workers are crucial to implementing any change. (Lourens & Ballard, 2016).

The study of Organisational development (OD) can serve as a learning paradigm for academic research by enhancing student knowledge about how change management can enable St Mary's and St Joseph's to create effective responses to changes. This study will provide information on resisting forces and stakeholder attitudes towards change, thus, assisting in restructuring the health system for greater efficiency through structural reforms that bring healthcare closer to the people and foster greater accountability and promote community participation.

1.2 Research problem

Implementing change is often a difficult process across organisations and could be more difficult for the health sector due to several barriers to implementing change. The health sector faces even more barriers because of the extraordinary complexity, many stakeholders, and the legal restrictions involved. This explains why change management in the healthcare industry is more challenging than every organisation's adjustment to change. It is difficult because of its severe complications and the fact that it is responsible for saving human lives. The healthcare sector is also important because it is influential in establishing a good economy.

South Africa and Nigeria share similarities as large African economies, accounting for around a third of the African continent's gross domestic product (GDP) (Bossuyt, 2016). The two countries have pursued common interests in technology, communication, manufacturing and health care for the past decade by implementing proactive change management programmes that would take Africa to the next level. However, the two countries' main problem has been the unsuccessful introduction and implementation of new programmes in the health sector, especially within hospitals where primary health care is provided (Andreasson et al., 2016).

Technology adoption is one of the biggest drivers of change due to its rapid evolution. In Africa, hospitals have been adopting electronic medical records (EMR). Changing to digital medical records has required many institutions to rework their entire medical records systems, and this task is daunting. Health sector governance changes have important implications on the design, implementation and impact of service delivery on patients (Dutta, 2018).

There has been a growing interest in organisational change management for hospitals in recent years. This is due to the need for healthcare organisations to be more agile and responsive to the constantly changing external environment. In a recent empirical study, Udekwe, (2022) submit that despite the policies, plans and strategies put in place by the South African government, the public health system in South Africa still faces a lot of difficulties which centred majorly on performance and service delivery. Corroborating this, Cline and Luiz (2013) posit that the health sector in most developing countries, South Africa and Nigeria, face weak health systems due to—resource facilities. Similarly, Olaniyan (2012), in a study, reports that the deterioration of Nigeria's key health indicators results from the economic crisis and political instability. Hence, the system is poorly developed and thus faces many challenges. The two hospitals were selected because they were previously missionary hospitals before been taken over by the government and underwent similar changes in their respective institutions. The author recommends policies that will develop the system and mitigate against ineffective performance in healthcare. In another study, Obansa and Orimisan (2013: 221) argue that after fifty years of Nigeria's independence, the healthcare sector is still a

labour-intensive handcraft industry' despite global advancement in healthcare. The study recommends improving access to primary health care, providing funding, and improving the condition of service.

Regrettably, despite several previous studies on the healthcare system's challenges in South Africa and Nigeria, there is a dearth of studies on organisational change management practices in the two Sub-Saharan African healthcare sectors. The dearth of comprehensive scholarly studies on the organisational change management practices in these countries' healthcare sectors leaves the policymakers and practitioners without evidence-based decisions since the understanding is based on conjecture and speculations. Without a proper change management framework, time and resources will be wasted on policies and programmes. Hence, two African healthcare sectors need organisational change management practices. The current study will explore organisational change management practices in two Sub-Saharan African hospitals and propose a change management framework that will serve as anecdotal evidence for a sustainable change in South African and Nigerian Hospitals.

1.3 Aim of the study

Drawing from Kurt Lewin's model of change and the study of organisational change management practices in hospitals in Nigeria and South Africa, this study seeks to explore the impact of organisational change management drivers and framework in hospitals in South Africa and Nigeria and to propose a conceptual framework of change management process for a sustainable development in hospitals.

1.4 Research questions

- How do change drivers influence employee performance at St Mary's Hospital and St Joseph's Hospital?
- How does change drivers impact organisational culture at St Mary's and St Joseph's?

- How does change drivers influence patient satisfaction at St Mary's and St Joseph's?
- How do the drivers of change influence resistance to change during the implementation process at St Mary's and St Joseph's?

1.5 Objectives of the study

- To determine the influence of change drivers on employee performance in St Mary's Hospital, Marianhill and St Joseph's Hospital, Adazi-Nnukwu;
- To examine the impact of change drivers on organisation culture on the practical in St Mary's Hospital and St Joseph's Hospital;
- To determine the influence of change drivers on patient satisfaction in St Mary's Hospital and St Joseph's Hospital; and
- To establish if drivers of change influence resistance to change during the implementation process at St Mary's Hospital St Joseph's Hospital.

1.6 Significance of the study

This study is significant in three major ways. First, it contributes to the body of knowledge in organisational change management practices in the healthcare sector, as much of the literature in the healthcare sector focuses on the challenges and the policy way out. However, this study specifically explores organisational change management practices in South Africa and Nigeria hospitals. Secondly, the primary goal of change programmes is to increase productivity, develop new managerial skills and increase employee morale. Hence, for an organisation to perform efficiently, it is imperative to increase employee involvement. The findings of this study are important to various healthcare managers, especially at St Mary's and St Joseph's, because it helps them understand employee behaviour better and assists the leaders in any other organisation that faces dilemmas of change. More importantly, it provides the policymakers with anecdotal evidence for proper decision-making.

In addition, the study outlines strategies and techniques to resolve problems and increase organisation effectiveness. The study also helps management to develop the foundation to improve HR policies, especially in implementing change programmes and rectifying any unsubstantiated perceptions they might have had regarding the importance of change management in South African and Nigerian healthcare organisations.

Thirdly, the study will serve as a 'springboard' for future studies of organisational change management practice, especially in delving into areas that this study did not cover. The recommendations in this study will enable consultants and change agents to use the model suggested as a guideline to get the best performance out of their employees and increase motivation and productivity in all departments.

1.7 Format of the Study

The study is organised according to the following chapters:

1.7.1 Chapter 1: Introduction and background

This chapter is an introduction. It introduces the background of the study, research objectives, and significance of the study. It explains how the research was designed to identify critical factors affecting change management in the healthcare sector.

1.7.2 Chapter 2: The nature of hospitals in South Africa and Nigeria

This chapter discusses the nature of hospitals in South Africa and Nigeria and reviews the organisation structures of South African and Nigerian health systems.

1.7.3 Chapter 3: Extended literature

This chapter is a detailed literature review which provides a critical analysis of various concepts and an evaluation of existing knowledge theories in the research areas of change management, OD, organisation resistance and the impact of organisational culture on the practical implementation of change; all these are aligned to objectives of the study.

1.7.4 Chapter 4: Research Design and Methodology

This chapter discusses the research methodology and research design adopted in the study. The discussion includes the research design, target population, sampling techniques, and ethical considerations. A breakdown of the research instrument and the procedures for gathering data was provided.

1.7.5Chapter 5: Data analysis and presentation

This chapter reports this study's findings through tables, graphs and figures and verbal descriptions. This chapter also presents information on the variables that were used in the analysis and a rationale for the selection.

1.7.6 Chapter 6: Discussion of findings

The thesis was summarised with emphasis on the results obtained, analysis and interpretation of the quantitative and qualitative data in detail.

1.7.7 Chapter 7: Summary, conclusions, and recommendation

This section provides the summary and findings from all the chapters and makes recommendations for future studies emanating from this research work.

1.8 Conclusion

The purpose of this chapter was to give an overview of organisational change management. This chapter also provided information on the background and statement of the problem, the aim and significance of the study, the research questions and the study format. The next chapter presents a detailed literature review to establish what various authors have written about research related to this study.

CHAPTER TWO: THE NATURE OF HOSPITALS IN SOUTH AFRICA AND NIGERIA

2.1 Introduction

The previous chapter introduced the study. This chapter presents the nature of hospitals in the two countries, South Africa and Nigeria, focusing on locating or positioning hospitals in the two countries. The chapter also identifies hospital levels, support systems, the hospital's environment, the need for change, and the challenges faced.

People make up society, and healthy people make up a healthy society. Illness and diseases have always challenged society. The effects of health on development can never be overemphasised. Countries with weak health and education conditions struggle to achieve sustained growth. Hospitals are social organisations and institutions with an increasingly important societal role. In primitive days, a person afflicted with a disease was condemned to suffer. The belief was that an afflicted person was useless to society and thus subjected to complete isolation.

As civilisation progressed from individuals to family and finally to an organised community, the community came to provide welfare for the sick. Sickness creates a sense of dependency. The sick requires medical attention, nursing care and shelter. One of the institutions that were established to cater for the sick is the hospital. King (2015) “believes hospitals have a social mission to fulfil their goals by providing quality services to the sick when required.

2.2 Hospitals

Reiner (1964), cited in Kelly et al. (2016), posits that the word hospital originates from the Latin word *Hospitalis* (adjective). *Hospes* is a noun which means a host, signifying stranger or foreigner. *Hospes* is thus the root of the English word host. Another noun derived from this is called *Hospitium* in Latin, which means a place to receive guests and thus giving birth to the French Word *Hospice*. Subsequently, the adjective came to be used as a noun like the *Hospitalis* (Latin), *hospitale* (French), and *Hospitalia* (German). The English word hospital is derived from the French word *Hospitale*. The term hospital means an establishment occupied by the injured or sick. Today, hospitals

are funded by the state, profit or non-profit health organisations, health insurance and charities.

A hospital is an institution which provides short-term and long-term medical, surgical and nursing care and treatment for patients suffering from diseases or injuries. According to the WHO (1948), health is the complete physical, mental and social well-being and not merely the absence of disease or infirmity. This definition has not been changed since 1948. Therefore, health encompasses biological, psychological, social and even cultural aspects and does not focus solely on physical well-being (Booyens, 2015).

Healthcare is broadly defined and includes care, service, or supply related to an individual's mental, social or physical health. An individual's contact with a hospital, nurse, physician, pharmacist or psychologist and diagnostic and therapeutic procedures are all examples of healthcare. The spectrum of healthcare refers not only to doctors, nurses and patients but to a vast array of healthcare facilities, insurance companies, medical associations, laboratories, public health and epidemiological concerns, chronic disease management and disease prevention (Jooste, 2016).

The history of hospitals began in the Greek and Roman civilisations. The Greek temples were dedicated as hospitals to treat the sick. Greek medicine dates back from 500 BC to 500 AD. The temple Aesculapius was a medical advice, prognosis, and healing centre. Treatment often began with a purgative bath series and abstinence from wines and certain foods. Then the prayers were sustained at the foot of the statue of Aesculapius to await the healing dream. With the birth of Christianity, hospitals became an integral part of the church (Valentinuzzi, 2009).

Jackson (1988), cited in Retief & Cilliers (2010), affirms that the earliest hospital Hôtel-Dieu of Lyon, opened in 542 AD and the Hôtel-Dieu of Paris in 660 AD. Religion continued to be the dominant factor in establishing hospitals during the middle ages. Notably, in the 12th century, the number of hospitals grew rapidly in Europe. The Domus Dei was the first hospital in Old Portsmouth in 1212. It was established as a hospice to shelter and help pilgrims from abroad bound for the holy shrines at Canterbury, Chichester and Winchester.

After that, following the Bethlem Royal Hospital in London was founded in 1247. Bethlem, popularly known as Bedlam, is currently known as the world's oldest institution caring for persons with mental disorders. In 1524, Spanish conquistadors built the first hospital in Mexico City (Hospital de Jesús Nazareno). The first general hospital opened in 1751 North America as Pennsylvania Hospital. After that, was Bellevue Hospital in New York in 1736. According to Retief and Cilliers (2010), the origin of the modern hospital came from Christians – under their control, hospices built to shelter pilgrims and messengers between bishops developed into hospitals.

From the modern perspective, the most important contribution of past civilisations to public health was establishing the hospital in the modern era. By the mid-19th century, Europe and the United States of America had established a number of private and public hospitals. Hospitals and the medical profession have become more professionalised. In many countries, most hospitals are owned and operated by the government (Booyens, 2015). The United Kingdom operates the hospital sector by the National Health Service (NHS); in the United States, the traditional hospital is a non-profit. However, in the late 20th century, the concept of the non-profit was changed to profit. Many hospitals in Africa are associated with universities; religious organisations founded others. Mental health facilities traditionally have been the responsibility of state governments, while the federal government has provided for military hospitals.

The current demands of society and improved technology (and systems) have added new challenges to hospitals in their responsibility, mission and function. Hospitals organise their health team to create a stable medical environment for each patient's illness. The modern hospital aims to become the centre of total health care for the community, consisting of a variety of complex patient care, educational programmes for allied health professionals and laboratories for clinical research (Abaerei & Ncayiyana, 2017). As globalisation emerged, the hospital system has transformed over time. In developing countries, the hospital as an institution has become complex and offers modern technology, which increases the range of diagnostic capabilities and expands the possibilities for treatment. This drives the need to employ more highly trained staff (Pomare et al., 2019).

Mousazadeh et al. (2013) affirm that public hospitals play a vital role in our national healthcare sector, delivering quality care and easy access to essential health in communities, especially for low-income patients. Public hospitals are funded by local, state, and federal government funds, focusing mostly on primary health care (PHC). PHC offers professional care to patients by integrating an efficient approach that utilises several preventive measures, management of chronic disease, and promoting self-care. These hospitals provide free healthcare services and help to reduce racial, linguistic and socio-economic disparities. They serve as a safety net for the uninsured and are more affordable than the private sector. However, there are some disadvantages, such as long waiting times due to higher doctor-patient ratios and non-personalised care (as patients overburden the nurses). With the help of PHC delivery work, public hospitals address and combat social determinants of health that harm an individual's well-being. Public hospitals' free health services help reduce and control disease outbreaks, as information on diseases and prevention is constantly provided to the communities (HST, 2010). For example, in South Africa, the national insurance scheme (NIS) aims to tackle the gap in healthcare between the rich and the poor. Before 2004, Anti-Retro Virals (ARVs) were not available to the public health sector in SA. As a result, many patients in the public sector died while private patients could access drugs for survival (WHO, 2015).

2.3 The hospital environment

According to Buchbinder & Shanks (2017), the hospital environment is the work environment for healthcare workers. It incorporates the sum of the elements, factors and conditions in the environment as well as the physical geographical location. Essentially, the term environment in hospitals includes the factors that influence the commitment of the staff working in the hospitals. Akinbode & Al Shuhumi (2018) state that every organisation has forces that surround and pervade it. Healthcare facilities' planning and designing phase should be logical and meet all comprehensive checklists, building requirements, and compliance (Al-Abri, 2007). The hospital environment is a major concern when it comes to the field of medical services. The hospital environment

can be classified as a nursing unit, operating theatres, diagnostic facilities, outpatient departments, administration areas and operational departments. To maintain a healthy environment, Roy (2017) argues that the hospital systems must provide extra services and support towards patient care. A culture of safety is crucial in the hospital environment. Leaders, managers and healthcare workers are responsible for performing with professionalism, accountability, transparency, involvement, efficiency, and effectiveness. Health and hygiene conditions, discipline, and cooperation from everyone are significant elements that influence the hospital environment. These elements must be taken seriously, as patients' survival depends on them. Empirical studies reveal that poor work environments are common in hospitals, thus impacting healthcare worker performance. Improvement of the work environment will ensure nurse retention and better-quality patient care (Alingh et al., 2018).

The field of healthcare management has evolved into a dynamic one, with the ability to offer various employment opportunities as the industry continues to grow (Abaerei & Ncayiyana, 2017). The healthcare industry is quite diverse and constantly changing due to scientific discoveries that significantly contribute to improving the health of communities. Healthcare managers are crucial as planners, organisers, leaders and watchdogs within the healthcare sector. The proportional link between the growth of the healthcare sector and the incremental demand for healthcare, and the significant role healthcare managers play in working towards quality, efficient and economical healthcare delivery, is quite evident. (Andreasson et al., 2016).

Barr & Dowding (2019) assert that due to the rapid increase in the burden of disease and disability in the world and the demand placed on the healthcare sector (which is often deprived of vital resources), there is a need to establish a cadre of leaders and professionals that can apply modern management and organisational techniques to successfully deliver maximum benefits to the community at large. Hospitals represent a complex environment where different aspects, including patients, staff, equipment, services and information, are interfaced (Oli et al., 2016). A hospital's physical environment affects the physiology, psychology and social behaviour of patients and healthcare workers. Evidence shows that the physical environment links patients and

healthcare workers in four areas: reducing staff stress and fatigue and increasing effectiveness in delivering care, improving patient safety, reducing stress and improving outcomes, and improving overall healthcare quality (Tabish, 2003).

Internal and external factors affect the hospital environment. In this context, Saleh (2017) notes that many internal factors significantly impact the hospital environment, such as noise, waste management and infection control. External factors are sources and treatment of water and sewage treatment and disposal. Risk factors such as waste management, noise, chemicals, toxic gases and radiation, lack of PPEs, space and lighting all impact the individual well-being. Studies show a link between environmental factors such as adequate lighting, interruptions, and error in the prescription or dispensation of medications (Andrade et al., 2017). Noise adversely affects patients' sleep patterns; it is a major cause of sleep loss (Cunha & Silva, 2015). Brain development in premature babies can also be disrupted by noise. Noise also increases stress in adult patients by heightening blood pressure and heart rate.

In contrast to patient care and recovery outcomes, Alingh et al. (2018) argue that less attention is given to the hospital environment's negative impact on healthcare employee well-being and productivity. Environmental control and surveillance services should be provided to help detect, avoid and limit harmful occupational exposures for healthcare workers. Harris (2015) and Robinson & Green (2015) suggest that to promote a safe and conducive environment in healthcare facilities, the management should take note of important points such as, but not limited to:

- Terrains that are level to accommodate wheelchairs and stretchers. Walls and floors should be non-absorbent, non-porous, anti-slip and fire-resistant;
- Automatic communication systems;
- Provision of conveniently located sinks/ alcohol-rub dispensers for hand washing- the importance of handwashing by healthcare workers cannot be overemphasised. It increases compliance;
- Situated in a location that is easily accessible to the community, transports, ambulances, and service vehicles for goods supply and waste disposal;
- There should be adequate space that allows ample parking;

- Adequate lighting, good drainage systems and safe drinking water facilities;
- Ventilation systems that minimise exposure to infectious agents and toxic chemicals to the patients and health care workers; and
- Mechanisms for the collection, storage and disposal of toxic wastes.

2.3.1 The changing environment in hospitals

Healthcare organisations are constantly changing due to technological advancements, new discoveries for the treatment of diseases, political reforms and policy initiatives. Lipcamon (2003) states that catalysts of change in hospital environments include government regulations, increased utilisation, patient expectations, cost-effectiveness, total quality management (TQM), competition and technology advancement. The hospital environment is technically complex and surrounded by many uncertainties. Yet hospitals are an integral part of the healthcare sector. Hospital redevelopment is often considered a physical rather than a total organisational change. A change in the organisation involves the physical environment, behavioural operations, structural relationships and roles, and the hospital's organisational culture. These changes can affect job satisfaction, stress and intention to leave (Pomare et al., 2019).

Changes in a hospital environment can be both exciting and challenging for staff. A notable example is that of the opening of a new hospital building in Austria; the staff attitude shifted from excitement during the initial stages of change to frustration and anxiety as the change progressed (Lady Cilento, 2015). Financing the health system is becoming more difficult, and this places a huge burden on the resources available and the mobility of the labour force. The length of stays in health facilities, acuity levels of disease, and disease chronicity lead to far more work and greater responsibilities for healthcare professionals and managers.

Changes create internal pressure in all organisations. It is important to understand that during change implementation, employees move through four stages of reaction: denial, resistance, exploration and commitment (Brown, 2015). Suppose hospitals are to experience greater levels of success in their development efforts. In that case, management should have a strategic framework for the need to change, understanding

the underlying key issues which accompany change management (Al-Abri, 2007). Changes in healthcare should focus on quality, safety and cost control which often means engaging in strategies that help patients manage their conditions and avoid hospitalisations. Hospitals are working hard to address and combat the social determinants of health in public healthcare. To address the social drivers of health disparities, government institutions, public and private hospitals, and other entities must collaborate.

In an interview with the New York Times, Dr Ezekiel Emmanuel argues that the decrease in the number of hospitals has become a positive trend. Dr Emmanuel described that cancer care, births and other clinical services are delivered in outpatients' settings and thus have successfully lowered costs and reduced the rate of hospital-acquired infections. In light of the above view, Dr Rick Pollack, CEO of the American Hospital Association, contends that hospitals provide vital services mostly during pandemics, outbreaks, community violence and natural disasters (Pollack, 2018). Hospitals and health systems must redefine themselves in many ways to thrive in the changing healthcare context. Healthcare should be easily accessible and focused on lowering cost settings.

In 2019, the South African government developed a programme called Central Chronic Medicine Dispensing and Distribution (CCMDD). This is to make access to medical supplies easier. Millions of South Africans have chronic conditions such as diabetes, high blood pressure or HIV; the best way to manage these is by regularly taking medications. The CCMDD service offers a simple, fast and efficient service for patients to collect their medications from safe and convenient medical pick-up locations. Thereby saving patients time, reducing transport costs and ensuring accessibility to medications to maintain effective treatment. The CCMDD programme has proved to be even more useful in reducing the spread of Coronavirus, as it is important to avoid places where many people gather (DOH, 2019). Improving the hospital environment greatly impacts patient experience, satisfaction, and a better hospital culture. The healthcare industry is evolving towards patient-centric approaches; hospital management must understand how their facilities affect this (Heath, 2016).

2.3.2 The Challenges to hospital changing environment

The most significant changes within the hospital have been the emergence of new technology. Due to the growing demand for personalised medicine, these technologies are increasing the cost and complexity of healthcare (Figueroa et al., 2019). Not only are they expensive to procure, but they also require the demand of highly specialised workers and facilities. These technologies include electronic patient records, new imaging technologies, novel drug therapies, 3-D printed devices, and robotics. Hence, hospital managers must be competent in understanding, assessing, and evaluating these technologies. Globally, the healthcare industry is in a dilemma of a growing shortage of skilled and qualified staff. This shortage is significant in occupations like nursing and their assistants, imaging technicians, doctors and pharmacists.

Consequently, these shortages will negatively impact the industry growth and affect costs due to the competitive labour market (Lotlikar, 2018). An organisation's success depends on how it copes effectively with the demands of its environment. The goals of the healthcare sector are likely not to be achieved without sharing the common objectives among care providers and patients. Tabish (2003) argues that challenges in hospital environments include the following: demographic pressure, technological pressure, and economic pressure.

Demographic pressure - there is an increase in demand in the healthcare sector. Hospitals are constantly faced with increasing costs or changes required to enhance efficiency. People live longer nowadays, and this is due to advances in diagnosis and causes of diseases and continuous improvements in treatments. The average life expectancy in the organisation for economic cooperation and development (OECD) has reached 80 years and continues to increase (CGI, 2014). Additionally, ageing populations are faced with more chronic conditions as they age. These elderly people occupy many hospital beds for acute specialities, which imposes a huge burden on the cost of care. Davalos & French (2011) assert that demographic changes and disease burden shifts profoundly affect the quantity and type of healthcare services required. Hence health reforms should emphasise prevention and early intervention.

Technological pressure - Cresswell & Sheikh (2015) posit that the healthcare sector is undergoing rapid digital transformation due to digitalised care processes. Technology has positive impacts on healthcare but also comes with its challenges. One of its positive benefits is the advent of telemedicine. Telemedicine, remote diagnostic tools and advanced communication tools have been reported by Sukkird & Shirahada (2015) to improve the quality of care and reduce the cost of care. Medical professionals have embraced technological advances to develop community-based care. They provide more interactive ways of curing, caring and training. Good examples are the telecommunication and computer technology industries. Many of these technologies have helped immensely with developing a less institutionalised health service and reducing the need for inpatient service in the future.

However, healthcare facilities are mandated to follow compliance rules, regulations and laws. Sometimes these laws hinder the adoption of new technology. This results in many hospital facilities avoiding using and procuring advanced technology. Another challenge that comes with the adoption process is the training of employees. Regulations change over time, and the employees are trained to adapt to the existing regulations. Once a new regulation is enacted, employees have to be trained all over again, making it difficult for organisations as the employees become overwhelmed.

Furthermore, as highlighted by Cresswell & Sheikh (2015), there is a need to adopt the greater use of health information technology (HIT). HIT is very crucial during the transformation change process in the hospital environment because it consistently delivers accessible, high quality and safe care to all. There are quite a high number of deaths in hospitals globally which can be prevented. The NHS reveals that an estimated 12 000 avoidable patient deaths occur in English hospitals annually (Hogan et al., 2012). HIT adoption can reduce these figures by enhancing quality and safety care and improving outcomes. Different applications of HIT include storage, management, and transmission of data; decision support tools and facilitating care from a distance (Esdar et al., 2021).

Economic pressure- Healthcare costs are a common concern for most countries globally. Good health holds an important position in the maintenance of economic

development. This is because health is a prerequisite for the outcome of a country's economic development, which contributes to the attainment of sustainable development goals (Hlafa et al., 2019). Interestingly, the WHO (2018) reveals that developed countries like the USA spend about 14 % of their GDP on health care. This compares with nine % in South Africa and 3.75 in Nigeria, and this is due to the economic downturn in recent years. According to Notara et al. (2013), the economic downturn has greatly impacted the public healthcare system since the cost of care is lower and people tend to shift more towards public healthcare facilities. Consequently, the economic downturn increases unemployment rates, adversely affecting the population's mental and physical well-being. Unemployment is the major driver of inequality and relative poverty. Thus, decreasing unemployment, which leads to higher income, can promote good nutritional intake and quality of life (Chreim & MacNaughton, 2016). The economy shapes the interaction among health coverage, employment and cost.

2.4 The Classification of Hospitals

Carr (2010) states that healthcare facilities encompass many types, from small and relatively simple medical clinics to large, complex, and costly teaching and research hospitals. The main function of a hospital is to provide people with complete health care; it also functions as the centre for training healthcare workers (Booyens, 2015). A healthcare facility (for-profit and non-profit) is generally where healthcare is practised regularly. The healthcare sector includes diverse healthcare facilities and activities, ranging in size from large general and specialist hospitals to small medical and dental offices and clinics. Mogotsi (2014) stresses that hospitals can be differentiated based on various factors, including functionality, size, location, ownership, control, and specialisation.

- a) **Functionality** – general-purpose hospitals, teaching hospitals, acute care facilities, long-term hospitals, community hospitals, and research hospitals. Hence these hospitals function within the communities they serve.
- b) **Size and capacity**- these hospitals are classified according to the number of beds they have. Hospitals having more than 500 beds are large hospitals. Hospitals with

bed capacity from 200 to 500 are called medium hospitals; hospitals with less than 200 beds are small hospitals.

c) Ownership or control

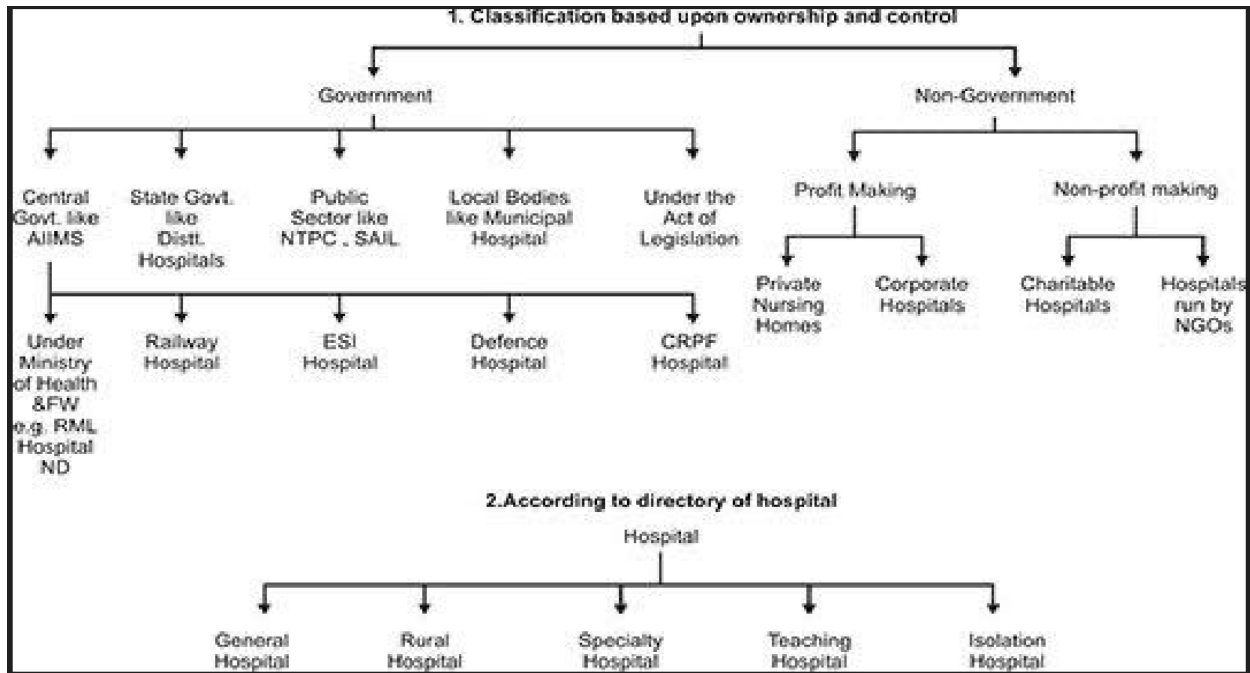


Figure: 2.1: Hospital Ownership, Booyens, 2009.

Based on ownership or control, hospitals are classified into the following:

1. Government or public hospitals

- Public hospitals are hospitals that are run and managed by the federal or state government;
- They operate via grants and other public funds;
- They can be general or specialised hospitals; and
- They have higher restrictions but also reach out to community members who may not afford private healthcare and medical treatment;

2. Non-Governmental hospitals:

Non-government hospitals are supported by clients' fees, donations or endowments.

They are further classified as proprietary or non-profit hospitals.

- a) Individuals, partners or corporations own proprietary/Private hospitals, are operated based on profit earning and are registered under the companies' act. They offer access to the latest technologies and equipment.
- b) Non-profit hospitals are categorised as voluntary hospitals, private nursing homes and corporate hospitals.
- c) Voluntary contributions and operations under trusts support voluntary hospitals. These hospitals may also be charitable;
 - Nursing home facilities are owned and managed by individual doctors. They provide skilled nursing care and specialised medical services to elderly or disabled patients. Some of the nursing homes provide only maternity care; and
- d) Corporate hospitals are public limited companies formed under the Companies Act and are run on commercial lines. They can be either general, specialised or both.
- e) Directory of the hospital- according to the directory of the hospital, other classifications are as follows:
 - General hospitals provide medical care services in many specialities, and thus there are no restrictive departments;
 - Rural hospitals are located in rural areas and provide services to community members;
 - Speciality hospitals provide specialised medical care like Tuberculosis (TB) hospitals, eye hospitals, heart hospitals and cancer hospitals;
 - Teaching hospitals are hospitals affiliated with medical colleges. They provide medical education and training to medical students; and
 - Isolation centres provide patient care for communicable diseases like Ebola and COVID-19. These centres are built to provide infection control measures and prevent transmitting communicable diseases from a patient to other patients, healthcare workers, and visitors (Mogotsi, 2014).

2.5 Hospital support systems

Different departments are responsible for providing the levels of services required to run a hospital. These support services are necessary for the hospital to thrive in patient care

and drive operational improvement. The World Health Report (2000) addressed questions about the elements of good health systems and the monitoring of system performance, highlighting that systems that work don't happen overnight; there is a need for planned, designed and built. A system approach is an important tool in management's planning and control functions. A system can be open or closed and is described as a set of goals and elements in interaction to achieve a specific goal (Booysens, 2009). A system is a collection of parts or subsystems integrated to accomplish an overall goal in an organisation. Its overall behaviour is dependent on the entire structure. The hospital system is open and applies scientific insights to understand the elements that influence health outcomes; models the relationship between the elements; and alters design, processes or policies to produce better health at lower costs (Amin, 2018). The elements of a system are represented in Figure 2.2 below.

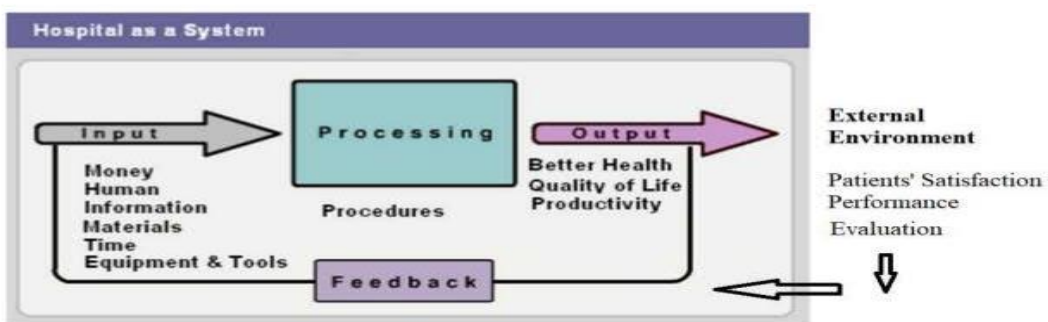


Figure 2.2: The Hospital system approach, Hayajneh, 2017

Input: This is the operating material of the system and includes factors such as facilities, human resources, equipment, finances, and clients. Inputs are strongly influenced by the environment within which they function (Booysens, 2009).

Process: This pertains to the process by which the system transforms the inputs into products and services to achieve goals. In a typical hospital environment, the processes usually include actions, activities, interactions, treatment and care.

Output: After the transformation process, the result is output. These may be either satisfactory or unsatisfactory in terms of the healthcare result of the patient.

Feedback: As part of monitoring and evaluation, feedback is required to communicate system errors to improve results.

Bhattarai (2010) notes that the hospital support system is critical to the facility's operations. Thus, failing to properly invest in it results in a higher workload for healthcare workers, unnecessary costs and poor patient experiences. As mentioned above, a hospital system is open and strongly influenced by the environment in which it functions. Uzochukwu et al. (2015) believe that the health system is part of a complex environment consisting of political, cultural, economic, ecological, social, legal and technological factors. Many actors influence the political and economic health environment. Federal governments are centrally involved in health regulation and provision – from public health measures (for example, the control of epidemics) to specific private sector regulations (for example, regulation of tariffs charged to clients) Healthcare managers should always be cognisant of the factors which may affect their relationship. Typically, a health system includes all activities primarily to promote, restore or maintain health. The goal of a health system is to improve the population's health and raise the level of health through creating sustainability in the system, innovation, improving access to health care and community involvement and participation (Booyens, 2015).

UCT (2005), cited by Gopee & Galloway (2017), describe that some of the functions of a health system include:

- Financing of healthcare within specific budgets;
- Provision of various services within the healthcare context;
- Resource generation; and
- Stewardship (set rules and standards; establishing equity for all participants in the system; and strategising direction for the system).

Dennil and Rendall-Mkosi (2013) assert that a health system responds to people's expectations and should provide financial protection against the cost of ill health. Figure

2.3 below demonstrates the two important keys to delivering good health in a system, i.e. the best average level health of health possible (goodness) and the reduction of inequalities (fairness).

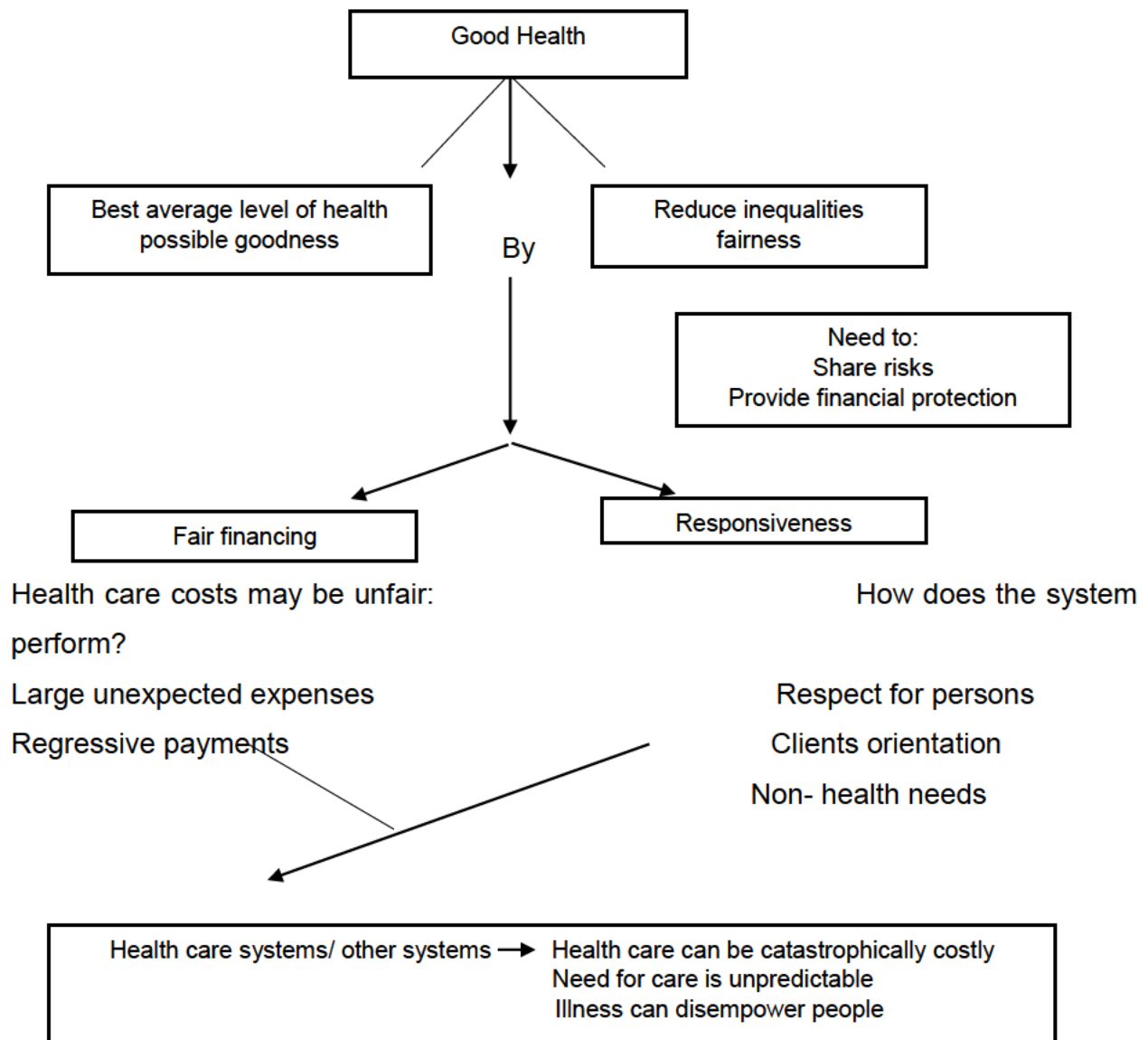


Figure 2.3: A health care systems framework, UCT, 2005

2.6 Hospitals in South Africa

According to the WHO (2006), most patients in South Africa access health services from the national health system via the district health system, which is the platform for health provision within a PHC approach. Emphasis is placed on the primary level of healthcare services since South Africa uses the PHC approach in their health system to deliver healthcare. The International Conference on Primary Healthcare (1978) reaffirmed the WHO's definition of health and acknowledged the gross healthcare inequalities in developed and developing countries (WHO, 1978).

PHC was defined as:

Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self –determination. It forms an integral part of the country's health system, the central function and main focus and the community's overall social and economic development. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work. It constitutes the first element of a continuing healthcare process. (WHO, 1978).

There is a major gap between private and public hospitals in South Africa. Conmy (2018) states that the current system has private and public sectors with an uneven distribution of economic funds to different regions. The private sector is made up of medical insurance schemes that were designed initially to exclude black South Africans. The schemes were established for white miners that did not want to receive the same healthcare as the black population. The cost of medical insurance makes quality health care inaccessible to most citizens as the scheme covers less than 15% of the population. Public hospitals are usually government funded but have many drawbacks, such as the long waiting period, poor quality care, old facilities, lack of healthcare personnel and poor disease control and prevention. Private hospitals offer many advantages and are much better than public facilities. Although private healthcare is expensive and not funded by the government, some advantages include the short waiting period, quality care, better facilities, adequate resources and highly skilled personnel, and proper disease control and prevention practices (Montgomery, 2016).

There are five levels of hospitals regulated by the National Health Act, NHA (2003) (Act No.61 of 2003), including:

- Level 1: District hospital – classified as small, medium and large hospitals. The services included trauma and emergency care, inpatient care, outpatient visits and paediatric and obstetric care. These services are provided by family physicians, paediatricians, obstetricians/gynaecologists, general practitioners and clinical nurse practitioners (PHC). For example, Wentworth Hospital, Durban, South Africa
- Level 2: Regional hospital – at the general specialist level, these hospitals receive referrals from district hospitals and provide specialist services to the district hospitals. They also serve as a platform for training healthcare staff and research purposes. Health care provided at this level will require the expertise of teams led by experienced specialists in general surgery, internal medicine, orthopaedics, obstetrics & gynaecology, family medicine and radiology. For example, Addington Hospital, Durban, South Africa
- Level 3: Tertiary hospital – they provide specialist and sub-specialist care to a number of regional hospitals, research and training to healthcare staff. Health care in this level will require the expertise of teams led by specialists in areas like cardiology, ear, nose and throat specialist (ENT), diagnostic radiology, craniology, human genetics, surgery, paediatrics, general medicine, obstetrics & gynaecology and anaesthetics. For example, King Edward VIII Hospital, Durban, South Africa
- Level 4: Central hospital - these hospitals render highly specialised and quaternary care nationally and serve as a research and training platform for health care staff". They are highly specialised referral units to other hospitals and provide high-cost and low-volume service. These hospitals boast advanced technology and highly skilled employees. For example, Inkosi Albert Luthuli Central Hospital, Durban, South Africa
- Level 5: Specialised hospitals – these are hospitals that are dedicated to serving a specific kind of speciality, such as psychiatric hospitals, which are for mentally and intellectually disabled people; Tuberculosis hospitals serve the acutely ill and TB patients; and rehabilitation centres that specialise in rehabilitating persons with

physical disabilities (Mogotsi, 2014). For example, McCord's Eye Hospital, Durban, South Africa.

The DOH (2012) “connotes that one of the most crucial aspects of this policy is to ensure the reclassification of hospitals to address issues of equity, affordability, efficiency and effectiveness. Bradshaw et al. (2006), cited in Coovadia et al. (2009), suggests that modern South Africa is a multiracial democratic country, with the black African majority (79,2% of the population), white minority groups (9,2%), coloured (9%), and Indian (2,6%). These terms do not imply acceptance of any form of racial attributes. The National Revenue Fund funds the South African health system; this fund is a collection of payments to the local, provincial and federal governments. However, the fund allocation to different provinces is based on population size. The National Health Insurance (NHI) initiative has established new plans to increase taxes by approximately 25,4% and create government-sponsored health insurance plans to pool into national insurance plans (South Africa Department of Treasury, 2017). This plan is established to encourage the wealthiest in the country to pay into the public plans to purchase health products and services directly from public and private hospitals.

The WHO (2000) ranked South Africa 160th in the world when enacting progressive and equity-driven health policies. The 1996 Constitution of the Republic of South Africa established the right to healthcare, food, water, social security, life, and the environment for all citizens. Delobelle (2013) argues that SA has a higher healthcare budget than other Sub-Saharan African countries, but the distribution of these resources remains disproportionate. In South Africa, the health sector is categorised into private and public hospitals with uneven distribution and allocation of funds to different provinces; the private hospitals boast medical schemes designed to exclude black South Africans (Mayosi & Benatar, 2014). Few South Africans can afford medical insurance, and the pools are continuously shrinking due to economic strain. With the rise in premiums, co-payments and out-of-pocket spending, medical schemes have less demand. However, consumers still prefer private hospitals due to the merits such as access to choose your doctor or specialist, shorter waiting times, quality care and better medical facilities. The large public hospitals serve the black African population with services ranging from PHC

to secondary and tertiary care offered at state-owned hospitals offering affordable medical care (Montgomery, 2016).

Abaerei & Ncayiyana (2017) posit that the disease burden of HIV challenges the South African healthcare system. SA has the largest number of HIV patients globally, with about 7.1 million (18.9%) cases. This has placed a huge strain on its economy. Some of the key areas South African hospitals can improve in include (Chopra et al., 2019):

- Attracting more resources whilst improving their efficient and equitable allocation and delivery of quality healthcare;
- Regularly collecting and managing data for monitoring and evaluation;
- Harnessing other sectors (private, voluntary, etc.) for better levels of healthcare; and
- Becoming more flexible and innovative to address changing needs of the population.

Whilst dealing with major health challenges, hospitals are duty-bound to ensure the continuity of care and services for patients under all circumstances. Hence, the government developed social health insurance which was presented as the NHI plan to reduce disease burden, improve overall health and make health care more affordable and accessible for South Africans (DOH, 2009).

The main challenges confronting public hospitals in South Africa are unmanageable patient loads, deficient manpower and a decline in the quality of services. McIntyre et al. (2017) argue that the allocation of resources is focused on national redistribution, which includes shifting resources from tertiary care towards PHC and community-based care in disadvantaged areas. Although redistribution of resources in public hospitals includes establishing tertiary care hospitals in the disadvantaged areas of Eastern Cape and KZN, posting health care workers in these areas can be challenging due to insufficient HR (Abaerei & Ncayiyana, 2017).

The pressure of migration on healthcare workers within South Africa, from rural to urban, public to private, results in a highly uneven distribution of skills, thus affecting the equitable provision of health services. On the contrary, Barr & Dowding (2019) assert that the emigration of healthcare workers outside the continent to countries like New

Zealand, the United Kingdom (UK), Canada, the USA and Australia has a huge impact on the public health sector.

Brain drain is associated with the migration of healthcare workers and is triggered by push and pull factors. Some of the push factors inherent to the health system may include low remuneration and salaries, poor working conditions, disease burden, job burnout, lack of opportunities for personal development or extrinsic to the health system, such as quality of life, social and political security, and education opportunities (Chopra et al., 2019). The pull factors include improved living standards, working conditions, and career prospects. Gopee & Galloway (2017) further argue that the migration of healthcare workers in South Africa should not only be attributed to the prospects of higher wages and better working conditions but also to dissatisfaction with the political instability, particularly violence and crime.

2.7 Hospitals in Nigeria

The provision of healthcare facilities is required to sustain human life. However, the provision of healthcare facilities in Nigeria today seems to be at its lowest, as many Nigerians are vulnerable to death (Abel, 2014). Demographically, with a population of 206 million, Nigeria faces the risk of limited health resources to cater for the growing population (Population Reference Bureau (PRB), 2020). Nigeria ranks as Africa's largest economy. Despite her strategic status in Africa and the large national resources from oil and gas, the country holds a GDP per capita of US\$ 5070, lower than the global average of US\$ 11 428. Thus, reflecting a low percentage of the budget allocation of only 3.8 % of the GDP to health (WHO, 2018).

This can be listed as contributing to the poor distribution of health infrastructures across the country, thereby predicting key health indicators. Healthcare amenities like medical equipment, infrastructure and employees are insufficient. Osain (2011) infers that the country continues to demonstrate a lack of cooperative efforts, poor distribution of services, a lack of amenities, insufficient infrastructure provision, depletion of resources and a lack of quality of care. Furthermore, the doctor-to-patient ratio in Nigeria is

1:3500, which further reduces the quality of care that is expected to be provided (Elumelu et al., 2014).

The Nigeria health system is very broad and comprises public, private, community-based organisations (CBO), faith-based organisations (FBO), and traditional health care providers. The private sector accounts for 70 % of all registered facilities in the country, while the public sector accounts for 30 % of primary care. The public health sector comprises the three-tier government structure in Nigeria- the local, state and federal government levels (Federal Ministry of Health (FMOH), 2018) and is delivered across three levels of care - primary, secondary and tertiary healthcare systems.

The LGAs are responsible for PHC. This is the entry point for community members into the health care system. Olaniyan (2012) notes large disparities in health inequities between rural and urban areas. The LGAs are the least funded due to poor financing and the Organisation of PHC, thus creating a weak healthcare system platform. FMOH (2011) states that PHC renders services such as sanitisation, family planning, prevention of infectious diseases through immunisation, health education, provision of essential health care and pre-referral care. On the other hand, the state government provides health care at the secondary level, mainly through general hospitals. General hospitals render services such as gynaecology, paediatrics, obstetrics and minor surgeries and serve as a point of referral from the PHC centres.

Lastly, tertiary facilities are the highest level of care in Nigeria, with specialist hospitals. The specialist hospitals are an important link of referrals from primary to secondary levels and provide access to medical, nursing, and allied health professionals for assessment and related diagnostic services, and are also responsible for information dissemination and training through teaching hospitals (Ahmed & Sibbel, 2014). According to the Nigerian Constitution, the local, state and federal governments provide regulations and designs of policy (FMOH, 2011). In terms of leadership or regulation, governance is a core function in theories and frameworks on health systems. It is also very critical to health system operations and their overall performance. Corporate governance is imperative because healthcare organisations are accountable to their stakeholders and the community (Barbazzza & Tello, 2014).

Nevertheless, the Nigerian Constitution failed to ensure shared responsibilities and roles in each tier of government, leading to ambiguity in the administration and management of health at each level. The local government lacks autonomy over PHC, which is predominately controlled by the state and federal departments of PHC. The World Bank (2010) cites that this lack of autonomy may have been attributed to financial dependence on state and federal funds. This argument reflects in recent health workforce crises and poor health service delivery. Crises within the health workforce have impacted global health system development and sustainability, mainly in Africa.

With the poor quality of governance in Nigeria, the quality of service delivery is constrained (Ejumudo, 2013). There is often a lack of balance in the services delivered by health care workers and coordination between management. The significance of quality healthcare is to meet and exceed the need and expectations of the customers. These customers may be external (patients, doctors, or any end user of service) and internal (employees of the organisation).

Barbazza & Tello (2014) note that healthcare managers have to be well aware of the needs and expectations of their customers in order to execute a strategy that is in line with the delivery of quality care. Significant inequities in service delivery exist from urban to rural areas across different socio-economic groups. This is evident in the unregulated private sector, which establishes well-equipped facilities that leave the poor unable to afford luxury care.

Deterioration in government facilities, low wages and poor working conditions have resulted in poor service delivery. South African health service delivery is quite distinctive compared to Nigeria's health service. The South African system is centred on the patient's needs and is given promptly. The patients perceive health services to be responsive and acceptable to them. As a way forward, Nigeria's government has to build sustainable leadership to develop strong administrative policies that align vision and goals, coordination and partnership in the health care workers and among various stakeholders (Senkubuge et al., 2014).

2.7.1 Challenges Faced by Hospitals in Nigeria

The health system continues to suffer major infrastructural damages, human personnel deficits and poor management. Nigeria is unable to meet the basic requirement for good health systems. This is a result of poor governance and HR challenges linked to ineffective integration of services. Consequently, the lack of quality hospitals in Nigeria has led to an increase in outbound medical tourism. According to Aiwerioghene (2020), Nigeria spends \$1.25 billion US dollars on medical tourism annually. An estimated 5000 Nigerians travel abroad for treatment yearly. The most popular destinations are UK, USA and India. Despite the adopted National Development Plans to redress the health sector, notable deficiencies exist, such as poor policy framework and a lack of human development and resource generation (Ahmed & Sibbel, 2014).

Current healthcare sector issues include out-of-pocket expenditure due to ineffective NHIs and poor service integration, poor working conditions, dilapidated hospital structures, lack of equipped facilities, and unreasonable financing and remuneration for healthcare workers (Aregbeshola & Khan, 2018). A study by Akinwale (2010) to investigate inappropriate facilities in Nigeria revealed that attempts to improve infrastructure had failed due to a lack of proper maintenance and corruption. The credibility of healthcare professionals has been greatly queried due to the lack of updated medical equipment and infrastructure. Yuan et al. (2017) believe there are large disparities in service delivery and the distribution of resources among the Nigerian states. PRB (2020) reported a higher shortage of healthcare workers in rural communities than in urban areas. Arguably this can be directed to poor funding at the local government level as a result of low payments to healthcare workers.

The healthcare workforce is essential to a well-functioning health system in any country. HR crises continue to be a major challenge in Nigeria. Consequently, many African governments have experienced rapid health workforce migration as healthcare workers leave for a better life. Some of the challenges are training, funding, employment and capacity building. Ojo & Akinwumi (2015) believe that the Nigerian public health sector is characterised by poorly equipped facilities and an inadequate and unmotivated healthcare workforce. These issues can be linked to poor management of resources in

the health sector. The low and inequitable distribution of the healthcare workforce is a major challenge in the Nigerian health sector. More than 50 % of Nigerian health workers are underpaid or receive late remuneration (Akinwale, 2010). The health workers regularly embark on industrial strike action due to unpaid salaries and poor working conditions. These poor working conditions can be attributed to poor welfare; lack of a reliable power supply, technology and conducive environment; and lack of essential supplies (Adeloye et al., 2017).

In Nigeria, the federal government funds the health system (public sector). It is distributed across the three government tiers to finance the country's different levels of care. These funds are mainly obtained from pooled and unpooled sources. Ejumudo (2013) highlights that the pool sources are obtained from direct taxation, budgetary allocation and donor funding, while the unpooled revenue includes out-of-pocket contributions for medical products and services, which contribute 70 % of the total health expenditure. The huge reliance on the government creates a significant barrier to access to health services due to poverty. Citizens pay out of their pockets to receive treatments in government hospitals (Aregbeshola & Khan, 2018). There are also long waiting times, many patients are left untreated and unattended to. Most people prefer to self-medicate to avoid the tedious process. Self-medication has contributed to the high mortality rate in the country. The WHO (2011) highlights that Nigeria's budgetary allocation to health barely exceeds 7% of the national budget, falling below the 2001 Abuja Declaration policy of allocating a minimum of 15% of the national budget to health.

Hafez (2018) cites that the allocation of these funds is based on the population size of each state using the federal quota system. Hence, regions with a high disease burden are left with limited funds. Bayelsa state is the least populated and records the highest infant mortality rate of 120 deaths out of every 1000 live births yet receives the lowest revenue allocation (Nigeria demographic and health survey, 2018). Chapman (2016) cites that the case of mismanagement and corruption at the different levels of healthcare has led to the lack of accountability of funds. The limited access to private

for-profit payments increases inequities in the utilisation of health care products and services.

2.8 Theoretical framework

Health care organisations are said to be difficult to change due to the complex and expensive care and treatment requirements for the increasing population of individuals with prolonged ailments (Carlström & Ekman, 2012). However, considering the changes in the increasing global technology, which gives rise to changes in organisational service delivery, it becomes expedient for organisations to understand and manage these drivers of organisational change to sustain their goal in a competitive environment. Organisations must change in order to satisfy customers and shareholders. Organisational changes do not just emerge; they are planned. Therefore, all stakeholders of the organisation must be involved before, during and after the change process to achieve a successful change programme. Several theories allow us to explain organisational change and development. In the private or public sector, models of change are very crucial as they set a guide for change interventions in the organisation. In literature, different models and theories exist to implement change in an organisation. Different organisations may utilise different change models to remain competitive in the market.

2.8.1 Kurt Lewin's Model of change

Most theories of organisational change originated from the landmark work of Kurt Lewin. Lewin's change management theory is based on a three-stage model of planned change - unfreezing, changing and refreezing which explains how to initiate, manage, and stabilise the change process. Many OD practitioners consider this framework the theoretical foundation of planned change. The assumptions underlying this model highlight that the change process involves learning something new, and withdrawing from current attitudes, old behaviours or organisational practices. Lewin believes that change will not occur unless there is a motivation to change and also that employees are the hub of every organisational change. Therefore, any change in structures,

groups, processes, rewards systems, or job design requires employees to change (Sarayeh et al., 2013).

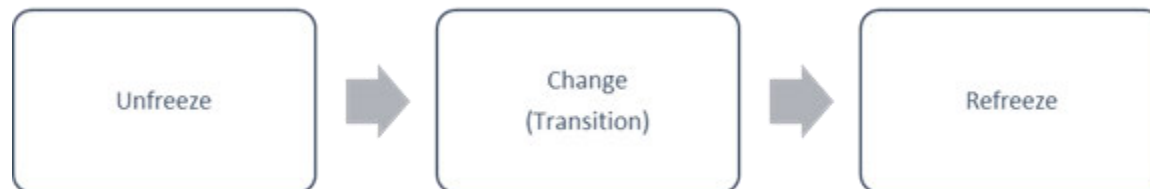


Figure 2.4: Kurt Lewin's model of change, Lewin, 1946

Step 1: Unfreeze - Sarayeh et al. (2013) depict that for Lewin, human behaviour was based on a quasi-stationary equilibrium supported by a complex field of driving and restraining forces. For change to be implemented, it must go through the unfreezing step. The focus of this stage is to create the motivation to change. By doing so, employees are encouraged to replace old behaviours and attitudes with those desired by the management. Managers usually create motivation for change by presenting information on effectiveness, efficiency, or customer satisfaction levels. This is because employees will naturally resist change. However, the equilibrium needs to be unfrozen before the old culture can be discarded and the new culture successfully adopted. This can be characterised as the ability of individuals or groups to change as fast as their environment functions. Unsuccessful organisations often ignore signs indicating the need for change (Burnes, 2017). Benchmarking is a great technique that can be used to help unfreeze an organisation. Benchmarking describes how an organisation can compare its performance to that of a high-performing organisation.

Step 2: Change— This can also be called the changing, transitioning or moving step. Organisational change, whether large or small, is carried out to improve some process, procedure, product, or service. Lewin marked this as the implementation phase involving the current state of an organisation being transformed to the desired goal, but this will not occur fairly quickly (Hussain et al., 2016). In this step, change becomes very

real. Consequently, employees resist change as they struggle with the new reality. During this transition, employees learn new behaviours, processes and ways of thinking. Hence, employers must create a strong support and communication system.

Step 3: Refreeze – This may be referred to as the final stage, symbolising the act of reinforcing, stabilising and solidifying the new status quo. The changes made are accepted and refrozen as the new norm. Viljoen (2015) highlighted that Lewin saw successful change as a group activity, and thus for changes to individual behaviour to be sustained, group norms and routines should be transformed. Hence from an organisational perspective, refreezing often requires changes to group norms, culture, policies and processes. This is an important step because it ensures that employees don't revert to their old behaviours before implementing change. Positive rewards and acknowledgement are usually adopted to reinforce the new state.

2.8.2 John Kotter – 8-step model

Kotter (1996) has further developed Lewin's theory to make it more practical in that it prescribes how managers should lead the change process. This model provides a clear description of the entire change management process. Campbell (2008) believes that John Kotter's eight-stage process for transformational change is the only model that has been successfully used in the healthcare sector regardless of the other models. On the contrary, Sarayeh et al. (2013) argue that Kotter's model only reiterates the changing employee's behaviour, not culture, strategy or process. The first four steps represent the Kurt Lewin unfreezing stage. Steps 5, 6, and 7 represent changing, and step 8 corresponds to refreezing.

Pollack & Pollack (2014) highlight that Kotter's model recommends a people-driven approach that helps employees to see the reason for the change in their organisations. Springer et al. (2012) review the use of the process to implement a cultural change at Boise State University School of Nursing; the study avails information on changes implemented within the organisation but does not focus on how the process was used to

facilitate the change done. This case study reveals that the use of Kotter's process was uncontentious. The idea behind this concept is to accept the change and prepare for it rather than change itself. These steps are:

Step 1: Establish the urgency of change- this is a critical step involving helping employees see and understand why change needs to occur (Campbell, 2008). Urgency is needed in the change process because, without it, employees do not want to perform or become complacent. Establishing a sense of urgency helps the organisation's managers fight against complacency. Complacency is often seen in employees who are satisfied with the status quo and resist change. When urgency is not established, moving to the next stage (creating a guiding coalition) becomes challenging because there is no employee commitment. Managers can create a sense of urgency by establishing open communication amongst all stakeholders and employees about the current market and competitive realities, sharing relevant financial and customer data, and discussing the organisation's opportunities and crises.

Step 2: Form a powerful coalition, leading change - in this stage, the successful change agents build a guiding team with credibility, skills, and a good reputation to provide change leadership. According to Kotter (1996), these team members must possess the knowledge, credibility, influence, and skills to mobilise change. The four characteristics of effective guiding are position power, expertise, credibility and leadership.

Step 3: Develop a new vision for change - a vision statement is a goal that is developed to reflect a sensible and appealing future for an organisation. The strategy for accomplishing the vision is a plan that provides a clear roadmap and guiding principles for achieving the desired goals. Goals give direction and purpose to organisations. Brown (2011) posits that in implementing the OD programme, managers and employees develop ideas about what the organisation needs, such as developing goals, which define the series of steps that will move the organisation along to accomplish the goals. Organisations have different approaches to goal setting. Management by objectives is a widely used method to improve total organisational effectiveness. Management by objectives produces a system of mutual goal setting and

performance review, enhancing planning, communication, and motivation. Once a vision and strategy are defined, the management creates plans with specific steps and timetables to accomplish strategies and budgets (Ramasamy, 2017). The vision and strategy creation are responsibilities of top management for an organisation

Step 4: Communicate the change vision - this step deals with how the organisation communicates the vision and strategies across the organisation by creating awareness among the stakeholders involved in change implementation. This stage aims to communicate expectations to all stakeholders to foster understanding and retention. According to Sanghi (2016), the vision of change must be communicated frequently and convincingly to all stakeholders to eradicate cynics that could lead to a failed change initiative. Vision is the essence of leadership, and it involves sharing the vision, empowering the individual, acknowledging performance, and rewarding performance. Winning the support of organisation members for the vision nearly means putting where we are going and why in writing, distributing the written vision organisation-wide, and having executives personally explain the vision and its rationale to the employees. An effectively communicated vision is a valuable management tool for enlisting the commitment of organisation employees to actions that get the organisation moving in the right direction (Hough et al., 2007).

Step 5: Empower others to act on the vision – the individual is one of the most critical elements in any large-scale organisational change. Central to empowerment is engaging all employees to develop a personal sense of pride, self-respect and responsibility and promulgating a shared vision of the future (Sutton, 2018). Employees who are empowered are more proactive and self-sufficient. The purpose is to have the individuals' purpose and vision congruent with the organisation. Employee empowerment has become a basic cornerstone of change and development programmes in many organisations.

Step 6: Create a short-term win – this is necessary to implement changes because using short-term wins eliminates any organisational discouragement. Pollack & Pollack (2014) note a win as any measurable visible, unambiguous performance improvement related to change effort – this can include actions are taken, new behaviours and

improved processes. A short-term win should materialise within 6- 18 months from the start of a change plan. Every individual wants to be a part of a winning team. Hence, the fear of failure to implement change and consequences leading to job loss makes employees resist change. The characteristics of a short-term win are shown in Figure 2.5.

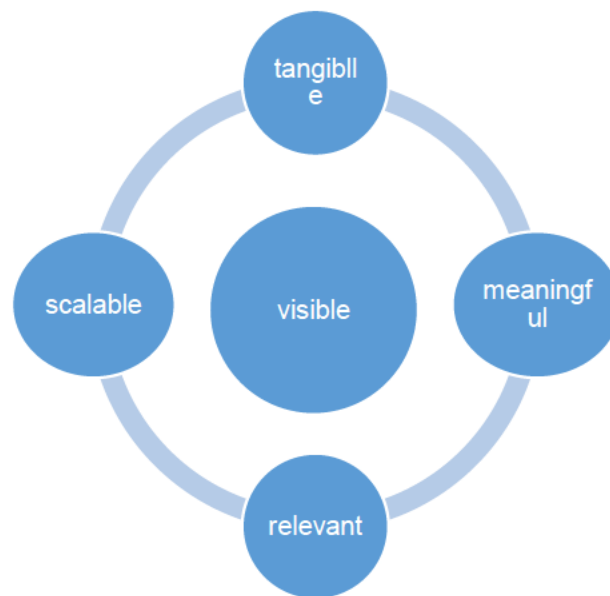


Figure 2.5: Short-term win characteristics, Lewin, 1946

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environment functions. Unsuccessful organisations often ignore signs indicating the need for change (Burnes, 2017). Benchmarking is a great technique that can be used to help unfreeze an organisation. Benchmarking describes how an organisation can compare its performance to that of a high-performing organisation.

Step 2: Change– This can also be called the changing, transitioning or moving step. Organisational change, whether large or small, is carried out to improve some process, procedure, product, or service. Lewin marked this as the implementation phase involving the current state of an organisation being transformed to the desired goal, but this will not occur fairly quickly (Hussain et al., 2016). In this step, change becomes very real. Consequently, employees resist change as they struggle with the new reality. During this transition, employees learn new behaviours, processes and ways of thinking. Hence, employers must create a strong support and communication system.

Step 3: Refreeze – This may be referred to as the final stage, symbolising the act of reinforcing, stabilising and solidifying the new status quo. The changes made are accepted and refrozen as the new norm. Viljoen (2015) highlighted that Lewin saw successful change as a group activity, and thus for changes to individual behaviour to be sustained, group norms and routines should be transformed. Hence from an organisational perspective, refreezing often requires changes to group norms, culture, policies and processes. This is an important step because it ensures that employees don't revert to their old behaviours before implementing change. Positive rewards and acknowledgement are usually adopted to reinforce the new state.

2.8.2 John Kotter – 8-step model

Kotter (1996) has further developed Lewin's theory to make it more practical in that it prescribes how managers should lead the change process. This model provides a clear description of the entire change management process. Campbell (2008) believes that John Kotter's eight-stage process for transformational change is the only model that has been successfully used in the healthcare sector regardless of the other models. On the contrary, Sarayeh et al. (2013) argue that Kotter's model only reiterates the changing employee's behaviour, not culture, strategy or process. The first four steps represent the

Kurt Lewin unfreezing stage. Steps 5, 6, and 7 represent changing, and step 8 corresponds to refreezing.

Pollack & Pollack (2014) highlight that Kotter's model recommends a people-driven approach that helps employees to see the reason for the change in their organisations. Springer et al. (2012) review the use of the process to implement a cultural change at Boise State University School of Nursing; the study avails information on changes implemented within the organisation but does not focus on how the process was used to facilitate the change done. This case study reveals that the use of Kotter's process was uncontentious. The idea behind this concept is to accept the change and prepare for it rather than change itself. These steps are:

Step 1: Establish the urgency of change- this is a critical step involving helping employees see and understand why change needs to occur (Campbell, 2008). Urgency is needed in the change process because, without it, employees do not want to perform or become complacent. Establishing a sense of urgency helps the organisation's managers fight against complacency. Complacency is often seen in employees who are satisfied with the status quo and resist change. When urgency is not established, moving to the next stage (creating a guiding coalition) becomes challenging because there is no employee commitment. Managers can create a sense of urgency by establishing open communication amongst all stakeholders and employees about the current market and competitive realities, sharing relevant financial and customer data, and discussing the organisation's opportunities and crises.

Step 2: Form a powerful coalition, leading change - in this stage, the successful change agents build a guiding team with credibility, skills, and a good reputation to provide change leadership. According to Kotter (1996), these team members must possess the knowledge, credibility, influence, and skills to mobilise change. The four characteristics of effective guiding are position power, expertise, credibility and leadership.

Step 3: Develop a new vision for change - a vision statement is a goal that is developed to reflect a sensible and appealing future for an organisation. The strategy for accomplishing the vision is a plan that provides a clear roadmap and guiding

principles for achieving the desired goals. Goals give direction and purpose to organisations. Brown (2011) posits that in implementing the OD programme, managers and employees develop ideas about what the organisation needs, such as developing goals, which define the series of steps that will move the organisation along to accomplish the goals. Organisations have different approaches to goal setting. Management by objectives is a widely used method to improve total organisational effectiveness. Management by objectives produces a system of mutual goal setting and performance review, enhancing planning, communication, and motivation. Once a vision and strategy are defined, the management creates plans with specific steps and timetables to accomplish strategies and budgets (Ramasamy, 2017). The vision and strategy creation are responsibilities of top management for an organisation

Step 4: Communicate the change vision - this step deals with how the organisation communicates the vision and strategies across the organisation by creating awareness among the stakeholders involved in change implementation. This stage aims to communicate expectations to all stakeholders to foster understanding and retention. According to Sanghi (2016), the vision of change must be communicated frequently and convincingly to all stakeholders to eradicate cynics that could lead to a failed change initiative. Vision is the essence of leadership, and it involves sharing the vision, empowering the individual, acknowledging performance, and rewarding performance. Winning the support of organisation members for the vision nearly means putting where we are going and why in writing, distributing the written vision organisation-wide, and having executives personally explain the vision and its rationale to the employees. An effectively communicated vision is a valuable management tool for enlisting the commitment of organisation employees to actions that get the organisation moving in the right direction (Hough et al., 2007).

Step 5: Empower others to act on the vision – the individual is one of the most critical elements in any large-scale organisational change. Central to empowerment is engaging all employees to develop a personal sense of pride, self-respect and responsibility and promulgating a shared vision of the future (Sutton, 2018). Employees who are empowered are more proactive and self-sufficient. The purpose is to have the

individuals' purpose and vision congruent with the organisation. Employee empowerment has become a basic cornerstone of change and development programmes in many organisations.

Step 6: Create a short-term win – this is necessary to implement changes because using short-term wins eliminates any organisational discouragement. Pollack & Pollack (2014) note a win as any measurable visible, unambiguous performance improvement related to change effort – this can include actions are taken, new behaviours and improved processes. A short-term win should materialise within 6- 18 months from the start of a change plan. Every individual wants to be a part of a winning team. Hence, the fear of failure to implement change and consequences leading to job loss makes employees resist change. The characteristics of a short-term win are shown in Figure 2.5.

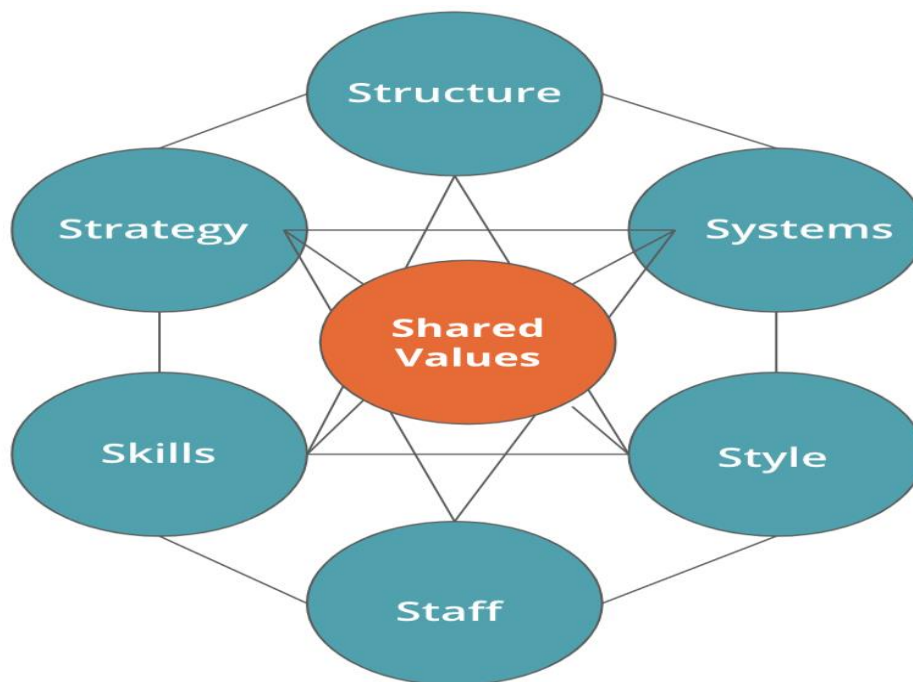


Figure 2.6: Short-term win characteristics, Lewin, 1946

- **Strategy** – relates to the management's action plan for running the business and conducting operations. Thus, an organisation's strategy is all about the competitive moves and business approaches that managers employ to grow the business, attract and please customers, compete successfully, conduct operations, and achieve the targeted levels of organisational performance (Hough et al., 2007). Strategy is the main element in managing change in healthcare organisations. Hence it must communicate the organisation's objectives and goals;
- **Structure** - this involves how an organisation is structured and organising value chain activities and business processes. The structure of a healthcare organisation is made up of a corporate hierarchy, a chain of command and a divisional makeup that outlines how their daily operations function;
- **Systems** - a system is a set of interrelated parts unified by design to achieve some goals. A system must be designed to accomplish an objective. Healthcare organisations should have proper systems in place to enhance business growth;
- **Shared values** are the organisation's beliefs, traits and behavioural norms that guide employees while pursuing its strategic vision and strategy. Shared values are the pinnacle of every organisation because they form the underpinning culture, strategy, effectiveness and performance and thus link to every element in this framework (Salvarli & Dogu, 2018);
- **Style** - aligning managerial style to suit the organisation's value system. The leadership approach that the management team exhibits influences performance, productivity and corporate culture;
- **Staff** - this refers to putting together a strong management team, recruiting and retaining employees with the required experience, technical skills, and intellectual capacity; and
- **Skills** – Skills relate to an individual's level of proficiency at performing particular tasks in achieving the objectives of an organisation. Organisations often assess their available skills to achieve the goals set forth in their change program.

2.8.4 The ADKAR model

According to Hiatt (2006), the Prosci ADKAR model was created by Prosci founder Jeff Hiatt. The ADKAR model name is an acronym derived from five tangible elements that assists organisations achieve benefits from their change initiatives depicted in Figure 2.7 below. The acronym for ADKAR can be derived as: A - Awareness of the need for change; D - Desire (to participate and support change); K - Knowledge (of how to change); A - Ability to implement skills and behaviour; and R - Reinforcement (to sustain change)

Gratiela (2014) cites that the application of the ADKAR model during the change process can separate change out into how things are done today (current state), how things will be done tomorrow (future state) and how to move the current state into the future state, which is the transition state. The model is a diagnostic tool used to diagnose the organisation as a system resistant to change, help managers and employees transition through the process of change, and create an action plan for development during change periods (Goyal & Patwardhan, 2018). The remedial measures and growth of change resistance is the key characteristic of the ADKAR model. Hiatt emphasises that achieving change in one area is impossible unless the previous acts have been addressed.

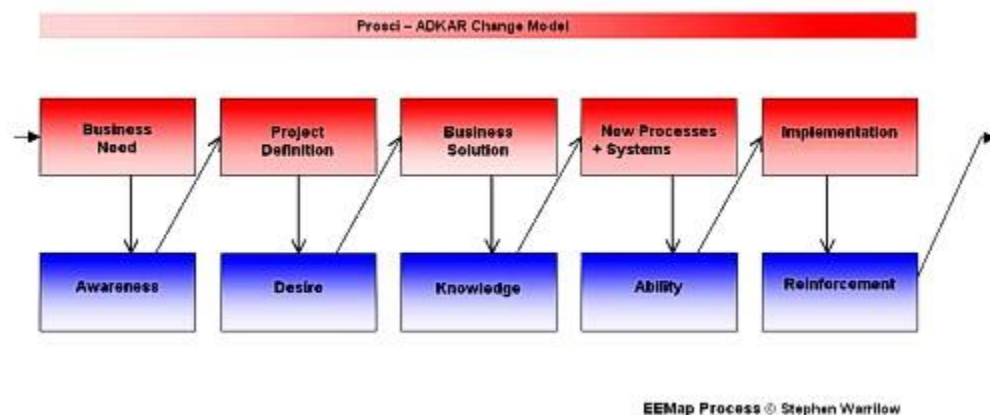


Figure 2.7: Model representation ADKAR, Warrilow, 2019

This model is easy to understand and thus focuses on individual change which is also imperative in any organisational change. The ADKAR model is very effective, and it is used for creating an action plan for employees' professional and individual development while implementing change in the Organisation (Bejinariu et al., 2017). By focusing on employees, the ADKAR method limits resistance to change and thus speeds up the implementation process. This model values employees input and support, fostering the desire to participate in the change implementation. Notably, this framework is mostly suitable for small incremental changes, as daily routines are not significantly disrupted simultaneously (Warrilow, 2019).

2.9 Organisation development (OD)

According to Kreitner & Kinicki (2002), OD is quite different from the above discussed change models. This is because it does not have a structured classification as proposed by Lewin and Kotter, but it does have the same diagnostic focus associated with the model of change systems. They further infer that OD is a set of techniques or interventions used to implement planned organisational change to increase an organisation's total effectiveness. OD is seen in Lewin's changing stage and during Kotter's steps 1, 3, 5, 6 and 7. Similarly, Brown (2011) defines OD as a series of planned behavioural science intervention activities to increase the system's effectiveness and develop the potential of all individual members. Cummings & Worley (2015) define OD as a systematic application and transfer of behavioural science knowledge to the planned development, improvement and reinforcement of the strategies, structures, and processes that lead to organisation effectiveness. Brown (2011) expound on the following characteristics of organisation development.

OD involves profound change - a planned strategy to bring about organisational change. The change agents design the change to meet some objective and it is dependent on the inputs from the diagnosis of the problem. OD is collaborative, including the involvement and participation of the organisation members affected by the changes. Hence, it is a collaborative approach. The input of all employees affected by change is important to instil a sense of ownership of the change process.

OD is humanist - OD programmes rely on a set of humanistic values about people and organisations with the objective of opening up opportunities for the increased use of people so that the organisation can become more effective (Alvesson and Sveningsson, 2016).

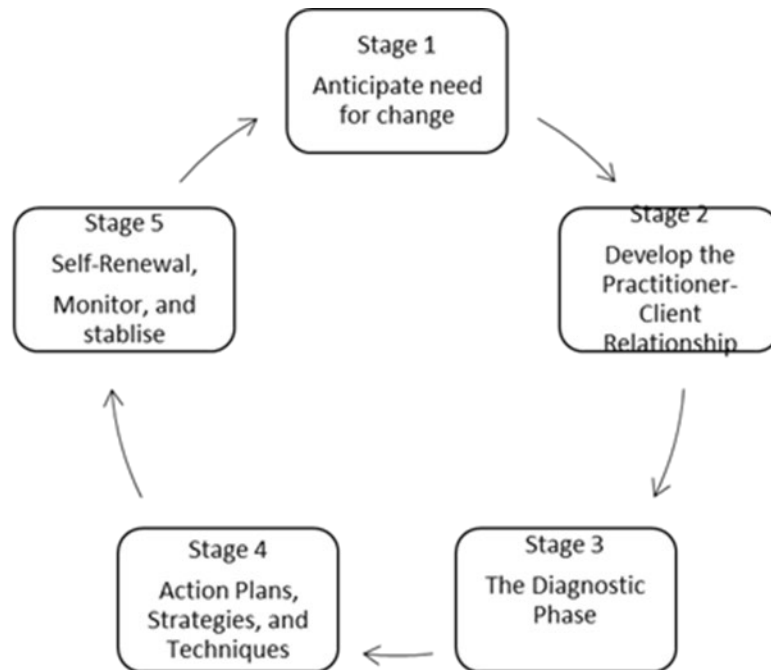


Figure 2.8: Model for Organisational Change – Five Stages of OD, Brown, 2011

Brown (2011) offers another viewpoint of change. He suggests that OD is a continuous process emphasising viewing the organisation as a system of interacting and interrelated elements consisting of several stages as shown in Figure 2.8 above. Stage one is to anticipate a need for change. People in the Organisation perceive that the organisation is in a dilemma or needs improvement. In stage two relationships develop between the practitioner and organisation members (the client). The practitioner establishes a pattern of open communication, a relationship of trust and an atmosphere of shared responsibility.

Stage three is the diagnostic phase where the practitioner and client gather data and analyse the data to identify problem areas and casual relationships. In stage four action plans, strategies, and techniques are developed to resolve identified problems to

increase the organisation's effectiveness". The plans and techniques include TQM, job design, role analysis, goal setting, team building and intergroup development.

Stage five, the last stage, is a period of self-renewal, monitoring and stabilising the OD programme. In this stage, the change programme must be closely monitored to ensure the new change is stabilised and internalised. If neglected, the system (Organisation) may regress to previous state. Zafar and Naveed (2014) highlight that "change creates resistance to change in every organisation. Resistance can simply mean employees' negative perception towards change. Employee resistance is expected in every change programme and considered a norm. Due to resistance most change programmes tend to fail. One of the key benefits to OD is increased communication, feedback and interaction within the organisation. The general goal of improving communication during change is to align all employees to the organisation's goals and values.

2.10 The WHO systems framework

Franken & Koolman (2013) opine that globally, health systems have contributed significantly to better health and life expectancy with varying degrees of success. In 2016 the WHO transitioned from Millennium Development Goals (MDGs) to Sustainable Developments Goals (SDGs) to improve healthcare quality at the ground level. The key purpose is to promote a common understanding of what a health system is and what constitutes health systems strengthening. The information-sharing and communication system has changed effectively since the introduction of the WHO health system framework. WHO formulated a health systems framework that describes health systems in terms of six core components or building blocks: service delivery, health workforce, information, medical products, vaccines and technologies, financing and leadership/governance.

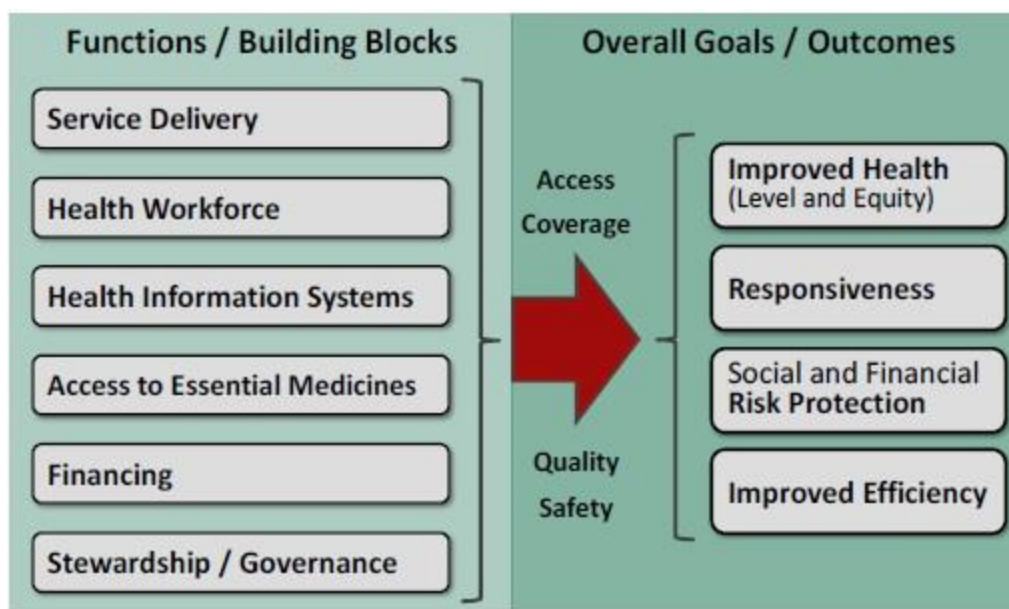


Figure 2.9: The WHO systems framework, WHO, 2007

- Service delivery - Manyazewal (2017) explains that efficient service delivery relates to health systems that deliver effective, safe, quality healthcare services to those that need them at the right time and place, with minimum waste of resources;
- Health workforce - a well-performing health workforce consists of HR management, qualified staff, job satisfaction, motivation, provision of a conducive work environment, skills and training;
- Health information systems – a well performing system ensures the production, analysis, dissemination and the use of reliable information;
- Medical products – procurement and supply programmes must ensure the equitable distribution, access, assured quality and cost-effective use of medical products, vaccines and technologies;
- Financing – an effective and efficient financing system raises adequate funds for health and ensures that people can access the required services and are protected from financial catastrophe associated with the costs.
- Leadership and governance – effective leadership and governance ensures the existence of strategic policy frameworks, new organisational practices and policies, the capacity to manage resources, combined with attention to system design and

accountability, coalition building, and innovation (Manyazewal, 2017). Good leadership is one of the most critical ingredients for a successful organisation.

Strengthening health systems in any country means improving these six components and managing their interactions to achieve more equitable and sustained improvements across the health sector. Countries at different economic levels engage with the WHO to improve their health system performance. Developing African countries are challenged with changing environment: epidemics, the impact of pandemics, HIV and Tuberculosis, the emergence of new threats and political instability. A study by Manyazewal (2017) on the current status of the six WHO health system building blocks in public healthcare facilities in Ethiopia revealed that the overall performance of public hospitals, which were in post re-form phase, was inadequate when weighed against the WHO six building blocks. The six building blocks contribute to the strengthening of health systems in different ways. Some components like leadership/governance and health information systems, provide the basis for the overall policy and regulation of all the other health system blocks. Inevitably, the core input components to the health system are financing and the health workforce. Medical products and technologies and service delivery reflect the outputs of the health system, that is, the availability and distribution of care. Strengthening a system is very challenging, hence strategies must be tailored to meet specific country requirements.

2.11 Proposed conceptual framework

The figure below depicts the interlink between the independent variables (drivers of change, organisational culture, practical implementation of change) and dependent variables (employees' performance, practical implementation of change, patients' satisfaction, and resistance to change). Regression analysis was applied in the justification of the formulated hypotheses.

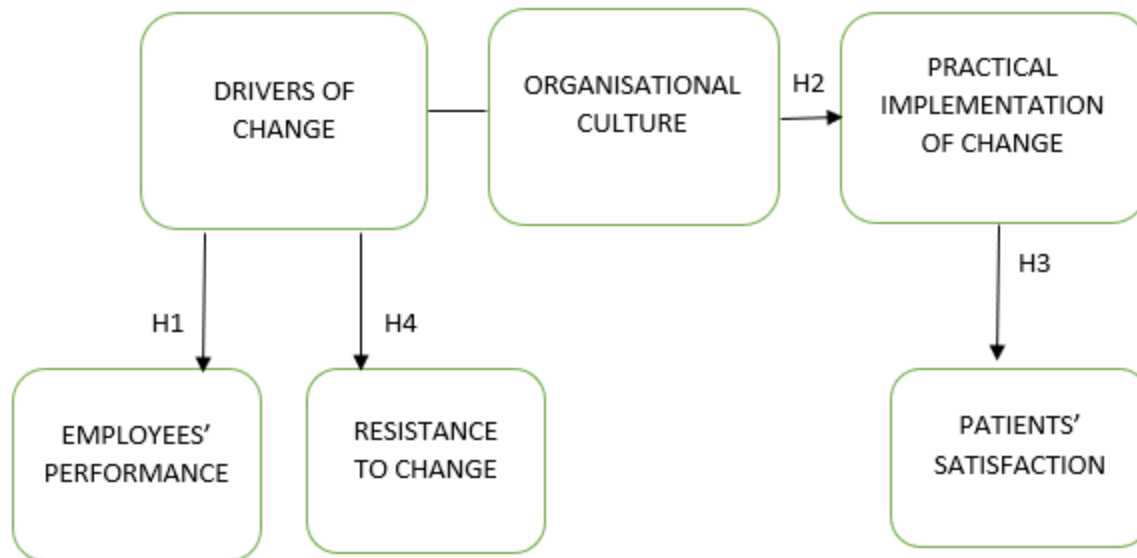


Figure 2.10: Proposed conceptual framework of organisational change management for hospitals

Source: Author's compilation

Organisational change management is an important part of managing hospitals, as it is essential for keeping hospitals efficient and up-to-date (Battilana et al., 2010). The drivers of change management for hospitals have changed over the years, and it is essential for hospitals to stay ahead of the curve and keep up with changing times. This study proposed a conceptual framework for organisational change management for hospitals. These constructs were conceived to explore the impact of change drivers on employee performance, organisational culture, patients' satisfaction, and resistance to change.

The concept of organisational change, especially in the health sector depends on several factors and employee performance is a key factor. In today's dynamic global environment, organisation do everything possible to improve performance. Various methods are being deployed to survive in this era of global change, especially with the explosion of knowledge in the information and communications world. However, it has been proven that this may be difficult to achieve without employees' efficient and effective performance (Elnaga and Imran, 2013; Tahir, Yousafzai, Jan, and Hasim, 2014; Onah and Anikwe, 2016). Like every other sector, the health sector is not left out of these challenges. The impact of change drivers on hospital employees can be both

positive and negative. Change drivers can help streamline processes and improve efficiency, but they can also require employee to adjust to new technologies and processes.

Similarly, one of the most important components of effective management of organisational culture is the use of change drivers. Change drivers are strategies that are can be used to facilitate change in an organisation, with the goal of improving its performance (Lewis, 2019). Change drivers include implementing new policies and procedures, providing training and development, and instituting effective information and technology system. When change driver is properly implemented, it will bring about significant impact on the culture of the public hospital where employees have freedom to express ideas and opinion that can improve the performance of the hospital. Also, change driver can have a profound impact on public hospitals by creating a collaborative environment where all stakeholders support the hospital, bringing about moral and commitment on the part of the hospital (Abaerei & Ncayiyana, 2017).

Furthermore, change drivers are responsible for creating an atmosphere of continuous improvement and patient-centred care. In essence, it tackles identified problems and ensures innovative solutions, implementing effective strategies to enhance patients' experience. Hence, when issues are handled and resolved, there is improved patient satisfaction, better care, and better result. Based on these constructs, hypotheses are formulated and tested. The hypotheses are stated below.

2.12 Research hypotheses formulation

Various organisational change model has been conceptualised to implement a successful change programme. However, a change model for healthcare organisations within a developing context like Africa remains elusive. Before proposing a conceptual framework of organisational change, there is a need to empirically validate the components of the change model. Hence, the formulation of the following hypotheses:

H1: Drivers of change have significant influence on employees' performance

Luo, Ma and Li (2021) investigated the effect of training, mentorship, and job satisfaction as drivers of change on 424 employees in China hotels. The authors found that training and mentoring positively influence employees' task performance directly and indirectly. Job satisfaction was also found to have positive effect on task performance. Kim, Kim, Kim, & Kim (2017) examined the relationship between work adaptability and organisational drivers among 488 casino workers in South Korea. Through the use of Structural Equation Model (SEM), the authors revealed that schedule flexibility and career development opportunity have significant effect on work adaptability, which foster employees' job performance and reduces labour turnover intention. Heidrich, Almeida and Jones's (2013) study on middle managers as drivers of change in a Local Government in Australia, indicated that middle Researmanager's leadership behaviour show positive and significant influence on employees' job satisfaction, commitment and welfare to the organisation. Furthermore, the study of Otchere-Ankrah (2015) on managing organisation change in Ghana found that introducing public-private partnership and banking services as driving forces of organisational change significantly impact the organisation's service delivery. From the foregoing, it is worthy of note that most of the research investigations on drivers of change and employees' performance are within the developed context and outside healthcare organisations. Research on drivers of change in hospitals within the African context is scarce. It is in the light of this that hypothesis one is presented.

H2: Organisational culture significantly impact practical implementation of change

Organisational culture plays a pivotal role in implementing change in any organisation. A study conducted by Allen and Kern (2001) on implementing Enterprise Resource Planning (ERP) found a significant misfit due to data arrangement and legal requirements. Iriana, Buttle and Ang (2013) demonstrated the influence of organisational culture on implementing the customer relationship management (CRM) system. The study indicated a significant and positive association between organisational culture and CRM's financial outcomes. The study conducted by Kloot and Marting (2007) in a local government that has undergone a series of change revealed

that, despite the change process, organisational culture did not address competitive practices. However, compulsory competitive tendering was achieved. These inconsistencies are one of the motivations for stating hypothesis two.

H3: Practical implementation of change has significant influence on patients' satisfaction

Patients' satisfaction has been at the heart of healthcare organisations. Implementation of change towards patients' satisfaction is well document. Bhuva, Lankford, Patel, and Haddas (2020) examined the implementation of telemedicine to aid patients' satisfaction due to the Covid-19 global pandemic. The result indicated that most patients preferred telemedicine than in-person appointment Bhuva et al., 2020). Harnett, Correll, Hurwitz, Bader, and Hepner's (2010) study on the implementation of education of clinical staff reveals that implementing changes in provider roles leads to improved patient satisfaction and reduced waiting time. In the same vein, the study conducted by Preyde, Crawford and Mullins (2015) revealed that implementing a process improvement programme in a healthcare centre corresponds with reduced waiting times, increased patients' satisfaction, and improved patients' flow. Despite the plethora of studies on patients' satisfaction and implementation of the change process, there is a dearth of research in Sub-Saharan Africa, particularly in Nigeria and South Africa. It is upon this premise that hypothesis three is formulated.

H4: Drivers of change significantly impact resistance to change

Resistance is a common attribute of the organisational change process. Most change process is confronted with resistance from the employees as a result of the effect of the change on employees' job insecurity (Lozano, 2013). Schulz-Knappe, Koch and Beckert (2019) assess 608 German employees who were recently subjected to a change process in their organisation. The authors submitted that involving employees in the change plan, with transparent communication result in positive attitude and support toward the change, thereby avoiding resistance. Boohene and Williams (2012) empirically measured motivation, communication and information exchange as change

drivers and factors influencing resistance to change. The study revealed that lack of motivation, lack of communication, less inclusion of employees in decision making, and lack of trust in management result in resistance from the employees. McKay, Kuntz and Näwall (2013) examined affective commitment, communication and participation as drivers of change on resistance to change. Findings from 102 employees affiliated to changing organisations in New Zealand and Australia revealed the relationship between contextual antecedents, readiness, and resistance to change. The above discussions show a lack of consistency in literature. Therefore, hypothesis four is stated.

2.13 Conclusion

Good governance is essential in achieving a functioning health system. The Nigerian health system lacks a strong leadership capacity and governance, hence the healthcare staff crises and poor service delivery in the health sector. Every country must ensure that necessary provisions are made to motivate and support a skilled health workforce. Furthermore, leaders should create and cultivate an environment in the health system where quality can flourish. South African health reform and transformation attempts have been evolving". The reform must focus on eradicating divided and discriminatory healthcare to improve quality service delivery, because all citizens should have equal access to healthcare services. The next chapter outlines a theoretical framework and insights into change management within the South African and Nigerian Health Sectors. Theoretical framework is reviewed in order to give methodological direction in this study.

CHAPTER THREE: EXTENDED LITERATURE

3.1 Introduction

The previous chapter discussed the nature of hospitals in South Africa and Nigeria, and identified hospital levels, hospital support systems, the environment in which hospitals operate and the need for change, as well as the challenges faced. The chapter further outlined the theoretical frameworks that aid in understanding the basis of the successful implementation of change, they included Lewin's model, McKinsey 7-S Model, Kotter's model and the ADKAR model.

This chapter presents the concept of change management, drivers of organisational change and the role of culture in change management. The key concepts underpinning the study are extensively defined.

3.2 Change management

The pace of global, economic and technological developments makes change an inevitable feature of organisational life (Cummins & Worley, 2005). Organisations operate in a period in which organisational change is so rapid that even the past eras are beginning to look good by comparison. Change is not just happening in organisations whose job it is to change and innovate like technology and software companies, but also to average companies that have offered the same product and service for many decades. Hence everyone is expected to renew, at least, the process by which they produce and deliver the same old offerings.

Khan (2014) argues that "the business world is moving very fast and new technology, new customer preferences as well as new strategies in managing organisations and motivating employees are emerging. The final output for change management is the long-term sustainability of the organisation. Increasing technological changes, globalisation, complex business models, economic pressures and customer demands have continued to force organisation leadership to change their organisation's structures and practices (Mosadeghrad & Ansarian, 2014). Lending support to the above view, Kanter (1992) cited in D'Ortenzio (2012) states that change involves the

crystallisation of new possibilities (new policies, new patterns, new methodologies, new products or new ideas) based on the reconceptualised patterns in the institution.

Hence, organisational change occurs due to certain factors which may be external or internal. The most common adopted change strategies include downsizing, reengineering, restructuring, merger and acquisition, and TQM (Van der Voet, 2014; Mosadeghrad & Ansarian, 2014). Additionally, in a recent study conducted by Bain & Company (2013) on 1208 organisations in various countries, revealed that customer relationship management, business process reengineering, and employee engagement programmes were mostly used by managers in Pacific-Asia, Latin America, and North America respectively. But within the healthcare organisations, patient-centredness has been the focus of change technique (Frampton, et al., 2017; Muls et al., 2015).

No organisation is exempt, to this extent Akinbode & Al Shuhumi (2018) state that, change is dynamic and change is the name of the game in organisations today. Wisse & Sleetbos (2016) argue that organisational change is an essential management skill that is required globally, wherever there is increased deregulation, rapid technological innovation, and a growing knowledge workforce. According to Brandt et al. (2016), change is about shifting the organisation's strategy and operations, and searching for new tools and techniques that would enable the organisation to navigate and adapt through the changes ahead.

Leana & Barry (2013) posit that organisational change is structured and intended to acclimatising to the work environment, improving overall firm performance and bringing about observed changes in employees' behavioural patterns towards work. Organisational change can either be planned or unplanned. For instance, sudden organisational exigencies can demand that managers instigate the need for unplanned change in order to remain competitive. On the other hand, a prevailing turbulent time might push managers to have a long-term change programme to avert the plausible consequences.

Odor (2018) suggested that organisations face rapid changes in three area: technological advances, environment changes, and social changes. In the business context, therefore, the scope of change management ranges from planned evolutions

and reforms to business transformation. Brown (2011) further indicates that management plays a dominant role in change management, and their responsibility to observe trends in the macro-environment and micro-environment before initiating and implementing any future change programmes.

Change management has been defined as the process of continually renewing an organisations direction and capabilities to serve the ever-changing needs of the internal and external environment (Moran & Brightman, 2001). Burnes (2017) posits that change management or organisational change is to change the activities of the organisation and this may include organisational culture, technology, business processes, job designs, HR techniques and even the organisation's brand image. Armstrong (2009) defined change as any changes in structure, management, employee, and processes. Moran & Humberman (1994) state that change management is a structured approach to change in individuals or organisations and enables the transition from a current state to a desirable future state. Change management is the process of continually updating the direction, structure and capabilities of an organisation. Furthermore, (Brenner, 2008) affirms that change management is the human factor in applying principles of change.

The starting point for setting a change programme in motion is the definition of a total change strategy. The scale of change can be categorised as transformational (radical) or incremental change (renewal). Transformational change is complex and multidimensional changes that will have a profound effect on organisational culture. Whilst incremental change is relatively simple, and the dimensional changes seldom affect the organisational culture (Zafar & Naveed, 2014). In other words, the existing conditions of the organisation would greatly determine the direction of the change programme as it were. Khan (2014) elaborates further that OD plays a vital role in the change management. Therefore, no change can be implemented without OD.

In a study regarding the tool for affecting change management implementation in manufacturing industries in Nigeria, Salami (2010) found out that change management was a vital element in the dynamic change environment. Consequently, the basic purpose of an organisational change is an adaptation to the internal and external environment or an improvement in organisation performance (Ikinchi, 2014). Ganta &

Manukonda (2014) stressed that change initiatives and programmes must align with organisational goals and visions to ensure organisational success. Change can bring about positive or negative outcomes, hence change need to be properly planned and implemented.

3.2.1 Change management in hospitals

Hospitals are in constant change due to politics, technology, relationships with patients and scientific discoveries. And there is always a requirement to increase the quality of healthcare services and patient safety. Therefore, hospitals act on the basis that they need to improve on the standards of corporate organisations through the adoption of change. Related research, like examples from a survey in Canada, presented how a change was planned in relieving health care was addressed (Pereira et al., 2016). 26 healthcare providers, patients and patient family members were recruited to plan change. The process was initiated by groups and committee. A lead transition committee was voted to complete implementation, which remains to be observed if it will be successful in future (Pereira et al., 2016)

In the Netherlands, a study focused on stress caused by change, in employees (Wisse & Sleebos, 2016). From the observation of three cases, it was found that change can cause anxiety when the consequences affect one's sense of self especially when the sense of uncertainty coexists (Wisse & Sleebos, 2016). Change in a hospital can be both an exciting and challenging time for employees. Organisational change in hospitals means that not only is the physical environment altered, but also the behavioural operations, structural relationships and roles, and the hospital organisational culture (Fitzgerald & McDermott, 2017). Buhanist (2000) highlights that change can be radical (or revolutionary) and incremental change. Radical change involves a clearly new direction and some action steps towards it. An example of radical change would be the introduction of new information systems that dramatically changes the entire work processes or organisational structures.

All these factors can affect job satisfaction, performance, stress and intention to leave. The role of healthcare employees is crucial to implementation of any change process. Pomare et al. (2019) argues that the support of actors (healthcare employees) can

determine the success of a change. Change can be resisted when imposed on employees but may be better accepted when they are involved and adopt a sense of ownership of the changes that may affect them. Cultivating a conducive environment to change requires gaining commitment and overcoming resistance. Improvement of the quality of hospital care is a fundamental element of health system strengthening that is linked directly to the service delivery of the WHO building blocks of an effective health system.

The reason for change in a hospital can be either external or internal (Lanning, 2001). External reasons include, driving forces that shape change like competition, customer demands, and regulations. These changes trigger radical change. Internal reasons can be challenging, but the organisation may have control over these changes. Examples include, staff capabilities, employee attitudes, resources, and inventions. Internal factors affecting change management in hospitals originates from the organisation itself. These factors are predictable because the leaders and management have a clear understanding of them and how to quickly analyse them.

3.2.1.1 Employees - employees are the human capital and heart of an organisation. An organisation without motivated and committed employees is unable to deliver regardless of the best resources. Employees must accept and embrace the initiative to change their organisation for more efficient and effective performance.

3.2.1.2 Organisational structure - this governs and guides the effective operation of the organisation. It outlines and clearly defines the authority and hierarchy in the organisation. Sometimes, the organisational structure may require reorganisation to accomplish the overall objectives.

3.2.1.3 Organisation processes - these are processes that need to be undertaken to produce an output to the system that offers value to customers. These various processes need to be constantly updated to keep serving the hospitals, such as new technology or the modification of existing systems.

Other factors like the organisational vision, mission and objectives, organisational culture and leadership style are also factors that are associated with the internal

environment of an organisation and have significant impact on the organisation (Nicholson et al., 2013).

Dawson (1994) has suggested that the external and internal factors are interdependent. All of the Political, economic, socio-cultural and technological factors illustrated below in Figure 3.1 will exist as part of an organisation's internal and external environments, and these would impact on the hospital's formal and informal subsystems, as well as their interrelated components.

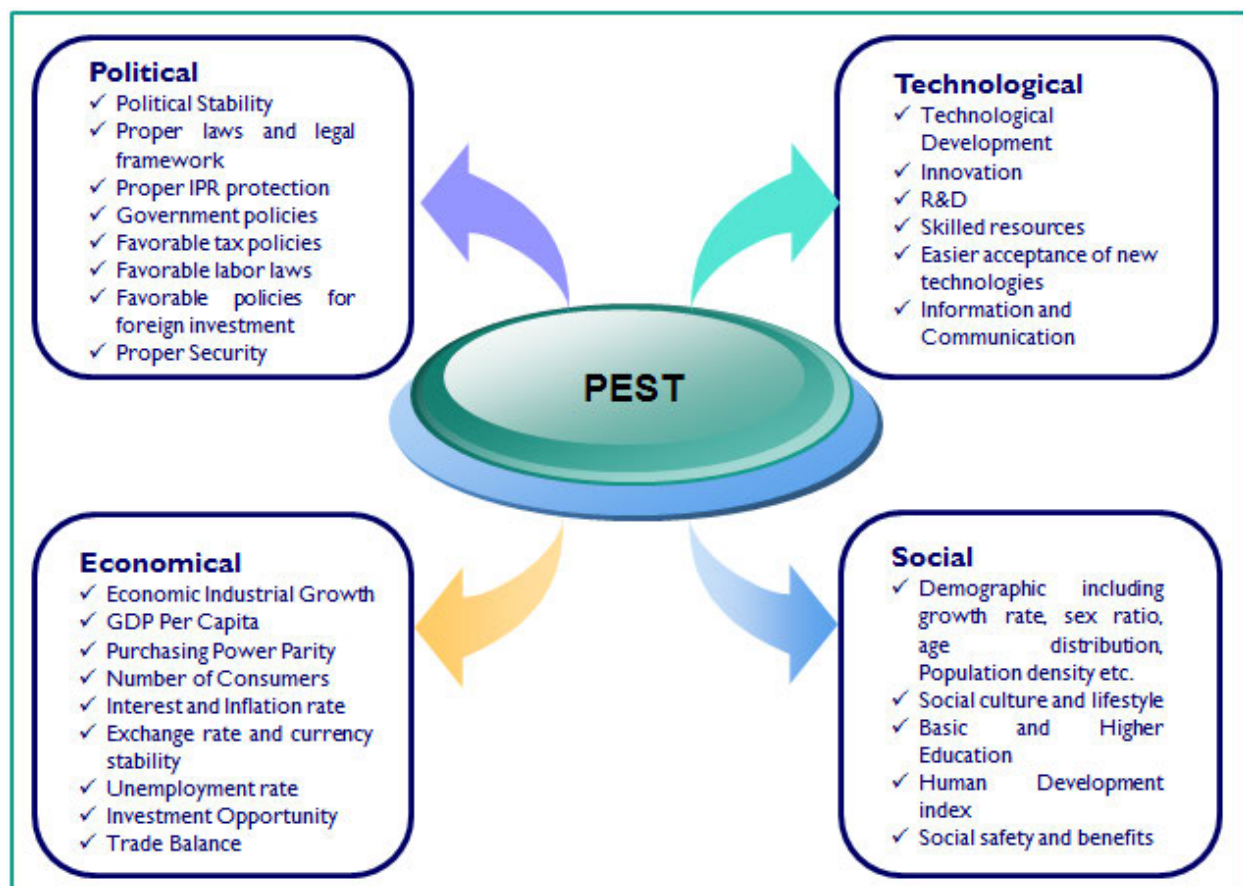


Figure 3.1: Political, economic, social and technological factors that affect organisational change, Booysen, 2007

3.2.1.4 Political Factors

The following political factors have been identified as key triggers for organisational change: government legislation, local regulations, and trade union activities. Within the

South African environment, the state is concerned with international policies and domestic policy and the wellbeing of its citizens. Policies may be government policy statements and documents, legislation, regulations and/or guidelines. The state has a central role in health policy; the process of decision-making and implementation is usually always political but should involve consultation with the stakeholders.

3.2.1.5 Socio-cultural factors

These factors influence the ways organisations are set up, run and managed as well as their capacity to attract people to work within them. Social culture and way of doing things impacts the organisational culture of a hospital. Shared beliefs and attitudes of the people directly impact their involvement in healthcare services (Ho, 2014). Some cultures prefer the traditional approach whilst others may resort to alternative medicine. Socio-cultural factors are closely linked to political factors, and within the South African context, the Employment Equity Act and Skills Development Act have been largely responsible for driving organisational change around HR planning. Some of the purposes of HR planning include:

- To reduce labour costs by helping management to anticipate shortages or surpluses of HR and to correct these imbalances early;
- To provide a basis for planning employee development; and
- To provide more opportunities for minority groups in future

3.2.1.6 Economic factors

Unemployment rates, inflation, government economic policies and interest rates are examples of triggers for change within the economic environment and provide serious concerns. These economic issues directly and indirectly influence the financial performance of a hospital and also impact public spending policies and purchasing power of consumers. In weak economies, hospitals might eliminate product and service offerings. Rising costs might deter hospital facilities from introducing new services or embracing new technology advancement. Given the backdrop of countries producing terrible health outcomes despite the large amounts of money being spent on healthcare services, and understanding of health economics, budgeting and financing is very essential.

3.2.1.7 Technological factors

Technological advancement can affect the performance of actors of change. These factors provide excellent growth opportunities in the hospital environment. There are positive changes in treatments because of technological advancements and this has led to better diagnosis and treatment of patients. Developments of technological applications allows patients to get care faster than ever before. The use of information technology in hospitals enables healthcare workers to store and retrieve patient's health records data. The use of this tools safeguards patient safety and enhances employee efficiency and ease of workflow.

3.3 The driving forces on resistance to change

Driving forces are anything that increase the inclination of an organisation to implement a proposed change programme. Stakeholders' demands, employees' commitment, policies and strategies have continued to shape the nature of most organisations particularly in the healthcare industry. A study conducted by Avgar et al. (2012) in the United States revealed that the decision to invest in the implementation and use of new information technology is a driver of organisational change within healthcare organisations. In Italy, Pinzone et al. (2016) empirically investigated the interplay between stakeholder pressure and internal barriers in driving proactive environmental strategies in healthcare organisations. The authors found that stakeholder pressure is a significant driver for environmental protection which necessitates the adoption of strategies among healthcare organisations. Abdallah & Langley (2014) affirms that leadership and employees are the drivers that can influence change process.

Furthermore, Mandle et al. (2015) demonstrated that the adoption of open software interfaces can transform and accelerate the United States healthcare system. It should however be noted that most of the drivers of change within healthcare organisations are patient-centred. According to Frampton et al. (2017), the physical environment, workplace culture, quality human relationship, and communication approach are the driving dimensions of patient and family care within healthcare organisations. Other

drivers of organisational change have been investigated, for example, innovation (Coccia, 2016), psychological state (Crawford et al., 2014), communication (Paddison et al., 2015; Klonek et al., 2015), patient safety (WHO, 2017), technology (Maheshwari & Vohra, 2015) to mention few.

3.4 Resistance to change

The most serious challenges to improving change programmes depends on people. Managers developing and implementing change programmes must deal with resistance to change. However, the question to be answered is, what is resistance to change? Resistance simply means people's negative perception towards change. For emphasis, Agaboola & Salawu (2014) discover that the introduction of change produces a variety of reactions due to the intrinsic uncertainty of change or the alterations of employee behavioural patterns including status quo, anxiety and lack of tolerance among others.

The greater the impact on the existing culture, the greater the amount of resistance that is likely to emerge and the more difficult it will be to implement change. Every changing environment must deal with resistance to change. Change becomes inevitable for any organisation that seeks new opportunities and competitive advantage. Organisations must query the status quo by initiating a transformational change (Appelbaum et al., 2015). However, resistance to change is a major hindrance to the implementation of such transformational change at an early stage. Resistance to change can be defined as an act of non-compliance or non-participation in a change process (Appelbaum et al., 2015).

The major cause of resistance to change has been associated with the human dimension (Lines et al., 2015). Erwin & Garman (2010) provides three dimensions of individual resistance modes which include, cognitive, affective and behavioural. The cognitive dimension describes how employees perceive the change and their capability to be effective with new tasks. Affective dimension refers to the emotional and psychological reactions that employees go through about their feelings concerning the

change (Denhardt et al, 2009). The behavioural dimension defines resistance in terms of action responses (Lines et al., 2015).

However, resistance to change is a part of human nature. People's resistance is the result of their perceptions of the psychological and social consequences of change. It is important to distinguish between rationalisations and misinterpretations and the possible deeper levels of reasons for resistance. Implementation of any hospital change programme needs to take into the account of sources of resistance to change and identify strategies to tackle and deflate them. Possible sources include;

- Uncertainty regarding change to the comfort zone- unwillingness to give up familiar tasks. Employees may have a psychological resistance to change because they want to avoid uncertainty;
- Redistribution of power - if there is reorganisation, it is implicit that there will be a redistribution of power and influence. Individuals or groups who see a change as lessening their influence will strongly resist it;
- Threat to job security - there may be concern about loss of job or reduced wages;
- Threat to position power- change that causes a manager or group to lose face will be resisted;
- Conformity to norms and culture - norms and culture cannot be easily changed because of strong support groups. The greater the impact on culture the greater the amount of resistance;
- Fear of the unknown - lack of information regarding change programme causes insecurity;
- Disruption of routine – human behaviour is largely governed by habit and routine. Proposed changes that disturb habitual routines or patterns will likely encounter some level of resistance;
- Loss of benefits – employees may interpret the change as a loss of individual security; and
- Disruption of social networks – friendships and social cliques may be threatened by changes.

3.4.1 Strategies to reduce resistance

A change programme is more likely to be successful if resistance to change can be reduced or minimised. The objective is to turn the energies generated by the anti-change resistance to good. Shvindina (2017) outlined a number of strategies to minimise change that healthcare industries can adopt;

- Education and communication - information concerning the how and the why of the change programme should be communicated to all organisation employees. Clear and honest communication helps to encourage and strengthen those relationships, which can assist employees in reaching maximum productivity thereby reducing resistance (Pearce, 2014). Most managers underestimate the amount of communication needed, so it is better to use overkill than to understate the situation. A workplace operates on the effective relationships built between employees, managers and all levels of the organisation. This strategy is useful when resistance is based on a lack of information;
- Create a vision - The CEOs and leaders of healthcare facilities can create strong vision which delineates organisational aspirations for the business, providing a view of where we are going and a compelling rationale for why this makes good business sense for the organisation. A strategic vision points an organisation in a particular direction and moulds organisational identity (Hough et al., 2007);
- Participation and involvement of employees – this is also a means of recognition as it appeals to the need for affiliation and acceptance. Allowing employees to participate in planning, designing and implementation of change programme encourages them to harness their full potential (Yılmaz & Kılıçoğlu, 2013). According to Koontz & Weihrich (2016), when employees are given authority and the freedom to participate in decision-making, it encourages them to discover and harness their full potential. Participation is also a means of recognition as it appeals to the need for affiliation and acceptance. This strategy is useful when change agents are developing a practitioner- client relationship;
- Facilitation and support - employees are likely to show anger and resentment towards the challenges resulting from change. Managers should support and

facilitate employees and if possible arrange promotions, monetary rewards or public recognition for those who participate in the change program;

- Reward system - this is very vital in every change programme because it motivates the employees. Flexible reward systems that take account of the differences between individual employees can win acceptance of changes. For example, including profit-sharing, bonus, gain sharing, and stock-ownership plans;
- Climate conducive to communications - attitudes of respect, understanding, and communication will help to reduce aggressiveness on the part of the resisters and the advocates of the change programme. A climate that focuses attention on the basic issues and the relevant facts is more likely to be productive;
- Negotiation and agreement - this strategy involves negotiating or bargaining with the potential resisters on various aspects related to the change. Compromise, reciprocity and trade-offs may be necessary in building political alliances;
- Leadership - Rukhmani et al. (2015) assert that leadership influences people to do things the right way so that they will contribute to organisational goals. To ensure that alignment is created within the organisation, where employee's objectives are aligned with the organisation's goals, the organisation must have forward-thinking leadership. Leaders must be flexible to show behaviour suitable to the followers as well as the specific situation. Top management plays a direct role in change programmes and must demonstrate an ability to lead with a vision through a process of effective communication and motivation. Effective performance of a team task requires cooperation and mutual trust and thus the primary role of a leader is to provide direction, integrate actions and develop employees (Georgalis et al., 2015); and
- Explicit and implicit coercion - change agents can explicitly or implicitly force employees into accepting change. Though without risks, dismissal or transfer may be necessary with some resisters in order to bring about change. However, this strategy makes change programmes difficult to obtain and in the long run will give birth to mass resentment, dissatisfaction, a high rate of absenteeism and even low productivity.

3.5 The role of culture in change management

Many of the existing literature on organisational change involves organisational culture in one sense or another. Culture is often seen as the key issue to be changed. Culture and organisation change management are two important components of an organisation that managers must consider when planning and executing change. Ultimately, as Elsmore (2017) explains, the subject of organisational culture is generally alluded and, in some instances, has assumed faddish proportions in management literature. Hence, it is occasionally put forward as the answer to all change management woes. Changing a culture is not easy and thus time is required because culture comes from shared behaviour and working relationships. Cultures often clash following any merger, downsizing, or restructuring in an organisation. Culture is often the key to an organisation's success. Cultural change occurs as a result of a complex change strategy. High performing organisations have strong cultures.

The coinage of the concept, organisational culture can be traced to the work of Elliott Jaques in 1951 in his book titled *The Changing Culture of a Factory*. Jaques (1951) defines organisational culture as the traditional way of thinking and acting which is shared by members of an organisation, and partly accepted by new employees. Schein (1990) cited by Brown (2014) provides one of the most widely quoted definitions of organisation culture as

A pattern of basic assumptions, invented, discovered, or developed by a given group, as it learns to cope with its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore is to be taught to new members as the correct way to perceive, think, and feel in relation to those problems.

Braithwaite et al. (2017) refer to culture as consistent practices, beliefs and attitude. The authors hint that culture is correlated with organisational performance. Evidence exists to suggest that organisational culture is a crucial factor in healthcare performance (Braithwaite et al., 2017). Whelan (2016) argues that organisational culture is a complex construct and largely debated. Mohelska & Pitra (2012) concur that the complexity of organisational culture is influenced by its emotional relativity rather than rational consideration of an individual.

Hence, organisation culture is directly linked to employee attitudes and behaviour and is important in order to ensure the success of organisation change. Understanding employee behaviour and attitudes plays a very crucial role in developing the relevant interventions to guide the change process. Whilst culture may be an element of resistance to change, it is also a great enabler of organisational change. In any major change initiative, like a hospital redevelopment, it is the role of the hospital leaders and management to figure out how to harness the strong cultural attributes of their organisation to build momentum and create sustainable change (Alvesson & Sveningsson, 2017).

Mohelska & Sokolova (2015) opine that organisational culture is an elusive phenomenon characterising the quality of the social climate within the organisation and determining the dominant work positions of all workers. Culture dictates an organisation's decision-making and problem-solving processes and therefore forms the foundation for the human activity in any organisation (Van der Berg & Wilderom, 2004; Hough et al., 2007). According to Al-Shammari & Al-Am (2018), organisational culture is seen as a management tool, used in shaping and controlling the beliefs, perceptions and behaviours of individuals for the achievement of organisational goals. Odor (2018) conceptualizes organisation culture as the way an organisation operates in relation to its beliefs, values and assumptions. From the outset, organisational culture can be summarised as a set of beliefs, values, and behaviours that depict the identity of an organisation. Furthermore, Muls et al. (2015) provide a conceptual model of an organisational culture that focuses on customer satisfaction or patient-centred care as shown in Figure 3.2 below.

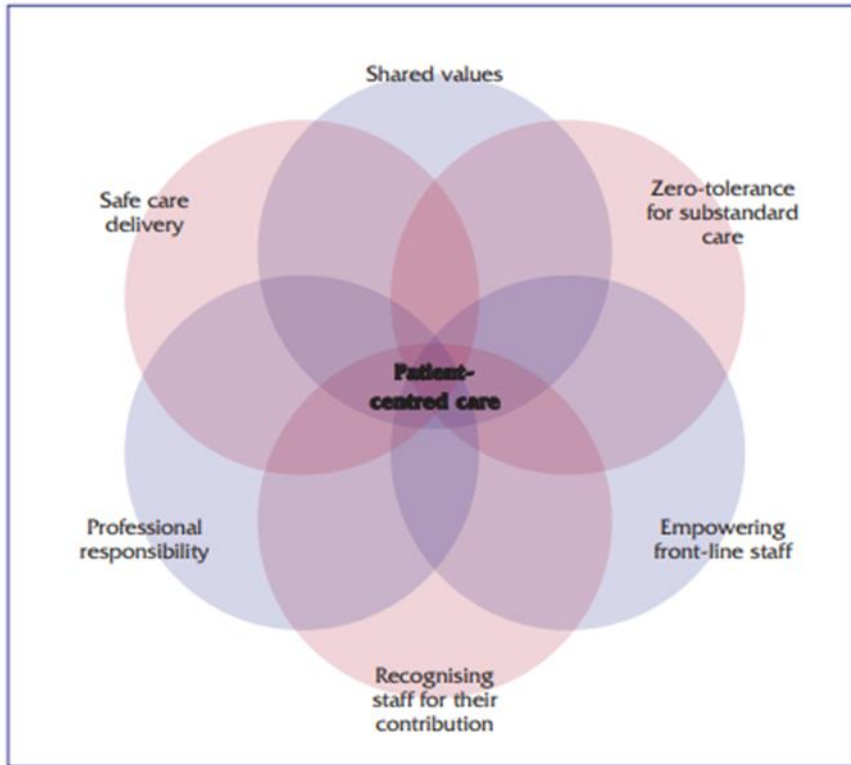


Figure 3.2: Positive Safety Culture, Muls et al. 2015

The authors believe that shared values, safe care delivery, zero-tolerance for substandard care, professional responsibility, empowering front-line staff, recognizing staff for their contribution and patient-centred care, are the essential components of culture in health care organisations. Rahimi & Gunlu (2016) also shows that companies who place a premium on cross functional team empowerment/staff motivation and training, risk taking/innovation commitment; teamwork customer-centric and staff involvement are more likely to be successful in their customer relationship management.

The culture of an organisation shapes the policy, attitudes and behaviours of members of the organisations (Johnson et al., 2016). However, the need to improve in healthcare quality and patient satisfaction requires a paradigm shift in culture. Nevertheless, change in organisational culture in the health care industry has been at the centre of debate. Stakeholders in healthcare industry who value safety and customer satisfaction mention that organisational culture is a major threat to organisational change (Carroll & Quijada, 2004). Johnson et al. (2016) concur that the culture of an organisation is

hugely challenging to management. This complexity can be attributed to the multiple and increasing components of culture within the healthcare organisations. Yet, transforming organisational culture becomes necessary when faced with dysfunctional culture systems (Johnson et al., 2016). A dysfunctional organisational culture in a healthcare organisation may lead to poor quality in patient satisfaction, physical harm or even death (Cooke & Szumal, 2000).

Despite the fact that organisational culture is critical to organisational performance (Rahimi & Gunlu, 2016), changing the culture of an organisation can be very difficult, as it influences values, behaviours and the attitudes of members of the organisation (Gharaveis, Hamilton, & Pati 2018). Evidence suggests that initiatives to change organisational culture often fail if they lack the sustainability process (Johnson et al., 2015). One of the earliest change management processes is the three stages to change process, proposed by Lewin (1951). The stages include, unfreezing (unlearning the existing order), change (process of transformation and change), and freezing (building a new mind set into comfort) (Johnson et al., 2015).

According to Lewin, the unfreezing stage involves foregoing the old mind set and behaviours. This stage requires the understanding that the status quo is unacceptable and must be discontinued, otherwise, it may become harmful to members of the organisation. It creates the necessary atmosphere for individual members to undo prevailing behaviour's and pattern of reasoning while testing the new method (Worley & Mohrman 2014). The second stage is the change period which involves transformation of the old behaviour, attitudes and norms. The Change stage requires motivation and enablement of people to adopt the new behaviours and mind-sets of doing things. The Freezing stage is associated with the sustainability of the new behaviours and attitudes through regular organisational approach. This stage suggests the transformation of the new pattern of thinking into culture for sustainability through leadership support, employee training and development and reward systems. However, there exists some level of criticism at Lewin's model of change for its broad and unspecific approach, which affects its adoption to specific organisational culture (Johnson, et al., 2015). Yet, it allows for the adoption of the framework to a broad range of culture change in many organisations.

3.6 Leadership and change management

Leaders have to exhibit appropriate leadership styles in order to promote change. The success of change is dependent on the leadership style of a leader. Through good leadership, change leaders can influence and ultimately change the behaviours of their employees, team and the organisation (Beaudoin, 2015). To ensure that strategic alignment is created in an organisation, the organisation must have far-sighted leadership. The organisation leader should be able to impart a common vision to the employees, as well as motivating them to work together as teams to achieve this vision within the organisation culture that supports the vision (Ann-Loiuse, 2015).

Leadership is the behaviour of an individual directing the activities of a group towards a shared goal. Effective leaders must view change as an integral responsibility, rather than as a peripheral one. Barr & Dowding (2019) describe organisational leadership as executive behaviour that encourages other individuals to take appropriate action. Leadership participation and styles are determinates of successful organisational change management. Chreim & MacNaughton (2016) and Nicholson et al. (2013) believe that the primary role of a leader in relation to change management is to ensure that a good process is implemented to determine what needs to be changed and how best that should happen as well as sustaining commitment and ensuring resources and support. Steven et al. (2015) identify four leadership styles related to change process: Laissez-faire, transactional, transformational and authoritarian.

Laissez-faire is a French word, meaning allow to act. The employees of Laissez-faire leadership have a high degree of autonomy. Leaders provide employees with the necessary tools to do their job without being directly involved in decision-making process, tasks and responsibilities. Laissez-faire leaders try to avoid change. However, this type of leadership can be successful when employees are skilled in their work and motivated to succeed themselves. The employees require no assistance.

Transaction leadership is also known as the managerial leadership style. The major focus of this leadership style is on planning, supervision and group performance. This leadership style establishes a clearly-defined structure that enables the organisation to meet short-term goals. Such leaders are mainly concerned with day-to-day transactions

in the organisation and hence do not really allow for much creativity and innovation in employees. They seek a compliance and punishment approach, employees may be rewarded or punished based on their performance (Ann-Loiuse, 2015).

Transformational leadership focuses on meeting organisational needs, satisfies employee's higher needs and promotes relationship-oriented behaviour. They delegate and assign tasks to employees, but also provide skills and support to complete task. Transformational leaders tend to have compassion and respect towards employees. This makes employees feel valued and empowered. Leaders who exhibit this style of leadership achieve both organisational and employee objectives. This kind of leaders are role models, build trust and develop teams by ensuring a shared vision. This is the appropriate leadership style when implementing change because a learning organisation will be able to adapt quickly to any change introduced to the organisation (Steven et al., 2015).

Barr & Dowding (2019) affirm that authoritarian leaders, also known as autocratic leaders provide clear expectations for what needs to be done. This leadership style is focused on both command by the leaders and control of followers. When a new strategy is implemented, there is no input from subordinates. All tasks, goals and decisions are made by the leader and the team faces consequences if goals are not met. This style of leadership is only beneficial to employees that require rigid processes. One of the pitfalls of an autocratic leader is creating a hostile work environment that leads to low staff turnover.

3.7 The effect of change management on patient/ customer satisfaction and employee performance

During change programmes in the healthcare system, it can be easy for management to lose focus on the patient. Change management affects the performance of employees during and after change. Employee commitment play a vital role in enhancing organisational performance. Further, St Mary's and St Joseph's hospitals employ health care workers with diverse attitudes, backgrounds and cultures, and therefore these healthcare workers should develop and maintain an attitude that will promote customer

satisfaction (Lo, 2016). Effective change management leads promote customer and stakeholder satisfaction which is critical for achieving successful competitive growth. Various work systems being implemented during change programmes can be extremely beneficial and as a result improve their performance, efficiency and organisational alignment through these systems.

At a glance, customer satisfaction is a crucial component of change management. Customer satisfaction is dynamic, however only the idea of patient-centredness/customer-centric can help health care organisation improve patient satisfaction. While improving customer satisfaction, employee satisfaction is very vital before achieving satisfaction. Fritz (2012) opines that positive influence and attitudes from employees create a climate of success, and will help to drive customer satisfaction in general, particularly when quality services and products are offered. Jooste (2016) argues that the responsibility for providing quality healthcare lies with the management of healthcare organisation. Many healthcare institutions are satisfied with their current levels of service and feel that they have a good quality management programme. However, for such a programme to **succeed** in improving the overall quality of the healthcare institution, it is imperative that dedication and loyalty of every employee is ongoing.

Oftentimes, people fail to realise the **significance** of quality healthcare, which is to meet and exceed the need and expectations of customers. Customers may be external (patients, doctors, or any other end user of the service) and internal (employees of the organisation). Healthcare managers have to be well aware of the needs and expectations of their customers in order to **execute** a change programme that is in line with the delivery of quality healthcare. Booyens (2015) cited that the DOH SA created the Patients' Rights Charter to highlight their **constitutional** rights of **access** to quality healthcare. This charter **reflects** the important rights that patients may have.

- Access healthcare, receive timely emergency care, treatment and rehabilitation;
- Be cared for by healthcare practitioners who are courteous, empathetic and tolerant;
- The choice of health service provider or healthcare facility for treatment;
- The provision of health information in a language understood by the patient;

- Referral for the second opinion; and
- To complain about the health service that they receive.

Undoubtedly, it is important to stress that during change management, new systems are introduced, processes and structures are changed, and staff rationalisations could be effected. All of these could have a significant effect on employees and if not properly managed will lead to a negative employee attitude. Therefore, it is necessary to understand the attitudes of employees within an organisation because these affect organisational performance. Employees are often concerned about the degree of change and its impact on their jobs. Wanberg & Banas (2000) opine that an employee's reaction to change could be influenced by the employee's characteristics and aspects of the change situation.

Even though Osei-Bonsu (2014) suggests that employees often respond negatively to change due to stress and job dissatisfaction. The stress can be seen in cases of heavy workload, poor communication, difficult work team, poor resources, lack of time, and staff shortage. An increase in the uncertainty surrounding changes and stress elements is associated with a decrease in job satisfaction and commitment. Absenteeism is one of the most common consequences of change management implementation in an organisation. Especially where employees are required to devote time in learning new systems and processes. Also, during change from old routines, employees may be required to take on new responsibilities which requires new skills or undergoing additional training. Many authors highlight how employees can overcome significant organisational change. Hence, it is important not to overlook employees' capability to adapt and move into new environments as an essential requirement for an organisation's performance.

In one study, Schweiger & Denisi (1991) cited by Wanberg & Banas (2000) observed that providing employees with real communication about an impending merger reduced resistance outcomes associated with the change program. Studies by Shaw et al. (1999) and Oreg (2006) found that open communication with employees was correlated with job satisfaction for 110 employees during AT&T's transition into a series of independent companies. After 12 months, the follow-up revealed that open

communication was significant to employees' attitude towards the divestiture, job satisfaction and organisational growth. Job satisfaction as defined by Noe et al. (2010) is a pleasurable feeling that results from the perception that one's job fulfills or allows for the fulfillment of one's important job values.

There are various theories of job satisfaction (Heizer & Render, 2014). However the psychological needs theory by Maslow & Herzberg (n.d.) considers the improvement of motivation a strong element in job satisfaction, such as the individual need of recognition, achievement, responsibility and status. Based on their research, by reasonable quality of work life – a job that is not only reasonably safe and for which pay is equitable, but which also achieves an appropriate level of both physical and psychological requirements. Mutual commitment and trust is reflected in employment policies that are honestly and equitably implemented to the satisfaction of both management and employees. A study by Osei-Bonsu (2014) to assess the extent of employee involvement in change management processes, assessed the impact of change management on employee job satisfaction and the attitudes of employees after change management. His study revealed that change had a positive impact on employees' job satisfaction.

Furthermore, Christian et al. (2011), highlight that employees' attitudes determine the degree of their work engagement and therefore determine an individual's performance, provided that they are familiar with their job characteristics. Employees that have a negative attitude towards their work perform poorly and at the lowest quality level. Empowering employees helps them take ownership of their jobs so that they have personal interests in improving performance. Dobre (2013) proposes that some factors which promote motivation create a favourable working environment and develop policies and practices that will result in higher level of employee performance in organisational change.

Kitur (2015) notes that employee performance plays a significant role for an organisation to achieve its objectives and goals. Also, employees are an integral part of an organisation that may affect it negatively or positively. Due to challenging environmental changes, organisations are mandated to advocate for changes that

influence employee performance. In fact, change in organisations comes in various forms such as, technology implementation, new leadership, merger, and change in product or regulation compliance and organisational restructuring (Kamugisha, 2013). For that change management to be successful and have positive impact, leaders must understand what motivates their team and promote employee participation.

According to Brown (2011), one of the most interesting approaches to motivation is the quality of working life (QWL) program, which is a systems approach to job design and a promising development in the broad area of job enrichment, combined with a grounding in the sociotechnical systems approach to change management. Great workplace conditions can build employee job satisfaction and an employee organisational commitment (Jobber & Lee, 2014). So, the employee will endeavour to give their best which can increase the employee work performance. Javernick-Will (2012) further inferred that there was evidence of directing the impacts of age on the relationship between psychosocial work conditions and wellbeing. Hence, the need for a favourable working condition is about defining the physical environment by recognising those components of the physical environment. Workers having poor working conditions will only incite negative performance, since their jobs are mentally and physically demanding.

In African, most healthcare organisations are undergoing a series of changes in order to compete globally (Olubayo, 2014). Further **emphasizing** that the rate of change in the healthcare industry has continued to soar more in the last five decades. This is as a result of technology advancements, ageing populations, changing disease patterns, new discoveries for the treatment of diseases, political reforms and policy initiatives (Nilsen et al. 2020). These changes can be challenging for the healthcare industry because they contradict humans' basic need for a stable environment. Employees are more likely to perform during organisational change in healthcare when the healthcare employees influence the change, feel prepared for the change and recognise the value of the change which includes perceiving the benefit of the change for patients (Day, et al. 2017).

Wanza & Nkuraru (2016) are of the view that change in management influences employees greatly and therefore if properly adopted and implemented would result in increased performance in employees. Kute et al. (n.d.) highlighted a positive relationship on change management factors and employee performance. Dauda & Akingbade (2011) found no significant relationship on technological changes and employee performance. On the contrary, Kute & Upadhyay (2014) examined the relationship between technological changes and its impact on employee performance in the commercial printing industry. Their study found that technological changes affect employee performance in many ways such as staff turnover, job dissatisfaction, redundancy, and demotivation because technological changes affected skills and performance.

Wambugu (2014) stresses that the establishment of strong cultures in an organisation during change management improves employee performance. The system of an organisation is based on a learning culture. Organisational culture has certain elements that enhance sustainability on the basis of effectiveness. Empirical studies have reported that improvement in productivity leads to employee commitment as norms, shared beliefs/values and objectives help in enhancing culture of an organisation (Awadh & Saad, 2013). A focus on building and sustaining organisational culture indicates to employees that they are valued and considered as an integral part of the organisation. And thus the positive energy and attitudes from employees will influence their performance.

3.8 Best practices in change management in hospitals

Successful healthcare delivery entails collective behavioural change in employees, changes in staffing, work processes, decision-making, communication and reward. The critical role played by HR managers or organisation leaders during change management has been highlighted in previous literatures (Maheshwari & Vohra, 2015). It can be argued that the implementation of change is a difficult task to accomplish, due to the complexity of the business environment (Worley & Mohrman, 2014). Similarly, there is

an indication that a major change management may be problematic without changing the underlying values and belief systems of the organisation.

It is in this sense that Worley & Mohrman (2014) assert that 70% of change management processes fail. In managing change, Ogbonna (1992) contends that one of the pivotal roles of HR functions is the development and sustenance of a strong organisational culture. Thus, the need to carefully and strategically manage the process of culture change by the HR professionals. Organisational culture has a significant impact on Human resource management (HRM) and also influences HRM practices in an organisation. It should however be noted that the major recipients of change are the employees, and the success of change management is dependent upon the employees' support (D'Ortenzio, 2012)". D'Ortenzio (2012) hints that management of an organisation must ensure that employees are practically involved in the change management process. This is because the perception of HR functions significantly **impacts** employee behaviour towards change (Maheshwari & Vohra, 2015).

Change management has been described as a continuous process that changes according to organisational demands and at the same time sustaining its overall vision (D'Ortenzio, 2012). Worley & Mohrman (2014) opine that "HR functions towards change management must take a cue from Lewin's three step model of change. These functions include, developing new behaviours, values and beliefs of organisation's structure and processes, motivating members of the organisation to embrace change activities, and providing supporting mechanism, such as rewards system to reinforce the new state of the organisation. In a similar vein, Kotter's model also shows some level of alignment with Lewin's change process that HR practitioners must take into consideration.

The basic steps in Kotter's approach include, developing a vision and communicating the change vision to organisation members. In achieving organisational change through employees' commitment to change, Maheshwari & Vohra (2015) found that HR functions must focus on culture, leadership, cross functional integration, employee training, communication and technology. Employee training entails the transfer of specific skills to an employee so that they can perform a very specific job. Training is

therefore more task-oriented in the sense that it is concerned with skills acquisition and job performance. Kash et al. (2014) argue that HR functions must align culture and values with change. Additionally, D'Ortenzio (2012) posits that organisations are subject to change from four fundamental influences which include environment, diversification, technology and people. Stemming from the aforementioned key areas of HR functions, it should be noted that organisational change is impacted by either internal or external factors or a combination of both (D'Ortenzio (2012). It is worthy to note that HR practices demand altering employees' perceptions and behaviours towards change (Maheshwari & Vohra, 2015).

Brown (2011) postulates that most managers underestimate the amount of communication needed, so it is better to use overkill than to understate the situation. Managers can stimulate employee total commitment by giving relevant information and making it readily available to the employees. A workplace operates on the effective relationships built between employees, managers and all levels of the organisation. Clear and honest communication helps to encourage and strengthen those relationships, which can assist employees in reaching maximum productivity and thus minimising resistance to change (Pearce, n.d.).

3.9 Continuous improvement processes

The healthcare of the 21st century places strong emphasis on quality and productivity. OD interventions are helping organisations like hospitals meet these challenges. Trends in organisations are toward decentralisation, fewer levels of management, a decrease in staff positions, and broader spans of control (Akinbode & Al Shuhumi, 2018). More decision-making authority is being pushed down to the lowest levels of the organisation where the employees are most aware of the problems. Through high-involvement management, line workers are planning, organising, controlling and leading. Brown (2011) opines that the design and organisation of jobs is changing to accommodate the demands of changing organisations.

Ogbonna et al. (2016) assert new concepts of health have been adopted as well as techniques and strategies for continuous improvement. Despite the implemented

programmes and activities the health of her citizens is still been threatened and impaired by poor and inefficient healthcare delivery system. On the contrary, significant improvements is still attainable if health managers and leaders will embrace effective strategies in restructuring of the health sectors for enhancing efficiency, equity and effectiveness. Some countries have relatively developed a solid health and welfare services with institutional arrangements that includes system for training and development, employing, supervising and also regulating the health personnel with well-defined mandates for ensuring safety, quality and coordination are in place. These countries have been able to modify these services taking into account the changing needs. Japan's health system is a good example as it has contributed to very good health indicators (Bloom et al., 2019). There is increasing recognition that employees offer the key to lasting change in the healthcare service.

In recent years, business process re-engineering (BPR) rose to prominence in the health care sector. One of the main concepts that underpin BPR – organisations should be organised around key process rather specialists' functions. A more recent evaluation indicated that BPR technique can be used as a prelude to change. For example, according to Kate Grimes, programme leader, transforming healthcare delivery NHS, King's college hospital London, the hospital uses a range of specific techniques for its change programme (Amin, 2018). The programme includes tackling outpatient's appointments systems and helping staff deliver bad news to patients in a more effective manner. Each project starts by 'mapping a common understanding of the current situation. This is often done by developing a process map (patient's journey).

However, this is done as a team with facilitation to reflect what happens in reality. This method has been found to alter individual's perceptions especially with the clinical professionals. BPR is a technique for organisation transformation. Brown (2014) posits that reengineering is the fundamental rethinking and radical redesigning of business processes to achieve a drastic improvement in performance. This redesign process seeks to ensure that all processes function more efficiently by combining, eliminating, or restructuring tasks to gain a large performance. Heizer & Render (2014) criticise this process as a top-down approach, but in its use of employees' involvement, empowerment and teams, reengineering is similar to the sociotechnical approach.

Less so a model, than a school of thought, the concept of learning organisations is becoming increasingly popular as organisations are being encouraged to become more adaptable and responsive to change, attempt to develop structures and systems that nurture innovation. According to Brown (2011), the learning organisation is a system-wide change programme that emphasises the reduction of organisational layers and the involvement of all employees in continuous self-directed learning that will lead toward positive change and growth in the individual, team, and organisation. According to Cummins & Worley (2005), the core values of learning organisation include the following;

- Structure: Learning organisation has flat managerial hierarchy that enhances opportunities for employee involvement in the organisation;
- Information systems: Transformational change requires more refined information systems that facilitate rapid acquisition, knowledge sharing of rich information that enables effective knowledge management;
- HR practices: Employees are recognised as the creator and users of organisational learning. The HRM focuses on provision of support to individual learning;
- Organisational culture: Learning organisations have strong cultures that promote openness, creative thinking among members;
- Leadership: Organisational learning depends largely on effective leadership. Leaders must lead the vision.

The healthcare is an open system which interacts in various ways with the components of the external environment (Waweru et al., 2013). Health sector governance changes have important implications to the design, Implementation and impact of service delivery. In 2000, Dr Wimal Karandagoda, director of Castle Street Hospital in Sri Lanka, first applied an industrial tool to the health sector at a maternity hospital (Hasegawa & Karandagoda, 2013). He experienced resistance from the workforce in the initial stage of his change management programme (Hasegawa & Karandagoda, 2013). Dr Wimal Karandagoda invented the stepwise approach from 5S to KAIZEN then to TQM.

KAIZEN is the Japanese word for Continuous Quality Improvement. This 5S-KAIZEN-TQM approach became recognised as one of the most important mechanisms of health sector reform and the Castle Street Hospital for Women became the centre of excellence of hospital management in Sri Lanka. The 5S-Kaizen TQM approach principles are the foundation of the pyramid of management. Hence making all hospitals a value co-creating organisation. The health system is a conceptual framework that illustrates the functional components the government can adopt to deliver promotional, preventive, curative and rehabilitative health services to general public. TQM is perhaps the most significant of the new ideas in management over the last few years because it is a philosophy of management that is driven by competition and customer needs and expectation.

In this respect, the term customer has a broadening meaning and is used to encompass anyone who interacts with any individual within the organisation. TQM, therefore, includes employees and suppliers as well as the people who receive organisations product and service. Feigenbaum (1950) cited in by Heizer (2014) defined TQM as an effective system for integrating the quality development, quality maintenance and quality improvement efforts of the various groups in an organisation, so as to enable production and service at the most economical levels which allow for full customer satisfaction. The objective is to create a learning organisation that is dedicated to continuous improvement. TQM concept tools are continuous improvement, six Sigma, employee empowerment, benchmarking, and just-in-time (Sunder, Mahalingam, & Krishna, 2020). The goal of TQM is not just to promote the KAIZEN programmes into hospitals, but to change organisational culture, management and learning style everyone associated with the hospitals in order to balance process, structure, outcomes and patient-centredness (Heizer & Render, 2014).

3.10 Conclusion

In this chapter, the basic components of change management have been highlighted, as well as the change management factors that trigger the implementation of change programmes". Successful change programmes consider the total organisation as well as its subsystems and also examine the way the organisation is designed, the organisation's work process, and the interaction of individuals and teams within the flows and structures of the system. The next chapter presents the research methodology adopted for this study.

CHAPTER FOUR: RESEARCH DESIGN AND METHODOLOGY

4.1 Introduction

The previous chapter provided the background literature underpinning the study. This chapter describes and explains the research methodology adopted in this study. Rajasekar et al. (2013) also asserts “that a research methodology explains the details of the entire research process. Hence, this study follows the step-by-step approaches to understanding the research procedure. This is referred to as the research onion. Like the typical onion, it comprises different layers.

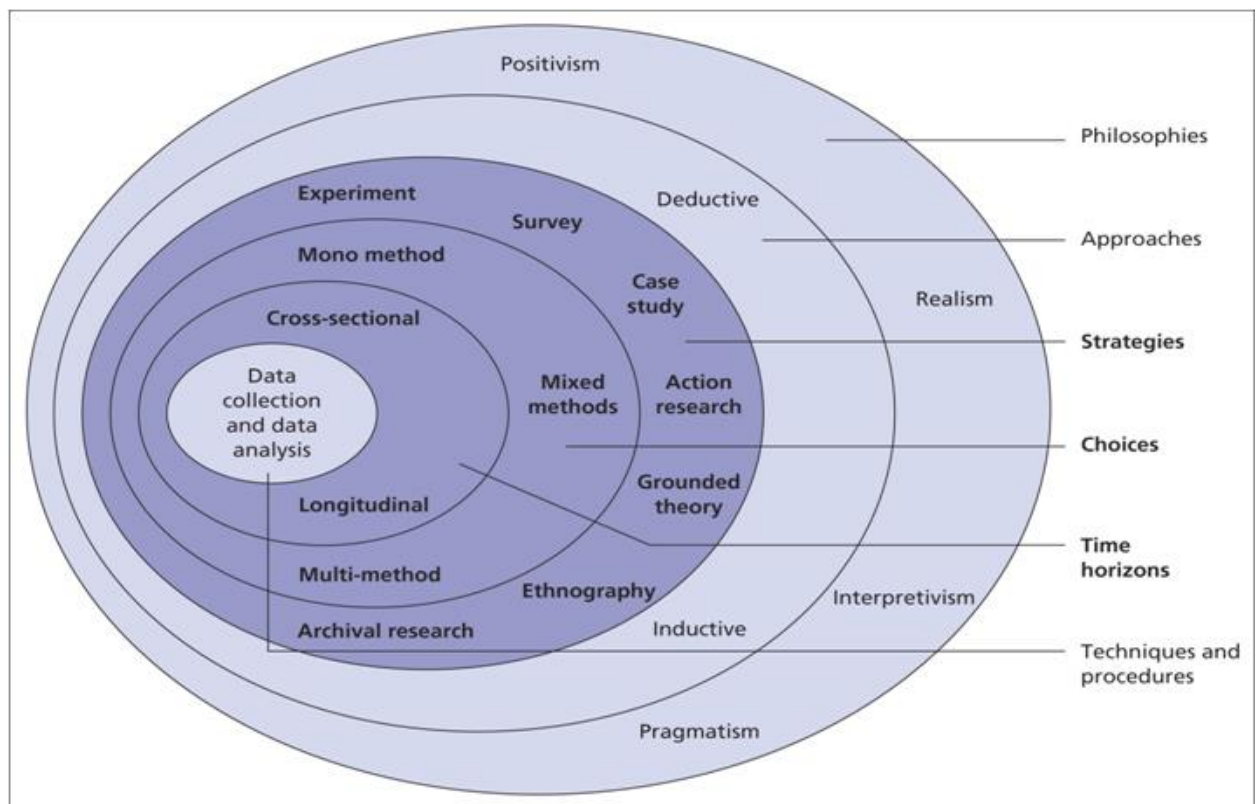


Figure 4.1: Research onions Saunder's research onions, 2009

This description clearly shows the research approach taken by the researcher in meeting the research objectives and dealing with the research problem. The details will include research design, philosophies and techniques employed by the researcher in attaining the study (Saunders et al., 2012) Other details to consider are the data collection method and instruments, data analysis and methods to ensure

trustworthiness and the process of disseminating the questionnaires. Furthermore, ethical considerations, and the reliability and validity of the study was discussed.

As indicated in chapter one, the main aim of this study was to explore the organisational change management practices in order to provide ways of dealing with organisational change in two sub-Saharan African hospitals that have undergone some change management. The study also intended to explore various factors that affect change initiatives in order to explore and understand the problem from these perspectives. The following section focuses on the research philosophy, design, and approach used to carry out the study.

4.2 Research Philosophy- Pragmatism

Pragmatism is a philosophical belief that explains knowledge from the alternative point of view. According to the proponents of this philosophy, knowledge can be objective/subjective reality (Felizer, 2010; Shank, 2013). It is a paradigm that is based on the assumption of what works, that is, practical steps to solve problems rather than just assumptions of knowledge (Maarouf, 2019). Drawing from Fetter & Molina-Azorin (2017), Barnes (2019) and Ghiara (2019), Maarouf (2019) posits that pragmatism is a philosophical belief that guides mixed-methods research. According to the author, pragmatism is a philosophy that holds that, the truth or meaning of an idea or concept is not static or fixed, but instead dynamic and can be changed over time. This further shows that any research using pragmatism must be adaptable and flexible in order to keep up with the changing nature of the truth. Pragmatism is a philosophical belief built on a comprehensive research approach with the perspective that focus more on the result rather than the method. Hence, pragmatism combines both the positivist and the constructivist points of view on the reality of truth and knowledge (Felizer, 2010). The researcher engaged Managers, Doctors, Nurses and other health and non-health workers in the selected hospitals using a qualitative approach and quantitative approach to elicit responses of change management. While questionnaires were distributed to the Doctors, Nurses and other health and non-health workers in the selected hospitals to generate the quantitative data, 10 senior management staff were interviewed to

generate the qualitative data. With the combination of questionnaires and interviews, the current study adopted a mixed-method research approach that justifies the pragmatism paradigm choice.

4.3 Research Design

According to Coldwell & Herbst (2009) and Malhotra (2011), research design is defined as the operational strategy drawn by a researcher in the quest to solve an identified research problem. Creswell (2014) provides a similar definition when he asserts that It involves the inclusive activities of the research process, which consequently determines the type of analysis to be espoused. Hence, the most appropriate research design will be one capable of enabling the researcher to achieve their research objective (Saunders et al., 2012).

Greetham (2014) concurs that a research design is an overall strategy that is chosen to integrate the different study components in a logical way of answering the research questions. Punch & Oancea (2014) further add that a research design is the basic plan for a research study that is usually concerned with the tools and procedures to be used for collecting and analysing data, especially with the question of who or what will be studied. Therefore, as stipulated by Krishnaswamy et al. (2009) and Creswell (2013), a research design can be seen as a type of enquiry within qualitative, quantitative or mixed method approaches that provide a specific direction for procedures in a research study.



Figure 4.2: Research Design Badland, 2009

Research centred on change programme strategies is often multifaceted; hence the involvement of key role players and beneficiaries is imperative. In consonance to this, the researcher opted for a mixed research approach whereby the qualitative and

quantitative approaches are utilised in gathering the relevant data to address the objectives of this study. For clarity, however, this study adopted the survey and case study research designs respectively. The survey is a positivist research design in which a sample is selected from a population and studied to make inferences about the population (Saunders et al., 2012). The adoption of this strategy helps the researcher to understand the opinion and perceptions of the Managers, Doctors, Nurses and other health and non-health workers in the selected hospitals. Also, the survey enhanced the data gathering of this study by using both questionnaires and interviews for data collection (Saunders, Lewis, and Thornhill, 2016; Ponto, 2015). Furthermore, through the knowledge gained from this method, the researcher was able to draw conclusions using statistical analysis tools on the studied population.

As postulated by Wilson (2012), survey research is employed in an investigation that is being carried out on a large population of people, events, or objects by collecting information from a sample drawn from the population. Nevertheless, the choice of survey research for this study is justified as the entire populations of St Mary's and St Joseph's hospitals could not be expediently utilised as the population for this study, hence, the need to adopt a representative sample through survey design was appropriate for easy generalisation of research findings on the large population of study. Furthermore, this study highlighted the emotional and psychological impact on the stakeholders using the various change models, which can aid managers in learning about their own organisation and implement a change strategy taking the stakeholder effect into consideration.

In addition, the researcher adopted a case study research design. Case studies are intensive investigations of the factors that contribute to the characteristics of the case under investigation (Creswell, 2014). St Joseph's Hospital and St Mary's Hospital are used as a case study. Both hospitals are situated in developing countries on the African continent. These two hospitals share a similar history as they were both previously run by missionaries before being taken over by the government. The effect of acquisition on employee morale can be significant if the reorganisation of the business is not managed effectively.

Learning a new culture can be challenging, especially when the employees are faced with the fear of the unknown. Thus, leading to employee resistance to change and reduced productivity (Teerikangas & Thanos, 2017). This case study used, offers an in-depth understanding of the phenomenon under study with emphasis restricted to the semi-structured interview of 10 selected management personnel of St Mary's and St Joseph's. Generally, case studies are most helpful when the researcher is dealing phenomena over which the researcher has little control or phenomena embedded in a real-life context (Kumar, 2011).

4.4 Mixed Methods

According to William (2011) and Salkind (2009), there are two main research paradigms which are scientific in nature and are based on assumptions, the nature of knowledge and the way in which research should be conducted, namely, qualitative and quantitative research approaches. Table 4.1 below depicts the two philosophies classified as positivism (quantitative) and Phenomenological (qualitative).

Table 4.1: Research Paradigms

Positivism Philosophy	Interpretative Philosophy	Pragmatism Philosophy
Quantitative	Qualitative	Quantitative/Qualitative
Objectivist	Subjectivist	Objectivist/ Subjectivist
Scientific	Humanistic	Scientific Humanistic(Mixed method)
Experiment	Interpretivist	Pragmatism

Source: Saunders *et al.* (2019)

Bryman (2011) notes that positivism is a quantitative research method that examines social phenomena using numerical measurement and statistical analysis of measurements. It views reality as consisting of phenomena that can be observed and measured. Coldwell & Herbst (2009) opine that quantitative analysis involves the collection of primary data from a determined population with the aim of projecting results to a wider population, whereas qualitative research is used to gain preliminary insights into research problems.

Furthermore, the quantitative method is based on meanings derived by numbers. It measures consumer behaviour, knowledge, opinion and attitudes. Such methodologies answer questions related to how, why, what and who (Yin, 2015). The advantage of this research approach is that the findings are reliable and objective, whereas the disadvantage is that the validity of the findings are reduced by the fact the social phenomena cannot be accurately and reliably measured (Cooper & Schindler, 2011).

On the other hand, Conversely, Flick (2011) suggests that the qualitative research method examines the social phenomena by gathering deep information and perceptions through inductive, qualitative methods such as interviews, discussions and respondent observation, and representing it from the perspective of the research respondent(s). Landy & Conte (2010) explain that qualitative methods recognise the value of collecting

and interpreting data from a variety of sources of evidence and often reveal a depth of understanding and richness of details. The advantage of phenomenological research method is that the findings have greater reliability and validity, whereas the disadvantage is that there is a high possibility that the findings may have poor reliability and objectivity is impossible (Ritchie et al., 2013).

However, for the purpose of this study, the researcher opted for mixed methods because the research philosophy that underpins this study is pragmatism. Pragmatism is offers a flexibility of combining methods. Pragmatism projects the benefit of both positions for the greater good (Hofer & Bendixen, 2012). The application of this theory helps the researcher to have a deeper understanding of the factors that determine the influence of driving forces of change in resistance to change management at St Mary's and St Joseph's. In this study the researcher formulated self-administered questionnaires designed in line with a 6-point Likert scale measurement ranging from (5) strongly agree to (1) strongly disagree (Wilson, 2012). Therefore, the use of a qualitative research approach produced a richness of detail through direct quotation from participants and careful description of situations, events, interactions and observed behaviour (Klenke, 2016).

Open-ended questions have been included by the researcher in both data collection instruments to gather qualitative data from the participants. The interviews guide was forfeited due to the sensitivity of the study. The researcher was surprised that participants were happy and excited with the idea of being interviewed and did not mind being recorded during the interview. Some of the participants were more concerned about ways that would improve change management practices and processes. Yin (2015) states that open-ended questions allow participants to freely furnish experiences and opinions and does not restrict the participants to preselected perceptions.

Another reason for collecting qualitative data is that it assists the researcher to make valid recommendations since qualitative data provides intimate details of the research problem. The research also adopted a quantitative research philosophy, as it is used to quantify problems by way of generating statistical data which is transformed into statistics. As Hussey & Hussey (1997) point out, the two main paradigms represent two

extremes of a continuum, using a mixed-method research benefits and strengthens a research study because it enabled the researcher to obtain in-depth information and understand the challenges that the organisation encountered during change initiatives (Heppner et al., 2015).

4.5 Target Population

This study has a target population of 540 gathered from the human resource management department of the two hospitals (see Table 4.2). The breakdown is as follows: 325 Managers, Doctors, Nurses and other health and non-health workers from St Mary's Hospital and 215 Managers, Doctors, Nurses and other health and non-health workers from St Joseph's Hospital. According to Bryman (2011), this is a group of individuals from which samples can be extracted for measurement. The group displays similar characteristics which can be used to identify necessary research information. Whitley & Kite (2013) concur that the target population refers to the full group of potential participants to whom the researcher wants to generalise the findings of the study. The population is the portion of the universe that the researcher has access to. It is often not being feasible to involve the entirety of the population due to limitation of resources (Saunders et al., 2019). For the purpose of this survey, the targeted population were the employees of St Mary's Hospital, Marianhill and St Joseph, Hospital, Adazi-Nnukwu of whom are 325 and 215 employees from different departments respectively.

Table 4.2: Target population

Sampling Breakdown – Quantitative Research		
Name	Designation	Number of participants from different departments
St Mary's Hospital	Managers, Doctors, Nurses and other health and non-health workers	325
St Joseph's Hospital	Managers, Doctors, Nurses and other health and non-health workers	215
Total		540

Source: Field survey data (2021)

4.6 Sampling

Kumar (2011) defines sampling as the process of selecting a few (a sample) from a bigger group (the sampling population) to become the basis for estimating the prevalence of an unknown outcome regarding the bigger group. Nelaankavile (2015) suggests that sampling uses a small number of elements of a given population as a basis for drawing conclusions about the whole population. Kapel (2015) further asserts that it is impossible to collect data for the entire population due to the limitation outcomes such as; time and financial constraints. Sampling is thus used to reduce the amount of data needed rather than to use the whole population of the group or sub-group (Sekaran & Bougie, 2010).

It is often not feasible to study the entire population. Hence, the goal of sampling is to characterise the targeted population and use appropriate methods that fall under the two broad types of sampling namely, probability or non-probability (Hussain & Tehil, 2011 and Neenkalavile, 2015). Probability or 'random' sampling is random sampling giving all members of the target populace a known equivalent probability of selection while non- probability sampling is a way which does not convey the selected populace a

same probability of being chosen (Bhattacharyya, 2012). The sample size for this study is derived using the Krejcie and Morgan's table as illustrated by Sekaran & Bougie (2015).

Table 4.3: Field survey, 2019

Name of hospitals	Hospital department	School department	Total	Sample size
St. Mary Hospital	248	77	325	169
St. Joseph Hospital	168	47	215	132
Total	416	124	540	301

Source: Field survey data (2021)

For the distribution the two sampling methods (probability and non-probability) were used in this study. These methods were adopted to select the sample for this study. The non-probability sampling techniques (purposive, convenience, and stratified) were deemed appropriate to select 10 senior management personnel, five from each hospital for the interviewed while simple random sampling was deployed to select 301 participants for the questionnaire survey. This makes a total of 311 participants as the sample size the Krejcie and Morgan's table as illustrated by Sekaran & Bougie (2015). A number of employees were derived from the HR department of the two hospitals. Saunders et al. (2019) justifies the significance of sampling in research by highlighting the following advantages: it is cost effective procedure for quality control, timeliness, convenience, and the adequacy of sample results.

In this study however, purposive and convenience sampling were also appropriate in selecting the 10 senior management personnel to enabled the researcher use personal knowledge to select those staff with adequate knowledge organisational change management framework for hospitals for the interview. The stratified (a type of

probability sampling technique, a type of non-probability sampling technique) were employed. Leedy & Amrod (2015) assert that the utility of the stratified sampling is justified since amongst the population of a study there exist different strata such as those working on contract and permanent terms, wage and salary earnings, males and females and those classified on junior and senior workers respectively. Therefore, to ensure non-bias in the selection of participants, the sample were divided into different strata based on the available population strata. Thereafter, with the different strata divided into groups, the number of elements were selected from each stratum with the simple random sampling technique.

For the qualitative study, purposive and convenience sampling were employed to select 10 management personnel who are in the possession of the required and useful information to organisational change initiatives. Cooper & Schindler (2012) explain purposive sampling as a generic term used to describe any sample deliberately chosen by the researcher based on a predefined nonprobability criterion. A purposive sample is an effective, time-efficient method. The adoption of the stratified and purposive sampling technique fittingly describes the utility of the mixed method research for this study.

4.7 Data collection

The terms measuring instruments and data collection instruments are often interchanged in research. Creswell (2014) affirms that a research instrument is a tool used to collect data. An instrument is a tool designed to measure knowledge attitude and skills. The data collection instrument is used to obtain realistic information that supports observations or assesses the opinions of research participants and also enriches the process of collecting research information to answer the question, or questions relevant to the research study (Mlilo, 2016).

Therefore, there are various instruments that can be used. The two most commonly used primary data collection methods are self- administered questionnaires and interviews. All research is generally concerned with obtaining answers to questions. Both these instruments, however, have distinct features that have a bearing on the

correct and appropriate use of each specific data collection purposes. The researcher utilised the following measuring instruments during the course of this research: interviews, questionnaires, as well as review of audited documents, journals, books and government publications for secondary data. According to Trochim (2011), interviews are a far more personal form of research than questionnaires.

Having identified the employees in the selected hospitals, the researcher went to the hospitals and met with the Human Resources managers to explain the objective of the study as well as the importance of the participation of their employees. Similarly, the confidentiality and anonymity of the participants and their responses in the study were assured. Furthermore, the right to the participants to withdraw from the survey if and when they no longer felt comfortable with the questions or the process was also explained. In the course of the study, the participants were asked about their age, gender, qualification, position, and years of working experience as part of the demographics of the participants for the purpose of analysis.

Cooper & Schindler (2012) further postulate that qualitative research uses focus groups, in-depths interviews, and observations as data collection methods. The research instrument for this study was in-depth interviews because it enabled the researcher to collect deeper qualitative data. A questionnaire was also used as the data collection instrument for this study. This enabled the researcher to uncover critical factors affecting St Mary's and St Joseph's hospital staff as they execute their daily work activities, and also to assess their skills and knowledge regarding change processes. The collection of data for this research study took place between June and October 2021 in both hospitals. It must be explained that the data collection took longer than expected because there was a poor response rate at St Mary's hospital as most of the participants were reluctant to participate due to the COVID -19 risks and lockdown restrictions.

The questionnaires were distributed to 301 randomly selected hospital employees (see Table 4.3). This included 169 employees from St Marys hospital and 132 employees of St Joseph's hospital (see Table 4.3). To ensure that participants understood their questions, simple English words were used, which were translated into the native

language spoken in the area of study; that is IsiZulu and Igbo. The questionnaires were directly distributed to the participants in the selected hospitals by the researcher from different departments respectively. This was a bit of a challenge as the researcher had to travel a number of times to distribute the questionnaires to these employees. The completed questionnaires from the participants were also collected directly by the researcher. The collection process was also a challenge as employees, especially those that took part in the survey, were not accessible due to the COVID-19 pandemic. This also affected the rate of return, especially in both hospitals (see Table 4.2).

4.7.1 Interview

According to Valenzuela & Shrivastava (2011), an interview involves the collection of data through direct verbal interaction (often face-to-face). When interviewing a participant, the interview situation permits the researcher to follow up leads and thus obtain more data and greater clarity. Valenzuela & Shrivastava (2011), state some advantages of interviews.

- They facilitate a full range and depth of information;
- They enable the researcher to develop a relationship with the participants; and
- They also permit the researcher to follow up verbal leads and thus obtain more data and greater clarity.

On the contrary, Neelankavil (2015) identifies the following disadvantages of interviews:

- Interviews are time consuming;
- Researcher bias in the framing of questions and the interpretation of responses is always possible; and
- Interviews are often costly.

Interviews are either structured, semi-structured or unstructured. Semi-structured face-to-face interview (accompanied by a translator) were conducted to interview 10 senior management personnel of St Mary's Hospital and St Joseph's Hospital. Semi-structured interview comprises of a blend of both open and closed question, and thus it was anticipated that this form of interview will enable flexibility in responding to a few

questions that require knowledge concerning the subject matter (Leedy & Amrod, 2015). The interviews were guided by an interview schedule with questions that were aimed at providing answers to the research questions. These questions include the following categories and can be found as (Appendix C):

Section A: this consists of the socio-demographic items and develops a profile of the participants by asking questions about gender, age group, occupation and related personal information; and

Section B: employee perceptions and opinions in an effort to measure the attitudes of employees towards the current change processes.

The data was also captured by a combination of note taking and audio recording. According to Merriam & Tisdell (2015), the advantages of audio recording method is that the interviewer can concentrate on questioning and listening, and the formulated interview question can be recorded for later use. The record is thus accurate and unbiased. Furthermore, to keep the research participants focused, the researcher ensured that the interview schedule was short and concise so as to complement data collected.

After identifying those that were to be involved in the interview sessions, the researcher sought an audience with the CEO and HR manager who are responsible for employees and welfare, through a permission letter written to the hospitals to conduct such interviews. The people interviewed were the senior management employees of St Mary's hospital and St Joseph's hospital. Hence, the researcher adopted purposive and convenience a non-probability sampling methods. Each interview took about 30-40 minutes on average. Since English is the official language in Nigeria, the semi-structured interviews were done in English language at St Joseph's hospital whilst at St Mary's hospital, the top management employees allowed the use of English to conduct the semi-structured interview even though IsiZulu was their official language but they were very fluent in English and we were also accompanied by a translator. The interview sessions were audiotaped with the consent of the interviewees. The audio recordings were later transcribed and transferred to Word documents.

4.7.2 Questionnaires

Sekaran & Bougie (2010) posit that a questionnaire is a written list of questions, which are expected to be answered by the participants. The questionnaire used in this study was designed and structured by the researcher. This questionnaire incorporates the research aim, objectives and problem statement. The self-administered questionnaire was designed in line with a 6-point Likert scale measurement ranging from (5) strongly agree to (1) strongly disagree (Wilson, 2012). The self-administered questionnaires were divided into two segments. While the first segment shouldered participants' demographic questions, the second section captured questions that reflected the research questions. To facilitate understanding of questions amongst participants, simple English words were used, which were also translated into the native language spoken in the area of study; that is IsiZulu and Igbo". This was done to break the communication barrier between the researcher and participants. The research questionnaires were self-administered by the researcher with the support of few research assistants who were collected immediately the participants completed the questionnaires. The participants were asked to complete the questionnaires on a voluntary basis, and were informed that, throughout the research study, their identity would be kept strictly confidential and that they were free to withdraw from the research at any time. Secondary data was gathered from literature on change management; Academic journals; relevant books; conference papers; government publications; and policy documents.

4.8 Data analysis

According to Saunders et al. (2019), data analysis is defined as a method of converting raw data by adding value to it in order to produce useful information. Krishnaswamy et al. (2006) further iterates that data analysis helps the researcher to understand the relative merits of any system, or strength, weaknesses, opportunities and threats, which provide the scientific basis for adjusting managerial decisions.

Silverman (2013) highlights that the following types of data analysis are available:

- Thematic analysis as a method of reviewing data, making of notes and sorting it into categories (Leedy & Amrod, 2015);
- The discovery of theory using systematic methodology of analysis of data is grounded theory;
- Baron (2012) postulates that pattern matching is the process of taking several pieces of information that seem logically related and connecting them to theoretical proposition;
- Narrative analysis may be used as a means to explore linkages, relationships and socially constructed explanations that naturally occur within narrative accounts, where fragmentation of these accounts into categories and themes would be rendered unnecessary (Silverman, 2013); and
- Computer assisted qualitative analysis software (CAQDAS) is used to analyse data. Merriam & Tisdell (2015) reveal that “CAQDAS programmes aid continuity and increase both transparency and methodological firmness. However, the disadvantage with CAQDAS is that most packages are not easily available at many universities.

The data obtained from the employees of St Mary’s and St Joseph’s hospitals through questionnaires were captured and coded into the Statistical Package for the Social Sciences (SPSS) according to the scales and items of the questionnaire. More so, the obtained data was analysed using the version SPSS 28.0.

Cronk (2017) explain that SPSS version 28.0 is designed to be relatively comprehensive data analysis package for use in research. It comprises factor analysis, descriptive and frequency analysis, and presentation is in the form of graphs, tables and bar charts. The SPSS avails a researcher the opportunity to analyse quantitative data in a vast range of means within a short timeframe (Bryman & Crammer 2009). The results were presented in the form of descriptive statistics as graphs, tables and figures. For reliability, the Test-Retest reliability test was employed. In addition, the Cronbach’s Alpha was applied to define the reliability, accuracy and internal consistency of the instrument.

However, the interview transcripts obtained through the semi-structured interviews, face-to-face interviews from employees of both hospitals were analysed using NVivo 12 software. The transcribed information from the interview was categorised into themes, and nodes were generated according to the transcribed information that emerged. The self-administered questionnaire for this study was validated through content validity by research statistician experts, including the researcher's supervisor to verify if the questions contained on the questionnaire contained the constructs of measurement.

The validity of the semi-structured interview was maximised through the Trochim & Donnelly's (2007) four indicators of the Principles of Trustworthiness and Authenticity including the question of credibility, transferability, dependability and confirmability of research findings. Hence this is to ensure that the research findings accurately address the research questions (Sekaran & Bougie, 2010). The study undertaken sought to analyse, capture and interpret the experiences, emotions and knowledge of each of the respective participants to ultimately identify common threads or themes, to reach conclusions on key areas within the field of assessing the impact of change initiatives and to ultimately answer the research questions posed.

Scale measurement has to do with the instrument or index from which research constructs are measured. Drivers of change (technology and organisational policy), employee performance, and organisational culture were measured from extensive literature analysis such as (Brown, 2014; Johnson & Christensen, 2017). The constructs, practical implementation of change and resistance to change were measured using adapted questions from the work of Oreg (2003.)

4.9 Statistical technique used in the study

4.9.1 The Kaiser-Meyer-Olkin (KMO)

KMO is a measure of how suited the researcher's data is for factor analysis. In this study, the test measured sampling adequacy for each variable in the model. It is used to ensure that the variables used in the analysis have actually measured the intended concepts. Field (2000) cited in by UL Hadi et al. (2016) recommends that a sampling is

adequate and acceptable if the value of KMO is greater than 0.5 or closer to 1.0. In this study, the test measured the sampling adequacy of the variables in the model. The computed statistic was > 0.5 for each of the variables. As noted, the data collected from participants was analysed using SPSS 28.0. The results were presented in a form of descriptive statistics as graphs, bar charts, tables and figures. Through the use of descriptive statistics, the researcher was able to describe and compare variables numerically through the use of means and standard deviations.

4.9.2 Bartlett's test of Sphericity

The purpose of Bartlett test is to measure the strength of the relationship in SPSS. Revelle (2016), compares correlation matrix to the identity matrix (An identity matrix means that the researcher's variables are unrelated and not ideal for factor analysis). In this study, the Bartlett's test was used to ascertain if there were certain redundancy between the variables that can be summarised with some factors. The obtained significant result (p value < 0.05) indicates that the data did not produce identity matrix.

4.9.3 Exploratory factor analysis (EFA)

This is a statistical method used to reduce a large number of observed variables to a small number of factors, indicating that the clusters of variables are in common (Favero & Belfiore, 2019). It is one of the statistical approaches used to check the internal reliability of a measure. It assesses the quality of the individual items. For this study, EFA was conducted to investigate the factors that might be represented by a set of items so as to summarise those items loadings. The result in this study showed that all items presented, had factor loadings higher than 0.69 which is a recommended value and considered appropriate.

4.9.4 Spearman's rank correlation

This is a non-parametric test, generally the most common method used to measure the degree of relationship between two variables. Hence it is most suitable for data that do not meet the standard for the Pearson product-moment correlation coefficient. The Spearman's rank correlation coefficient quantifies the strength of the relationship

between variables. The result is usually between 1 and minus 1. The closer the obtained value is to one (or minus one), the stronger the relationship and the closer the value is to 0, the weaker the relationship. A positive value indicates a positive relationship while a negative value indicates a negative relationship.

4.9.5 Analysis of variance (ANOVA)

Analysis of variance is a statistical technique used to check if the means of two or more groups are significantly different from each other. ANOVA tests the effect of one or more factors by comparing the means of different samples. In this study, the ANOVA test was done to check if there is mean difference among the variables and to see how good the model is.

4.9.6 Coefficient tables

The coefficient tables used in this study displayed the significant and non-significant effects of the predictor variables to the dependent variable.

4.10 Pilot study

A pilot study is one of the essential stages in a research study. The analysis of the pilot study in a research study reveals flaws in some questions, suggests improvements and supplies a range of possible answers to open-ended questions (Kumar, 2011). Taylor et al. (2008) asserts that a pilot study is a trial run done in preparation of a complete study. Saunders et al. (2012) further suggests that before administering questionnaire to participants, the researcher must test it on a small sample. To ensure this, a pilot study test was conducted with 10 prospective participants selected across the different department of both hospitals. This was to ensure reliability, preciseness and suitability of both questionnaires to enable amendments before the final questions. Adjustment were made on the questionnaire which included rewording a question to reduce the probability of ambiguity.

The pilot study also gave the researcher an opportunity to find out how long both questionnaires would take. The first question on the interview guide asked employees

to explain the types of changes that have taken place in their organisation as a result of change programmes. Feedback from the pilot study confirmed that the classification of the questions was easily understood by the participants. The pilot study also ensured that the level of attempt to ensure anonymity and also to evaluate the adequacy of the data for the research interview questions. The findings of the pilot study did assist the researcher in gaining a general idea of what the future responses to the questionnaires asked of the participants might be. Effectively the pilot study proved to be very useful in making amendments necessary to maximize returns and minimise the error rate on answers. However, the employees involved in this pilot test did not form part of sample participants. In addition, both questionnaires were also given to the researchers' supervisor to check the appropriate information and layout before conducting pilot study.

4.10.1 Distributions of questionnaire

According to Rose, Spinks & Canhoto (2015), questionnaire distribution must fit the nature of the sampling frame being used, and the type of contact details of the participants this is to ascertain whether the researcher has access to emails, telephone and other contact details as well as being appropriate for the sampling method. The researcher distributed the questionnaires directly to the participants and collected completed questionnaires about 7 days and two weeks respectively in both hospitals. The questionnaires were hand-distributed to one hundred and 132 participants in St Joseph's Hospital and 169 participants in separate meetings. However, 128 were successfully collected in St Joseph's hospital and 150 in St Mary's hospital. A total of 23 questionnaires were not considered because they were either incorrectly filled in or some employees were reluctant to fill in the questionnaires. The unit heads of the departments followed up by reminding their team (participants) to ensure that questionnaires were completed and returned within two weeks.

As mentioned above, unfortunately a few participants were reluctant to participate, or to fill the consent form, due to the Covid-19 risks, the busy nature of their jobs and some lost their copies of questionnaires. In this circumstance, the researcher decided to reprint copies misplaced by the participants and redistributed to them at their work

stations. During these follow-up visits all participants were reassured that the collected data would be kept confidential. The researcher also distributed the following documents during the dissemination of the questionnaire: a letter of approval from the DOH, a letter of approval from the hospitals' CEO, a Letter of Information and Consent form for the study, letter introducing the researcher and the background of the study and the questionnaires. The researcher continually emphasised to the participants that all responses were to be treated as confidential, and all participants would remain anonymous.

4.11 Limitation and delimitation of the study

4.11.1 Limitations

A limitation refers to restriction on a study which the researcher has no control over that may affect the results of a study or how the results are interpreted (Baron 2008; Creswell 2014). This study was limited to only qualitative research methods because data was collected using a small sample of participants. Despite the fact that measures were taken to ensure confidentiality, some participants tried withholding information that is critical to the attainment of the objectives of the study. This was minimised by informing participants the significance of the study.

Time was the main constraint of the study as far as the number of participants were concerned, as participants needed to assimilate questions before answering. From the pilot study a rough estimate of the duration of interviews was set out and was used by researcher in setting appointments. Notwithstanding, three of the interviews over-ran the target time set due to phone interruptions. More so, there was budgetary constraints with traveling and accommodation costs to St Joseph's Hospital, Adazi-Nnukwu, Nigeria. The researcher also battled paying the language translators and buying the specific statistical software for the study.

The scope of this study was limited to developing countries in West Africa and Southern Africa. Therefore, findings from this study may not be generalisable to healthcare organisations within the Northern and Eastern region of Africa. Covid -19 restrictions

had its toll on this study. Some participants did not want to participate in the study due to risks associated with Covid-19 and some were not in the right frame of mind.

4.11.2 Delimitation

The study used the case of St Mary's Hospital, Marianhill situated in Pinetown, KwaZulu-Natal Province, South Africa and St Joseph's Hospital situated in Adazi-Nnukwu, Anambra State, Nigeria. With a focus on two hospitals in different geographical zones, it might be unrealistic to assert with certainty that the findings of this study can be generalised to every public hospital in sub-Saharan Africa.

4.12 The principles of trustworthiness and authenticity

According to Ezzat Khamis Amin et al. (2020), the two criteria for judging the richness of quality of an inquiry in a qualitative inquiry are trustworthiness and authenticity. Authenticity incorporates a quality and credible standard that assesses whether the interpretations and findings are genuine and also worthwhile. In a qualitative study, Connelly (2016) asserts that the examination of trustworthiness is crucial to the usefulness and integrity of findings in research. Validity and reliability are highly connected to trustworthiness and thus reliability relates to trustworthiness and validity to authenticity. Trustworthiness in a qualitative study is determined by four indicators:

Credibility: Curry & Nunez-Smith (2015) outline that credibility involves establishing confidence in the truth of the findings and finding if they are credible from the perspective of the research participant in the research. Therefore, credibility, which is synonymous to validity in quantitative research, was established in this study through member checking technique. Saunders et al. (2019) proposes that member checking is one of the validation techniques that qualitative researchers use to establish credibility. The researcher shared the data interpretations and conclusions with participants to check for accuracy and resonance with their experiences. This allowed participants to clarify their responses and also to provide additional information if necessary;

Transferability: this is synonymous with generalisability in quantitative research. Transferability establishes the degree to which results of qualitative research can be

generalised or transferred to other situations. Though it is difficult to establish whether the outcomes based on the interpretation of the data are transferable, to some extent this was achieved in this study since the researcher extensively and thoroughly described the process adopted for others to follow and replicate.

Dependability: this concept is very similar to that of reliability in quantitative research. Hence it refers to the consistency and reliability of the research findings (Johnson & Christensen, 2017). Dependability determines whether the researcher will obtain the same results in an inquiry if the researcher were to observe the same phenomenon twice with the same participants. Detailed coverage on methodology and methods employed was provided to highlight that appropriate research practices that have been followed. To some extent, this concept was difficult to establish unless the researcher kept an extensive and detailed record of the process for others to ascertain the level of dependability.

Confirmability: according to Creswell & Poth (2018) confirmability refers to the degree to which findings are based on participants' responses and not the perspectives of the researcher. In achieving confirmability, the researcher demonstrated that the results are clearly linked to the conclusions of the study in a manner that can be followed. For this study the researcher maximised all four indicators of the principles of trustworthiness and authenticity in order to ensure that the research findings accurately addressed the research questions.

4.13 Reliability

Plano Clark & Ivankova (2016) explain reliability as the degree of consistency of a measuring instrument each time. Trochim et al. (2015) concur that the reliability of a research instrument refers to the consistency or repeatability in the measurement of findings. As a result, it is the degree to which the research findings can be depended upon by the researcher whenever used as a measure in obtaining the findings. To enhance the reliability of questionnaires, a pilot test was conducted amongst 10 employees (5 each) in both hospitals under the study.

The pilot study was done on two separate accounts with an interval of a week, and the scores compared to ascertain the reliability of the instrument. In this study, research reliability was also observed to be highly parable in measuring research responses, proper design of the research and knowledge inclusion of the research in dealing with organisational change programmes. Furthermore, to facilitate understanding of questions posed in the questionnaires, questionnaires administered at St Mary's were translated into isiZulu; while the administered questionnaires at St Joseph's were translated into Igbo (these are native languages spoken in these communities). This was done to ensure a smooth flow of communication and understanding, a translator who can communicate in the English language as well as the mother tongue of these communities was recruited for translation purposes but fortunately every participant understood and could communicate fluently in English. Lastly, the researcher ensured that the participants of this study filled the questionnaires without any form of bias or intimidation. In ensuring that feedbacks obtained from the semi-structured interviews were reliable, pseudonyms were used as a means to protect participants' identities". Participants usually provide honest answers over sensitive issues and more at ease when their identities are not revealed (Silverman, 2016).

4.14 Validity

Tuffour (2017) defines "validity as the degree to which a researcher is actually measuring what the researcher has set out to measure, including the interpretation or meaning of the scores obtained from the instrument. Croucher & Cronn-Mills (2014) stipulate that validity is the most important criteria in developing and evaluating measuring instruments. Therefore, in this study, the researcher checked the validity of the questionnaires to remove ambiguous questions by conducting a pilot study and after that altered a question for vagueness, ambiguity and objectiveness. The researcher chose a sample representative of the 10 employees (5 each) across all departments in St Mary's and St Joseph's and they understood the questions and provided information that was relevant to the objectives of the study. According to McBride (2015), validity normally takes forms of internal validity and content validity and thus, internal validity

prevents flawed research measures that incorporate vagueness and ambiguity in questions, poor sampling frameworks and irrational questions.

4.15 Confidentiality and anonymity

Saunders et al. (2019) affirm that the researcher has the responsibility of ensuring that the information to be collected is not used for anything other than the purpose of the study. Confidentiality and anonymity are in consonance to ethical considerations. The Letter of Information and Consent (Appendix G) assured the participants of their anonymity, confidentiality and the protection of their rights. The letter of information gave a brief introduction and purpose of the study, explained the procedures of the study, and informed participants that participation was voluntary and that they could withdraw from the study if they chose to do so. Participants were assured that they need not fill in the form if not comfortable. The researcher further assured the participants that their responses would be kept confidential throughout the course of the study. To ensure anonymity in this study, names of participants were not disclosed; while pseudonyms were used when required. More so, the researcher ensured that the identity of all participants was protected, and all information obtained from research participants kept confidential. The raw data from the study is only accessible to the researcher and supervisor to ensure confidentiality. Furthermore, five years after the completion of the study, all questionnaires will be shredded and discarded, while data stored electronically will be deleted from devices used in storing them.

4.16 Ethical considerations

There are many ethical issues to consider in relation to the participants of a research activity. Leedy & Amrod (2015) assert that the data collection stage is associated with various ethical issues and thus ethical integrity is expected from all researchers. Hence it is the duty of the researcher to recognise and balance subjectivities, provide accurate research accounts and act within the law in order to develop the required expertise. Coldwell & Herbst (2004) explain ethics as ideals and standards of conduct aimed at

protecting research participants of a study from any form of abuse and exploitation. Hegde (2015), further connotes that ethics in research are about proper conduct related to the processes and consequences of the research, also it helps to promote the aims of the research, and the values which are essential for collaborative research work.

The ethical standards stipulated by the Durban University of Technology through the Institutional Research Ethics Committee were adhered to throughout the research process. Permission to conduct interviews was requested from institutions involved in this study. All participants were offered a consent letter which enabled them to participate voluntarily or withdraw at any stage of the research process. In this study, the researcher considered ethical procedures for the study by requesting permission from the Provincial DOH South Africa, St Mary's Hospital, Marianhill and St Joseph's Hospital, Adazi-Nnukwu. Ethical clearance approval was received from DUT on 8th May 2020. Then approvals were received from the DOH on 19th August 2020, St Mary's hospital on 19th March 2021 and St Joseph's hospital on 10th March 2021. (Appendix B, C and D).

To summarise, the following documents were required in order to obtain ethical clearance for the study:

- A letter to request permission to conduct the research study to the Provincial DOH, South Africa (Appendix: A);
- A letter to request permission to conduct the research study in St Joseph's Hospital, Adazi-Nnukwu and a letter of approval from the Chief Executive Officer (Appendices: B and C);
- A letter to request permission to conduct the research study in St Mary's Hospital, Marianhill and a letter of approval from the Chief Medical Director (Appendices: D and E);
- DUT Ethical Clearance letter (Appendix: F);
- The Letter of Information and Consent form (Appendix G); and
- Questionnaires submitted (Appendix H).

4.17 Conclusion

The chapter has discussed the research methodology used by the researcher. After discussing the rationale of the study, the researcher also provided the reason for choosing the specific method being used, the sampling, the research instrument used and the target population. In terms of the research process, the administration and data analysis were explained to give the reader an indication of the ethical considerations and the limitations of this study". The obtained results and findings from the research were presented and further explored in the next chapter.

CHAPTER FIVE: RESULTS AND INTERPRETATION OF FINDINGS

5.1 Introduction

The previous chapter discussed the research methodology and research design and how the data was collected. The discussions also included the target population, sampling techniques, ethical considerations, data collection instruments, reliability and validity of the study. This chapter presents the results and discusses the findings obtained from the data collected from research participants. The various findings of the study are presented and discussed according to the various study objectives. The quantitative data was analysed using SPSS version 28.0. The results are presented as descriptive statistics, in the form of frequency graphs, bar charts, and other figures for the presentation of the quantitative data collected. Tables and other common statistical tools such as correlation and regression analysis were used in presenting and analysing the data generated. The semi-structured interviews were grouped into category themes and nodes for analysis using Nvivo 12.0 for the qualitative data.

5.2 Statistical analysis

Statistical analysis is usually performed after data has been collected. The analyses should be planned before the data is collected as part of the process of evaluating the suitability of the research design (Privitera, 2015). According to Sarmiento and Costa (2019), "statistics helps one extract information from data to get a better understanding of the phenomenon. Therefore, the two phases of analysis consist of – a descriptive phase which is used to describe the essential features of the data in the study and allows presenting quantitative descriptions in a convenient manner. It provides summaries about the samples and the measures. Whilst the inferential phase process requires that the probability density function is known when inferences are drawn (Sarmiento & Costa 2019). This pattern has been followed in this chapter.

5.2.1 Reliability

Reliability refers to the degree to which a result of the measurement can be depended upon to be accurate. The researcher consulted a qualified statistician to assist with the accurate analysis of the data and the SPSS 28.0 and Nvivo 12 software that was used for analysis. Cronbach's alpha measures how well a set of variables relate to one another.

5.2.2 Research Instrument

A factor analysis was conducted as a data reduction technique to summarise the items loading under factors summarising the research instrument. A Kaiser-Meyer-Olkin (KMO) of 0.929 and Bartlett's Test of sphericity measure of sampling adequacy was $p < 0.5$, thereby revealing that the sample is adequate and the factor analysis appropriate, producing reliable results as correlations are comparatively compact. Factor analysis is the statistical method used to describe variability among observed variables, correlated in terms of a potentially lower number of unobserved variables. Results of the KMO and Bartlett's test of appropriateness are presented in the table below:

Table 5.1: KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.929
Bartlett's Test of Sphericity	Approx. Chi-Square	2023.385
	Df	21
	Sig	0.000

Source: Field survey data (2021)

5.3 Response rate

The researcher administered a total number of 301 questionnaires to the end-users who receive services from supply chain management administrators. Out of the total number

of distributed questionnaires, 278 questionnaires were returned by the participants and the response rate was therefore 92%.

5.4 Presentation of findings

According to Saunders et al. (2012) delivered and collected questionnaires with a response rate greater than 50% can be considered as moderately high, there was a total response rate of 92% and this is considered an acceptable response rate. In order to provide a clear overview of the findings, the presentation of the findings for both employees of St Mary's and St Joseph's were analysed separately. This section only focuses on the analysis of the data. The results are presented in a form of graphs, tables and bar charts. The qualitative data is analysed and discussed later in this chapter. The presentation of the findings starts with the analysis of biographical information taken from Section A. Sections B involves structured questions and Section C has open-ended questions.

5.4.1 Biographical data

This biographical data section was a compulsory section and was answered by all research participants. The data was analysed according to gender, age, level of education, marital status, and occupation. Data collected from the sampled participants is presented descriptively using frequency tables and percentages.

Table 5.2: Gender of participants

Gender	Frequency	Percent
Male	78	28
Female	200	72
Total	278	100

Source: Field survey data (2021)

A greater percentage of the participants are female with 72% while the male participants are 28%. This reveals a reflection of the fact that most positions in St Mary's and St Joseph's hospital are most likely to be held by females.

Table 5.3: Age of participants

Age	Frequency	Percent
18 - 24 Years	74	26.3
25 - 29 Years	79	28.1
30 - 34 Years	42	14.9
35 - 39 Years	35	12.5
40 - 44 Years	18	6.4
45 - 49 Years	13	4.6
50 - 54 Years	10	3.6
55 - 59 Years	4	1.4
60 + Years	3	1.1
Total	278	100

Source: Field survey data (2021)

As shown in Table 5.3, the highest number of the participants (approximately 28%) are between the ages of 25 -29 years, whilst the lowest number of participants (approximately 1%) belongs to those that are 60 years and above.

Table 5.4: Educational qualifications of participants

Qualification	Frequency	Percent
No Schooling	1	4
Primary Schooling	1	4
Secondary Schooling	32	11.4
Tertiary Schooling	244	86.8
Total	278	98.9

Source: Field survey data (2021)

According to Table 5.4, the majority of the participants (approximately 87%) have attended tertiary institutions. The lowest number of participants are employees who only completed primary education and those that have no schooling, both groups represent approximately 4% each.

Table 5.5: Marital status of the participants

Marital Status	Frequency	Percent
Single	171	61.5
Married/Living together	83	29.9
Widowed	10	3.6
Separated	13	5.4
Total	278	100

Source: Field survey data (2021)

Table 5.5 is the marital status of the participants, there is a clear indication that most of the participants (62%) are single, followed by the participants that are married which is (approximately 30%). The lowest number of participants are those who are separated, standing at approximately 5%.

Table 5.6: Race of the participants

Race	Frequency	Percent
African	223	80.2
White	10	3.5
Indian	32	11.5
Coloured	7	2.5
Other	6	2.1
Total	278	99.7

Source: Field survey data (2021)

Table 5.6 is the race of participants, 80.2% are Africans, 11.5% are Indians, 3.5% are Whites, and 2.5% are coloured while 2.1% described themselves as other.

Table 5.7: Department of the participants

Department	Frequency	Percent
Admin	13	4.6
Finance	11	3.9
Human Resources	6	2.2
Nursing	143	51.4
Supply Chain	12	4.3
Medical	65	23.4
Maintenance	4	1.4
Operations	6	2.1
Other	18	6.5
Total	278	100

Source: Field survey data (2021)

Majority of the participants as shown in Table 5.7 are from the nursing department (51, 4%) while the least participants are in medical department (1, 4%).

Table 5.8: Job position of the participants

Job Position	Frequency	Percent
Medical Officer	32	11.4
Finance Officer	9	3.2
Human Resources Officer	6	2.1
Nursing assistant	13	4.7
Nurse	129	46.4
Pharmacist	7	2.5
Maintenance Officer	5	1.8
Food services clerk	3	1
Operation officer	3	1
Other	48	17.2
Supply Chain Clerk	16	5.7
Admin Clerk	7	2.5

Total	278	98.9
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Source: Field survey data (2021)

For the job positions as presented in Table 5.8 above, most of the participants are nurses (46.4%), whilst the lowest number of participants were food services clerks (3%) and operation officers (3%) respectively.

Table 5.9: Organisation of the participants

Hospital	Frequency	Percent
St Mary Hospital, Marianhill	150	53.7
St Joseph Hospital, Adazi-Nnukwu	128	45.2
	278	98.9

Source: Field survey data (2021)

Table 5.9 represents the organisation of the participants, approximately 54% participants are from St Mary's Hospital, Marianhill, while 45% of the participants are from St Joseph's Hospital, Adazi-Nnukwu.

Clustered 3-D Bar of Age of Respondent by Gender of Respondent by Marital Status of the Respondent by Job Position of the Respondent

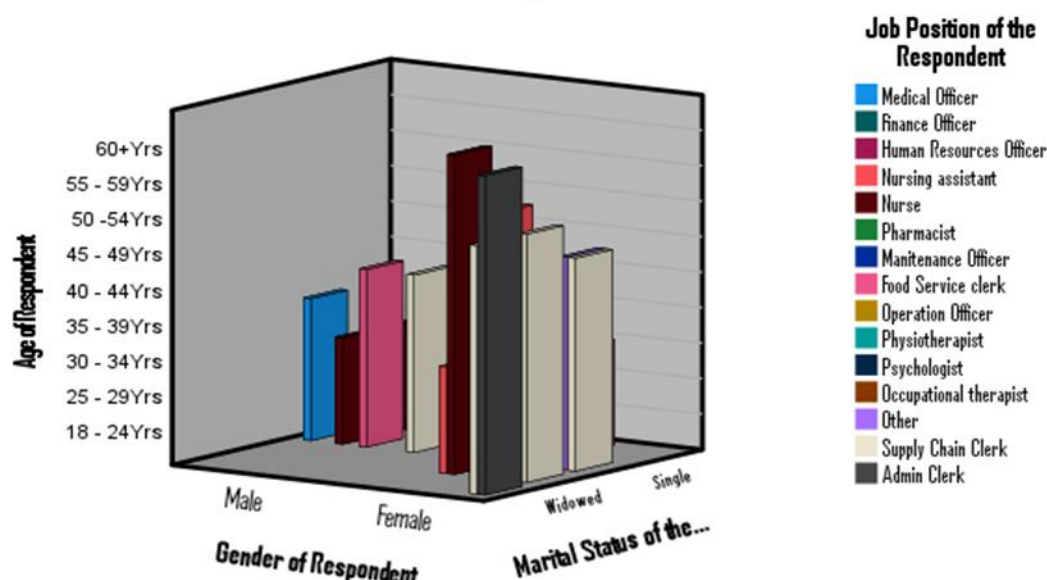


Figure 5.1: Clustered 3-D Bar Graph of the age, gender, marital status and occupation of the study's participants

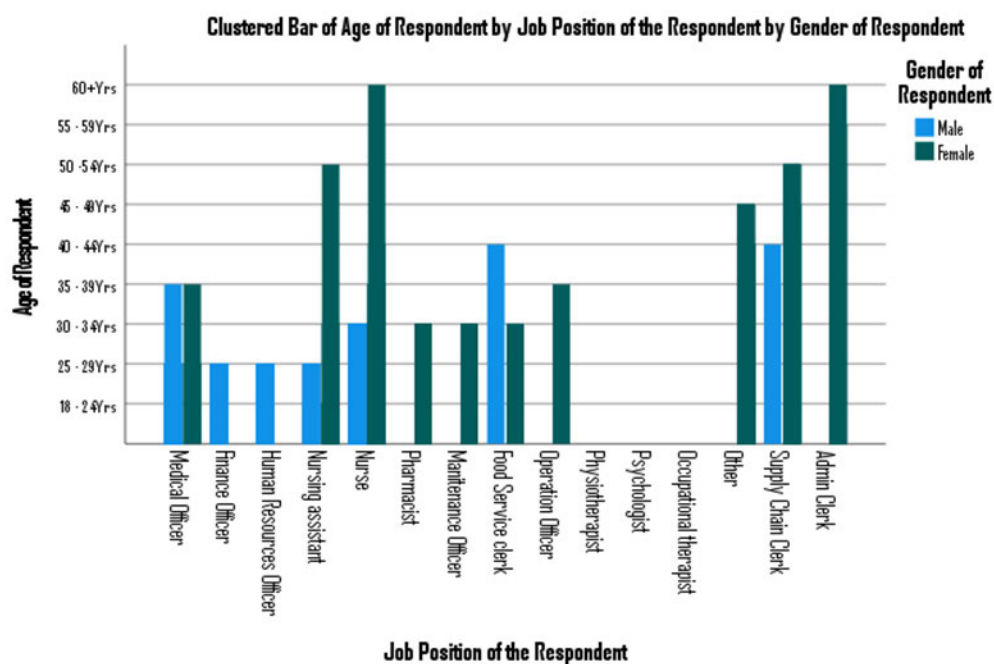


Figure 5.2: Clustered bar graph of job position by age and gender for participants

5.5 Exploratory factor analysis result

The determinants of organisational change were subjected to an EFA to assess their validity and reliability. The results report the suitability of the data to be analysed, factor extraction and rotation and interpretation.

5.5.1 Exploratory factor analysis for use of technology

In the below Tables of 5.11, 5.12 and 5.13 items measure the use of technology, the result of Cronbach's alpha is >0.7 (0.956) which indicates acceptable internal reliability. Hence, we conclude that the instruments used for this study can be said to be reliable. The KMO of 0.929 with Bartlett's Test of sphericity of $p < 0.05$ suggest that factor analysis could be conducted with the data.

Table 5.10: Reliability statistics (use of technology)

Cronbach's	Cronbach's Alpha based on standardised	N of
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Alpha	Items	Items
0.956	0.9597	7

Source: Field survey data (2021)

Table 5.11: KMO and Bartlett's Test (use of technology)

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.929
Bartlett's Test of Sphericity	Approx. Chi-Square	2023.385
	Df	21
	Sig	0.000

Source: Field survey data (2021)

Table 5.12: Use of Technology

Item	Measure	Factor Loadings
UT01	Information and communication technology is effective in all departments	0.929
UT02	Operate electronic payment services	0.928
UT03	Has diagnostic equipment that allows for accurate detection of disease	0.923
UT04	Make use of electronic records	0.910
UT05	Has competitive advantage over other health care providers in the community	0.879
UT06	Operate door-to-door healthcare delivery for elder patients with chronic illness	0.864
UT07	Diagnostic equipment's are easy to use	0.814

Source: Field survey data (2021)

The seven measures (UT01 - UT07) are expected to define the use of technology obtained factor loadings greater than 0.814 as reported in the above table. These were higher than the recommended value of 0.5 and above. An Eigenvalue greater than 5.615 was established in this factor, this explains 81.4% of the variance in the data therefore sufficient evidence of convergence validity was provided for this construct. It

can therefore be indicated that the use of technology is reliable and valid to measure the determinants of change management at St Mary's and St Joseph's respectively.

5.5.2 EFA for Patient Satisfaction

In the below Tables 5.13, 5.14 and 5.15 items measure patient's satisfaction, the result of Cronbach's alpha is >0.7 which indicates acceptable internal reliable. In this instance, Cronbach's alpha was 0.944 hence we conclude that the instruments used for this study can be said to be acceptable and reliable. The KMO of 0.913 with Bartlett's Test of sphericity of $p < 0.05$, suggest that factor analysis could be conducted with the data.

Table 5.13: Reliability statistics (patient satisfaction)

Cronbach's Alpha	N of Items
0.944	7

Source: Field survey data (2021)

Table 5.14: KMO and Bartlett's Test (patient's satisfaction)

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.913
Bartlett's Test of Sphericity	Approx. Chi-Square	1794.333
	Df	21
	Sig	0.000

Source: Field survey data (2021)

Table 5.15: Patient's Satisfaction

Item	Measure	Factor Loadings
PS01	Patient needs are addressed through online	0.866
PS02	Patients have access to electronic communication	0.908
PS03	Patients have timely access to specialist through	0.916

	electronic communication service	
PS04	Use of electronic medical records to access patients' health information	0.870
PS05	Online database for all our clients	0.875
PS06	Physical environment is assessable to people with disabilities	0.794
PS07	Competent staff to cater for visiting and online patients daily	0.836

Source: Field survey data (2021)

The seven measures (PS01 - PS07) expected to define patient satisfaction obtained factor loadings greater than 0.794 as reported in the above table (Table 5.15). These were higher than the recommended value of 0.5 and above. An Eigenvalue greater than 5.266 was established in this factor, this explains 75.2% of the variance in the data therefore sufficient evidence of convergence validity was provided for this construct. It is indicated that patient's satisfaction is reliable and valid to measure the determinants of change management at St Mary's and St Joseph's respectively.

5.5.3 EFA for organisational policy

In the below Tables 5.16, 5.17 and 5.18 items measure organisational policy, the result of Cronbach's alpha is >0.7 which indicates acceptable internal reliability. In our case it is 0.959 hence we conclude that the instruments used for this study can be said to be acceptable and reliable. The KMO of .921 with Bartlett's Test of sphericity of $p < 0.05$. These suggest that factor analysis could be conducted with the data.

Table 5.16: Reliability statistics (organisational policy)

Cronbach's Alpha	N of Items
0.959	7

Source: Field survey data (2021)

Table 5.17: KMO and Bartlett's Test (organisational policy)

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.921
Bartlett's Test of Sphericity	Approx. Chi-Square	2147.930
	Df	21
	Sig	0.000

Source: Field survey data (2021)

Table 5.18: Organisational policy

Item	Measure	Factor Loadings
OP01	Organisation maintains privacy and confidentiality of medical records	0.863
OP02	Adheres to equity and ethical standards in health delivery	0.848
OP03	New organisational policy is better than the old one	0.934
OP04	The new organisational policy has made my work easier and convenient	0.913
OP05	The new organisational policy has improved our doctor customer relationship	0.947
OP06	Organisational policy always considers the safety of patients	0.902
OP07	Organisational policy usually considers employee working conditions	0.893

Source: Field survey data (2021)

The seven measures (OP01 - OP07) expected to define organisational policy obtained factor loadings greater than 0.848 as reported in the Table 5.18. These were higher than the recommended value of 0.5 and above. An Eigenvalue greater than 5.678 was established in this factor, this explains 81.1% of variance in the data therefore sufficient

evidence of convergence validity was provided for this construct. It can therefore be indicated that organisational policy is a reliable and valid to measure the determinants of change management at St Mary's and St Joseph's.

5.5.4 EFA for employee performance

In the below Tables 5.19, 5.20 and 5.21 items measure employee performance, the result of Cronbach's alpha is >0.7 which indicates acceptable internal reliability. Cronbach's alpha was 0.902 which concludes that the instruments used for this study is acceptable and reliable. The KMO of 0.933 with a Bartlett's Test of sphericity of $p < 0.05$. These suggest that factor analysis could be conducted with the data.

Table 5.19: Reliability statistics (employee performance)

Cronbach's Alpha	N of Items
0.902	7

Source: Field survey data (2021)

Table 5.20: KMO and Bartlett's Test (employee performance)

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.933
Bartlett's Test of Sphericity	Approx. Chi-Square	2850.369
	Df	21
	Sig	0.000

Source: Field survey data (2021)

Table 5.21: Employee performance

Item	Measure	Factor Loadings
EP01	This change process has enabled me to perform my duties more efficiently and effectively	0.939
EP02	This current change has provided me with the opportunity to work in line with my interests, skills, and attitudes	0.915
EP03	The support received during the change process has improved my working psyche	0.912
EP04	The implementation of this change has provided the motivation, ability, and desire to do my job	0.688
EP05	The change system in place has made it possible for me to take extra responsibilities in my work	0.802
EP06	The change system in place has enhanced me to manage my time at work efficiently	0.895
EP07	This change has enabled me to collaborate more easily with others at work	0.895
EP08	The automated tool and equipment's received during the change process has enabled me to work efficiently	0.921
EP09	The training received during the change process has improved my skills to perform more productively	0.905
EP10	The change system has enhanced my performance to meet patient's requirements	0.648

Source: Field survey data (2021)

The ten measures (EP01 - EP10) are expected to define employee performance obtained factor loadings greater than 0.648 as reported in the above table. These were higher than the recommended value of 0.5 and above. An Eigenvalue greater than 7.033 was established in this factor, this explains 70.3% of variance in the data therefore sufficient evidence of convergence validity was provided for this construct. It

can therefore be indicated that employee performance is reliable and valid to measure the determinants of change management in St Mary's and St Joseph's respectively.

5.5.5 EFA for organisational culture

In the below Table 5.22, 5.23 and 5.24 items measure culture, the result of Cronbach's alpha is >0.7 (0.939) which indicates acceptable internal reliability. Hence, we conclude that the instruments used for this study can be said to be acceptable and reliable. The KMO of 0.919 with Bartlett's Test of sphericity of $p < 0.05$, suggest that factor analysis could be conducted with the data.

Table 5.22: Reliability Statistics (organisational culture)

Cronbach's Alpha	N of Items
0.939	7

Source: Field survey data (2021)

Table 5.23: KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.			0.919
Bartlett's Test of Sphericity	Approx. Chi-Square		1680.334
	Df		21
	Sig		0.000

Source: Field survey data (2021)

Table 5.24: Organisational culture

Item	Measure	Factor Loadings
OC01	Communication from management is clear	0.888
OC02	My manager solicits my individual input	0.848
OC03	My organisation provides a culture that encourages teamwork	0.879
OC04	Managers work closely with us to achieve realistic goals	0.913
OC05	Managers encourage employees to adjust changing situations through innovation and creativity	0.886
OC06	The new method of our health care services are better than the old methods	0.900
OC07	There is need to change some aspects of our service delivery	0.674

Source: Field survey data (2021)

The seven measures (OC01 - OC07) are expected to define organisational culture obtained factor loadings greater than 0.674 as reported in Table 5.24. These were higher than the recommended value of 0.5 and above. An Eigenvalue greater than 5.162 was established in this factor, this explains 73.7% of the variance in the data and therefore sufficient evidence of convergence validity was provided for this construct. It can therefore be indicated that organisational culture is reliable and valid to measure the determinants of change in St Mary's and St Joseph's respectively.

5.5.6 EFA for Implementation of change

In the below Tables 5.25, 5.26 and 5.27 items measure the implementation of change, the result of Cronbach's alpha is >0.7 which indicates acceptable internal reliability. Therefore, in this case it is 0.963, hence we conclude that the instruments used for this study can said to be acceptable and reliable. The KMO of 0.934 with Bartlett's Test of sphericity of $p < 0.05$, suggest that factor analysis could be conducted with the data.

Table 5.25: Reliability statistics (Implementation of change)

Cronbach's Alpha	N of Items
0.963	7

Source: Field survey data (2021)

Table 5.26: KMO and Bartlett's Test (Implementation of change)

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.934
Bartlett's Test of Sphericity	Approx. Chi-Square	2812.390
	Df	36
	Sig	0.000

Source: Field survey data (2021)

Table 5.27: Implementation of change

Item	Measure	Factor Loadings
IC01	We employees are educated and trained to adjust to the change of operations in the organisation during change implementation	0.888
IC02	During the change initiatives, information and communication technology were introduced to all the department in my organisation	0.844
IC03	Managers get us involved in the decision-making process of the change	0.915
IC04	There is effective information and communication dissemination before any change can take place in my organisation	0.940
IC05	Employees that are affected by a change within the organisation are usually compensated through promotion, monetary rewards or public recognition	0.864
IC06	Change in my organisation has led to dismissal or transfer of some personnel in the past	0.726
IC07	Change in my organisation is usually successful because there is leadership support for employees	0.891
IC08	Change in the organisation is usually to satisfy our clients demands	0.919
IC09	Management gives honest information on the need to make a change in the organisation	0.929

Source: Field survey data (2021)

The nine measures (IC01 - IC09) expected to define implementation of change obtained factor loadings greater than 0.726 as reported in Table 5.27. These were higher than the recommended value of 0.5 and above. An Eigenvalue greater than 6.999 was established in this factor, this explains 77.7% of variance in the data and therefore sufficient evidence of convergence validity was provided for this construct. It can be

indicated that the implementation of change is reliable and valid to measure the determinants of change management at St Mary's and St Joseph's.

5.5.7 EFA for resistance to change

In the below Tables 5.28, 5.29 and 5.30, items measure resistance to change management, the result of Cronbach's alpha is >0.7 which indicates acceptable internal reliability. In this case, it is 0.965, hence it can be concluded that the instruments used for this study are acceptable and reliable. The KMO of 0.938 with Bartlett's Test of sphericity of $p < 0.05$, suggest that factor analysis could be conducted with the data.

Table 5.28: Reliability statistics (resistance to change)

Cronbach's Alpha	N of Items
0.965	11

Source: Field survey data (2021)

Table 5.0.29: KMO and Bartlett's Test (resistance to change)

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.938
Bartlett's Test of Sphericity	Approx. Chi-Square	3178.063
	Df	55
	Sig	0.000

Source: Field survey data (2021)

Table 5.30: Resistant to change management

Item	Measure	Factor Loadings
RCM01	I preferred working in a specific position to working with different groups during the change programme in my organisation	0.805
RCM02	During the change in my organisation, I got worried about information on transfer to another department for a new challenge	0.838
RCM03	I don't think I have something to gain about the change process	0.844
RCM04	I prefer having a stable routine work rather than having changes to my work during the change process	0.829
RCM05	When things don't go according to my plans I get frustrated at work	0.848
RCM06	I got nervous and scared to lose my job during the change process	0.855
RCM07	Once I have made plans about my work I am not likely to change them	0.884
RCM08	No one can pressure me to adapt to change even if it is of good benefit to me	0.869
RCM09	Being informed of a change in my role at work gets me easily stressed out before knowing the benefit of the actual change	0.891
RCM10	I don't like surprises or uncertainty at work	0.910
RCM11	Any change in my working hour will frustrate me.	0.906

Source: Field survey data (2021)

The eleven measures (RCM01 - RCM11) expected to define resistance to change management obtained factor loadings greater than 0.726 as reported in the Table 5.30. These were higher than the recommended value of 0.5 and above. An Eigenvalue greater than 8.179 was established in this factor, this explains 74.3% of the variance in the data therefore sufficient evidence of convergence validity was provided for this

construct. It can therefore be indicated that resistance to change management is reliable and valid to measure the determinants of change management in St Mary's and St Joseph's respectively.

Table 5.31: Kolmogorov-Smirnov and Shapiro Wilk Test of Normality

	Kolmogorov-Smirnova			Shapiro-Wilk Test		
	Statistic	df	Sig.	Statistic	df	Sig.
Use of Technology	0.152	278	<.001	0.898	278	<.001
Patient's Satisfaction	0.084	278	<.001	0.958	278	<.001
Organisational Policy	0.115	278	<.001	0.920	278	<.001
Employee performance	0.095	278	<.001	0.937	278	<.001
Organisational Culture	0.103	278	<.001	0.943	278	<.001
Implementation of Change	0.106	278	<.001	0.949	278	<.001
Resistant to Change	0.051	278	.075	0.974	278	<.001

Source: Field survey data (2021)

Table 5.31 illustrates the non-normality of the data since the Sig <0.05, hence we proceed with the non-parametric correlation analysis.

5.6 Correlation analysis for St. Joseph's hospital Adazi-Nnukwu and St. Mary's Marian Hill hospital

5.6.1 Objective one: Influence of driving forces of change on employees' performance

Table 5.32: Spearman's Rank correlation for drivers of change on employee performance at St Joseph's hospital

			Employee Performance	Use Of Technology	Organisational Policy
Spearman's rho	Employee Performance	Correlation Coefficient	1.000	0.638	0.669
		Sig. (2-tailed)	0	0	0
		N	128	128	128
	Use Of Technology	Correlation Coefficient	0.638	1.000	0.601
		Sig. (2-tailed)	.0	.0	0
		N	128	128	128
	Organisational Policy	Correlation Coefficient	0.669	0.601	1.000
		Sig. (2-tailed)	0	0	0
		N	128	128	128

Source: Field survey data (2021)

The results of the above correlation in Table 5.32 suggest that the correlation coefficient (R) between the drivers of change (use of technology and organisational policy) and employees' performance are 0.638, and 0.669 with a significant p-value. This shows that there is a strong and positive relationship between the drivers of change and employees' performance. The strength of correlation is determined by the value of variables within the range. This range is from –1.00 to 1.00. This value indicates the strength of the relationship (Pallant, 2010). A correlation of 0 shows no relationship at all. On the other hand, a correlation of 1.0 shows a perfect positive correlation while a value of –1.0 shows a perfect negative correlation. Hence, technology and

organisational policy and employees' performance which are 0.638, and 0.669 indicates that there is a strong and positive relationship.

Table 5.33: Spearman's Rank Correlation for drivers of change on employee performance at St Mary's Hospital

			Use of Technology	Organisational policy	Employee Performance
Spearman's rho	Use of Technology	Correlation Coefficient	1.000	0.265	0.363
		Sig. (2-tailed)	.	0.032	0.002
		N	150	150	150
	Organisational policy	Correlation Coefficient	0.265	1.000	0.712
		Sig. (2-tailed)	0.032	0	0
		N	150	150	150
	Employee Performance	Correlation Coefficient	0.363	0.712	1.000
		Sig. (2-tailed)	0.002	0.000	.
		N	150	150	150

Source: Field survey data (2021)

The results of the above correlation in Table 5.33 suggest that the correlation coefficient (R) between the drivers of change (use of technology and organisational policy) and employee performance are 0.363, and 0.712 with significant p-values. This shows that there is a positive relationship between the drivers of change and employee performance. The p-values indicate that the results are significant and did not occur by chance.

5.6.2 Objective two: Impact of organisational culture on practical implementation of change

Table 5.34: Spearman's Rank correlation for organisational culture and practical implementation of change in St Joseph's hospital

		Organisational Culture	Practical Implementation of Change
Organisation Culture	Correlation Coefficient	1.000	.816
	Sig. (2-tailed)	0	0
	N	128	128
Practical Implementation of Change	Correlation Coefficient	0.816	1.000
	Sig. (2-tailed)	0	0
	N	128	128

Source: Field survey data (2021)

Conversely, Table 5.34 shows that the correlation coefficient between the organisational culture and practical implementation of change is 0.816 with a p-values <0.001. This reveals that there is a strong and positive relationship between the organisational culture and practical implementation of change. The p-values indicated that the results are significant and did not occur by chance.

Table 5.35: Spearman's Rank correlation for organisational culture and practical implementation of change at St Mary's hospital

		Organisational Culture	Implementation of Change
Organisational Culture	Correlation Coefficient	1.000	0.769
	Sig. (2-tailed)	0	0
Implementation of Change	Correlation Coefficient	.769	1.000
	Sig. (2-tailed)	0	0
	N	150	150

Source: Field survey data (2021)

Table 5.35 is the correlation coefficient between the organisational culture and practical implementation of change is 0.769 with a p-value <0.001. This shows that there is a strong and positive relationship between the organisational culture and practical implementation of change. The p-value indicated that the result is significant and did not occur by chance.

5.6.3 Objective three: Influence of practical implementation of change on patient satisfaction

Table 5.36: Spearman's Rank correlation for patient satisfaction and practical implementation of change

			Patients Satisfaction	Practical Implementation of Change
Spearman's rho	Patients Satisfaction	Correlation Coefficient	1.000	0.536
		Sig. (2-tailed)	0	0
		N	128	128
	Practical Implementation of Change	Correlation Coefficient	0.536	1.000
		Sig. (2-tailed)	0	0
		N	128	128

Source: Field survey data (2021)

The correlation coefficient between practical implementation of change and patient satisfaction is 0.536 with a p-value < 0.001. This shows that there is a strong and positive relationship with practical implementation of change and patient satisfaction and this relationship did not occur by chance.

Table 5.37: Spearman's Rank Correlation for patient satisfaction and practical implementation of change

			Patients Satisfaction	Implementation of Change
Spearman's rho	Patients Satisfaction	Correlation Coefficient	1.000	0.400
		Sig. (2-tailed)	0	0
	Implementation of Change	Correlation Coefficient	0.400	1.000
		Sig. (2-tailed)	0.001	0
		N	150	150

Source: Field survey data (2021)

The correlation coefficient between practical implementation of change and patient satisfaction is 0.400 with a p-value < 0.001 in table 5.37. This shows that there is a weak and positive relationship with practical implementation of change and patient satisfaction.

5.6.4 Objective four: Impact of drivers of change on resistance to change

Table 5.38: Spearman's Rank Correlation for drivers of change and resistance to change at St Joseph's Hospital

			Use of Technology	Organisational Policy	Resistant to change management
Spearman's rho	Use of Technology	Correlation Coefficient	1.000	0	0
		Sig. (2-tailed)	0	0	0
	Organisational Policy	Correlation Coefficient	0.601	1.000	0
		Sig. (2-tailed)	0	0	0
	Resistant to change	Correlation Coefficient	-0.059	-.135	1.000
		Sig. (2-tailed)	0.506	.128	0.
		N	128	128	128

Source: Field survey data (2021)

The correlation coefficient (R) between the drivers of change (use of technology, and organisational policy) and resistant to change management are -0.059, and -0.135 respectively. This indicates that there is a weak and negative relationship between the drivers of change and resistance to change.

Table 5.39: Spearman's Rank Correlation drivers of change and resistance to change at St Mary's Hospital

			Use of Technology	Organisational policy	Resistant to change
Spearman's rho	Use of Technology	Correlation Coefficient	1.000	0.265	0.064
		Sig. (2-tailed)	0	.032	0.610
	Organisational policy	Correlation Coefficient	0.265	1.000	0.090
		Sig. (2-tailed)	0.032	0	0.481
	Resistant to change	Correlation Coefficient	0.064	0.090	1.000
		Sig. (2-tailed)	0.610	0.481	0.

Source: Field survey data (2021)

Finally, the correlation coefficient (R) between the drivers of change (use of technology and organisational policy) and resistance to change are 0.064 and 0.090 respectively, all with an acceptable p-values. This indicates that there is a weak and positive relationship between the drivers of change and resistance to change. The p-values indicated that the results are significant. Since we cannot obtain the cause/effect or impact using correlation we therefore proceed with regression analysis for the objectives of the study.

5.7 Regression analysis for St. Joseph's hospital Adazi-Nnukwu and St. Mary's Marian Hill hospital

5.7.1 Objective 1: To determine the influence of driving forces of change on employees' performance

Table 5.40: Model Summary for St Joseph's Hospital

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.609 ^a	.370	.355	.73115
a. Predictors: (Constant), Use of Technology and Organisational Policy				

Source: Field survey data (2021)

Table 5.41: ANOVAa for St Joseph's Hospital

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	39.007	2	13.002	24.322	.000 ^b
	Residual	66.288	124	0.535		
	Total	105.295	127			
a. Dependent Variable: Employee Performance						
b. Predictors: (Constant), Use of Technology and Organisational policy						

Source: Field survey data (2021)

Table 5.42: Coefficients^a for St Joseph Hospital

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.021	0.464		2.201	0.030
	Use of Technology	0.297	0.108	0.248	2.760	0.007
	Organisational Policy	0.281	0.091	0.272	3.106	0.002
a. Dependent Variable: Employee performance						

Source: Field survey data (2021)

The result of the regression analysis is summarised above, Table 5.42 specifically shows that the model for the driving forces of change, use of technology, organisational policy and employee performance in St Joseph Hospital Adazi-Nnukwu is:

$$EP = 1.021 + 0.297(UT) + 0.281(OP) + \epsilon_i \dots \dots \dots$$

This reveals that use of technology (UT) has an influence on employee performance (EP) at St Joseph hospital Adazi-Nnukwu. Furthermore, the p-value =0.007 indicates statistically significant effect at 5% level of significance. Organisational Policy (OP) is statistically significant on employee performance at St Joseph's with the p-value =0.002 which indicates a significant influence at 5% level of significance.

The coefficient of determination which is 0.370 reveals that approximately 37% of the variation observed by the dependent variable (employee performance) is caused by the independent variable (driving forces of change). The F value and the p-value (24.322, <0.001) in table 5.42 shows that these regression results are significant.

Table 5.43: Model Summary for St Mary's Hospital Marianhill

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.747 ^a	0.557	0.543	0.58750
a. Predictors: (Constant), Organisational policy, Use of Technology				

Source: Field survey data (2021)

Table 5.44: ANOVAa for St Mary's Hospital, Marianhill

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	27.381	2	13.691	39.665	.000 ^b
	Residual	21.745	63	0.345		
	Total	49.126	65			
a. Dependent Variable: Employee Performance						
b. Predictors: (Constant), Organisational policy, Use of Technology						

Source: Field survey data (2021)

Table 5.45: Coefficients^a for St Mary's Hospital, Marianhill

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	0.808	0.382		2.118	0.038
	Use of Technology	0.195	0.077	0.222	2.523	0.014
	Organisational policy	0.581	0.079	0.647	7.348	0
a. Dependent Variable: Employee performance						

Source: Field survey data (2021)

The result of the regression analysis summarised in Table 5.45 specifically shows that the model for the driving forces of change (use of technology and organisational policy) and employee performance at St Mary's Hospital, Marianhill is

$$EP = 0.808 + 0.195(UT) + 0.581(OP) + \epsilon_i \dots \dots \dots$$

This reveals that use of technology has a potential influence on employee performance in St Mary's hospital Marianhill. Furthermore, the p-value =0.014 which indicates a statistically significant effect at 5% level of significance.

Organisational Policy is statistically significant on employee performance at St Mary's Hospital, Marianhill with the p-value <0.001 which indicates a significant influence at 5% level of significance.

The coefficient of determination which is 0.557 reveals that approximately 55.7% of the variation observed by the dependent variable (employee performance) is caused by the independent variable (driving forces of change). The F value and the p-value (39.665, <0.001) in table 5.44 shows that these regression results are significant.

5.7.2 Objective 2: To examine the impact of organisational culture on practical implementation of change

Table 5.46: Model Summary for St Joseph's Hospital, Adazi-Nnukwu

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.787 ^a	0.620	0.614	0.48651
a. Predictor: (Constant), Organisational Culture				

Source: Field survey data (2021)

Table 5.47: ANOVAa for St Joseph Hospital, Adazi-Nnukwu

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	48.265	2	24.132	101.95	0.000 ^b
	Residual	29.587	125	0.237		
	Total	77.852	127			
a. Dependent Variable: Practical Implementation of Change						
b. Predictor: (Constant), Organisational culture						

Source: Field survey data (2021)

Table 5.48: Coefficientsa for St Joseph Hospital Adazi-Nnukwu

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	0.996	0.258		3.854	.000

	Organisational culture	0.667	0.075	0.709	8.834	.000
a. Dependent Variable: Practical Implementation of Change						

Source: Field survey data (2021)

The result of the regression analysis is summarised above in Table 5.48, specifically showing that the model for the organisational culture and practical implementation of change in St Joseph's hospital is

$$IC = 0.996 + 0.667(OC) + \epsilon_i \dots \dots \dots$$

Organisational culture (OC) is statistically significant on practical implementation of change (IC) at St Joseph's hospital with the p-value <0.001 which indicates a significant influence at 5% level of significance. The coefficient of determination which is 0.62 reveals that approximately 62% of the variation observed by the dependent variable (practical implementation of change) is caused by the independent variable (organisational culture). The F value and the p-value (101.955, <0.001) in Table 5.47 shows that these regression results are significant.

Table 5.49: Model Summary St for Mary's Hospital, Marianhill

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.774 ^a	0.600	0.587	0.62061
a. Predictors: (Constant), Organisational Culture				

Source: Field survey data (2021)

Table 5.50: ANOVAa for St Mary's Hospital, Marianhill

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	36.951	1	18.476	47.969	.000 ^b
	Residual	24.650	64	0.385		

	Total	61.601	66			
a. Dependent Variable: Implementation of Change						
b. Predictor: (Constant), Organisational culture						

Source: Field survey data (2021)

Table 5.51: Coefficientsa for St Mary's hospital Marianhill

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	-0.145	0.380		-0.381	0.705
	Organisational Culture	0.584	0.128	0.553	4.563	0.000
a. Dependent Variable: Implementation of Change						

Source: Field survey data (2021)

The result of the regression analysis is summarised above, Table 5.51 specifically shows that the model for organisational culture and practical implementation of change at St Mary's Hospital, Marianhill is

$$IC = -0.145 + 0.584(OC) + \epsilon_i \dots \dots \dots$$

Organisational culture is statistically significant on practical implementation of change at St Mary's Hospital, Marianhill with the p-value <0.001 which indicates a significant influence at 5% level of significance.

The coefficient of determination which is 0.6 reveals that approximately 60% of the variation observed by the dependent variable (practical implementation of change) is caused by the independent variable (organisational culture). The F value and the p-value (47.969, <0.001) in Table 5.50 show that these regression results is significant.

5.7.3 Objective 3: To determine the influence of practical implementation of change on patient's satisfaction

Table 5.52: Model Summary St Joseph's Hospital, Adazi-Nnukwu

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.565 ^a	0.320	0.314	0.64843
a. Predictors: (Constant), Patients Satisfaction				

Source: Field survey data (2021)

Table 5.53: ANOVAa for St Joseph Hospital, Adazi-Nnukwu

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	24.874	1	24.874	59.159	0.000 ^b
	Residual	52.978	126	0.420		
	Total	77.852	127			
a. Dependent Variable: Practical Implementation of Change						
b. Predictors: (Constant), Patients Satisfaction						

Source: Field survey data (2021)

Table 5.54: Coefficientsa for St Joseph Hospital, Adazi-Nnukwu

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.499	0.271		9.221	.000
	Patients Satisfaction	0.485	0.063	0.565	7.692	.000

Source: Field survey data (2021)

The result of the regression analysis is summarised above, Table 5.54 specifically shows that the model for the patient satisfaction and practical implementation of change in St Joseph Hospital Adazi-Nnukwu is

$$IC = 2.499 + 0.485(PS) + \epsilon_i \dots \dots$$

This reveals that patient satisfaction has an influence on practical implementation of change at St Joseph's Hospital, Adazi-Nnukwu. Furthermore, the p-value =0.001 which indicates a statistically significant effect at 5% level of significance. The coefficient of determination which is 0.32 reveals that approximately 32% of the variation observed by the dependent variable (practical implementation of change) is caused by the independent variable (patient satisfaction). The F value and the p-value (59.159, <0.001) in Table 5.53 show that these regression results are significant.

Table 5.55: Model Summary St Mary's Hospital, Marianhill

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.407 ^a	0.165	0.153	0.88934
a. Predictors: (Constant), patient satisfaction				

Source: Field survey data (2021)

Table 5.56: ANOVAa for St Mary's Hospital, Marianhill

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	10.192	1	10.192	12.886	0.001 ^b
	Residual	51.410	65	0.791		
	Total	61.601	66			
a. Dependent Variable: Implementation of change						
b. Predictors: (Constant), Patient satisfaction						

Source: Field survey data (2021)

Table 5.57: Coefficientsa for St Mary's Hospital, Marianhill

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.326	0.314		7.411	0.000
	Patient Satisfaction	0.354	0.099	0.407	3.590	0.001
a. Dependent Variable: Implementation of change						

Source: Field survey data (2021)

The result of the regression analysis is summarised above in Table 5.57 specifically shows that the model for the patient satisfaction and practical implementation of change at St Mary's Hospital, Marianhill is

$$IC = 2.326 + 0.354(PS) + \epsilon_i \dots \dots$$

This reveals that patient satisfaction has an influence on the practical implementation of change at St Mary's Hospital, Marianhill. Furthermore, the p-value =001 which indicates a statistically significant effect at 5% level of significance. The coefficient of determination which is 0.165 reveals that approximately 16.5% of the variation observed by the dependent variable (practical implementation of change) is caused by the independent variable (patient satisfaction). The F value and the p-value (12.886, <0.001) in table 5.57 Shows that these regression results is significant.

5.7.4 Objective four: to establish if drivers of change (Use of technology and organisational policy) influence resistance to change during the implementation process

Table 5.58: Model Summary for St Joseph's Hospital, Adazi-Nnukwu

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.160 ^a	0.025	0.002	1.15736
a. Predictors: (Constant), Use of technology and organisational policy				

Source: Field survey data (2021)

Table 5.59: ANOVAa for St Joseph's Hospital, Adazi-Nnukwu

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	4.345	3	1.448	1.081	0.360 ^b
	Residual	166.097	124	1.339		
	Total	170.442	127			
a. Dependent Variable: Resistance to change						
b. Predictors: (Constant), Use of technology and organisational policy						

Source: Field survey data (2021)

Table 5.60: Coefficients for St Joseph's Hospital, Adazi-Nnukwu

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.991	0.734		5.435	0.000
	Use of Technology	0.016	0.170	0.011	0.096	0.924
	Organisational Policy	-0.232	0.143	-0.176	-1.618	0.108
a. Dependent Variable: Resistant to change						

Source: Field survey data (2021)

The result of the regression analysis is summarised above in Table 5.61 specifically shows that the model for the driving forces of change (Use of technology and organisational policy) and resistant to change at St Joseph's Hospital, Marianhill is

$$RC = 3.991 + 0.016(UT) - 0.232(OP) + \epsilon_i \dots \dots \dots$$

The use of technology has a potential influence on resistance to change (RC) in St Joseph's Hospital. Furthermore, the p-value =0.924 indicates a non-statistically significant effect at 5% level of significance. Organisational Policy is not statistically significant, though has a potential influence on resistant to change management (RCM) in St Joseph's hospital with a p-value =0.108. The coefficient of determination which is 0.025 reveals that approximately 2.5% of the variation observed by the dependent variable (resistance to change) is caused by the independent variable (drivers of change). The Beta value of -0.176 for organisational policy indicates that lack of organisational policy can affect resistance to change. The F value and the p-value (1.081 =0.360) in Table 5.60 Shows that this regression result is significant.

Table 5.61: Model summary for St Mary's Hospital, Marianhill

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.125 ^a	0.016	-0.017	1.00497
a. Predictors: (Constant), Organisational policy, use of technology				

Source: Field survey data (2021)

Table 5.62: ANOVAa for St Mary's Hospital, Marianhill

Model	Sum of Squares	df	Mean Square	F	Sig.
1					
Regression	0.960	2	0.480	0.475	0.624 ^b
Residual	60.597	60	1.010		
Total	61.557	62			
a. Dependent Variable: Resistant to change management					
b. Predictors: (Constant), Organisational policy, Use of Technology					

Source: Field survey data (2021)

Table 5.63: Coefficients St Mary's hospital Marianhill

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.864	0.676		4.235	0.000
	Use of Technology	0.092	0.135	0.091	0.678	0.500
	Organisational policy	0.067	0.139	0.064	0.479	0.634
a. Dependent Variable: Resistant to change Management						

Source: Field survey data (2021)

The result of the regression analysis is summarised above in Table 5.64 specifically shows that the model for the driving forces of change (use of technology and organisational policy) and resistance to change at St Mary's Hospital, Marianhill is

$$RC = 2.864 + 0.092(UT) + 0.067(OP) + \epsilon_i \dots \dots \dots$$

The use of technology has a potential influence on resistant to change at St Mary's Hospital, Marianhill. Furthermore, the p-value =0.500 which indicates a non-statistically significant effect at 5% level of significance. Organisational policy is not statistically significant, though has a potential influence on resistance to change at St Mary's Hospital Marianhill with a p-value =0.634

The coefficient of determination which is 0.0169 reveals that approximately 16.9% of the variation observed by the dependent variable (practical implementation of change) is caused by the independent variable (resistant to change). The F value and the p-value (0.475 =0.624) in Table 5.63 shows that these regression results are not significant.

5.8 Qualitative analysis findings

This section explores and analyses the qualitative interview data which culminates in the discussion of findings in relation to the study's objectives. The impact of globalisation, technological change and increased competition are factors that organisations are currently forced to deal with if they are to survive. Beregszaszi & Hack-Polay (2012) assert that organisations embrace diverse change initiatives in an attempt to adjust to the rapidly changing environment. This section discusses the results of the qualitative data gathered via in-depth interviews from a total of 10 management employees at St. Joseph's Hospital, Adazi-Nnukwu in Nigeria and St. Mary's Hospital, Marianhill in South Africa. According to Klenke (2016) qualitative data analysis produces a wealth of details through non-numeric information from participants and description of situations, interactions and observed behaviours.

These themes were created and prepared based on the information gathered from the participants. The responses obtained were analysed by establishing the main themes established during the data collection process. Thematic analysis of qualitative data is the process of identifying themes. Boyatzis (1998) cited by Bergstrom (2010) argues that thematic analysis is understood from the perspectives of seeing and seeing as. Bergstrom (2010) further highlights that to see something means to find patterns in the data that begins with a coding procedure; whereas to see as focuses on the interpretation of the analysis by bringing parts of things together. For the identification of the themes discussed hereunder the researcher coded all the interview transcriptions and also made use of inductive thematic analysis of qualitative data and NVivo 12 software.

The aim of the interview was to collect data with regards to: (1) determine the influence of drivers of change on employees' performance, (2) investigate the impact of organisational culture on practical implementation of change, (3) understand the influence of practical implementation of change on patient satisfaction, and (4) examine the impact of drivers of change on employee resistance to change.

5.8.1 Sample characteristics

The researcher sent out 10 interview schedules to a total of 10 management employees across different departments at St Mary's and St Joseph's and all 10 interview schedules were completed. This shows that there was a high response rate and this made it easier to analyse and make conclusions on the data collected. The net response rate was a hundred percent which denotes that the data was fit for analysis and validates the trustworthiness and authenticity. Bhattacharyya et al. (2012) highlights that there are two sets of criteria for judging the richness of quality of an inquiry in the constructivism paradigm, these are: trustworthiness and authenticity. Sekaran & Bougie (2010) agree that authenticity incorporates a quality standard that accesses whether the interpretations and findings are real in impressions of the research participant's experiences.

The five pilot participants at St Joseph's hospital comprised of two females and three males. The data collected revealed that the age group 30 - 40 years recorded the highest number of two participants, followed by the age group 40 – 50 years with one participant. Only two participants were 50 years and above. Whilst the gender of all five participants at St Mary's Hospital consisted of two females and three males. The data collected also revealed that the age group 30-40 years recorded the highest number of three participants, followed by the age group 40 – 50 years with one participant. Only one participant was 50 years and above. This study highlighted that St Mary's Hospital participants are of a millennial age group and St Joseph's participants fall under the Generation Z.

A young workforce is considered more productive than an ageing workforce. This is in tandem with Javernick-Will's (2012) statement that there were evidences of directing impacts of age on the relationship between psychosocial work conditions and wellbeing. However, with an ageing population comes an ageing workforce. The main challenges of an ageing workforce include, bias, absenteeism, lack of physical fitness to carry out duties and knowledge loss. Hence, organisations can reduce the strain on ageing workforce by embracing technology in the workplace (Javernick-Will, 2012; Hertel, Guido & Zacher, Hannes. 2018). In addition, the researcher interviewed one participant

from each department in both hospitals, this was mainly due to the fact that the sample size was small. The departments of the participants included, administrative, medical, nursing, HR and finance. In terms of job level, all ten participants were in management.

Furthermore, the results indicated that most of the participants at St Mary's Hospital have served the organisation for more than ten years. Whilst two participants have been with St Joseph's Hospital between 11 to 25 years. Lastly, the data results revealed that three out of the five participants in St Mary's Hospital have post graduate qualifications. One participant had a Bachelor of Science degree and the other had a diploma. On the contrary, four out of five participants at St Joseph's hospital had Bachelor of Science degrees and one out of five participants had a Doctor of Philosophy (PhD) degree. Srivastava & Barmola (2011) propose that productivity is dependent on two important factors, namely: technology relevant to the organisation and employee performance. The employees' performance, on the other hand is dependent on two variables which include, professional and technical competences of employees (involving the possession of relevant knowledge, skills, and techniques) and motivation.

5.8.2 Core Themes

In the following sections the results from the analysis are presented. The figure below illustrated seven themes that emerged from the interview questions, which aimed to explore the various factors that affect change initiatives in the two sub-Saharan African hospitals. Each theme is discussed with regard to its relevance to the research objective. The figure below shows the holistic view of the objectives of the study within the context of organisational change management in hospitals. The sub-themes that emerged from each of the themes are explained below.

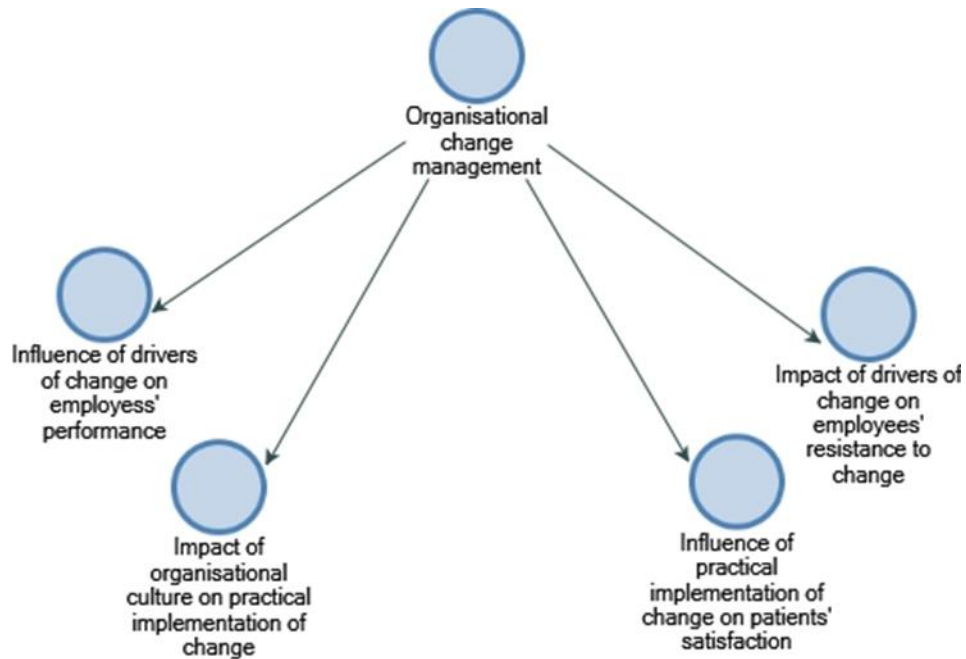


Figure 5.3: Project map for change management, NVivo 12

As revealed in Figure 5.1, all the change management variables were found to be embedded in the change management process of the two hospitals. The interview questions were designed in line with the key constructs and responses were themed according to the information that emerged in line with the variables. Most of the participants were well-educated with a diploma certificate being the lowest qualification and PhD degree the highest qualification. Furthermore, the majority of the participants have between ten to 25 years working experience with their organisation, therefore, the information provided by these participants during the change process can be relied upon. The next paragraph discusses the views and perceptions of the participants with regards to the impact of drivers of organisational change.

5.8.3 Objective one: Influence of drivers of change on employees' performance

The transcribed data received from the structured questions revealed that both St. Joseph's Hospital and St. Mary's Hospital have undergone a process of organisational change as shown in Figure 5.3 and 5.4 below. The interview responses that emerged

from the in-depth interview sessions with regards to organisational change management were coded into different sub-themes.

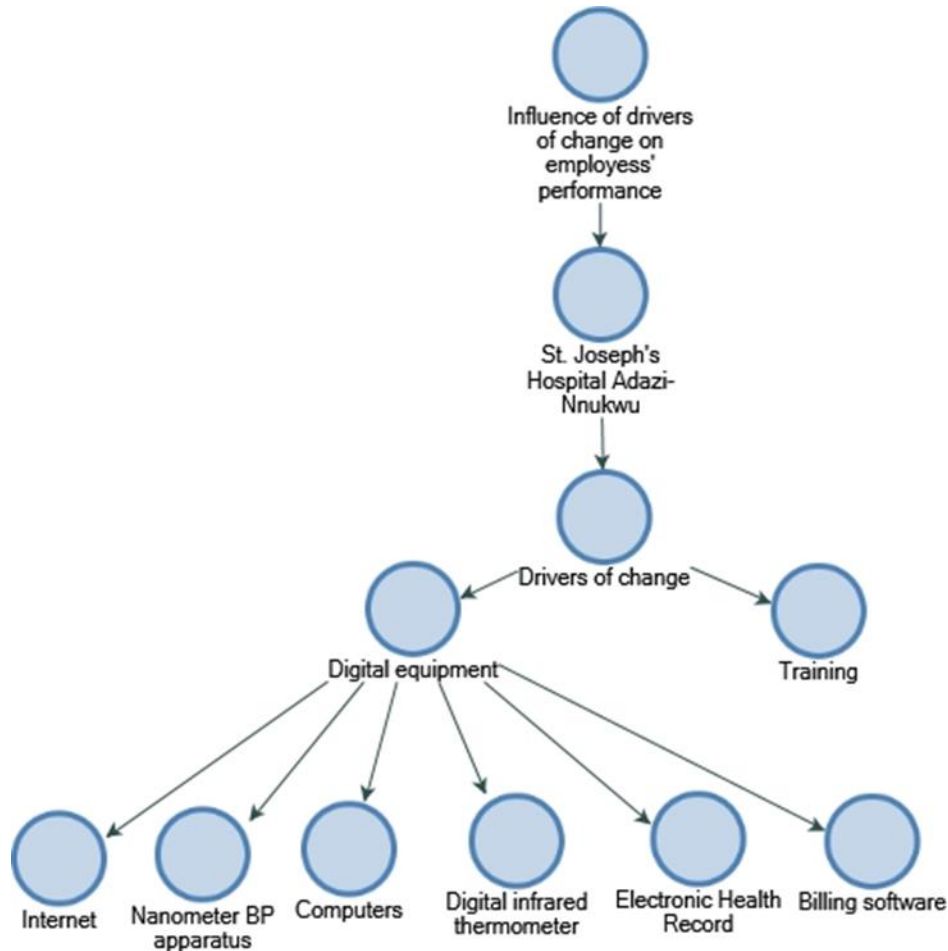


Figure 5.4: Influence of drivers of change on employees' performance in St. Joseph's hospital

The composition in Figure 5.4 above presents the components of drivers of change as it influences employee performance. The themes that emerged as drivers of change were digital equipment and training. The sub-themes that emerged for digital equipment include, internet, Nanometre BP apparatus, computers, digital infrared thermometer, electronic health record and billing software. However, types of training were not mentioned.

The introduction of digital equipment alongside the training of employees were the major drivers of change at St Joseph's Hospital. Some of the participants identified the digital gadgets and shared their previous experiences with the current administrative system, giving credit to the present administrative regarding the new digital change. Some of the participants asserted this:

When I came here, there was only one computer in the hospital and that was in the administration department. But right now, there are computers at every department. We are working digitally now with many technologies. Right now, there are many computerised systems that doctors work with, even consulting from their phone. We are trying to facilitate patient care. A lot of patients are very satisfied with the level efficiency in the hospital (participant 2, interview – St Joseph's).

This comment is buttressed by other participants:

Currently, the organisation has introduced computers to document information, though it not available to all departments. However, it is available in the medical, pharmacy, data, billing and laboratory departments (Participant 3, interview – St Joseph's).

A lot, everywhere technology has brought about a lot of changes. It is a welcome development, and it is very encouraging. Some of the changes are technology infrastructure, systems, automations and tools (Participant 4, interview – St Joseph's)

With respect to enhancing performance as part of a team, all the interview participants concurred that the introduction of digital facilities had had a significant impact on their performance. Technology has revolutionised the way organisations carry out business transactions, hence organisations must embrace an array of technology to develop a competitive advantage in the economic marketplace. Digital facilities increase employee productivity through the uses of computer programmes and software which allows employees to process more information than the manual methods. Technology has the ability to improve the efficiency of a hospital as an organisation and improve the quality of care delivered to patients. Participants 1 and 5 affirmed this claim below:

I prefer the current change because like I said it makes our job more effective and the patients are very satisfied (Participant 1, interview – St Joseph's).

I will say that this impacted me positively because it makes my job easier and more efficient. For me technology and training is a driving factor for employee's efficiency (Participant 5, interview – St Joseph's)

The training of the employees also helps to improve performance. Some of the participants indicated that the training they received helped to drive the implementation of change. The response provided by participant five reflects the significance of training on employee productivity. The response goes to show that, if appropriate mechanisms are put in place to train the employees, there is a tendency for employees to be more committed to the job which invariably enhances productivity. This line of thought aligns with the response provided by respondent three and respondent one illustrated below.

Yes, constantly we have training. We collaborate with a lot of organisations when it comes to training. We have a German NGO organisation who offers training to the doctors and nurses voluntarily. We work with FHI 360, some of their equipment are in our laboratory and they offer training on how to operate the equipment. Even the other hospitals from different states send in their employees to get trained by us both ethically and technology advancement (Participant 3, interview – St Joseph's).

Yes, always. Our hospital is very keen about training. We receive trainings on quality, customer service, technical and skills (Participant 1, interview – St Joseph's).

From the information gathered from the employees, it is evident that the drivers of change (digital equipment and training) had significant impact on employees' performance at St. Joseph's hospital. Training can be an instrument for St Joseph hospital to provide their realisation of organisational goals because employee performance impacts the bottom line of an organisation. Training and development assists every organisation and employees to attain diverse goals, such as, improved morale, sense of job security, employee engagement and overall skill competencies needed to perform a particular job (Walters & Rodriguez, 2017). According to Arinanye (2015), training and development promotes employee involvement in the change process by providing the competencies necessary to adjust to the new and challenging times. Training and development does not only increase knowledge and skills but also promotes employee confidence, morale and motivations.

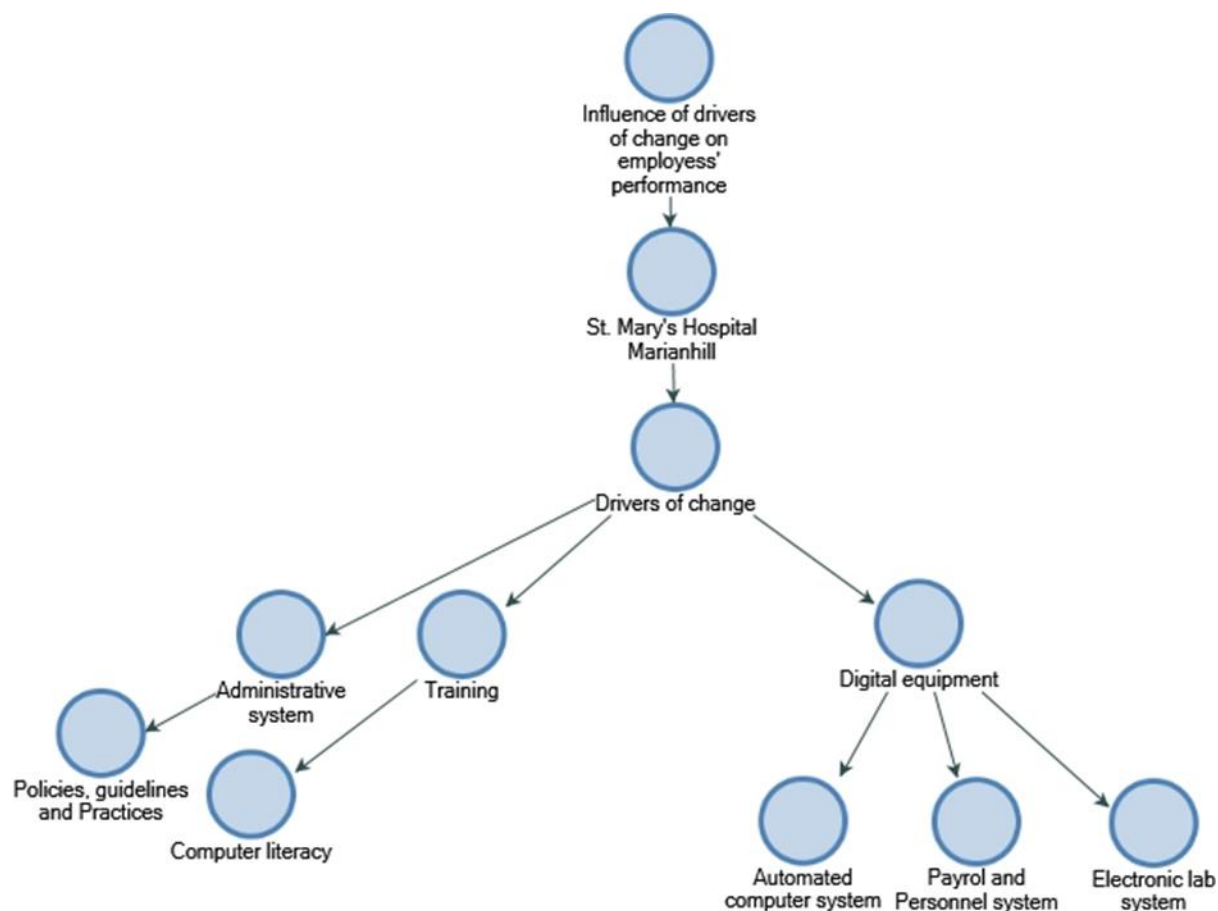


Figure 5.5: Influence of drivers of change on employees' performance in St. Mary's hospital

As shown in Figure 5.5 above, the themes that emerged as drivers of change in St. Mary's hospital include, the administrative system, training, and digital equipment. Figure 5.5 also revealed that policies, guidelines and practices were the sub-themes under administrative system, while computer literacy was the only sub-theme under training. Three sub-themes emerged under digital equipment which include, automated computer systems, payroll, personnel systems, and electronic lab systems.

As shown from the NVivo analysis, administrative system, training, and digital equipment were identified as drivers of change at St Mary's Hospital. According to the participants, the system of administration such as the new policies, guidelines and practices had brought about a lot of changes. Some of the participants commented below:

There were change of policies, guidelines, and practices. This new change was totally different from the private era and we had to be trained to fit into the new practices (Participant 3, interview – St Mary's).

The change that has occurred is change of systems. Shifting from the private era to the government era. The major impact was change in systems and the new systems brought about training. In my view, the organisation enhances my productivity and efficiency through training on patient satisfaction. In that way we are skilled in how to deliver quality service to our patients (Participant 1, interview – St Mary's).

Training of employees to adapt to the new system was also identified by the participants as a driving force of change. These participants implied that employees who receive training are motivated and happy about their jobs. They carry out their job responsibilities to the best of their capacity and patient satisfaction increases as a result. Since employees are an organisation's most valuable assets, thus, it is then necessary for the training of the employees at St Mary's to be enhanced in order to increase productivity during change implementation.

Yes, definitely, in order for people to learn new practices you have to subject them to a certain training. Though the trainings were hasty because it was learning on the go. But the organisation provided the HR and finance as internal change agents that mentored some of the employees (Participant 2, interview – St Mary's).

We have had training in terms of the grade progression process and pay progression. Those were the things we weren't really doing before, you know. We have been introduced to a new way of doing things and it seems to be working out perfectly fine (Participant 5, interview – St Mary's).

During the introduction of new systems, we did attend training for both systems. But prior to that there was training on computer literacy for those who are not computer literate. And after training we received certificates as a proof that we completed training and were competent (Participant 1, interview – St Mary's).

The above assertions were the general submission of other participants. Digital equipment was the last sub-theme that emerged as another driver of change at St. Mary's Hospital. Participant 4 indicated below:

Over the years with the previous administration, we used to do things manually, and then with the new era, we have transformed from doing things manually to automated computer systems. Just to mention but a few, we have the metro filing- it deals with filing. And with the capturing of patients' information we have a system called Rev-Light. Rev-Light is user-friendly and helps us perform our job effectively and efficiently (Participant 4, interview – St Mary's).

After the change to the current management by the DHA, there were serious transformations in our technology systems to accommodate the new change. Like the introduction of PERSAL which is an HR system, and BAS - a basic accounting system for payments to suppliers (Participant 5, interview – St Mary's).

Furthermore, all the employees were in agreement that the current dispensation is better than the previous era. Storey (2013) asserts that Herzberg's motivation theory lays emphasis that motivation factors like job security have the probability of raising job satisfaction. This statement is supported by the majority of participants who cite that the benefit of job security improves good attitude towards work which improves employee efficiency level and productivity (Reijseger, et al. 2017). A positive attitude in every organisation gets goals accomplished. The participants identified job security as a key motivation factor that makes the difference.

Even with all the challenges we are facing now, I have to say that I prefer the DOH. For two main reasons. One is that we did not have job security with the previous era because it was private and did run into financial difficulties at some point. And that's why the DOH came on board to take over. Then secondly, with the previous dispensation, we didn't have a structure. Decisions and certain policies were made abruptly. However, with the current era, it's not so easy to override or take certain decisions without recognising the hierarchy. We now have structures in place that must be embraced (Participant 1, interview – St Mary's).

This current dispensation is much better because of policies, and job security. Previously it was private owned and there wasn't any job security (Participant 3, interview – St Mary's).

The introduction of job security is another factor influencing employees' performance. Hence it can be said that job security plays a significant role on the overall performance of the employees as well as the organisation. From the abovementioned, it can be

inferred that all the identified drivers of change have significant impact on employees' performance.

5.8.4. Objective two: Impact of organisational culture on practical implementation of change

As shown in Figure 5.6 and 5.7 below, participants from both St Joseph's hospital and St Mary's hospital identified the presence of organisational culture within the organisation. The gathered information was transcribed to generate themes and sub-themes as revealed below:

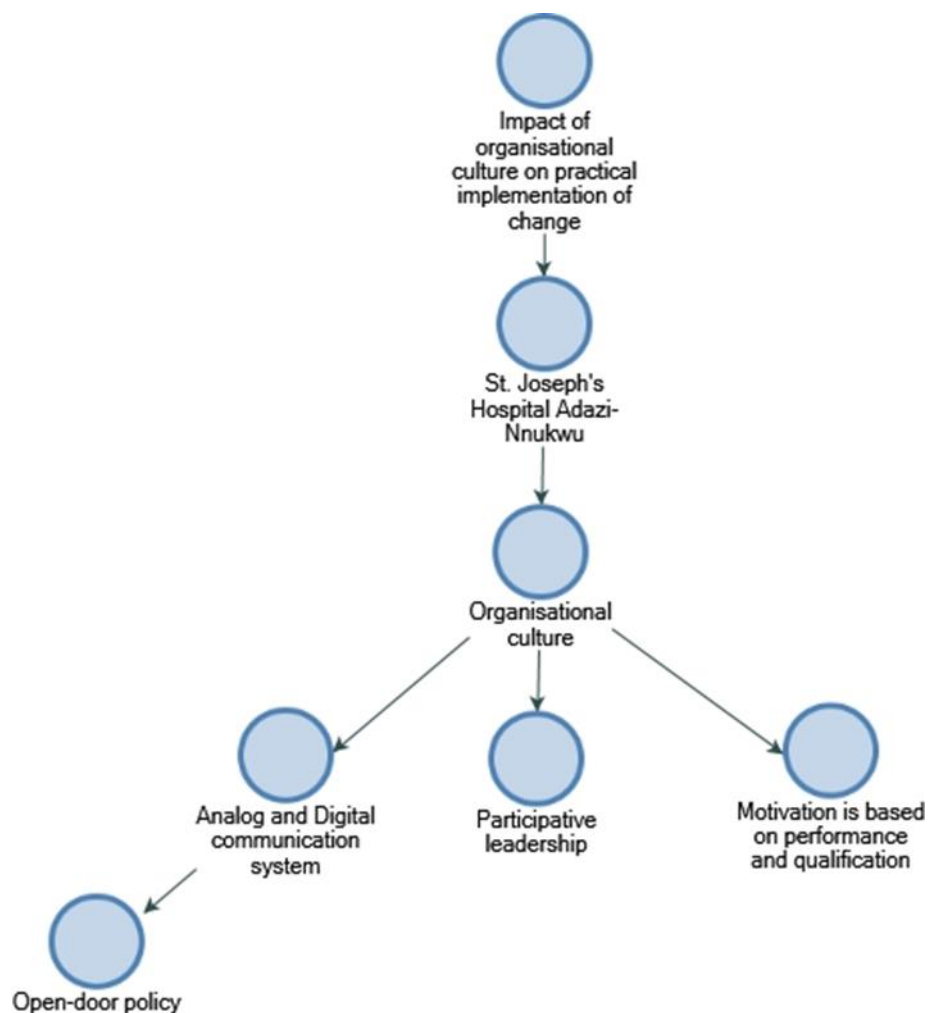


Figure 5.6: Impact of organisational culture on practical implementation of change in St Joseph's hospital

The composition in Figure 5.6 shows the themes and sub-themes that emerged for St. Joseph's hospital. The three themes that emerged for organisational culture include

analogue and digital communication system, participative leadership and motivation that is based on performance and qualifications. Open-door policy is the only sub-theme that emerged for analogue and digital communication systems.

Organisational culture refers to the values and belief system that guides the operation of an organisation and thus is an important element in implementing a change programme and represents a key factor in implementing planned change in an organisation (Alvesson & Sveningsson, 2016). The communication system, leadership style and motivation system are embedded in the culture of an organisation. For St Joseph's hospital, the participants identified analogue and digital mode of communication having impact on implementation process. This communication system is described as being effective and valued by the organisation. The participants also affirmed that the communication mode encourages open-door practice, which allows the change implementation to be successful as mentioned below:

The communication flows very well both from the management to the staff and vice versa, they pass information through memos and WhatsApp group chats. We do not have any challenges in our communication. In fact, the management keeps us involved, they speak plainly and politely to us (Participant 1, interview – St Joseph's).

In light to that note, we have an open-door practice. The management doors are open to every staff because I consider communication important. Communicating telephonically is very expensive but we have been able to reduce that cost by installing intercom to ensure that communication flows. We also have a WhatsApp group open to all. We all have access to the WhatsApp group (Participant 2, interview – St Joseph's).

The forms of formal communication are downward and upward exchange of information. And we have a WhatsApp group for communicating instantly (Participant 3, interview – St Joseph's).

From the foregoing, it is found that the effective flow of communication enhances the change process. However, highly contributing variables are those having relative importance given by employees. Poor communication in an organisation leads to unmotivated staff leading them to question their abilities and inevitably in the organisation.

When asked to advise whether the leadership style impacted their performance during the change implementation, the participants agreed that they all participate in the decision-making process making it a participative leadership style.

We participate in joint committees and councils through which we can contribute to and share in making the organisations a better place to work (Participant 5, interview – St Joseph's).

If the management wants to make any decision, depending on the area the decision making would affect, they do ask of our opinions before making any decision. They always want to hear our views and mostly consider our opinions if appropriate (Participant 4, interview – St Joseph's).

However, one of the participants argued that the previous communication system excluded the key employees until he assumed leadership position.

In the previous era, there wasn't really a forum that allowed employees to participate in decision making process. I instituted that when I took over as the manager, I set up an admin council drawn from all the heads of the departments. In that way they were able to reach out to their teams and their opinions and suggestions are taken into account (Participant 2, interview – St Joseph's).

Participative leadership allows the management to accommodate the views of the employees thereby allowing for easy implementation of change. Caillier (2014) opines that participative leadership empowers employees to utilise their creative skills to develop more work processes in order for the organisation to become more efficient.

The last theme is motivation, in which all the participants agreed that it is performance and qualification driven. Some of the motivation may be in form of salary increase, and acquisition of skills. Employees who are motivated have their goals aligned with those of the organisation and direct their efforts in that course. However, some of participants place more value on extrinsic motivation.

We get increases in salary, we receive frequent training, and we have the necessary tools, equipment and technology to enhance our productivity. Motivation enhances good working procedures and makes me go the extra mile for the hospital (Participant 1, interview – St Joseph's).

Well, Nigerians understand nothing but money. We motivate employees by increasing their salaries by 10%. But we have also reviewed salaries in that regard but according to academic and experience scale. The truth is motivation is very important in every organisation for an organisation that wants a sustainable growth. As a human being it keeps us going (Participant 2, interview – St Joseph's).

Like I said earlier, motivation for our employees is about money (Participant 4, interview – St Joseph's).

Through extrinsic motivation, the management was able to motivate performance geared toward the implementation of change. The analysis of the data received from the participants below identifies that motivation should be an important concern for every organisation. Ganta (2014) is of the opinion that motivated employees usually produce more than others and hence the patient satisfaction increases.

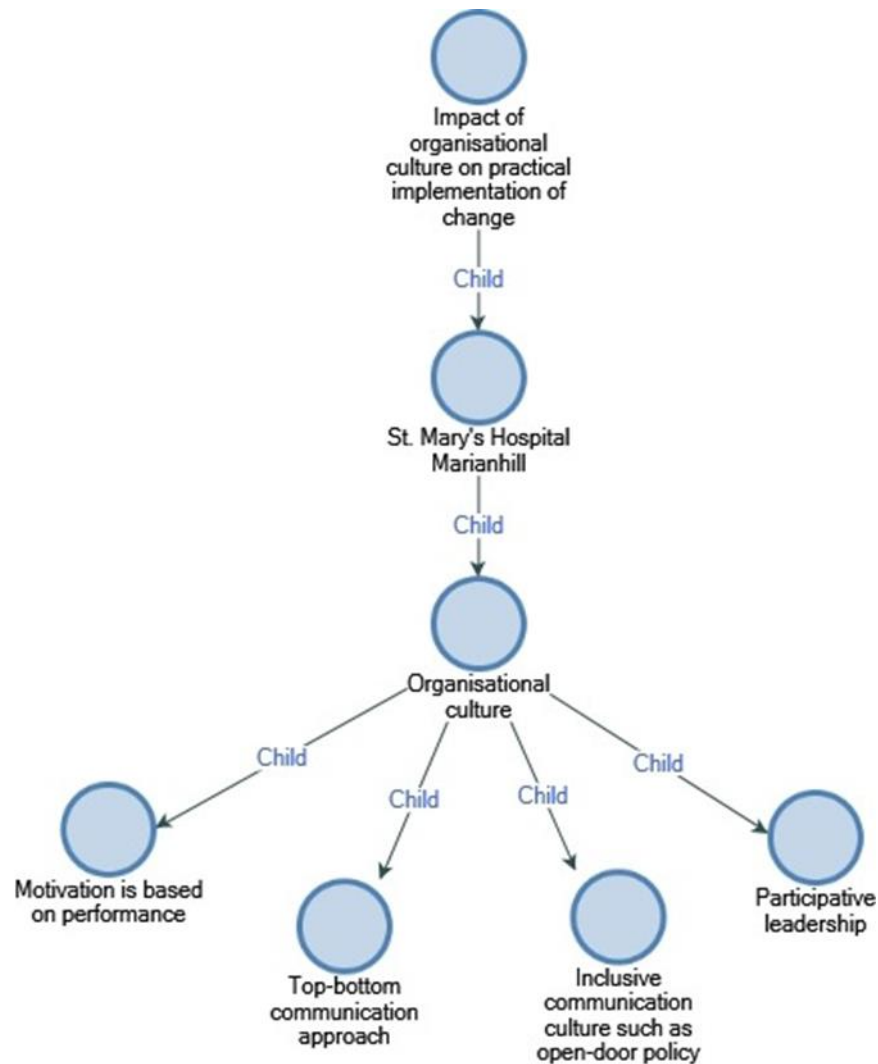


Figure 5.7: Impact of organisational culture on practical implementation of change in St Mary's hospital

Figure 5.7 reveals the components of organisational culture in St Mary's Hospital. This includes, motivation based on performance, recruitment and advert policies, top-bottom communication approach and participative leadership. Similar to St. Joseph's Hospital, motivation at St Mary's Hospital is performance driven. However, the reward for performance is more intrinsic unlike at St Joseph's Hospital. According to participant 4:

From my opinion, the truth is that the government doesn't have money to give its employees. So currently we receive awards and certificates for good performance. We have a system running whereby employees who are doing well will be published in our in-house magazine as employee of the month to encourage staff in doing better. We also have complaints and compliments section when one does well, they will be rewarded for their generous doing and

now the CEO has recently introduced another practice to say if a department performs well that department will be given an incentive (Participant 4, interview – St Mary's).

It is important to note that management motivate employees to implement the change process. However, participant 1 believes in intrinsic motivation because it propels employees to perform better. Kassa (2015) argues that intrinsic motivation enhances employees to be more engaged in their work and thus leading to better performance and higher job satisfaction which increases turnover.

To motivate staff, I know we have a forum which is for compliments and reviews. We use that to award staffs according to number of compliments received according to the standard of service provided. Motivation helps to implement management's directives and it has been working for us (Participant 1, interview – St Mary's).

The lack of recognition in an organisation is becoming a challenge to most organisations. Meyer and Orpen (2016) asserts that many employees need recognition from their employers to produce quality work. Recognition and reward systems identify top-performing employees. Acknowledging a job well done or a simple compliment makes employees feel good and encourages them to perform more. Recognition is a priceless tool that should be embraced by managers of organisations because it increases employee loyalty and enhances performance.

Before the current administration, we used to have yearly celebrations for various awards. There were various categories of awards. We also publish best performing employee on our internal newsletter every quarter. We recently initiated best department with less complaints and treat them with lunch voucher and a day off. Unfortunately, it is not monetised and sometimes I wish that they monetised it (Participant 2, interview – St Mary's).

Participant two and five suggested that there is a need to motivate extrinsically by raising money to reward performance.

The one thing I will suggest is not only recognising employees by publishing their photos. Usually with human nature, it works better if you can actually be giving them a small token, it will mean a lot to that person. But the hospital might need additional budget in trying to factor that in, so it will be good for the officials in higher positions to consider that. I believe it will make an employee feel that

his/her effort is being recognised thereby achieving organisational goals (Participant 5, interview – St Mary's).

The above assertions by the employees suggests that both intrinsic and extrinsic motivation positively influence the implementation of change process, however, the employees are more drawn toward extrinsic motivation.

The type of communication system was also identified as part of the organisational culture to the implementation of change. While some identified a top-down approach, others mentioned an open-door communication policy. Management support and communication with their employees has a major effect on their performance and motivates them toward the best.

Communication, you know, is a two-way thing. The management communicates to the middle management and the middle management escalates to the bottom and then we take feedback from the bottom to the top. That's how we interact with each other (Participant 4, interview – St Mary's).

In terms of the organisation. The way it works is that the lower-level category of staff approaches their supervisors. If the supervisors are not able to assist then it will be escalated to the management. So, we work with a hierarchy of management. But here in HR, I have an open-door policy. I am fine with any of my staff members approaching me (Participant 5, interview – St Mary's).

It's through engagement process. It's not a rigid system. Matters are thoroughly discussed before conclusion is made. That's why we have monthly meetings with everyone to discuss issues (Participant 3, interview – St Mary's)

Yes, I do. I am part of the senior management and extended management committee and we have an open-book communication (Participant 5, interview – St Mary's).

Participative leadership, which is a leadership style, was also indicated as an organisational culture that aided in the implementation of the change process. Effective leaders need to master to communicate well and with their employees and thus, effective communication skills are a critical aspect of any leader's portfolio of skills and experience (Kassa, 2015). Autocratic leadership and top-down decision-making creates a rigid work environment and in these organisations innovation is suppressed and

motivation decreases, which has in turn a negative impact on performance (Brown, 2014).

In terms of decision-making process, we attend management meetings and that is where we participate in decisions that will affect the hospital at large. Further to that we do have extended management meetings apart from other meetings we may have. But these are the two we do have where you are given a chance to participate in the decision-making process and present your point of view (Participant 4, interview – St Mary's).

I participate a lot, because we have this culture of including everyone when we adopt any kind of change. We have an open-door policy where when an employee is not clear he or she can always seek clarity from both senior and middle management. So, I guess that everyone has opportunity to participate (Participant 1, interview – St Mary's).

The above assertions suggest that the implementation of change process is well communicated to the employees through an open-door policy for interactions and participative leadership. Feedback from management is very important as it builds a good relationship between management and employees. Saeed & Asghar (2012) cited by ODOR (2018) state that an important aspect of communication is the ability to listen because leaders who listen actively inspire and motivate employees to perform better because credibility is built on authenticity and honesty. This implies that all the feelings and interests of the employees were considered before embarking on the change process. Therefore, the culture of motivation, effective communication and participative leadership have significant impact on the implementation of change.

5.8.5 Objective three: Influence of practical implementation of change on patients satisfaction

It is evident from Figure 5.8 and 5.9 below that some practical changes have been implemented at St Joseph's Hospital and St Mary's Hospital. These practical changes were basically technological changes.

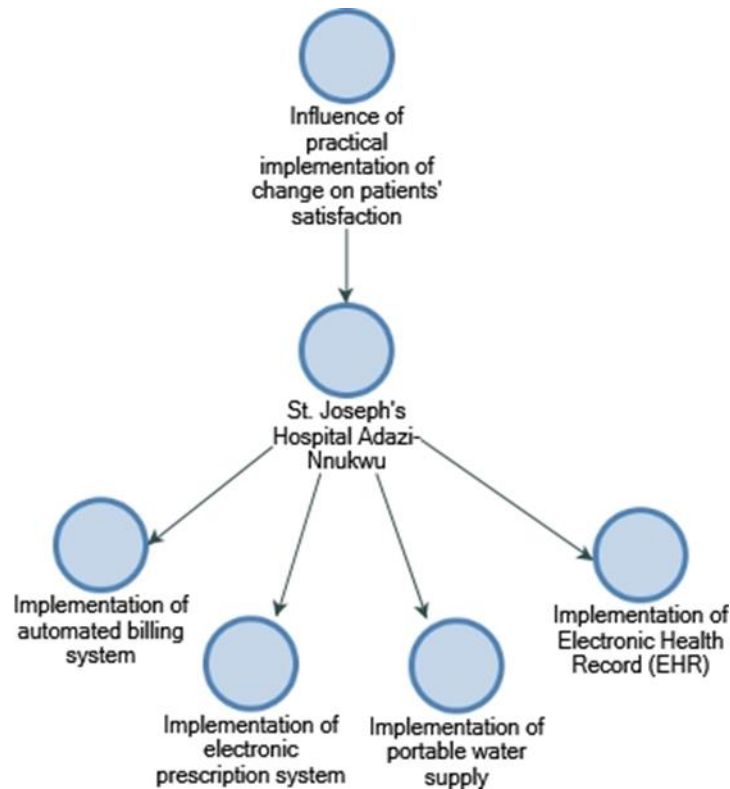


Figure 5.8: Influence of practical implementation of change on patient satisfaction

Some of the practical changes that were implemented at St. Joseph's hospital include, the introduction of an automated billing system, an electronic prescription system, portable water supply and electronic health record.

As shown in Figure 5.8, the digital infrastructural facilities were the major practical implementations that influenced changes within the organisation. These changes had a drastic transformation with significant impact on the patients. Some of the participants were in agreement that the digital transformation has improved their finance system and improved patient satisfaction. Technological innovations in the healthcare system have facilitated easier communication in hospitals.

In the area of finance, I would say the change is useful, at least the management can easily see and track the accounts after the billing process. I prefer the current change because like I said it makes our job more effective and the patients are very satisfied (Participant 4, interview – St Joseph's).

Yes, I would say beyond measures. The benefit of technology developments can't be overemphasised. It is difficult for someone to evaluate themselves. But in the last two years a lot of changes have taken place which is unbelievable. We

have been able to control the flow of finances (Participant 2, interview – St Joseph's).

My dear, I can tell you categorically now that there is a lot of improvement, because initially when we were using the manual equipment, especially during billing process, we would write it out with pen before calculating the bill and sometimes there are errors. But right now, every patient information and billing process is automated. It has decreased patients long waiting times in all departments. The electronic billing system is a game-changer and brings accuracy and speed (Participant 3, interview – St Joseph's).

One of the participants affirmed that the implementation of electronic prescription system has also improved doctors' work efficiency.

Currently the doctors have been introduced to prescribing from their system to the pharmacy and to the billing office, and that has been able to reduce unnecessary queues, cut costs, streamline excessive HR and enhance efficiency and improved customer satisfaction (Participant 4, interview – St Joseph's).

Most of the participants also opined that the implementation of the electronic health record has improves patient data and efficiency.

Well, I'm one of the managers here and hence don't treat patients. But for my department I would say the electronic health record (EHR) – this is a software that digitalises patient data and has improved our productivity by 90%. We also have billing software, internet and electronic communication. Now we have shorter waiting periods and patients are happier (Participant 3, interview – St Joseph's).

We are working digitally now with many technologies. Right now, there are many computerised systems that doctors work with, even consulting from there phone. We are trying to facilitate patient care. A lot of patients are very satisfied with the level efficiency in the hospital (Participant 5, interview – St Joseph's).

Providing the right tool is imperative to the successful completion of task. Hence, almost all the participants agree that the right tools allow them to complete their job task efficiently. One of the biggest benefits of EHRs is that it offers easier and faster access to information required by healthcare workers and patients. Health care professionals no longer have to rely on manual physical records to access patients' information. Utilisation of EHRs also enables faster, smoother and easier medical billing. Digital

technology has greatly improved and enhanced operational efficiency within the healthcare industry with respect to quality care. Every organisation should provide the best technology, devices and equipment needed by employees to yield error free results in the shortest possible time. A good number of the participants responded positively that St Joseph's Hospital provides them with the necessary work tools that enhance their performance.

The implementation of piped water was also identified as a major contribution to patient satisfaction. Work environment plays a critical role since it influences employee performance during the implementation of change. Heizer & Render (2014) assert that the physical work environment in which employees work affect their performance, safety, and quality of work life. Illumination, noise and vibration, temperature, humidity, water and air quality are work-environment factors under the control of the organisation and managers.

Yes absolutely, like previously we had poor supply of water. However, we have been able to drill a pole hole to enable patients and employees to have access to a good supply of water (Participant 5, interview – St Joseph's).

Javernick-Will (2012) inferred that there are evidences of directing the impacts of age on the relationship between psychosocial work conditions and wellbeing. Therefore, access to safe drinking water and basic sanitation are vital for health. A conducive work environment should promote employee safety, growth opportunities and wellbeing. The need for a favourable working condition is about defining the physical environment by recognising those components of the physical environment (Khugshal & Chaubey, 2015).

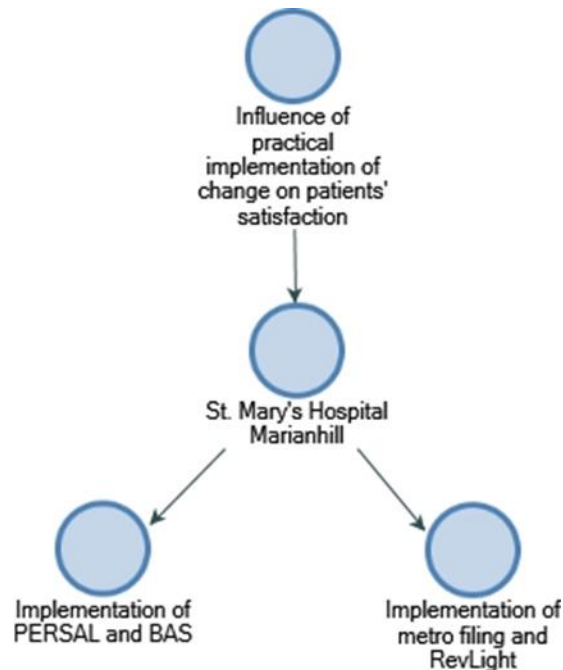


Figure 5.9: Influence of practical implementation of change on patients' satisfaction in St Mary's hospital

The two major practical changes that impact patient satisfaction at St. Mary's hospital were the implementation of PERSAL, BAS software, Metro Filing and Rev-Light.

The implementation of these software have equally helped in the improvement of health care delivery toward patient satisfaction. The participants from the HR and finance departments applauded the introduction of the electronic devices for efficient service delivery.

After the change to the current management by the DHA, there were serious transformation in our technology systems to accommodate the new change. Like introduction of PERSAL which is an HR system, and BAS - a basic accounting system for payments to suppliers (Participant 2, interview – St Mary's).

We have the Metro Filing- it deals with filing. And with the capturing of patients' information we have a system called Rev-Light. Rev-Light is user-friendly and helps us perform our job effectively and efficiently (Participant 4, interview – St Mary's).

Most of the participants further stated specifically the areas of improvement and how it has influenced their activities.

Yes, there has been. In terms of the complaints, the number of complains has reduced. Doctors are able to see patients faster. In fact, the number of compliments has increased due to shorter waiting times (Participant 3, interview – St Mary's).

It's not direct per say with improving customer satisfaction. In terms of the systems, yes, it is because it ensures that invoices are paid on time to suppliers within a specified date. When invoices are up to date the suppliers are happy and that indirectly affects customer satisfaction positively as we have resources to run the institution effectively (Participant 4, interview – St Mary's).

Yes, we have improved in terms of service delivery and waiting times. Before it was taking time to access patient's information manually. It has contributed greatly to my performance. I'm saying this because it is easier to get the required information and tracking patient's information which is not time consuming (Participant 1, interview – St Joseph's).

From the onset, the practical implementation of change showed significant impact on patient satisfaction at St Mary's Hospital. It is evident that St Mary's Hospital was able to use information systems to achieve important business objectives, such as operational efficiency, patient satisfaction, and new products and services. According to Laudon & Laudon (2014), information systems and technologies are some of the most important tools available to managers for achieving higher levels of efficiency and productivity in business operations. It is imperative that today's managers should note that technology not only eases work task but promotes flexibility and aids the development of employees. When healthcare workers lack the efficient tools they get frustrated and so do the patients. Employees must realise that the provision of technology – be it software or hardware has a direct significance on their happiness and well-being of employees in every organisation.

5.8.6 Objective four: Impact of drivers of change on employee resistance to change

The outcome from the NVivo analysis shows that there were resistance reactions from the employees during the change process as revealed in Figure 5.10 and 5.11 below.

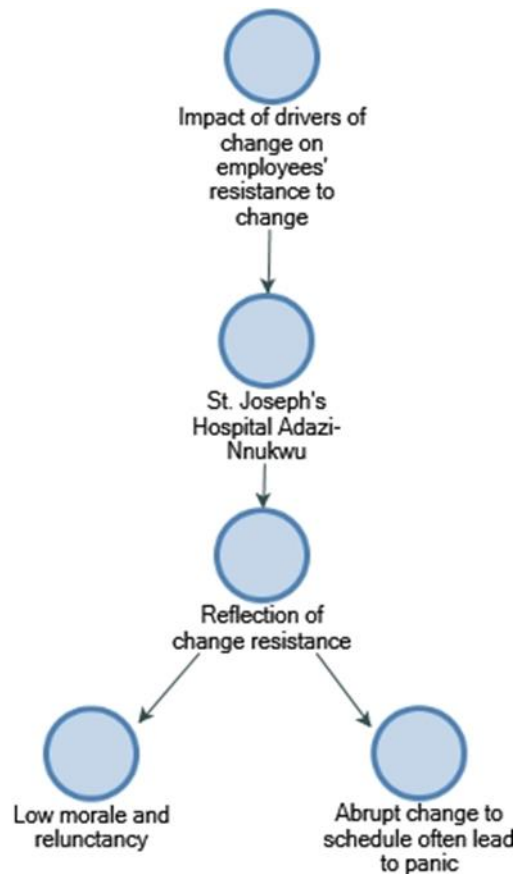


Figure 5.10: Impact of drivers of change on employees' resistance to change in St Joseph's hospital

The illustration from Figure 5.10 shows that the implementation of change had significant effect on the employees which include, low morale and reluctance, and panic as a result of abrupt change.

The participants were interviewed on their reaction as a result of the impact of drivers of change and resistance to change. This is because it was difficult adjusting to the new way of doing things. Participant 1 and 3 concur with the stated theory. Two of the participants indicated that the impact of the change led to low morale and reluctance, and another reacted that the change process often leads to panic.

An abrupt announcement about my schedule may cause me to panic. But I like to keep things in perspective (Participant 1, interview – St Joseph's).

When operational policy changes are made, it's not a stretch to expect organisational performance to be impacted until employees become familiar with new practices. Implementing new procedures, instituting different operational systems, transitioning to new equipment or software as directed by policy can be

daunting. But sometimes I have low morale (Participant 3, interview – St Joseph's).

However, participant 2, 4 and 5 elude this claim:

I personally see why changes are importance, even though with our employees they become quite edgy. I will say it affects me positively because change is good if aligned to organisational goals and vision. I face people differently and try to manage them accordingly. When we include new system, employees try to resist but we still try to communicate with them (Participant 2, interview – St Joseph's).

However, some of the participants were able to adapt to the change despite the difficult times.

I am always ready for any type change. Like previously I was in the maternity department for years before moving to the GOPD. Some colleagues were worried and thought I was not going to adapt easily. But I was able to settle easily (Participant 4, interview – St Joseph's).

Personally, I easily adapt to any good change. In life, one must be always prepared for change because it is constant (Participant 5, interview – St Joseph's).

Therefore, it is safe to say that drivers of change have a significant impact on resistance to change of the employees. Resistance to change is a normal fact of human nature because change creates anxiety and fear. Physical and emotional reactions during change implementations are a powerful force that can create resistance amongst employees. Even though some impacted employees can align the change with the self-interest, the uncertainty and fear of the unknown is a significant barrier to change (Smollan, 2015).

It is imperative that change agents try to mitigate or possibly minimise the impact of resistance. Oftentimes, resistance may not be avoided or completely eliminated, and some resistance is important in order to create opportunity to inform employees about the aspects of the change required in applying effective change management. Hence, an effective communication strategy should be embraced to strengthen employee's confidence in facilitating the changes for progress.

According to Serbani & Iorga (2016) the first step towards any change is to educate employees about the change before it is implemented, and to help them understand the necessity of the change process.

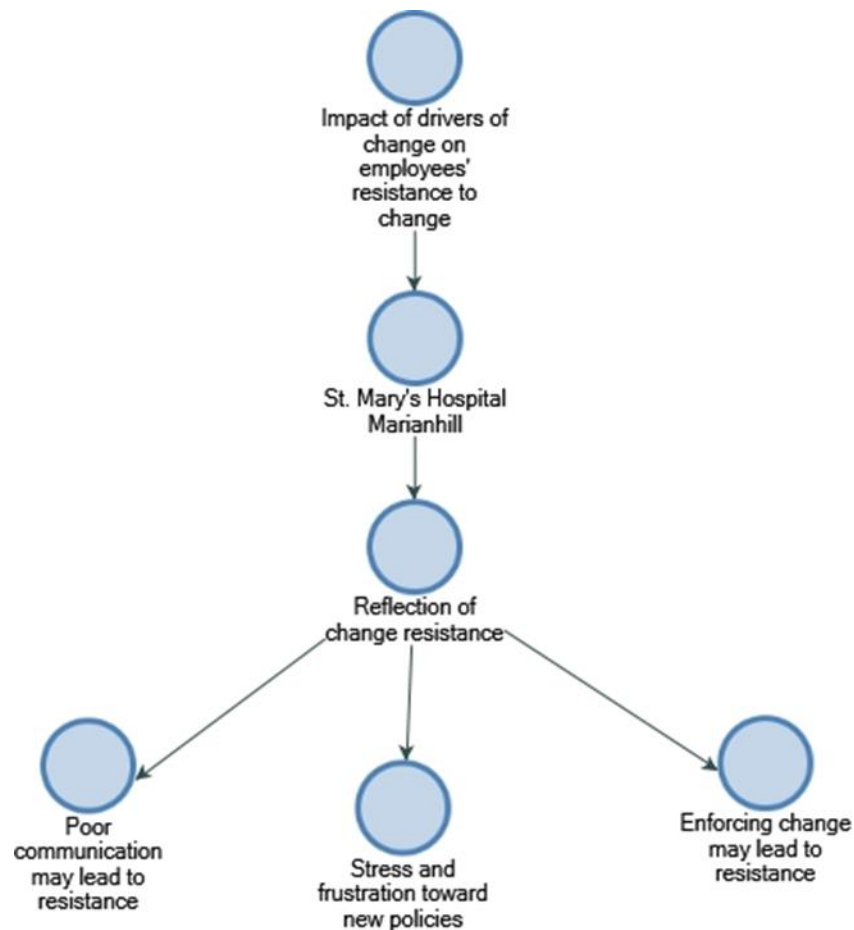


Figure 5.11: Impact of drivers of change on employees' resistance to change at St Mary's Hospital

The composition in Figure 5.11 shows the reflection of resistance to change as result of the change that took place within the organisation. The resultant effect of change on the employees includes poor communication, stress and frustration toward new policies, and enforcement of change which may lead to resistance.

The implementation of digital changes at St. Mary's hospital was met with some level of employees' resistance. Some of the reflections on the resistance include poor

communication, stress and frustration, and enforcement of change. Some of the participants stated thus:

In all spheres of life, change is not easy at all. It also depends on the nature of the change. I believe some changes should be enforced to for it to happen. Surely I would react to change if the benefit is not communicated to me. But if I understand then it's easy for me to accept and implement (Participant 5, interview – St Mary's).

By human nature we don't like a new thing. We like our normal routines. I mean with new policies; it was a bit frustrating to adapt. For example, like patient's safety incidence, when something goes wrong in your management of patients then you need to write a report so that there is evidence for the next line of action. And also, opportunity to tell your own side of the story. But often you will see employees who are very reluctant to do that because they think it's incriminating or additional paperwork. In terms of new policies it is mandatory. It is important to orient people to see the importance of change and how it can benefit you as an individual (Participant 2, interview – St Mary's).

Furthermore, it was stated that adapting to the new drivers of change led to stress and frustration, which are is a form of resistance. Stress is the most notable impact of organisational change (Brown, 2015). Employees have their expectations about change that is to be received if they are to perform to a certain capacity. Therefore, these expectations determine the level of performance from the employee in an organisation. One of the participants argued thus:

Hhawu, it's stressful! I feel frustrated at times especially when too much is expected of me and it takes a toll on my physical body. Though I always say that it depends on how passionate you are about your work. I always want to deliver the best. So, if there is new change that is being introduced, I personally take it very seriously. I put all my best in it. It is frustration with some motivation that at the end of the day I will achieve the best needed for my job to thrive (Participant 1, interview – St Mary's).

Another participant identified a communication gap between the management and the junior staff during change processes, which often leads to the enforcement of change.

It depends on the type of change and its benefits. I'm not a person that resists change, but I would like to get the facts first as to how is going to benefit me and the community at large. Not all change is right you know, so I would prefer to have evidence that the change would be beneficial to me and also if I'm given the

opportunity to contribute towards the change. I say this because some changes are enforced on people because top management does not know how we operate on the ground (Participant 4, interview – St Mary's)

The above comment was buttressed by another participant stating the importance of communicating the benefits of any change action.

Well with me, I'm open to change. I'm willing to adjust; I'm willing to learn new things. I like to find new innovative ways of doing things effectively. I am not extremely rigid as long as the need for change is communicated (Participant 4, interview – St Mary's).

Most managers underestimate the importance and amount of communication needed. Involvement and participation of employees in matters that concern them increases the probability that they will find the change programme acceptable. Effective change programmes try to increase the driving forces toward acceptance of change and simultaneously to decrease the restraining forces blocking the change (Stouten et al., 2018). Khugshal & Chaubey (2015) further concur that effective communication throughout the entire process is absolutely essential to its ultimate success. And this also involves informing the employees about the progress of change initiatives to keep them motivated and reassured. The various roles, methods and responsibilities for communication must be defined not only to facilitate the process of change, but also to put a lid on possible resistance.

To this end, one can say that the drivers of change informed some level of resistance from the employees. It is important to state that the implementation of change cannot be successful with resistance from employees. Therefore, drivers of change have no positive relationship with resistance to change.

5.9 Chapter summary

This chapter illustrated the quantitative and qualitative data analysis gathered via structured questions and open-ended questions respectively. Descriptive statistics were used to explain the demographic data. Inferential statistics such as the Pearson correlation coefficient and multiple regression were employed to answer the research

questions and achieve the research objectives. Objectives one, two, three and four were also examined through data collected from semi-structure interview questions for thematic analysis.

The results of the quantitative analysis for objective one, two, three and four revealed that there is a positive association between drivers of change and employee performance, organisational culture and practical implementation of change, practical implementation of change and patient satisfaction". However, a non-significant association was found between drivers of change and employee resistance to change from the two hospitals. Discussion and substantiation of research findings with previous studies will be unpacked in the next chapter.

CHAPTER SIX: DISCUSSION OF FINDINGS

6.1 Introduction

This chapter provides discussions concerning analysis of the research findings for both the quantitative and qualitative data as shown earlier in chapter five. This chapter also examines if the findings of this study support or refute the existing claims of other studies. Explanations on the achievement of the research objectives, and the provision of answers to the research questions were also presented in this chapter. The adoption of the Pearson correlation coefficient and regression analysis allow for the determination of the nexus between drivers of change and employee performance, organisational culture and practical implementation of change, practical implementation of change and patient satisfaction. Further, the impact of drivers of change on employee resistance to change was also demonstrated.

6.2 Discussion of research findings with regards to the research objectives and research questions

The discussion of the research findings aims to provide answers to the research questions in order to achieve the research objectives. The Pearson coefficient was employed to respond to the research questions. The level of impact between the variables were also tested via multiple regression analyses. The discussion of the research findings with regards to the research questions and research objectives is illustrated below.

6.2.1 Influence of driving forces of change on employee performance

Research objective one was formulated to test the influence of driving forces of change on employee performance. The result of the quantitative data analysis shows that there is a positive and significant relationship between driving forces of change and employee performance. The Pearson coefficient, on the link between driving forces of change and employee performance for St Joseph's hospital revealed that there is a relationship between driving forces of change and employee performance. However, while technology, which is a component of drivers of change shows positive and significant

correlation ($r = 0.638$, $p < 0.001$) with employee performance, the organisational policy shows a positive significant relationship with employee performance ($r = 0.669$, $p < 0.001$). For St Mary's hospital, all the components of drivers of change (use of technology $r = 0.363$, $p < 0.001$; organisational policy $r = 0.712$, $p < 0.001$) show positive and significant relationships with employee performance.

The outcome of the multiple regression analysis for St Joseph's Hospital revealed that all the components of drivers of change had 60.9% variation in employee performance, where $R = 0.0609$. While the all the components show significant effects (use of technology $p < 0.001$; organisational policy $p < 0.001$) with employee performance, the F_{cal} and the p -value (24.322, $p < 0.001$ respectively) show that these regression results are significant on the aggregate. Findings from St Mary's Hospital revealed that $R = 0.747$, which indicates an estimate of 74.7% significance of the impact of drivers of change on employee performance. Organisational policy was statistically significant $p < 0.001$ with employee performance, use of technology was also significant $p < 0.001$. However, on the aggregate, the F_{cal} and the p -value (39.665, <0.001 respectively) show that these regression results are significant. These findings imply that the use of technology (digital facilities) and implementation of organisational change policies are significant tools for organisational change. In essence, this means that there is a positive organisational change in St Mary's and St Joseph's hospitals as a result of the deployment of technological devices. Similarly, the significant relationship between technological deployment and employee performance is a pointer to the fact that technological is driver of change. More importantly, in this era of 4th industrial revolution and internet of all things (IoT), where every activity is technological driven. The positive impact of technology on performance in this study supports the research study conducted in Canada by O'Connor & O'Reiley (2018) on the infusion of mobile technology by healthcare practitioners in hospital context. The study established that a significant association exists between mobile health infusions and health practitioner performance. This suggests that an increase in the use of technology leads to improvements in delivering clinical care services to patients.

This finding also aligns with the empirical study conducted in Malaysia by Ghaleb et al. (2021) on “the adoption of Big Data technology in healthcare organisations. The authors found that technology adoption significantly influenced healthcare employees and organisational performance. Furthermore, the positive and significant impact of organisational policy on employee performance buttresses the findings of Kouhy et al. (2009) on the influence of human resource policies on organisational performance in Canada, Japan and the UK. The authors found that all the HR policies had significant impact on performance.

The outcome of the qualitative analysis reveals that there is a link between drivers of change and employee performance. For St Joseph’s Hospital, digital facilities and training had a positive and significant impact on employee performance, while the administrative system, digital facilities and training had positive and significant influence on employee performance at St Mary’s Hospital. Therefore, technological infrastructures, training and administrative system are key drivers that determine the success of a change management. This finding concurs with the study conducted by Timilsena and Rimal (2019) on drivers of employee performance in Nepal. The authors demonstrated that training, motivation and attitude are the key drivers of employee performance. Although, the result indicated that technological deployment is a positive change driver, however, how much this is deployed is a point of concern. For instance, the reality of employee performance in most public hospital negates the outcome of the study. Many public hospitals in Nigeria especially do not use technological devices. Where it is used, there is no power supply to operate this equipment. Additional, many employees in the public hospital are technological illiterates. Hence, the need for a change in policy.

Based on these findings, it is imperative for healthcare organisations in Nigeria and South Africa to embrace the implementation of digital facilities, and appropriate training programmes through effective organisational policy for the management of the change process.

6.2.2 Impact of organisational culture on the practical implementation of change

Research objective two examined the impact of organisational culture on the practical implementation of change at St Joseph's Hospital and St. Mary's Hospital. To respond to the research question, the Pearson correlation coefficient was adopted to determine the bivariate relationship between the variables. The result for St Joseph's shows that organisational culture has a strong and significant impact ($r = 0.816$, $p\text{-values} < 0.001$) on the practical implementation of change. In a similar vein, St Mary's organisational culture also showed a significant relationship ($r = 0.769$, $p\text{-value} < 0.001$) with the practical implementation of change at the hospital.

The regression analysis for St Joseph's also revealed that there is significant (78.7%; $F = 101.955$, $p < 0.001$) association between organisational culture and practical implementation of change. In addition, organisational culture shows a significant (77.4%; $F = 47.969$, $p < 0.001$) association with practical implementation of change at St Mary's. These findings suggest that organisational culture is a key determinant in the implementation of change processes within an organisation. These findings concur with the empirical study of Dark et al. (2017) on the implementation of cognitive therapies into routine psychosis care in two communities. The authors found that organisational culture recorded a positive influence on the implementation of cognitive therapies compared with the other service. The scholars further argued that organisational culture is robust and resilient within healthcare organisations. Azanza et al. (2013) revealed that organisational culture has a significant impact on authentic leadership and employee job satisfaction. This implies that a flexible organisational culture can impact the implementation of change through an effective leadership style and employee attitude.

The qualitative analysis indicated that all the components of organisational culture such as communication system, participative leadership and motivation have significant impact on the practical implementation of change at both St Joseph's and St Mary's. Therefore, effective communication, participative leadership and motivation system are factors of a successful implementation of change process within the two hospitals. The positive and significant impact of communication and leadership style on change

implementation aligns with the study conducted in the United States by Yue et al. (2019) on the examination of transformational leadership, transparent communication, and employee openness to change. The findings suggested that transformational leadership and transparent communication were positively associated with employee trust, which in turn, positively impacts employee openness to change. In addition, Gilley et al. (2009) demonstrated the adoption of motivation, communication, and effective leadership as strategies for organisational change. The authors found that motivation, communication, and effective leadership were essential components that could influence organisational change. Organisational culture is an effective tool of implementing change within an organisation. Unfortunately, as good as this sounds, many public hospitals both in South Africa and Nigeria have organisational culture characterised by bottle neck that leads to inefficiency. For instance, many people will rather patronise private hospitals where they pay more than go to the public hospitals where the service is almost free. This is due to the culture of nonchalant attitude to patients, negligence of care, laziness and ineptitude. Hence, the need for a re-orientation and a shift from just organisational culture to a total quality management.

6.2.3 The link between practical implementation of change and patient satisfaction

Research objective three was formulated to determine if the practical implementation of change influenced patient satisfaction at St Joseph's and St Mary's. This is to examine the impact of the change process on patient satisfaction. The Pearson correlation indicated that a significant ($r = 0.536$, $p\text{-value} < 0.001$) relationship exists between the practical implementation of change and patient satisfaction at St Joseph's Hospital, while a weak and positive relationship exists between practical implementation of change and patient satisfaction at St. Mary's Hospital ($r = 0.400$, $p < 0.001$).

The result of the regression model shows that there is a significant (56.5%; $F = 59.159$, $p < 0.001$) relationship between the practical implementation of change and patient satisfaction at St Joseph's Hospital. In the same vein, the practical implementation of change was found to significantly (40.7%, $F = 12.886$, $p < 0.001$) impact patient satisfaction in St. Mary's hospital.

The significant impact of change implementation on patient satisfaction has been widely investigated. This finding corroborates with the application of Lean Six Sigma in a mobile hospital in India to improve patient satisfaction (Kam et al., 2019). Kam et al. (2019) found that the practical implementation of Lean Six Sigma led to improved patient satisfaction by reducing turnaround time. Similarly, Altin & Stock (2016) investigated the adoption of health literacy, patient-centredness communication and shared decision-making on patient satisfaction in a German care centre. The results suggested that the transfer of health literacy skills to German patients increased care satisfaction and the needs of patients.

The qualitative findings revealed that the implementation of digital components such as automated billing systems, electronic prescription systems, portable water supplies and EHRs were the major determinants of patient satisfaction in St Joseph's Hospital, while the implementation of PERSAL, BAS software, Metro Filing and Rev-Light were the main determinants of patient satisfaction at St Mary's Hospital. It is noteworthy that digital transformation within the two organisations was the key success factor of patient satisfaction. Therefore, practical implementation of technology as a change factor has positive and significant impact on patient satisfaction. This finding aligns with the study conducted by Preyde et al. (2012) in Guelph General Hospital using a Canadian Triage and Acuity Scale (CTAS) before and after implementation. The study reported that the implementation of a project improvement programme in the emergency department decreased patient waiting time and increased patient satisfaction, and improved patient flow with CTAS.

6.2.4 Impact of drivers of change on employee resistance to change

Research objective four was stated to establish if the drivers of organisational change influenced resistance from employees. The Pearson correlation coefficient from St. Joseph's Hospital revealed that all the components of drivers of change (use of technology and organisational policy) show an insignificant and negative correlation ($r = -0.059$, $p > 0.001$; $r = -0.135$, $p > 0.001$) with resistance to change respectively. This suggests that lack of technology and organisational policy affects the level of resistance to change. In addition, a positive but insignificant correlation ($r = 0.064$, $p > 0.001$; $r =$

0.090, $p > 0.001$) was found between all the components of the drivers of change and resistance to change, respectively, at St Mary's hospital.

Multiple regression analysis was also conducted to comprehend the link between drivers of change and employee resistance. The outcome of the regression model from St Joseph's and St Mary's indicated that all of the components of drivers of change demonstrated non-significant (16%, $F = 1.081$, $p = 0.360$; 12.5%, $F = 0.475$, $p = 0.624$) association with resistance to change, respectively. These findings align with the results of the bivariate analysis. This implies that the implementation of technology such as digital facilities and organisational policies did not provoke resistance from the employees in both hospitals. In other words, the practical implementation of change within the two organisations was embraced by the employees without resistance. This outcome may be as a result of the implementation strategy applied by the management of the two healthcare organisations. The result is consistent with the assertion of Lorenzi & Riley (2000). The scholars identified effective communication, flexible organisational culture, good leadership, technology and training as major reasons that bring about successful change processes, thereby preventing resistance from employees. It is worthy to note that the aforementioned elements of successful change management have had significant contributions to the implementation of change at both St Joseph's and St. Mary's as indicated in the analysis chapter. The insignificant relationship between change drivers and resistance to change in both healthcare organisations is an indication of participative leadership, open and effective communication system, adaptable technological facilities, and good organisational culture.

Borg (2013) also demonstrated that organisational culture, which influences behaviour, is a determinant to drivers and implementing effective change within the healthcare system. Various studies have also identified key determinants of implementing change without resistance (Borg, 2013). Findings from the qualitative analysis revealed that the implementation of change drivers led to a minimal level of resistance from the employees. This may be due to the effective communication and participative style of leadership being practiced by the new management of the organisation. Resistance

leading to low morale and panic were reported at St Joseph's. Whilst frustration and stress as a result of poor communication and enforcement in some departments of the organisation were mentioned by the employees from St Mary's. Generally, there was a successful change management process in both hospitals as affirmed by the employees, and by extension, the patients. Although, the outcome of the empirical study showed an insignificant relationship between change drivers and resistance to change, however, the reality on ground in many public hospitals in both countries contradict this outcome. For instance, recently, there was an industrial action in the health in South Africa over a deduction policy. Similarly, public health workers in Nigeria are known for their regular incessant strike action. Recently, in Nigeria, many patients lost their lives because the doctors down tool as a result of salary arrears.

6.3 Nexus between quantitative and qualitative findings

The result of the quantitative and qualitative analysis for objective one, two, three and four show some areas of agreement and validation, hence, the need for triangulation.

6.3.1 Relationship between driving forces of change and employee performance

The influence of change drivers on employee performance was examined. The results of the quantitative data derived via the structured questionnaire and interview reports of the qualitative data revealed some areas of agreement. The result of the quantitative data analysis showed that there is a significant relationship between drivers of change and employee performance at St. Joseph's Hospital, Adazi-Nnukwu, Nigeria and St. Mary's Hospital, Marian Hill, South Africa. The Pearson Product-Moment Correlation Coefficient (PPMC) and regression analysis revealed that there was a positive and significant relationship between drivers of change and employee performance in both healthcare organisations. The result of the regression model revealed that a significant (60.9%, 24.322, $p < 0.001$; 74.7%, 39.665, $p < 0.001$) relationship between drivers of change and employee performance for St. Joseph's and St. Mary's respectively. The findings from the bivariate analysis were used to answer the research questions.

Similarly, findings from the qualitative analysis revealed that there is a significant association between drivers of change and employee performance. The implementation of digital facilities and training of employees towards the use of the newly introduced technology were the major drivers of the change process in both hospitals in Nigeria and South Africa. This suggests the need for a flexible organisational change management, considering the effect of advanced technological changes. Therefore, there is an alignment between the findings of the quantitative and the qualitative.

6.3.2 Impact of organisational culture on the practical implementation of change

The relationship between organisational culture and practical implementation of change was investigated. Results of the regression model indicated that a significant (78.7%, $F = 101.955$, $p < 0.001$; 7.4%, $F = 47.969$, $p < 0.001$) relationship exists between organisational culture and change implementation at St. Joseph's and St. Mary's respectively. Furthermore, results from the qualitative analysis revealed that all the components of organisational culture (effective communication, participative leadership, and motivation) have significant influences on the practical implementation of change. In other words, the communication systems, leadership style and the type of motivation that were adopted allowed for a resistance-free implementation of change within the two hospitals. Therefore, there is a strong agreement between the quantitative and qualitative findings in both hospitals.

6.3.3 Relationship between practical implementation of change and patient satisfaction

The bivariate analysis provided response to research question three, while the outcome from the regression model was helpful in answering research objective three. The practical implementation of change was found to positively and significantly (56.5%, $F = 59.159$, $p < 0.001$; 40.7%, $F = 12.886$, $p < 0.001$) impact patient satisfaction in St Joseph's and St Mary's respectively. The result of the qualitative analysis shows that the practical implementation of technological or digital facilities had positive and

significant impacts on patient satisfaction at the two hospitals. Therefore, findings from the quantitative analysis are consistent with findings from the qualitative analysis.

6.3.4 The link between drivers of change and resistance to change

The outcome of the regression model from St Joseph's and St. Mary's indicated that all the components of drivers of change demonstrated a non-significant (16%, $F = 1.081$, $p = 0.360$; 12.5%, $F = 0.475$, $p = 0.634$) association with resistance to change respectively. In the same vein, results of the qualitative analysis show that drivers of change did not impact significantly on the resistance from the employees. Despite a little resistance from a few of the employees, the implementation of change processes via drivers of change were proven to be successful in both hospitals. The successful implementation of change in St. Joseph's Hospital and St. Mary's Hospital has positive impact on the patients, particularly through reduced waiting times". Therefore, findings from the quantitative analysis are in concordance with results from the qualitative analysis.

The next chapter focuses on the conclusion, summary and recommendations for future studies.

CHAPTER SEVEN: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

This research study aimed at developing a conceptual framework of organisational change management for hospitals in developing countries. Various theories of organisational change management have been examined within the global context. The objectives of this study were to examine the influence of drivers of change on employee performance, observe the impact of organisational culture on the practical implementation of change, examine the effect of the practical implementation of change on patient satisfaction, and to dissect the relationship between drivers of change and resistance to change. The outcome of this investigation was useful in developing a conceptual framework of organisational change management for hospitals in developing countries, particularly Nigeria and South Africa. Change management theories and frameworks were discussed and criticised. This study was able to answer the research questions and achieved the research objectives. PPMC coefficients were adopted to answer the research questions, and regression analysis was conducted to validate the research objectives one to four. This chapter presents the summary, conclusion and recommendations of the research findings as demonstrated through quantitative and qualitative data analysis. The mix-method approach was adopted to remove bias and allow for valid generalisability of findings. The research limitations were also being discussed in this chapter.

Table 7.1: Objectives, conclusions, and recommendations

Research objective	Conclusions	Recommendations
<ul style="list-style-type: none"> <i>To determine the influence of the driving forces of change on employee performance in St Mary's Hospital, Marianhill and St Joseph's Hospital, Adazi-Nnukwu;</i> <i>To examine the impact of organisation culture on the practical implementation of change in St Mary's Hospital</i> 	<ul style="list-style-type: none"> The result of the regression analysis revealed that drivers of change have a significant impact on employee performance. Similarly, the implementation of digital equipment and organisational policy has a significant influence on employee performance. The introduction of digital facilities necessitated the adoption of required training, which improved employee performance. Based on this outcome, objective one, which aimed to examine the influence of drivers of change on employee performance is achieved. The second objective was stated to determine the influence of organisational culture on practical implementation of change. The result of the regression analysis indicated that organisational culture had a significant impact on the implementation of change. In addition, motivation systems, communication approaches, and leadership style, which are components of organisational culture, had significant influences on the implementation of change within the investigated organisations. 	<ul style="list-style-type: none"> Technology and organisational policy have been documented as key drivers of organisational change and performance. The positive and significant impact of digital facilities and organisational policy on employee performance as revealed by the quantitative and qualitative analysis indicated the need to continue to adopt technological transformation through organisational policy. The implementation of digital equipment in the two hospitals helped employees to spend less time and effort on attending to individual patients. It is recommended that management teams of the two healthcare organisations continue to implement technological changes with the appropriate and required training, this is because of the continuous increase in technological advancement. Training on conflict resolution methods, communication, skills development, leadership, customer service, and team building will harness employee potential to full capacity. Training and retraining are important when an organisation shifts to a strategy requiring different skills, competitive capabilities, managerial approaches, and operating methods (Beer & Walton, 2011). Therefore, it is recommended that management ensure the involvement of employees in decision-making systems in order to integrate their interest. Employees easily adapt with a change process that addresses their interest. Research findings from the quantitative and qualitative data revealed that all the components of organisational culture significantly impacted the practical implementation of change at the two healthcare organisations. In other words,

<p><i>and St Joseph's Hospital;</i></p> <ul style="list-style-type: none"> <i>To determine the influence of practical implementation of change on patient satisfaction in St Mary's Hospital and St Joseph's Hospital</i> 	<p>As a result of this finding, research objective two was established.</p> <ul style="list-style-type: none"> On the impact of practical implementation of change on patient satisfaction at St Joseph's Hospital, the major implemented change included, an automated billing system, an electronic prescription system, portable water supply and EHR. The major changes that were implemented at St Mary's Hospital included PERSAL and BAS software, Metro Filing and Rev-Light equipment. The outcome of the NVivo 12 analysis revealed that the practical implementation of these digital equipment had significant impact on patient satisfaction in both hospitals. The majority of the employees from both healthcare organisations affirmed that the technological implementation of change had improved their performance, which in turn helped in reducing patient waiting times. This finding aligns with the quantitative results, which revealed that the practical implementation of change had significant impacts on patient satisfaction. 	<p>the communication systems, leadership style and the type of motivation that were adopted allowed for the easy implementation of change within the healthcare organisations.</p> <p>Therefore, it is recommended that management continue to improve the adopted communication system, participative leadership, and motivation systems to enhance the implementation of change. Furthermore, the management teams at both hospitals should utilise the themes found in this study as a framework of evaluating employee concepts by reviewing and developing plans to reduce the currently existing gaps and strive towards overall improved performance. Hence, continuous strategies should be devised to enhance effective communications and feedback across all levels of the organisation, specifically the construction of information aligning to the performance of employees and organisational values. An open-door approach to communication is founded on collaboration and a conducive environment that is stimulating to encourage exchanges between employees. Continuous feedback, when constructive, can be seen as a motivating factor when it is prompt, frequent and precise. Team building is very crucial for the wellbeing of the employees of both hospitals. Team building helps the employees to bond better with their colleagues, hence better working relationships are created. Management of St Joseph's and St Mary's hospital should invest in team building exercises because it is very necessary for motivation. Creating a positive and employee-friendly organisation culture is a great motivational tool.</p> <ul style="list-style-type: none"> The research findings statistically confirmed the significant influence of the practical implementation of change on patient satisfaction in the healthcare organisations. All the operations that were practically implemented at the healthcare organisations including, automated billing systems, electronic prescription systems, portable water supply and EHR, PERSAL and BAS software, Metro Filing and Rev-Light equipment. The quantitative and qualitative results suggest that the implemented projects improved employee skills, which in turn had positive and significant influence on patient satisfaction, especially the reduction in
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<ul style="list-style-type: none"> • <i>To establish if drivers of change influence resistance to change during the implementation process at St Mary's Hospital St Joseph's Hospital.</i> 	<ul style="list-style-type: none"> • The relationship between drivers of change and resistance to change was investigated in objective four. Outcome of the regression model revealed that a non-significant relationship exists between drivers of change and resistance to change. In addition, little or no resistance was exhibited by the employees, as a result of the implementation of change drivers. This suggests that the implementation programme had little or no confrontation from the employees. Therefore, the implementation of the change programme was successful. Based on this finding, research objective four was established. 	<p>waiting time. It is recommended that management must ensure that projects for change are targeted towards improving employee skills and patient satisfaction, especially in the use of technology.</p> <ul style="list-style-type: none"> • The outcome of the quantitative analysis indicated that drivers of change had no significant influence on resistance to change. This means that the implementation of drivers of change did not lead to resistance from the employees even though resistance is a natural reaction to change initiatives. In addition, the qualitative result showed that little resistance was mentioned by the employees. Despite this, the healthcare organisations had successful implementation of change because they were able to support their employees through the change programme which opened doors to improved change outcomes and benefit realisations. These findings suggest that the implementation strategies adopted by the healthcare organisations allowed for a relatively hitch-free change process. Therefore, it recommended that change strategies, such as effective communication, participative leadership, training systems, and motivation systems must be improved to foster successful change management processes without resistance.
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7.2.1 Summary of findings from the quantitative data analysis

Research objective one

The research outcome as presented in the analysis chapter revealed the association between the adopted research constructs. The research findings from research objective one, using the PPMC statistical tool, indicated that there is a significant association between drivers of change and employee performance. This implies that the implementation of digital facilities and organisational policies brought about significant changes within the two healthcare organisations. Research objective one was achieved via the adoption of the regression model. Findings from the regression analysis suggests that a significant (60.9%, 24.322, $p < 0.001$; 74.7%, 39.665, $p < 0.001$) relationship exists between drivers of change and employee performance for both St Joseph's Hospital and St Mary's hospital respectively. These empirical findings justified the report of Ghaleb et al. (2021), in which, "technology adoption significantly influences healthcare employees and organisational performance. Based on this result, hypothesis one is accepted.

Research objective two

The influence of organisational culture on the practical implementation of change was stated as objective two. The Pearson correlation statistical tool was employed to answer research question two and achieve objective two. Significant ($r = 0.816$, $p\text{-values} < 0.001$; $r = 0.769$, $p\text{-value} < 0.001$) association was found between organisational culture and the practical implementation of change for St Joseph's Hospital and St Mary's Hospital respectively. The regression analysis for St Joseph's Hospital and St. Mary's hospital also revealed that there was significant (78.7%, ($F = 101.955$, $p < 0.001$; 77.4%, $F = 47.969$, $p < 0.001$) association between organisational culture and the practical implementation of change respectively. This result was not surprising as several research investigations had demonstrated the significant impact of

organisational culture on the implementation of change in healthcare organisations (Dark et al., 2017; Azanza et al., 2013).

During the practical implementation of change, it is important that organisations select managers that promote a learning environment. De Gieter & Hofmans (2015) highlight that effective leadership is required to revitalise an organisation and facilitate adaptation to a changing environment. Therefore, hypothesis two is accepted.

Research objective three

Another research finding between the practical implementation of change and patient satisfaction revealed a positive and significant correlation. The implementation of technological and policy changes showed significant impact on patient satisfaction in St. Joseph's Hospital ($r = 0.536$, $p < 0.001$) and St Mary's Hospital ($r = 0.400$, $p < 0.001$). The regression analysis was conducted to achieve research objective three. It was established that practical implementation of change had a significant relationship with patient satisfaction in both St. Joseph Hospital (56.5%, $F = 59.159$, $p < 0.001$) and St. Mary's Hospital (40.7%, $F = 12.886$, $p < 0.001$). These results further affirmed the importance of technological transformation in the provision of care services in hospitals in Africa. As a result of these findings hypothesis three is accepted.

Research objective four

Objective four established the influence of drivers of change on resistance to change. The Pearson correlation coefficient indicated that all components of drivers of change indicated that a non-significant ($r = -0.059$, $p > 0.001$; $r = -0.135$, $p > 0.00$) relationship existed between drivers of change and resistance to change in St Joseph's Hospital in Nigeria. Besides, the negative value of the independent variable suggests that lack of drivers of change affects the level of resistance to change. This implies that increase in the application of change drivers influence the level of resistance to change. It is safe to say that the implementation of change drivers is effective and successful as it leads to less resistance from the employees. Furthermore, a non-significant ($r = 0.064$, $p >$

0.001; $r = 0.090$, $p > 0.001$) relationship was found between drivers of change and resistance to change in St Mary's Hospital, South Africa. In the same vein, the regression model from St Joseph's and St Mary's hospitals indicated that all the components of drivers of change demonstrated a non-significant (16%, $F = 1.081$, $p = 0.360$; 12.5%, $F = 0.475$, $p = 0.624$) association with resistance to change respectively. Based on the outcome of the regression analysis, hypothesis four is rejected.

These findings imply that the implementation of change process from the two healthcare organisations show less resistance from the employees. In other words, the implementation of change process was successful with a collaborative effort from the employees. In addition, the adopted training system, motivation, communication system and leadership style were effective tools in the implementation of the change process (Lorenzi & Riley, 2000; Yue et al., 2019) in both healthcare organisations from Nigeria and South Africa.

7.2.2 Summary of findings from the qualitative data analysis

Research objective one

The qualitative data was gathered through in-depth interviews. The interview questions were categorised according to the independent variables (drivers of change and organisational culture), as well as their sub-constructs. The interview questions were on the implementation of the change process in two healthcare organisations from Nigeria and South Africa. NVivo 12 software was used to code the data and generate themes and sub-themes under each sub-construct. Five sub-themes were generated for drivers of change at St Joseph's hospital, which included: the internet, Nanometre BP apparatus, computers, digital infrared thermometers, EHR, and billing software. Three themes emerged from drivers of change at St Mary's Hospital, these included, administrative systems, training, and digital equipment. The NVivo model also revealed that policies, guidelines and practices were the sub-themes under administrative system, while computer literacy was the only sub-theme under training. Three sub-

themes emerged under digital equipment which included, automated computer systems, payroll and personnel systems and electronic lab systems.

The outcome of the NVivo analysis showed that the introduction of the digital facilities informed the need for the training of employees. The training aided the effective use of all digital equipment towards employee performance. All the employees from both healthcare organisations affirmed the improvement in their performance as a result of the use of digital facilities. It is fair to say that drivers of change had significant impact on employee performance in both healthcare organisations.

Research objective two

Regarding the influence of organisational culture on the practical implementation of change, part of the organisational culture that is practiced at St Joseph's Hospital included analogue and digital communication system, participative leadership and motivation that is based on performance and qualification(s). The open-door policy is the only sub-theme that emerged for analogue and digital communication systems. For St Mary's Hospital, components of the organisational culture included motivation, recruitment and advert policy, top-bottom communication approach and participative leadership. Findings from the qualitative analysis revealed that motivation systems, communication approach, and leadership style were the major organisational elements that significantly influenced the practical implementation of change in both healthcare organisations from Nigeria and South Africa. These findings are consistent with the quantitative results, which indicated that organisational culture had a significant impact on practical implementation of change.

Research objective three

On the impact of practical implementation of change on patient satisfaction at St Joseph's Hospital, the major implemented change included, an automated billing system, an electronic prescription system, portable water supply and EHR. The major

changes that were implemented at St Mary's Hospital included PERSAL and BAS software, Metro Filing and Rev-Light equipment. The outcome of the NVivo 12 analysis revealed that the practical implementation of these digital equipment had significant impact on patient satisfaction in both hospitals. The majority of the employees from both healthcare organisations affirmed that the technological implementation of change had improved their performance, which in turn helped in reducing patient waiting times. This finding aligns with the quantitative results, which revealed that the practical implementation of change had significant impacts on patient satisfaction.

Research objective four

Objective four investigated the influence of drivers of change on resistance to change. Findings from the qualitative analysis indicated that low morale and reluctance, panic, poor communication, stress and frustration toward new policies, and enforcement of change which led to resistance were identified elements of resistance towards the implementation of change from both healthcare organisations. It is important to note that these resistances had little or no impact on the implementation processes. This is because of the leadership style, communication system, training system, and motivation adopted by the management of the two hospitals. Most change programmes require all employees to acquire not only new skills, but also new ways of thinking and behaving. Mosadeghrad & Ansarian (2014) argued that unsuccessful change programmes could be attributed to a lack of employee training and development, poor leadership, inadequate communication, poor organisational culture and inadequate resources. Hence, most of the employees easily adapted to the change process, and the implementation of change was successful. This outcome is in concordance with the quantitative result, in which, drivers of change had no significant impact on resistance to change.

7.2.3 General summary

This study examined the implementation of change processes at St Joseph's Hospital, Adazi-Nnukwu, Nigeria and St. Mary's Hospital Marianhill, South Africa. This investigation aided in the development of a conceptual framework of change management for hospitals in developing countries, particularly in Sub-Saharan Africa. The developed conceptual framework presents the constructs, which include, drivers of change, organisational culture, and implementation of change, employee performance, patient satisfaction, and resistance to change. These constructs were measured and empirically tested. Previous studies have shown that implementation of change within the organisation requires the collaborative efforts of management and employees (Pomare et al., 2019; Lewis, 2019). It is in this sense that Kotler's theory of organisational change incorporated the importance of employee behaviour, organisational culture, and strategies as core elements in the implementation of change. The individual is one of the most critical elements in any large-scale organisational change. Employees who are empowered are more proactive and self-sufficient. Employee empowerment has become a basic cornerstone of change and development programmes. This study has demonstrated that technological transformation, organisational culture such as, communication systems, leadership style, training systems and organisational policies are vital factors in the implementation of change within the healthcare organisations.

7.3 Validation of proposed conceptual framework

The figure below depicts the interlink between the independent variables (drivers of change, organisational culture, practical implementation of change) and dependent variables (employees' performance, practical implementation of change, patients' satisfaction, and resistance to change). Regression analysis was applied in the justification of the formulated hypotheses.

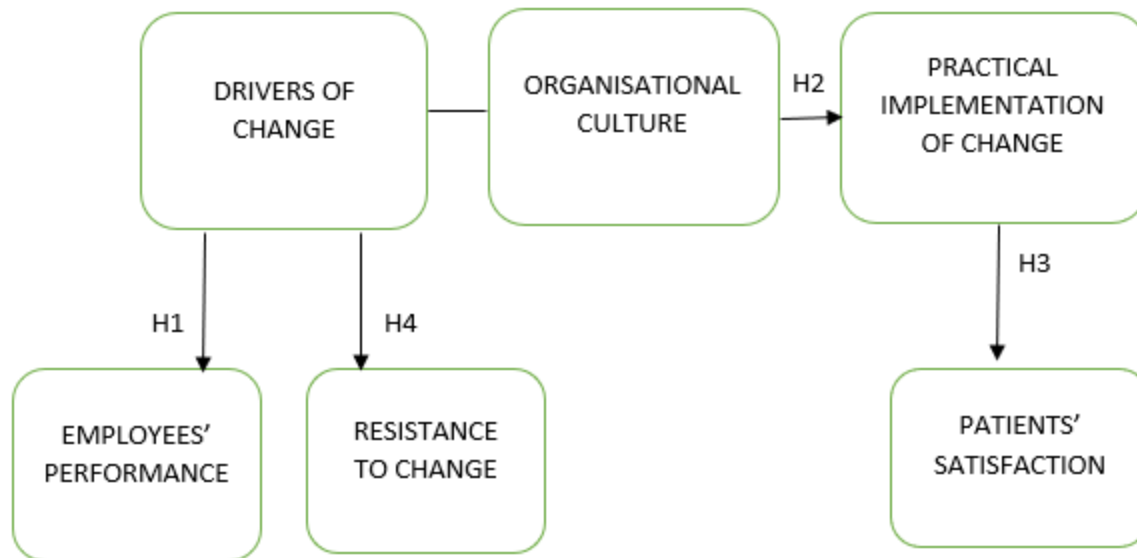


Figure 7.1 Proposed conceptual framework of organisational change management for hospitals.

Source: Author's compilation

As shown in Figure 7.1, the first hypothesis measures the impact of drivers of change on employees' performance. Components of drivers of change such as technology and communication system have been demonstrated to influence employees' performance (O'Connor & O'Reiley 2018). Both quantitative and qualitative outcome from this study indicated that the adopted technology and organisational policy as drivers of change show significant impact on employees' performance. This implies that technological infrastructures, training and administrative system are key drivers that determine the success of a change management. Hence, the H1 was accepted.

The second hypothesis was formulated to measure the relationship between organisational culture and practical implementation of change. Research findings from the regression analysis revealed that there is a positive and significant association between organisational culture and practical implementation of change. The values, leadership style, and belief system of the organisation show significant influence on the implementation of change. This finding was not surprising as various evidence have proven that organisational culture is a critical tool for successful implementation of change process (Yue et al., 2019; Gilley et al., 2009). Therefore, the second hypothesis (H2) was accepted.

Hypothesis three (H3) was stated to establish the impact of practical implementation of change on patients' satisfaction. Findings from the regression analysis and in-depth interviews revealed that practical implementation of change at the two selected hospitals has positive and significant impact on patients' satisfaction. There is evidence to suggest that implementation of change process leads to reduced turnaround time and increased care satisfaction for the patients (Altin & Stock, 2016; Kam et al., 2019). Based on this result, H3 was accepted.

Figure 7.1 depict the relationship between drivers of change and resistance to change as hypothesis four (H4). Findings from the regression model revealed that there is an inverse relationship between drivers of change and resistance to change in St. Joseph hospital. This implies that increase in the application of change drivers lead to decrease in resistance to change. Therefore, the implementation of change drivers is effective and successful as it leads to no resistance from the employees. In similar vein, non-significant association was found between drivers of change and resistance to change in St. Mary's hospital. This implies that the introduction of all the components of drivers of change did not lead to resistance from the employees. This also means that the implementation of the change process was effective and successful. Therefore, hypothesis four (H4) was rejected.

The model in Figure 7.1 is therefore recommended based on the empirical findings from this study, which was revealed from the Pearson Correlation Coefficient and the standardised regression coefficient values. These empirical findings implied that the change management process from St Joseph's Hospital, Adazi-Nnukwu, Nigeria and St. Mary's Hospital, Marian Hill, South Africa was successful as it leads to employees' performance, patients' satisfaction, and there was no resistance from the employees. It is instructive to note that patients' satisfaction is at the heart of healthcare goals and objectives (Muls et al., 2015) especially during this Covid-19 pandemic.

7.4 Conclusion

This study examined the implementation of change processes at St Joseph's Hospital, Adazi-Nnukwu, Nigeria and St. Mary's Hospital, Marianhill, South Africa. Research questions were answered through the application of Pearson moment correlation coefficient (PMCC). Multiple regression analysis was applied in the achievement of the hypotheses. The result of the regression analysis revealed that drivers of change have a significant impact on employee performance. Similarly, the implementation of digital equipment and organisational policy has a significant influence on employee performance. The introduction of digital facilities necessitated the adoption of required training, which improved employee performance. Based on this outcome, objective one, which aimed to examine the influence of drivers of change on employee performance is achieved.

The second objective was stated to determine the influence of organisational culture on practical implementation of change. The result of the regression analysis indicated that organisational culture had a significant impact on the implementation of change. In addition, motivation systems, communication approaches, and leadership style, which are components of organisational culture, had significant influences on the implementation of change within the investigated organisations. As a result of this finding, research objective two was established.

Objective three was developed to assess the relationship between the practical implementation of change and patient satisfaction. Findings from the regression analysis indicated that the implementation of change had a positive and significant relationship with patient satisfaction. Furthermore, all the elements of change, particularly digital facilities (automated billing system, electronic prescription system, PERSAL and BAS software, Metro Filing and Rev-Light, and EHR) show significant impact on patient satisfaction with regards to reduced waiting time.

The relationship between drivers of change and resistance to change was investigated in objective four. Outcome of the regression model revealed that a non-significant relationship exists between drivers of change and resistance to change. In addition, little or no resistance was exhibited by the employees, as a result of the implementation of

change drivers. This suggests that the implementation programme had little or no confrontation from the employees. Therefore, the implementation of the change programme was successful. Based on this finding, research objective four was established.

7.4.1 General observation

Health care organisations are constantly changing as a result of technological advancements, new discoveries for the treatment of diseases, and increases in global demography. The hospital environment is technically complex and surrounded by many uncertainties, particularly in this current global Covid-19 pandemic. Organisational changes in response to these uncertain times become inevitable. A change in the organisation involves not only the physical environment but the behavioural operations, structural relationships and roles, and the hospital organisational culture (Pomare et al., 2019). References have been made to the poor service delivery of healthcare in developing countries, especially in Sub-Saharan Africa.

This study aimed at examining change management process at St Joseph's Hospital, Adazi-Nnukwu, Nigeria, and St Mary's Hospital, Marianhill, South Africa. This investigation provides important knowledge and strategies for healthcare organisations within Sub-Saharan Africa to adopt when planning and implementing changes in order to create greater chances of being successful. Responses were given to the research questions using PMCC. The regression analysis was useful in validating the study and achieving the research objectives. A significant relationship was established between drivers of organisational change and employee performance. Organisational culture significantly impacts practical implementation of change. Practical implementation of change showed significant relationships with patient satisfaction. However, a non-significant association was found between drivers of change and resistance to change.

7.5 Recommendations

This study, through extensive literature reviews, justified the research constructs as key components of organisational change management. Based on the outcomes of this study, the following recommendations were made below:

Recommendation one

Technology and organisational policy have been documented as key drivers of organisational change and performance. The positive and significant impact of digital facilities and organisational policy on employee performance as revealed by the quantitative and qualitative analysis indicated the need to continue to adopt technological transformation through organisational policy. The implementation of digital equipment in the two hospitals helped employees to spend less time and effort on attending to individual patients. It is recommended that management teams of the two healthcare organisations continue to implement technological changes with the appropriate and required training, this is because of the continuous increase in technological advancement. Training on conflict resolution methods, communication, skills development, leadership, customer service, and team building will harness employee potential to full capacity. Training and retraining are important when an organisation shifts to a strategy requiring different skills, competitive capabilities, managerial approaches, and operating methods (Beer & Walton, 2011). Therefore, it is recommended that management ensure the involvement of employees in decision-making systems in order to integrate their interest. Employees easily adapt with a change process that addresses their interest.

Recommendation two

Research findings from the quantitative and qualitative data revealed that all the components of organisational culture significantly impacted the practical implementation of change at the two healthcare organisations. In other words, the communication systems, leadership style and the type of motivation that were adopted allowed for the easy implementation of change within the healthcare organisations. Therefore, it is recommended that management continue to improve the adopted communication

system, participative leadership, and motivation systems to enhance the implementation of change. Furthermore, the management teams at both hospitals should utilise the themes found in this study as a framework of evaluating employee concepts by reviewing and developing plans to reduce the currently existing gaps and strive towards overall improved performance. Hence, continuous strategies should be devised to enhance effective communications and feedback across all levels of the organisation, specifically the construction of information aligning to the performance of employees and organisational values. An open-door approach to communication is founded on collaboration and a conducive environment that is stimulating to encourage exchanges between employees. Continuous feedback, when constructive, can be seen as a motivating factor when it is prompt, frequent and precise. Team building is very crucial for the wellbeing of the employees of both hospitals. Team building helps the employees to bond better with their colleagues, hence better working relationships are created. Management of St Joseph's and St Mary's hospital should invest in team building exercises because it is very necessary for motivation. Creating a positive and employee-friendly organisation culture is a great motivational tool.

Recommendation three

The research findings statistically confirmed the significant influence of the practical implementation of change on patient satisfaction in the healthcare organisations. All the operations that were practically implemented at the healthcare organisations including, automated billing systems, electronic prescription systems, portable water supply and EHR, PERSAL and BAS software, Metro Filing and Rev-Light equipment. The quantitative and qualitative results suggest that the implemented projects improved employee skills, which in turn had positive and significant influence on patient satisfaction, especially the reduction in waiting time. It is recommended that management must ensure that projects for change are targeted towards improving employee skills and patient satisfaction, especially in the use of technology.

Recommendation four

The outcome of the quantitative analysis indicated that drivers of change had no significant influence on resistance to change. This means that the implementation of drivers of change did not lead to resistance from the employees even though resistance is a natural reaction to change initiatives. In addition, the qualitative result showed that little resistance was mentioned by the employees. Despite this, the healthcare organisations had successful implementation of change because they were able to support their employees through the change programme which opened doors to improved change outcomes and benefit realisations. These findings suggest that the implementation strategies adopted by the healthcare organisations allowed for a relatively hitch-free change process. Therefore, it recommended that change strategies, such as effective communication, participative leadership, training systems, and motivation systems must be improved to foster successful change management processes without resistance.

Recommendation five

Organisations can adopt survey research and feedback because it plays an important role in the formation and history of OD. Survey feedback is a process in which organisations provide questionnaires on different organisational problems to employees to complete in order to receive feedback on results, then thereafter take appropriate actions to address the critical issues and concerns raised by employees. However, the key to a successful survey is for management to clearly define the purpose of the survey and explain what will be done with the results. Employee attitude surveys serve two important functions; as an improvement tool and communication tool.

Results of survey research and feedback indicate positive changes in employee attitudes and perceptions. The greater the involvement of all employees, the greater the change. When feedback is combined with other interventions, the effects are usually more substantial and long range (Brown, 2015; et al., 2019). In addition, the proposed and validated conceptual framework may be adopted by hospitals for change management in hospitals and other healthcare organisations.

7.6 Contribution to theory in change management

Organisational change management within healthcare organisations is becoming more inevitable, especially in the era of the Covid-19 pandemic. There is no better time than now for healthcare organisations to launch continuous change management projects in this time of uncertainties to improve quality, safety and save money. This study has contributed to the body of knowledge by empirically measuring components of change management for hospitals in Nigeria and South Africa. This study is one of the first to validate change management components in Nigeria and South Africa.

Exploring the relationship between drivers of change and employee performance also contributed to theory because this has not been examined in Nigerian and South African hospitals before. Empirical findings indicated that organisational culture had a significant influence on the practical implementation of change. The determination of the relationship between practical implementation of change and patient satisfaction showed significant association. Furthermore, a non-significant association was found between drivers of change and resistance to change at the healthcare organisations in Nigeria and South Africa. This suggests that the proposed framework may be adopted to provide a resistance-free change process.

This study could help professionals, academics, and stakeholders in organisational change management to address strategic issues towards the development of change programmes.

7.7 Limitations of the study

A case study research design was adopted for this study. Explanatory sequential mixed methods were used for data collection and analysis. Survey questionnaires were used for quantitative data collection, while open-ended questions were used for the collection of qualitative data. Quantitative data collection and analysis was conducted first before the qualitative data collection was done through in-depth interviews. Interview questions were based on the outcome of the quantitative data analysis to complement some

findings of the quantitative analysis. The researcher encountered budgetary constraints with traveling and accommodation costs to St Joseph's Hospital in Nigeria. Due to Covid -19 risks and restrictions, some participants did not want to participate in the study.

The scope of this study was limited to developing countries in West Africa and Southern Africa. Therefore, findings from this study may not be generalisable to healthcare organisations within the Northern and Eastern regions of Africa. However, inferences can be made to healthcare organisations in other African countries since the selected countries are within the context of the same continent. Furthermore, external factors such as the environment, and socioeconomic factors that may influence organisational change management were not considered in this study. However, the adopted constructs in this study have been empirically validated, moreover, Nigeria and South Africa are at the forefront of healthcare delivery in Africa.

7.8 Area(s) for future research

This study explored the change management process of healthcare organisations in two African countries. However, future research may incorporate healthcare organisations from other regions of Africa. The course of change anticipated for organisational change will surround the issue of a changing workforce and transformation within healthcare organisations. Hence, there is need for more empirical studies on change interventions. This study demonstrated the impact of drivers of change on employee performance, and the influence of organisational culture on the practical implementation of change. Further research may be conducted using socioeconomic factors, with reference to the current Covid-19 global pandemic". Future study may test the relationship between drivers of change and organisational culture within the context of hospitals in Sub-Saharan Africa.

7.9 Concluding remarks

Chapter seven has outlined the major conclusions from the study which showed that the objectives of this study were met. The chapter further answered the research questions that were presented in the study. The study further confirms that drivers of change and organisational culture impact employee productivity and performance. Management of St Joseph's and St Mary's should continue in supporting and motivating their employees to harness their full potential, and also remain accountable for maintaining a culture that holds clear and transparent policies and procedures to enhance employee performance to promote patient-centredness.

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APPENDICES

Appendix A



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

Physical address: 83 King Cotswayn Highway, Highway House, Mayville 4091
Postal Address: private Bag X 54318, Durban 4000 eThekweni District Office
Tel: 031 240 5308 Fax: 031 240 5555 Email: Ntombile.Ngoobo@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Mrs. N.P Ngoobo
Date: 19/08/2020

Dear Ms. H. I. Nweke
Durban University of Technology
Research Ethics Committee

**RE: SUPPORT FOR RESEARCH STUDY IN "ORGANIZATIONAL CHANGE
MANAGEMENT FRAME WORK FOR HOSPITALS: A CASE OF ST MARY'S MARIAN
HILL, SOUTH AFRICA AND ST JOSEPH'S ADAZI-NNUKWU NIGERIA"**

I have pleasure in informing you that the District is granting you support to conduct the research study entitled "Organizational Change Management Frame Work For Hospitals: A Case Of St Mary's Marianhill, South Africa and St Joseph's Adazi-Nnukwu Nigeria" in one of its facilities.

Please note the following:

1. Please ensure you adhere to all the policies, procedures, protocols and guidelines of the department of health with regards to this research.
2. This research will only commence once this office has received confirmation from the provincial health research committee in the KZN department of health.
3. Please ensure this office is informed before you commence your research.
4. The District office/facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the district office/facility.

Thanking you.
Sincerely,

Mrs. N.P. Ngoobo
(P. Monitoring and Evaluation Manager)
EThekweni Health District

Appendix B



March 9, 2020

St Joseph's hospital
Adazi-Nnukwu
Anambra State

Request for Permission to Conduct Research study

Dear Rev Fr. Jerome,

My name is Ifunanya Nweke, a doctoral student at the Durban University of Technology. The research I wish to conduct for my Doctoral thesis involves Organisational change management framework for hospitals. A case study of St Mary's Marianhill, South Africa and St Joseph's Adazi-Nnukwu, Nigeria.

Change management in healthcare is ever challenging and demanding and also a process that helps ease any organisational transition. Change can occur in an organisation in many ways- strategic, leadership, or technological changes and thus this often causes resistance to change as most employees find it challenging in conforming to new norms, patterns and routine thereby resisting change.

Furthermore, this study will be very beneficial to your organisation during any change initiatives. The mixed methods will serve as the primary study design. The estimated sample size will be 132 members of staff from the hospital at different levels. Semi-structured interviews will be conducted with 5 senior management personnel and questionnaires will be administered to the 127 fellow employees.

I am hereby seeking your consent to conduct this research. Your taking part in this research is of importance and highly valuable towards the completion of my studies.

(The anonymity of participants and confidentiality of their responses will be maintained always throughout the study period and after). Your approval to conduct this study will be greatly appreciated. Should you wish to discuss this further please feel free to contact me or my supervisor.

Dr Emmanuel Mutambara
+27 31 260 8104
mutambarae@ukzn.ac.za

Ifunanya Nweke
+27 74 911 4181
Ifunanya22@gmail.com

Appendix C



ST. JOSEPH'S HOSPITAL

Adazi - Nnukwu
Anaocha Local Govt., Area
Anambra State. 08037462342



Our Ref:.....
Your Ref:.....

March 10, 2020.
Date:.....

Ifunanya Nweke
Durban University of Technology,
South Africa.

Dear Ifunanya Nweke,

PERMISSION TO CONDUCT RESEARCH AT ST JOSEPH'S HOSPITAL ADAZI-NNUKWU.

I do hereby grant you the permission to carry out your doctoral research at our hospital. This permission does not include exposing personal information of our patients and publication of the official data of the hospital.

I wish you the best in your research.

Yours Faithfully,



Appendix D



March 5, 2021

The CEO
St Marys Hospital Marianhill
KwaZulu- Natal

Request for Permission to Conduct Research study

Dear Sir/Ma,

My name is Ifunanya Nweke, a doctoral student at the Durban University of Technology. The research I wish to conduct for my Doctoral thesis involves Organisational change management framework for hospitals. A case of St Mary's Marianhill South Africa and St Joseph's Adazi-Nnukwu Nigeria.

Change management in healthcare is ever challenging and demanding and also a process that helps ease any organisational transition. The dynamic changes in this environment leave managers totally unprepared to cope with it. Change can occur in an organisation in many ways- strategic, leadership, or technological changes and thus this often causes resistance to change as most employees find it challenging in conforming to new norms, patterns and routine thereby resisting change.

Furthermore, this study will be very beneficial to your organisation during any change implementation. The mixed methods will serve as the primary study design. The estimated sample size will be 169 members of staff from the hospital at different levels. Semi-structured interviews will be conducted with 5 senior management personnel and questionnaires will be administered to the 174 fellow employees.

I am hereby seeking your consent to conduct this research. Your taking part in this research is of importance and highly valuable towards the completion of my studies. (The anonymity of participants and confidentiality of their responses will be maintained always throughout the study period and after).

Your approval to conduct this study will be greatly appreciated. Should you wish to discuss this further please feel free to contact me or my supervisor.

Dr Emmanuel Mutambara
+27 31 260 8104
mutambarae@ukzn.ac.za

Ifunanya Nweke
+27 74 911 4181
Ifunanya22@gmail.com

Appendix E



KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE: ST MARY'S HOSPITAL

Private Bag X15, Ashwood, 3015

The Office of the Chief Executive Officer

No. 1 Hospital Road, Abbot Francis, Mariannhil, 3010

Tel: 031 717 1000 Fax: 031 717 1100 Email: Phe Mgobozi@kznhealth.gov.za

TO	: MS IFUNANYA NWEKE: DURBAN UNIVERSITY OF TECHNOLOGY
FROM	: MRS P.B. MGOBOZI: CHIEF EXECUTIVE OFFICER: ST MARY'S DISTRICT HOSPITAL
DATE	: 19 MARCH 2021
SUBJECT	: REQUEST TO CONDUCT RESEARCH ON ORGANISATIONAL CHANGE MANAGEMENT FRAMEWORK FOR HOSPITALS

Dear Ms Nweke

The e-mail dated 05th March 2021 anent the above-cited matter has reference.

Your request is approved provided that:

1. You can furnish us with a letter of approval from the Provincial Health and Ethics Committee (PHREC), and that you are granted full ethical approval by the university
2. You adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research
3. All research activities are conducted in a manner that does not interrupt clinical care at the health care facility.
4. St Mary's District Hospital will not provide any resources for this research
5. You will be expected to provide feedback on your findings to St Mary's District Hospital Mariannhil.

Kind regards

MRS P.B. MGOBOZI
CHIEF EXECUTIVE OFFICER
ST. MARY'S HOSPITAL MARIANNHIL

19/03/2021

DATE



Appendix F



MANAGEMENT SCIENCES: FACULTY RESEARCH ETHICS COMMITTEE (FREC)

8 May 2020

Student Name: Ms HI Nweke

Student No: 21856844

Dear Ms HI Nweke

DOCTOR OF PHILOSOPHY IN MANAGEMENT SCIENCES: BUSINESS ADMINISTRATION

TITLE: Organisational change management framework for hospitals: A case of St Mary's Marianhill, South Africa and St Joseph's Adazi-Nnukwu Nigeria

Please be advised that the FREC Committee has reviewed your proposal and the following decision was made: **Approved – Ethics Level 2**

Date of FRC Approval: 8 May 2020

Approval has been granted for a period of two years from the above FRC date, after which you are required to apply for safety monitoring and annual recertification. Please use the form located at the Faculty. This form must be submitted to the FREC at least 3 months before the ethics approval for the study expires.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the FREC according to the FREC SOP's. Please note that ANY amendments in the approved proposal require the approval of the FREC as outlined in the FREC SOP's.

Yours sincerely

Prof JP Govender
Chairperson: Faculty Research Ethics Committee

Appendix G



LETTER OF INFORMATION

Title of the Research Study: Organisational change management framework for hospitals. A case study of St Mary's Hospital Marianhill and St Joseph's Hospital.

Principal Investigator/researcher: Ifunanya H. Nweke

Co-Investigator/supervisor/s: Dr Emmanuel Mutambara,

Brief Introduction and Purpose of the Study: The healthcare industry faces more barriers because of its extraordinary complexity, large stakeholders and legal restrictions. This explains why change management in the healthcare industry is more challenging than the adjustment to change that every organisation faces. It is difficult because of its severe complications and the fact that it is responsible for saving human lives. Healthcare sector is a very important sector because it is an influential factor in establishing a good economy.

The healthcare industries utilise different models in different countries. Technology adoption is one of the biggest drivers of change due to its rapid evolution. In Africa, hospitals have been adopting electronic medical records (EMR). Changing to digital medical records has required many institutions to rework their entire medical records systems and this task is daunting.

Hence, the complexity of healthcare organisations requires massive coordination on multiple levels. The human resources management section is of particular interest to this study because it is an integral part of every organisation and plays a major role in facilitation of change. The aim of this study is to explore the various factors that affect change initiatives in two sub-Saharan African hospitals.

Outline of the Procedures

1. The 301 participants in this study are expected to fill questionnaires relating to change management framework.
2. The questionnaires will be distributed among the employees of St Mary's hospital Marianhill and St Joseph hospital Adazi-Nnukwu.
3. Each of the participants will be guided while filling the questionnaire to ensure they understand the questions being asked.
4. It will take each of the participants about 10-15 minutes to fill a questionnaire.

Risks or Discomforts to the Participant: No form of discomfort or risk is envisaged in the current research.

Benefits: Practicable recommendations relating to healthcare change initiatives will be provided to the hospitals under study; more so, the current study will produce two-four publications.

Reason/s why the Participant May Be Withdrawn from the Study: Participants may be withdrawn from participating if they are non-compliant, ill or as a result of an adverse reaction. Participants could also withdraw from participating if they so wish.

Remuneration: None

Costs of the Study: Participants are not expected to cover cost

Confidentiality: Names of participants would not be mentioned, and if for any reasons named are mentioned, permission will be requested from participant(s) first.

Research-related Injury: Possibility of research – related injury not feasible.

Persons to Contact in the Event of Any Problems or Queries:

Please contact Dr Emmanuel (supervisor) on 074 561 5083, or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvc@ip@du.ac.za.

General:

Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population e.g. isiZulu and Igbo.

Appendix H



CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ifunanya Happiness Nweke (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____.
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant _____ Date _____ Time _____ Signature/Right Thumbprint _____

I, Ifunanya Happiness Nweke herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Ifunanya Happiness Nweke
Full Name of Researcher

30/03/21
Date

HIN
Signature

Full Name of Witness (if applicable)

Date

Signature

Full Name of Legal Guardian (if applicable)

Date

Signature



LETTER OF CONSENT AND INFORMATION IN ISIZULU
(For the participants of St Mary's Hospital Marianhill in the KwaZulu-Natal Province)

Imvume

Isvumelwano sokubamba iqhaza esefundweni sezocwaningo

- Ngilyaqinisekisa ukuthi umowaningi Ifunanya H. Nweke (Igama lomowaningi) ungazisile wangichazela ngohlobo, izinzuzo Kanye nobungozi balesifundo- Research Ethics Clearance Number _____.
- Ngilyitholile, ngayifunda ngayiqonda inowadi yolwazi yokubamba iqhaza ngalisesifundo.
- Ngilyazi ukuthi imphumelo yalesisifundo kubalwa imininingwane yami okungama-gama ami, ubulili, iminyaka, Kanye nosuku lwami lokuzalwa okuzogcinwa kuyimfihlo kumbiko wokutadisha.
- Ekubhekeni izimfuneko ngalolucwaningo, ngiyavuma idatha etholakale ngesikhathi kutadishwa kungasetshenzwa ngumowaningi.
- Noma ngabe sekutheni, angeke ngibandlulule noma ngihoxise Imvume yam neqhaza kulesisifundo.
- Ngilyakuqonda ukubaluleka kokuthuthukiswa kokutholakelelengesikhathi kufundwa lolu cwaningo okungahlanganisa nokubamba kwami iqhaza ngiyokwazi ukukuthola.

Amagama aphelele

usuku

Isikhathi

sayina

Mina Ifunanya Happiness Nweke (umowaningi) ngilyaqinisekisa ukuthi umfundi obaluliwe ngnhla wazisiwe ngokuphelele ngohlobo, ukuziphatha Kanye nobungozi balesifundo esingenhla.

Ifunanya Happiness Nweke

Full name of Researcher

Date

signature

Full Name of Witness (If applicable)

Date

Signature

Full Name of Legal Guardian (If applicable)

Date

Signature

Appendix I



INTERVIEW GUIDE

Dear Respondent

My name is Ifunanya Nweke, a Doctoral student at Durban University of Technology. I am conducting a research study on Organisational change management framework for hospitals: A case of St Mary's Marlandhill, South Africa and St Joseph's Adazi-Nnukwu Nigeria. I therefore kindly request your cooperation in responding to the interview questions. Your contribution to this study will be greatly appreciated since it will provide a stepping stone towards my academic endeavour and the advancement of the St Joseph's Adazi-Nnukwu at large.

Please be advised that the Information which you will provide in the Interview will ONLY be used for academic purposes and the findings will be used to improve the organisation performance. Your ethical right to privacy and confidentiality and anonymity is much guaranteed since you are not expected to reveal your names or any personal Information which might identify you as a responded in this study.

Please feel free to answer all the questions as honestly as possible.

A: DEMOGRAPHICS (Please tick ☐ or circle the appropriate box)

A1	Gender	Male <input type="checkbox"/> (1)	female <input type="checkbox"/> (2)								
A2	Age	<24 yrs <input type="checkbox"/> (1)	25-29 yrs <input type="checkbox"/> (2)	30-34 yrs <input type="checkbox"/> (3)	35-39 yrs <input type="checkbox"/> (4)	40-44 yrs <input type="checkbox"/> (5)	45-49 yrs <input type="checkbox"/> (6)	50-54 yrs <input type="checkbox"/> (7)	55-59 yrs <input type="checkbox"/> (8)	60+ yrs <input type="checkbox"/> (9)	
A3	Language	isiZulu <input type="checkbox"/> (1)	English <input type="checkbox"/> (2)	Igbo <input type="checkbox"/> (3)							
A4	Highest level of education	Metric and below <input type="checkbox"/> (1)	Certificate <input type="checkbox"/> (2)	Diploma <input type="checkbox"/> (3)	Degree <input type="checkbox"/> (4)	Postgraduate <input type="checkbox"/> (5)					
A5	What is your department	Admin <input type="checkbox"/> (1)	Finance <input type="checkbox"/> (2)	Human resources <input type="checkbox"/> (3)	Nursing <input type="checkbox"/> (4)	Medical <input type="checkbox"/> (5)	Operations <input type="checkbox"/> (6)	Maintenance <input type="checkbox"/> (7)	Other <input type="checkbox"/> (8)		
A6	What is your Job position?	Medical Officer <input type="checkbox"/> (1)	Finance officer <input type="checkbox"/> (2)	Human Resources <input type="checkbox"/> (3)	Nurse <input type="checkbox"/> (4)	Pharmacist <input type="checkbox"/> (5)	Radiologist <input type="checkbox"/> (6)	Operations officer <input type="checkbox"/> (7)	Laboratory scientist <input type="checkbox"/> (8)	Physiotherapist <input type="checkbox"/> (9)	Other <input type="checkbox"/> (10)
A7	What is your race?	African <input type="checkbox"/> (1)	White <input type="checkbox"/> (2)	Indian <input type="checkbox"/> (3)	Coloured <input type="checkbox"/> (4)	Other <input type="checkbox"/> (5)					
A8	Name of Organisation	St Mary's Hospital Marlandhill <input type="checkbox"/> (1)	St Joseph's Hospital Adazi-Nnukwu <input type="checkbox"/> (2)								
A9	Duration of service	0-5 years <input type="checkbox"/> (1)	6-10 years <input type="checkbox"/> (2)	11-15 years <input type="checkbox"/> (3)	16 – 20 years <input type="checkbox"/> (4)	21 years and above <input type="checkbox"/> (5)					

B: DRIVERS OF CHANGE (Please fill in the given space) – there is no right or wrong answer.

B1	Please explain the type of changes that have taken place in your organisation during the change programme
B2	Where there various forms of training adopted in your organisation to enhance employee performance during this change process? Please elaborate.
B3	How has these changes improved your performance?
B4	Please explain if there has been improvement in patient satisfaction through these changes in the hospital.
B5	In your opinion, how does change in organisational policy affect you?

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C: GENERAL COMMUNICATION *(Please fill in the given space) - there is no right or wrong answer.*

C1 How did you participate in the decision-making process of your organisation during this change initiative?

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C2 How was the communication approach from management in your organisation?

--

C3 What current motivation practices are adopted in your organisation to motivate staff?

--

C4 During the change process, how did you react to changes in your work schedule?

--

D: GENERAL COMMENTS *(Please fill in the given space)*

D1	In your opinion, what recommendations can managers adopt in providing staff motivation through favourable extrinsic and intrinsic techniques that inspire and assist employees to be more productive?

Thank you for your time and cooperation

Dear participant thank you for taking your time to respond to this research questionnaire. This questionnaire or survey will take no more than 30 minutes to complete. Please mark the appropriate box with a cross (X). Please be assured that your responses will be kept anonymous and confidential.

SECTION A: Demographic Data

DM-01	Gender (Do not read)	Male [1]	Female [2]
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DM-02	Age	18-24 yrs[1]	25-29 yrs[2]	30-34 yrs[3]	35-39 yrs[4]	40-44 yrs[5]	45-49 yrs[6]	50-54 yrs[7]
							55-59 yrs [8]	60+ yrs [9]

DM-03	Have you ever attended school?	Yes [1]	No [2]
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DM-04	Highest level of school you attended	No schooling [0]	Primary [1]	Secondary [2]	Tertiary [3]
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DM-05	What is your marital status?	Single[1]	Married/living together [2]	Widowed [3]
				Separated/Divorced [4]

DM-06	What is your race?	African [1]	White [2]	Indian [3]	Coloured [4]	Other [5]
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DM-07	What is your department	Admin[1]	Finance [2]	Human Resources [3]	Nursing [4]	Supply chain [5]	Medical [6]	Maintenance [7]
							Operations [8]	Other [9]

DM-08	What is your job position?	Medical officer [1]	Finance officer [2]	Human Resources officer [3]	Nursing assistant [4]	Nurse [5]	Pharmacist [6]
		Maintenance Officer [7]	Food services clerk [8]	Operations officer [9]	Physiotherapist [10]	Psychologist [11]	Occupational therapist [12]
		Maintenance officer [13]	Other [14]	Supply chain clerk [15]	Admin clerk [16]		

DM-09	Name of your organisation?	St Mary's Hospital Marianhill [1]	St Joseph's hospital Adazi-Nnukwu [2]
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DM-10	What is your duration of service?	0-5 years [1]	5-10 years [2]	10- 15 years [3]	15 years[4]	-20 [5]	20 and above [6]
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SECTION B: Determinants of organisational change management

	MY ORGANISATION:	Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
UT: USE OF TECHNOLOGY							
UT-01	Information and communication technology is effective in all the departments.	1	2	3	4	5	6
UT-02	Operates electronic payment services.	1	2	3	4	5	6
UT-03	Has diagnostic equipment that allows for accurate detection of diseases.	1	2	3	4	5	6
UT-04	Make use of electronic health records.	1	2	3	4	5	6
UT-05	Has competitive advantage over other health care providers in the community.	1	2	3	4	5	6
UT-06	Operates door-to-door health care delivery for elder patients with chronic illness.	1	2	3	4	5	6
UT-07	Diagnostic equipment are easy to use.	1	2	3	4	5	6
PS: PATIENTS SATISFACTION							
PS-01	Patient needs are addressed through online	1	2	3	4	5	6
PS-02	Patients have access to electronic communication	1	2	3	4	5	6
PS-03	Patients have timely access to specialist through electronic communication services.	1	2	3	4	5	6
PS-04	Use of electronic medical records to access patient's health information.	1	2	3	4	5	6
PS-05	Online database for all our clients	1	2	3	4	5	6
PS-06	Physical environment is accessible to people with disabilities.	1	2	3	4	5	6
PS-07	Competent staff to cater for visiting and online patients daily.	1	2	3	4	5	6
OP: ORGANISATIONAL POLICY							
OP-01	Organization maintains privacy and confidentiality of medical records.	1	2	3	4	5	6
OP-02	Adheres to equity and ethical standards in its health deliveries.	1	2	3	4	5	6
OP-03	Organization's policy is better than the old ones.	1	2	3	4	5	6
OP-04	The new organisation's policy has made my work a lot easier and convenient.	1	2	3	4	5	6
OP-05	The new organisation's policy has improved our doctors-patient relationships.	1	2	3	4	5	6
OP-06	Organization's policy always considers the safety of patients/consumers.	1	2	3	4	5	6
OP-07	Organizational policy usually considers employees' working conditions.	1	2	3	4	5	6
EP: EMPLOYEE PERFORMANCE							
EP-01	This change process has enabled me to perform my duties more efficiently and effectively.	1	2	3	4	5	6
EP-02	The current change has provided me with the opportunity to work in line with my interests, skills and attitudes.	1	2	3	4	5	6
EP-03	The support received during the change process has improved my working psyche.	1	2	3	4	5	6
EP-04	The implementation of this change has provided the motivation, ability and desire to do my job.	1	2	3	4	5	6
EP-05	The change system in place has made it possible for me to take extra responsibilities in my work.	1	2	3	4	5	6
EP-06	The change system in the place has enhanced me to manage my time at work efficiently.	1	2	3	4	5	6
EP-07	This change has enabled me to collaborate more easily with others at work.	1	2	3	4	5	6
EP-08	The automated tool and equipment's received during the change process has enabled me to work efficiently.	1	2	3	4	5	6
EP-09	The training received during the change process has improved my skills to perform more productively.	1	2	3	4	5	6
EP-10	The change system has enhanced my performance to meet patients requirements.	1	2	3	4	5	6

OC: ORGANISATIONAL CULTURE						
OC-01	Communication from management is clear, transparent and frequent	1	2	3	4	5 6
OC-02	My manager solicit for our individual input	1	2	3	4	5 6
OC-03	My organisation provide a culture that encourages teamwork	1	2	3	4	5 6
OC-04	Managers work closely with us to realise realistic goals	1	2	3	4	5 6
OC-05	Managers encourage employees to adjust to changing situations through innovation and creativity	1	2	3	4	5 6
OC-06	The new methods of our health care services are better than the old methods.	1	2	3	4	5 6
OC-08	There is need to change some aspects of our service delivery.	1	2	3	4	5 6

IC: IMPLEMENTATION OF CHANGE						
IC-01	Employees are educated and trained to adjust to change of operations in the organization	1	2	3	4	5 6
IC-02	Information and communication technology have been introduced to all departments in my organization	1	2	3	4	5 6
IC-03	Employees are involved in the decision-making process of a change	1	2	3	4	5 6
IC-04	There is effective information and communication before any change can take place in the organization	1	2	3	4	5 6
IC-05	Employees that are affected by a change within the organization are usually compensated through promotion, monetary rewards or public recognition	1	2	3	4	5 6
IC-06	Changes in my organization have led to dismissal or transfer of some personnel in the past	1	2	3	4	5 6
IC-07	Changes in my organization is usually successful because there is leadership support for employees	1	2	3	4	5 6
IC-08	Changes in the organization is usually to satisfy our patients' demands	1	2	3	4	5 6
IC-09	Management gives honest information on the need to make a change in the organization.	1	2	3	4	5 6

RCM: RESISTANCE TO CHANGE MANAGEMENT						
RCM-01	I prefer working in a specific position to working with different groups during the change programme in my organisation.	1	2	3	4	5 6
RCM-02	During the change process, I got worried about information on transfer to another department for a new challenge.	1	2	3	4	5 6
RCM-03	I don't think I have something to gain about the change process	1	2	3	4	5 6
RCM-04	I prefer having a stable routine work rather than having changes to work during the change process.	1	2	3	4	5 6
RCM-05	When things don't go according to my plans, I get frustrated.	1	2	3	4	5 6
RCM-06	I got nervous and scared to lose my job during the change process	1	2	3	4	5 6
RCM-07	Once I have made plans about my work, I am not likely to change them.	1	2	3	4	5 6
RCM-08	No one can pressure me to adapt to change even if it is of good benefit to me.	1	2	3	4	5 6
RCM-09	Been informed of a change in my role of work gets me easily stressed out before knowing the benefit of the actual change.	1	2	3	4	5 6
RCM-10	I don't like surprises or uncertainty at work.	1	2	3	4	5 6
RCM-11	Any change in my working hours will frustrate me.	1	2	3	4	5 6

Thank you for your time