

**THE PERFORMANCE OF HEALTH WORKERS IN DECENTRALISED  
SERVICES IN UGANDA**

**by**

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**JUNE 2011**

**DECLARATION**

I declare that **THE PERFORMANCE OF HEALTH WORKERS IN DECENTRALISED SERVICES IN UGANDA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

.....  
**Dr George William Lutwama**

.....  
**Date**

## **DEDICATION**

To my mother Bernadette, my father Peter, and my late grandfather Emmanuel  
who introduced me to the academic world

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# THE PERFORMANCE OF HEALTH WORKERS IN DECENTRALISED SERVICES IN UGANDA

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## ABSTRACT

This study investigated the performance of health workers in the decentralised services in Uganda in order to develop a management framework that may be used to improve performance. The study followed a mixed research methodology and was descriptive. The survey design was used to collect quantitative data by means of a structured questionnaire. Qualitative data was collected using a semi-structured interview guide.

The study population for the quantitative strand comprised 276 health workers including doctors, clinical officers, and professional nurses working in four districts: Kumi, Mbale, Sironko and Tororo. The health workers were selected using stratified random sampling. The population for qualitative strand was health services managers (N=21) from the same districts. The managers were selected purposively. Quantitative data was analysed using SPSS version 18.0, while qualitative data was coded and analysed manually.

The findings revealed that the performance of health workers is generally affected by health systems and work environment related factors. The findings indicated that health workers are skilled, competent, and generally have positive attitudes and behaviours towards their clients. The study uncovered loop holes in performance management in the district health sectors. In most cases there is no target setting, no performance management planning, performance indicators are not clearly defined, and the schedules for performance measurement are not always followed. There is limited career progression and lack of functional performance feedback and rewarding mechanisms. Although health workers are committed, there is widespread political interference and nepotism in the district health sector management. Overall, the researcher is optimistic that if the proposed performance management framework is implemented, the performance of health workers might improve.

**Keywords:** health workers; districts; decentralised services; performance management; performance management framework; health sub-districts; health services; health service managers; mixed research methodology; health sector reforms.

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## LIST OF ACRONYMS AND ABBREVIATIONS

ACA	American Correctional Academy
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BSC	Balanced Scorecard
CAO	Chief Administrative Officer
CME	Continuing Medical Education
DDHS	District Director of Health Services
DFID	Department for International Development
DHC	District Health Committee
DHMT	District Health Management Team
DHO	District Health Officer
DIRPSER	Department of Industrial Relations, Public Sector and Employee Relations
DMO	District Medical Officer
DSC	District Service Commission
EMR	Eastern Mediterranean Region
FY	Financial Year
GoU	Government of Uganda
HC II	Health Centre at parish
HC III	Health Centre at Sub county level
HC IV	Health Centre at Sub-district or county level
HC V	Health Centre at District Level (District Hospital)
HC	Health Centre
HIV	Human Immune Virus
HMIS	Health Management Information System
HR	Human Resources
HRD	Human Resource Development
HRH	Human Resources for Health
HRM	Human Resource Management
HSC	Health Service Commission
HSD	Health Sub-District
HSSP II	Health Sector Strategic Plan number two
HSSP	Health Sector Strategic Plan

IMCI	Integrated Management of Childhood Illnesses
ISCO	International Standard Classification of Occupations
JLI	Joint Learning Initiative
LC III	Sub-County Local Council (III)
LC IV	District Local Council
LC V	Local Council five
LC	Local Council
MBO	Management by Objectives
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoPS	Ministry of Public Service
N	Population
n	Sample
NGO	Non Government Organisation
NHP	National Health Policy
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
PNFP	Private Not for Profit
ProMES	Productivity Measurement and evaluation system
PRP	Performance related payment
SPSS	Statistical Package for Social Sciences
TB	Tuberculosis
TQM	Total Quality Management
UK	United Kingdom
UN	United Nations
UNCST	Uganda National Council for Science and Technology
UNMHCP	Uganda National Minimum Health Care Package
USA	United States of America
SWOT	Strengths, Weaknesses, Opportunities and Threats
WHO	World Health Organization



# CHAPTER 1 ORIENTATION TO THE STUDY

## 1.1 INTRODUCTION

There is growing recognition on the importance of health workforce studies. This is motivated by links that have been established between human resource issues and health systems performance resulting from the health sector reforms (Fritzen 2007:[1]). The World Health Organization (WHO 2006: xxv) launched the health workforce decade (2006-2015) with high priority given to countries to develop effective workforce strategies through: improving recruitment, improving performance and reducing attrition of health workers. It is widely accepted that human resources are the most important assets of the health system and play a critical role in the attainment of the reform objectives (Ssengooba, Rutebemberwa & Hongoro 2005:2). Fritzen (2007:[2]) describes health workforce issues as strategic because they affect the overall systems performance, feasibility and sustainability of health sector reforms. Hence, addressing the health workforce issues strategically helps in identifying the gaps in policy and implementation of health sector reforms.

The health workforce crisis in developing countries is receiving increasing worldwide attention. Policy makers realise that it will not be possible to attain the millennium development goals (MDGs) unless availability and performance of health workers are addressed more effectively. Poor performance of health workers leads to inappropriate health care which in turn contributes to undesirable health outcomes (Dieleman, Gerretsen & van der Wilt 2009:[2]; WHO 2006:67-70). Scholars have documented problems related to poor performance of health workers, yet there is still no sufficient evidence on what actually works to improve health workforce performance (Chopra, Munro, Lavis, Vist & Bennett 2008:673; Garcia-Prado & Chawla 2006:98; Rowe, de Savigny, Lanata & Victora 2005:1028).

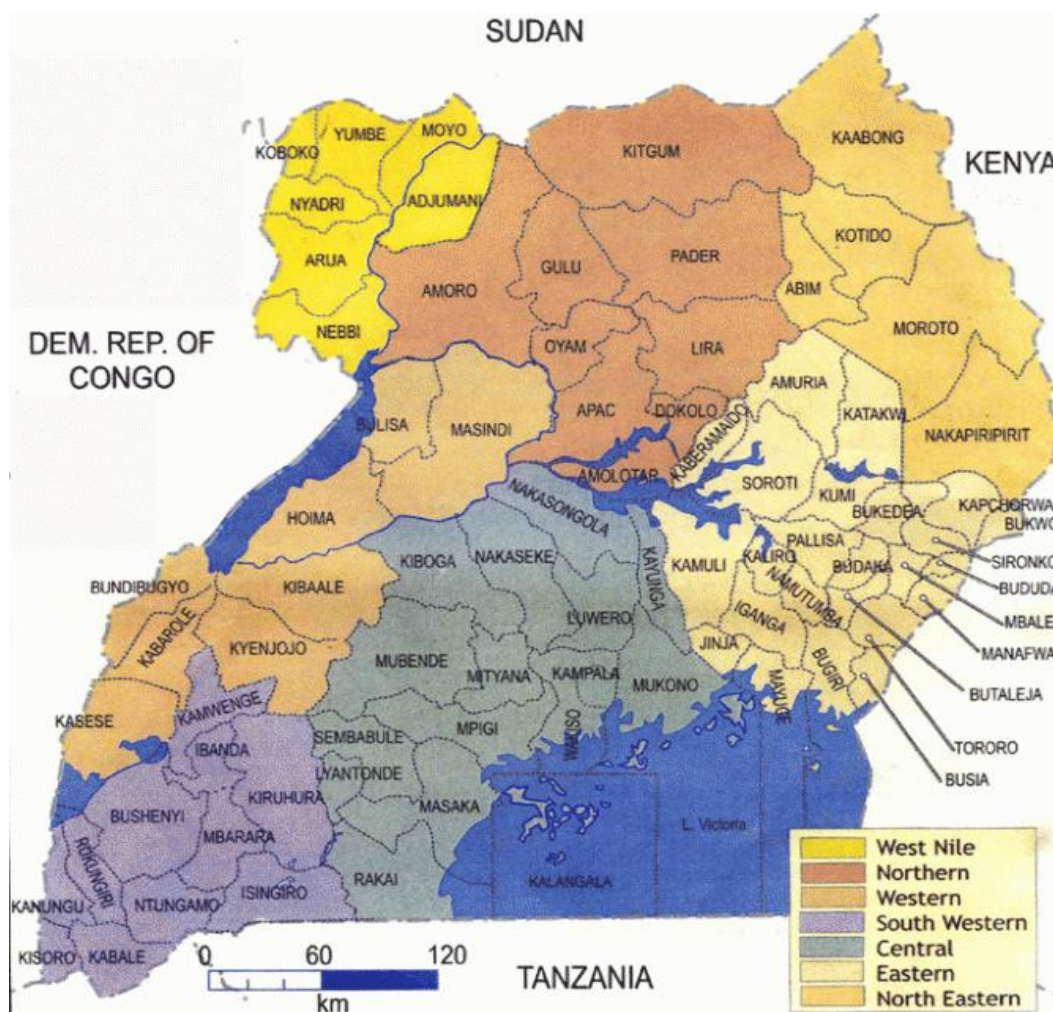
Performance management has been described by many writers as an effective tool in strengthening health services delivery. Currently it has become an area of

great research interest. Internationally, health systems are faced with the demands to trim costs and get better health outcomes (Lozan, Soliz, Gakidou, Abbott-Klafter, Feehan, Vidal, Ortiz & Murray 2006:1729; Tawfik-Shukor, Klazinga & Arah 2007:[10]). Since the 1990s a series of reforms have taken place in Uganda. These reforms, including decentralisation and organisational restructuring were meant to improve systems performance. However, the reforms did not pay much attention to the human resource issues (Okuonzi 2004:1174; Ssenooba et al 2005:3). Cognisant of the situation, it is important to uncover more evidence on health workforce performance. This evidence may assist policy makers to recognise and apply appropriate strategies for improving performance. This chapter presents the source and background to the problem, states the research problem, study aim and objectives, and the significance of the study. Furthermore, the researcher presents the definition of key concepts and terms, the theoretical foundations, a brief of the research methodology, and the ethical considerations. Lastly, the researcher presents the scope and anticipated limitations of the study.

## **1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM**

Uganda is a land locked country situated in East Africa. It is bordered by Sudan in the north, Kenya in the east, Tanzania and Rwanda in the south, and Democratic Republic of Congo in the west. Uganda is divided into 112 districts across four regions namely; Central, Eastern, Western, and Northern (see Figure 1.1). Each district is further divided into counties, sub-counties, parishes, and villages. The total population of Uganda is estimated to be 31 million people, with an annual growth rate of 3.2% (Uganda Bureau of Statistics & Macro International Inc 2007:1-2). During the post independence era (1962 -1971) Uganda was one of the countries with the best health indices and vibrant health care system in Africa. Following the two decades of civil unrest, the health system collapsed. After the civil war, the Government of Uganda (GoU) began reconstruction and rehabilitation programmes by nurturing the political and economic environment conducive for growth. Since the early 1990s the government of Uganda has placed high priority to improving the health status of

the people, yet, the health indicators have remained poor (Ministry of Health Uganda (MoH) 2009:1-2).



**Figure 1.1: The map of Uganda showing the districts as of July 2010**

Source: [http://molq.go.ug/Content/images/uganda\\_2010.gif](http://molq.go.ug/Content/images/uganda_2010.gif)

### 1.2.1 The source of the research problem

The researcher was inspired to carry out this study in the field of human resource for health by a number of reasons. These emanate from the researcher's eight-year hands-on experience as a medical officer and later as District Director of Health Services in the decentralised health system. During this period the researcher observed a number of performance problems facing health workers that necessitate further investigations. Secondly, the current press reports in Uganda provide staggering evidence regarding health worker performance problems in decentralised health services. Some of these include;

absenteeism, neglect of patients, drug pilferage and poor staff motivation among others. The press has also reported the current Minister of Health in Uganda, blaming decentralisation as the cause for poor delivery of health services in the country (Lirri 2008:1). Thirdly, as a result of the deterioration of the health sector, the President of Uganda, Mr. Yoweri Museveni wrote a letter to the Minister of Health in April 2008 demanding explanation for health sector failures (Fanaka Kwa Wote 2008:1). Furthermore, the annual report for 2007/2008 of the Uganda Ministry of Health (MoH) clearly states that some health indicators are either stagnating or deteriorating, thanks to inadequate health worker performance (Ministry of Health Uganda 2008:25). It is therefore worth investigating the performance of health workers in the decentralised services in order to establish the root cause of the problems.

### **1.2.2 Background to the research problem**

As part of the health sector reforms which began in the early 1990s, decentralisation is one of the major reforms that have been implemented across the Ugandan health care delivery system. These reforms were operationalised through the Health Sector Strategic Plan (HSSP) under the National Health Policy (NHP) with the focus on reducing morbidity and mortality from major illnesses. Among the anticipated benefits of health sector reforms were responsiveness, efficiency, and accountability in decision making among stakeholders (Awio & Northcott 2001:75-76). In Uganda the delivery of health services is decentralised to the district level. Decentralisation entails significant changes to the way human resources are managed in public service, transforming the authority, accountability structures, career paths, recruitment, payment, training, and discipline of staff. The degree of responsiveness of the district systems to the needs of the health workers such as payment of salaries, promotion, social and personal development is essential in understanding the impact decentralisation on health workers' performance (Ssenooba et al 2005:3).

### **1.2.2.1 Human resources for health (HRH) in Uganda**

There are over 20 categories of health workers within the health sector. However, for the purpose of this study, the researcher considered three main categories that are critical for the implementation of the Uganda National Minimum Health Care Package (UNMHCP) and these include doctors, clinical officers and nurses.

A medical doctor is referred to as medical officer in the Ugandan public service. Medical doctors are trained for a minimum of five years, and graduate with Bachelor of Medicine and Bachelor of Surgery degree. They undergo a mandatory one year of supervised internship. After the internship, medical doctors are fully registered with the Uganda Medical and Dental Practitioners Council to practice medicine. Postgraduate training in any medical specialities takes between 3 to 4 years. There are three public medical schools in Uganda that train doctors and these are; Gulu University, Makerere University, and Mbarara University of Science and Technology. A medical doctor joins the service as medical officer and progresses to medical officer special grade (specialist) and eventually to senior consultant (Matsiko & Kiwanuka 2003:18-19).

The clinical officers are health care providers that are commonly found in sub-Saharan Africa. In Uganda, clinical officers are trained for three years and graduate with a diploma in clinical medicine and community health. Clinical officer's training covers approximately 60% of the curriculum for medical doctors and the emphasis is placed on solving community problems by applying their knowledge of medicine. Unlike some other African countries, clinical officers in Uganda are not required to undergo internship. They are registered by the Uganda Allied Health Professionals Council. Clinical officers either work independently or with a medical officer to provide healthcare services largely to the rural population (Matsiko & Kiwanuka 2003:18). In Uganda, there are three public schools for training clinical officers based in the towns of Fort Portal, Gulu, and Mbale. There is no clear career path for clinical officers. When a clinical

officer wants to upgrade to the level of a medical doctor, she or he enters the university medical school through mature age entry programme and has to start from the first year.

Nurses are the largest cadre of health workers who are critical to the implementation public health interventions. The nurses in Uganda have varying qualification levels ranging from degree to certificate holders. Nurses holding a university degree are referred to as professional nurses, those with diplomas are associate professional nurses (registered nurses/midwives) and those with certificates are either enrolled nurses or midwives (Orach 2009:3). The training of nurses varies from three years (3 years) for enrolled nurses/midwives to 4 and 5 years for diploma and degree holders respectively (Matsiko & Kiwanuka 2003:16-18). In order to practice nursing in Uganda, all nurses are supposed to be registered with Uganda Nurses and Midwives Council, which is the national regulatory body for this profession. There is a clear career path for nurses in Uganda and opportunities for post-graduate training is available up to doctoral level.

Uganda is among the 57 countries with critical human resource shortages. The situation is worse at the lower levels of the health system where the burden of disease is high (WHO 2006:196). By November 2008, only 51% of the approved positions at national level were filled. The situation is said to be worse in rural, conflict and post-conflict, and the hard-to-reach areas (Ministry of Health Uganda 2009:5). Many factors have been attributed to the many vacancies, which include but are not limited to insufficient training capacity, low remuneration and poor working conditions. These conditions make it difficult for the districts to recruit and retain health workers. Additionally, there is inequitable distribution of health workers among districts, rural and urban areas, and between public and private providers. There has been attrition of health workers from private not for profit (PNFP) facilities to public facilities over the past few years due to the decision by government to increase salaries and incentives of civil servants.

Emigration of health workers to other countries is also common due to more attractive salaries and opportunities. The Centre for Global Development (2000) quoted in Clemens and Pettersson (2008:[7-9]), report that in the year 2000 out of 4266 Ugandan born doctors, 1837 (43%) were residing outside their country. Most of them were working in Great Britain (62%), United States of America (16%), Canada (9%), South Africa (10%), Australia (3%) and the rest (0.3%) were in France, Belgium, Portugal and Spain. Additionally, during the same period, out of the 9851 Ugandan born professional nurses, 1122 (10%) were working or residing outside their country. The biggest percentage was in Great Britain (64%), United States of America (26%), Canada (7%), Australia (3%) and South Africa (1%). Hagopian (2006:21) reports that from the year 2000 to 2005, a total of 586 nurses applied for external licensing. The majority of these (75%) were either registered nurses or midwives who are crucial in the delivery of the UNMHCP. Furthermore, a study carried out among nursing students at Makerere Nursing School and Aga Khan University Nursing School in Kampala in July 2006; reveals that 70% of the participants would like to work outside Uganda. They indicated that within five years they would be working in USA (59%) or the United Kingdom (49%). About 27% indicated their intention of working in another African country and only 8% of all students reported the unlikelihood to emigrate upon completion of their studies (Nguyen, Ropers, Nderitu, Zuyderduin, Luboga & Hagopian 2008:[4]).

Several writers report that productivity of health workers in public facilities is low due to high rates of absenteeism and rampant dualism. Poor attitudes of health workers towards patients also affect the utilisation of services. Health workers do not feel accountable to communities. At the same time leadership and management of human resources are weak at all levels (Ministry of Health Uganda 2009:6). Shortage of health workers poses a challenge to achieving the millennium development goals (MDGs). The few health workers available on the ground are faced with the burden to implement a wide range of services within the UNMHCP and to meet the targets of the second Health Sector Strategic Plan (HSSP II), the national Poverty Eradication Action Plan (PEAP) and the MDGs (Orach 2008:31).

### **1.2.2.2 The health care system in Uganda**

Health services are provided both by public and private sectors. In the public sector, the UNMHCP has been developed as a basis for services delivery. The UNMHCP comprises the most cost-effective priority health interventions and services that address the major causes of high disease burden. The UNMHCP is intended to be the basic indication for determining the allocation of public funds and other essential inputs. The UNMHCP includes the following components:

- Health promotion, disease prevention and community health initiatives. Examples of these are school health, health education, environmental health services, and epidemic and disaster preparedness.
- Nutrition and food security.
- Maternal and child health services such as Integrated Management of Childhood Illnesses (IMCI), immunisation, and sexual and reproductive health and rights.
- Prevention, management and control of communicable diseases like malaria, HIV/AIDS, and Tuberculosis.

The different levels of health care system are expected to provide the UNMHCP in an integrated manner (Ministry of Health Uganda 2009:14-15).

The public health system in Uganda consists of the national and regional referral hospitals, and the district health system. The national and regional referral hospitals are autonomous and self-accounting institutions. The district health care systems are managed by the local governments which are aligned to the administrative structures as shown in Table 1.1.



**Table 1.1: The district health system structure in Uganda**

<b>Administrative structure</b>	<b>Local council level</b>	<b>Corresponding health care structure</b>
Village	I	Village Health team (VHT)
Parish	II	Health Centre II (HC II)
Sub-county	III	Health Centre III (HC III)
County (Sub-District)	IV	Health Centre IV (Health Sub-district (HSDs))
District	V	District General Hospital (HC V)

Source: Ministry of Health Uganda (2002:2)

Politically, the head of the district local government is an elected chairperson of local council five (LC V). The district council (LC V) oversees the functions of the district including the health services. The Chief Administrative Officer (CAO) is the head of administration and civil service. The District Health Officer (DHO) is the head of district health system assisted by the District Health Management Team (DHMT). The local councils V (LC V), IV (LC IV) and III (LC III) are local governments, while the local councils II (LC II) and I (LC I) are local administrative units. The local governments have administrative, financial and legislative authority. However, the local administrative units largely have administrative powers (United Nations Department for Economic and Social Affairs 2004:7).

As indicated in Table 1.1, the district health care system consists of the district general hospitals, health centres (HC) level II, III IV, and the village health teams. At the district level, the district hospital is the highest level of health care. The district hospital is headed by the medical superintendents, assisted by a number of doctors, clinical officers, nurses and midwives and other allied health professionals.

The district health system is further subdivided into health sub-districts (HSDs) or health centre level IV (HC IV). This usually corresponds with the administrative structure of the counties or parliamentary constituencies. The health sub-district is headed by a medical doctor, assisted by 2 clinical officers, registered nurses, and enrolled nurses, midwives, and laboratory technician. The health centre IV offers operation theatre services for emergency obstetric care, maternity services, laboratory services, in and outpatient services. The staff at HC IV

supervise the operations of the lower level health care units within their catchment areas. Every county is divided into sub-counties. This is the lowest level of local governments. At this level, the health care services are provided by health centre level III (HC III). Usually a clinical officer heads the services at this level assisted by a nurse and midwife, laboratory technician, and nursing assistants. The services provided at this level include maternity, laboratory services, as well as in and outpatient services. The sub-counties are further sub-divided into parishes or wards. The health care facility at the parish or ward level is health centre level II (HC II). An enrolled nurse and midwife manage the HC IIs. This is the lowest level of health care facility and offers primary health care services. These health centres do not offer any maternity, theatre, laboratory or inpatient services. Lastly, parishes/wards are divided into villages (LC Is), which are the lowest administrative units. At this level there are village health teams, which are teams of local residents appointed to oversee the performance of health activities in their communities (Kavuma 2009:1-2).

Generally, the management capacity at the districts is still very limited due to inadequate leadership, poor management, lack of specialist skills and high attrition rates which inhibit capacity building initiatives. About 72% of households in Uganda live within 5km from a health facility. However, utilisation is limited due to poor infrastructure, lack of drugs, shortage and low motivation of health workers (Ministry of Health Uganda 2009:3). Therefore, the functionality of the health system in Uganda remains a challenge such that system strengthening, especially at district level is required to facilitate effective service delivery.

### **1.2.2.3 Health care sector performance during reforms**

Although Uganda's decentralisation has been praised, it has brought with it some obstacles to service provision. This is because most of the funds allocated to the local governments are assigned by MoH for specific activities. Hence, local governments use funds as directed by the MoH and not according to their needs.

Despite the analysis of the achievements and failures of health reforms, in general, little attention has been paid to the human resources yet they play a significant part in determining the achievements of the health reforms (Okuonzi 2004:1173). The Joint Learning Initiative (JLI) (2004:21-26) outlines the importance of health workforce in performing services by stating that 'health worker numbers, quality, and professionalism determine output and productivity'.

A significant number of information sources have documented problems of poor health care outcomes resulting from inadequate performance of health workers. For instance, Garcia-Prado & Chawla (2006:98); JLI (2004:1); Rowe et al (2005:1026-1027); Van Lerberghe, Conceição, Van Damme & Ferrinho (2002:581); and WHO (2006: xvii) note that the poor performance may result from too few health workers or from health workers providing substandard care which is not responsive to the needs of the clients. Some of the performance problems may be attributed to factors such as unclear expectations, skills deficit, resource or equipment shortages, and lack of motivation among others. These problems are entrenched in a deteriorating health system characterised by low salaries, difficult working and living conditions and inappropriate training.

Performance management in the Ugandan health sector is still weak, with little or no documented proof of its practice. Although official reports on the effects of health sector reforms may paint a rosy picture, the reality has often been, and remains shockingly different. Okuonzi (2004:1174) reports that Uganda has failed to achieve a functioning health system despite the reforms. The performance of health systems has actually deteriorated after the introduction of the reforms and from 1990-1995 and 2000-2004 key health statistics worsened as shown in Table 1.2. It is thus imperative to ascertain whether this trend could possibly be due to performance of health workers or poor performance management systems within the decentralised services.

**Table 1.2: Uganda's health status during reforms**

<b>Aspect of performance</b>	<b>1990-1995</b>	<b>2000-2004</b>
Nutrition (% of children with stunting)	6.2	7.8
Access to safe water (%)	39.4	53.8
Access to proper sanitation (%)	34	51
Infant mortality (deaths/1000 live birth)	81	88
Neonatal mortality (death/1000 live birth)	27	33.2
Malaria morbidity (%)	25	37
Diarrhoea morbidity (%)	17.7	17.8
Maternal mortality ratio (death/100,000 live birth)	506	505
Child mortality (death/1000)	147	151
Life expectancy (years)	50	47
Deliveries in health facilities (%)	38	47
Fertility rate (average number of children/mother)	7.4	6.9

Source: Okuonzi (2004:1174)

The Uganda annual health sector performance report for 2007/2008 financial year (FY) has shown some successes in attaining some of the health indicators under the second Health Sector Strategic Plan (HSSP II). However, the report has also indicated a significant stagnation and sometimes a decline in important health indicators. For example, the proportion of children under one year who have received 3 doses of the pentavalent vaccine as per schedule reduced from 89% in financial year 2005/06 to 78% in 2007/08 against the target of 87%. Tuberculosis (TB) cure rate reduced from 73% to 68.4% during the same period. The proportion of sick under-five children seen by a health worker, using Integrated Management of Childhood Illnesses (IMCI) guidelines, reduced to 30% (2007/08) from 45% baseline and below the target of 55%. The outpatient new attendance rate stagnated at 80% for the past consecutive two years (Ministry of Health Uganda 2008:25). This decline in health sector performance could either be attributed to the failure of the health system itself or to individual health workers. Table 1.3 shows some of the achievements against the target for the PEAP indicators for the FY 2007/08 and compared with the performance in FY 2006/07, FY 2005/06, and the baseline year FY 2004/05.

**Table 1.3: Performance against the 8 PEAP indicators for FY 2007/08**

Indicator	Baseline FY 04/05	Achieved FY 2005/06	Achieved FY 2006/07	Target 2007/08	Achieved FY 2007/08
OPD Utilisations in Govt & PNFP Units	90%	90%	90%	90%	80%
DPT 3 /Pentavalent vaccine coverage	89%	89%	90%	95%	82%
Percentage of deliveries taking place in health facilities (Govt & PNFP)	25%	29%	32%	35%	33%
Proportion of approved posts filled by trained Health workers	68%	75%	38.4%	85%	79%
National average HIV sero-prevalence at ANC Surveillance sites	6.1%	No data	6.4%	-	-
Proportion of Health facilities without stock (out of 5 tracer medicines & supplies)	35%	27%	35%	60%	28%
Household latrine coverage	57%	58%	58.5%	100%	63%
Couple Years of protection (CYP)	234,259	309,757	325,407	325,407	361,080

Source: Ministry of Health Uganda (2008: xvi)

Human resource management challenges have been reported in Uganda by various documents. For example, the value for money audit conducted in the MoH by the Auditor General in 2006, discovered significant staffing gaps in most of the health facilities. The District Service Commissions (DSCs) had difficulties in attracting and retaining qualified medical personnel. Additionally, the districts did not have clear policies on training, staff transfer and rotation, leading to maldistribution of health workers, with a bias towards urban areas. At the same time, districts did not regularly appraise and supervise staff. Monitoring and evaluation of performance was irregularly done leading to sloppiness by districts and health workers in providing health services. Finally, the districts and health facilities were not utilising the existing Health Management Information System (HMIS) to report their performance (Auditor General Uganda 2006:7).

Poor performance of health systems and workers is not unique to Uganda. Other countries within Africa and beyond experience the same problem. Dieleman, Toonen, Toure and Martineau (2006:[5-6]) report poor performance management in Mali, evidenced by lack of job descriptions and training needs analysis; inadequate and subjective supervision and appraisal system. Based on

their findings, Dieleman et al (2006:[6]) recommend improvements in existing performance management strategies. Researchers have identified some factors that impact on individual performance and job satisfaction. These include personality, values, attitudes, perceptions, abilities, and motivation. Once these factors are optimised they improve individual health worker performance and job satisfaction, which in turn translate into superior organisational performance (Dieleman & Harnmeijer 2006:5; Dussault 2006:7; Fritzen 2007:[5]; Marchant 1999:63).

El-Jardali, Jamal, Abdallah and Kassak (2007:[9]) describe the lack of development in human resource for health issues in the WHO Eastern Mediterranean Region (EMR). These authors report inadequate information on health workers' productivity and lack of informed human resources policies to guide planning beyond the usual health worker density and indicators. Therefore, without credible information on existing health workers' productivity, it is almost impossible to implement interventions for improving performance. Dieleman et al (2009:[7-8]) indicate that human resource management interventions in health sectors such as training, local performance analysis and payment combined with organisational change can improve workforce performance.

Against this backdrop, the researcher carried out this study to fill knowledge gaps on performance management of health workers in the decentralised services. According to the researcher's knowledge, no such research has been carried out in Uganda. It is hoped that by identifying the factors involved, a framework for effective performance management will be put forward.

### **1.3 STATEMENT OF THE RESEARCH PROBLEM**

Delivery of health services in Uganda has been decentralised since the 1990s. The decentralisation of health care services was part of the reform processes that were initiated in 1993 (Jeppsson & Okuonzi 2000:276; Kisubi 1996:83-106). District and urban authorities were expected to take over responsibility for health facilities from the district hospital level to HC IIs, school health services, rural ambulance services, hygiene services and health education. Districts were broadly given the authority to set fees for any services provided, including health care. Through the DSCs, districts could confirm appointment of public servants including health workers, exercise disciplinary control, protect them against arbitrary dismissal and facilitate their career development through training (Kyaddondo & Whyte 2003:332).

In a decentralised system, health workers form significant links between the health system and the final consumers of services. They play a major role in translating policy from paper to practice. Yet, most studies on decentralisation of health services concentrate on the formulation processes, reorganisation, and the impact it has on users. This reflects the main objectives of decentralisation which are: improved service delivery and reduced costs, the goals that mainly benefit the central level and consumers. Although decentralisation of the health care sector is highly popular worldwide, it is problematic in many low resources countries. Little emphasis has been put on its implications for health workers both professionally and socially (Kyaddondo & Whyte 2003:330).

Despite the ongoing health sector reforms in Uganda, services have remained poor. The inadequate performance of health workers coupled with lack of adequate support from the central and local governments are believed to have partly contributed to this deterioration and stagnation of some of the important health indicators under the second Health Sector Strategic Plan (HSSP II). Whatever the case, poor performance of individual health workers culminates into poor organisational performance. Failure of the stakeholders in the health

sector to implement programmes meant to enhance workforce performance has led to poor quality of health services seen currently in the country.

The Ugandan Ministry of Health (2009:5) reports the critical situation of human resources for health, which is a result of insufficient training capacity of health workers with the right skills mix, low remuneration, and poor working conditions both in public and private not for profit (PNFP) sectors. There is also an inequitable distribution of health workers among the districts, between rural and urban areas, and between public and private providers. The researcher believes that performance management has a bearing on the way health workers execute their duties. Hence, the necessity to investigate factors that impede or enhance the performance of health workers in the decentralised services. Informed policies are required to guide the planning and management of human resources for health (HRH). This can only be attained through rigorous gathering and analysis of facts. Health sector planning practices need to go beyond numbers and health status indicators to concrete management of available health workers. This study has assisted the policy makers by developing a management framework outlining the strategies and recommendations for improving performance management.

#### **1.4 AIM AND OBJECTIVES OF THE STUDY**

The aim of this study was to investigate the performance of health workers in order to come up with a management framework that may be used by stakeholders to improve performance in the decentralised services in Uganda.

##### **The objectives of this research were to**

- identify factors that impede or enhance performance of health workers
- assess the current practices used to manage performance of health workers
- determine the views of health workers and their managers on how to improve performance



- develop a performance management framework for health workers based on the findings of this research.

## **1.5 SIGNIFICANCE OF THE STUDY**

The researcher believes that the findings of this study will add to the existing body of knowledge and understanding of the subject of performance management and its application in the decentralised health systems. The results will be useful to health planners, policy makers and other stakeholders by contributing towards the formulation of a performance management framework which is specific to the health workers. This makes the study useful not only in Uganda but also in other countries both within and outside Africa.

This research will:

- Provide useful information on factors that might contribute to success or failure of health workers' performance.
- Support and enrich theories and models of performance management that take into account the nature of work and performance of health workforce.
- Generate greater awareness among the public health sector on the importance of having appropriate and practical performance management frameworks as media to organisational effectiveness.
- Allow the identification of concepts and frameworks of performance management that acknowledge the nature of work and the setting of the decentralised health systems.

## **1.6 DEFINITION OF KEY CONCEPTS**

### **Decentralisation**

Decentralisation is a change in the organisation of government or other institution, involving the transfer of power and functions from the top of the hierarchy of power and service provision to peripheral levels. This organisational

shift involves transfer of decision-making, and other functional roles such as services delivery from national to various sub-national levels such the districts. One of the key motivations for decentralisation is its capacity to empower the local institutions and people to make their own decisions and to introduce appropriate delivery of services (Mayanja 2005:1; Muriisa 2008:84-86).

In this research, decentralisation refers to the transfer of power and functions of health service delivery from the ministry of health to the local governments (districts, counties and sub-counties). During the reforms, the responsibility for delivery of health service (preventive and curative) from the level of general hospitals (HC Vs) to HC IIs was decentralised to the districts and urban authorities. The other services that have been decentralised include school health services, rural ambulance services, hygiene services and health education. Lastly, recruitment, confirmation of appointments of health workers, disciplinary control and facilitation of career development through training were all decentralised to the districts (Kyaddondo & Whyte 2003:332).

### **Health workers**

Health workers are all people that engage in the promotion, protection, or improvement of the health of the population (Diallo, Zurn, Gupta & Dal Poz 2003:3). This definition includes other non-medical professionals such as family members looking after the sick and other unpaid caregivers and volunteers that contribute to the improvement of health. For the purpose of this study however, the researcher defines health workers as health service providers that are directly engaged in the delivery of health services as described in the three-digit International Standard Classification of Occupations (ISCO-88) system used in the South African Census of 2001 (Dal Poz, Kinfu, Dräger & Kunjumen 2006:1-4). In this study, the term health workers refer to medical doctors, nurses/midwives and clinical officers.

## **Performance**

Performance implies the actions of doing things; using things; attending to conditions; processing; communicating, and achieving results (Langdon 2000:12). Performance is understood as achievements of the health workers in relation with their set goals. This includes outcomes accomplished through contribution of individuals or teams to the organisation's strategic goals. Performance has a linkage with the individual potential and how best it is realised by the individual (Noe, Hollenbeck, Gerhat & Wright 2008:344-345). In this study, health worker performance refers to availability, competence, productivity, and responsiveness of health workers.

## **Performance management**

Performance management is the means through which managers ensure that employees' activities and outputs are congruent with organisation's goals (Noe et al 2008:344). By implication, performance management is a mechanism by which organisations, teams, and individuals can obtain improved results. A clearly defined set of performance goals and competency requirements can aid in this regard. Thus, performance management involves creating a common understanding of performance targets, and employee management and development. In this research, performance management refers to planning, managing, reviewing, and recognising individual health worker's performance.

## **Responsiveness**

Responsiveness is the willingness or readiness of employees to provide service (Heizer & Render 2008:212). In this study, health workers' responsiveness is described as their ability and willingness to understand and address the clinical and emotional requirements as well as the demands of existing and potential clients.

## **Service**

A service is any action or assistance that one party can provide to another that is basically intangible and does not result into ownership (Kotler & Keller 2006:402). According to Kotler and Keller (2006:405-408) services cannot be seen, tasted, touched before they are purchased. Services usually depend on people who provide them and where they are provided, hence their variability in quality. Additionally services cannot be stored; they are typically produced and consumed simultaneously. In this study, service refers to health care activities that are carried out by the health workers and are geared towards improving the well being of clients or their communities.

## **Skill**

Oxford Advanced Learners Dictionary, defines the term skill as 'the ability to do something well' (Hornby 2005:1378). Skill involves carrying out a task which regularly requires the use of motor functions as well as explicit knowledge. In this study, skill means the health workers' proficiency in carrying out of their routine activities in delivering care to the patients.

## **1.7 FOUNDATIONS OF THE STUDY**

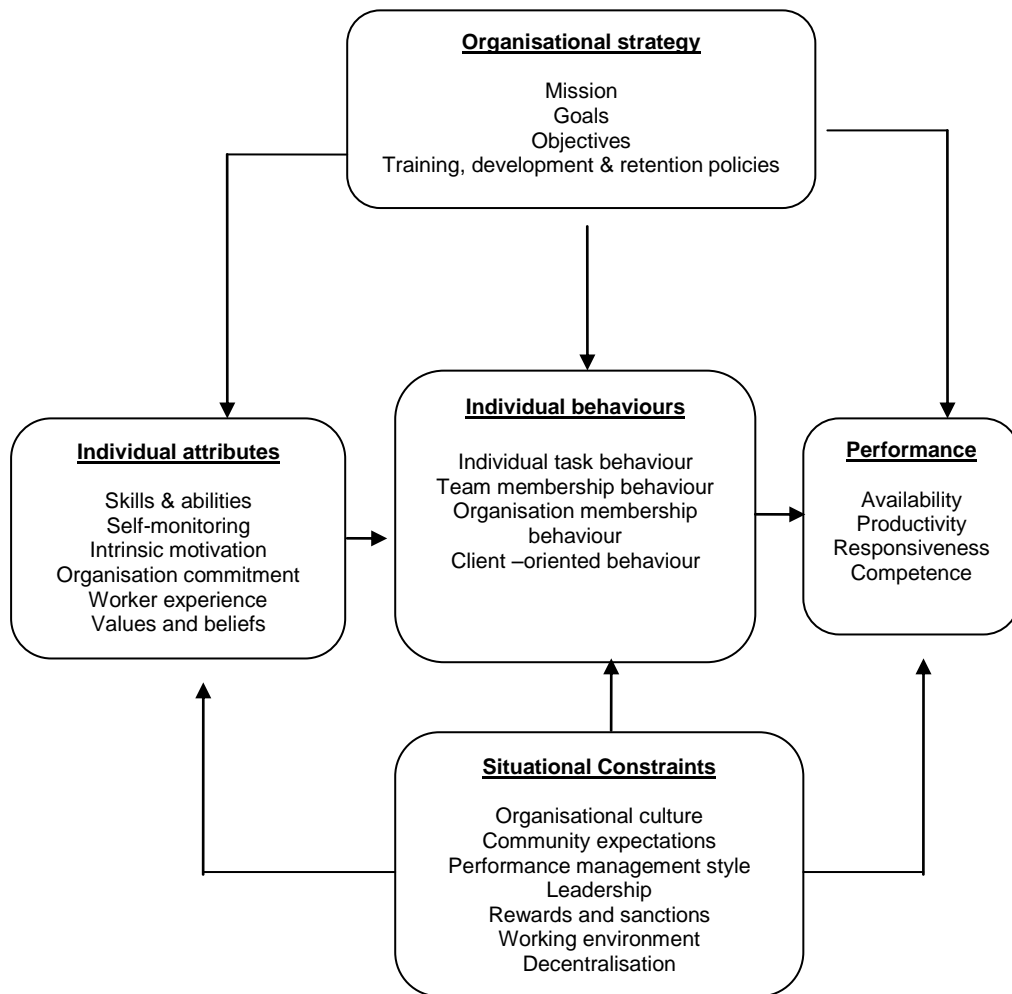
The following section presents the theoretical framework that the researcher used to structure and to maintain the focus of this study.

### **1.7.1 Theoretical framework**

Burns and Grove (2007:171) describe a theoretical framework as a brief explanation of the theory or those portions to be tested in a quantitative study. The theoretical framework forms the basis of explanation of what variable is expected to lead to another and the idea is usually expressed as a research question to be answered by the study methodology.

In this study, the researcher used the process model of performance developed by Noe et al (2008:345). In their model the authors suggest that individual attributes such as knowledge, skills, and personality are the vital ingredients for performance. Therefore, for an individual to perform these attributes have to be translated into behaviour. The individual behaviour will then lead to results. The authors further suggest that the various work groups and individuals must align their activities to the overall organisation strategy in order to achieve results. The model emphasises the impact of situational constraints on achievement of the individual and organisational results. The workers might have the necessary skills yet they may not exhibit the necessary behaviour. For example, a rigid organisational culture may discourage the employees from performing effectively. Lack of motivation may prevent workers from exhibiting the right behaviour especially if they believe that their activities will not be rewarded. Finally, workers may exhibit effective behaviour and yet results do not follow due to misalignment of their activities with the overall mission of the organisation (Noe et al 2008:344-345).

Figure 1.2 illustrates the theoretical model that guided this study, which the researcher calls 'the strategic performance model'. This model is an adaptation from Noe et al's (2008:345) performance process model. The researcher has named it 'strategic' in order to emphasise the call for alignment of individual attributes, behaviour and results to the overall organisational strategy.



**Figure 1.2: The strategic performance model (adapted from Noe et al 2008:345)**

The model consists of the following:

- *Organisational strategy* that include mission, goals, objectives, training and development policies, and retention policies.
- *Individual attributes* that include skills and abilities, self monitoring, intrinsic motivation, organisation commitment, worker experience, values and beliefs.
- *Individual behaviours* which include client-oriented behaviour, individual task behaviour, team membership behaviour, and organisational membership behaviour.

- *Situational constraints* that include organisation culture, community expectations, performance management style, leadership, rewards and sanctions, working environment and decentralisation.
- *Performance dimensions* that include availability, productivity, responsiveness, and competence of health workers.

### **1.7.2 Relevance of the theoretical framework to this study**

The theoretical model presented is very useful because it describes performance enhancing dimensions which the researcher explored at length. This model helped the researcher to determine and maintain focus of study. The model also assisted the researcher in organising literature review, data collection instruments, presentation of data, discussion of findings and the development of a performance management framework.

## **1.8 RESEARCH DESIGN AND METHODOLOGY**

Burns and Grove (2007:38) define research design as the detailed plan of how the study is to be conducted with full advantage of control over factors that could interfere with the desired outcomes. Mouton (2001:56) refers to research methodology as the research process and the kind of tools and procedures to be used. This study was descriptive and used mixed research methodologies to collect data from the participants. Mixed methodology is an approach where both quantitative and qualitative research methods are used at the same time or in a series of studies (Creswell, Plano-Clark & Garrett 2008:66). In order to achieve the study objectives and ensure that the research process was logical, two different study populations as well as two different methods of sampling and data collection were used (see Table 1.4). This was done in order to achieve methodological triangulation, which ensured the validity and trustworthiness of results (Polit & Beck 2008:309). The detailed discussion of the research design and methodologies is given in chapter 3.

**Table 1.4: Data sources, methods of sampling and data collection**

	<b>Level 1</b>	<b>Level 2</b>
<b>Source of data</b>	Health workers (doctors, clinical officers, and nurses/midwives)	Health service managers
<b>Method of data collection</b>	Self administered questionnaire	Semi-structured interview guide
<b>Nature of data</b>	Quantitative	Qualitative
<b>Sampling</b>	Probability	Non-probability

### **1.8.1 Level 1 of the study**

Level 1 used quantitative methods and the study population comprised of health workers (doctors, clinical officers and nurses) from the health facilities in Kumi, Mbale, Sironko and Tororo districts. In order to collect data on factors influencing the performance of health workers and the current practices used to manage performance, the researcher used probability sampling specifically stratified random sampling to ensure that the samples were unbiased (Polit & Beck 2008:340; Saunders, Lewis & Thornhill 2009:222). The researcher used the health workers' registers to list all the health workers in the respective facilities from which a sample was randomly drawn. A total of 331 health workers were included in the final sample and out of these 83.4% (n=276) completed questionnaires (see chapters 3 & 4).

The data was collected using a self-administered questionnaire, where the participants were asked to record answers in a structured manner. All the questions except one (see annexure H) were based on a 5-point Likert scale. The data was cross-checked for completeness, coded, and entered into a computer using the Statistical Package for Social Sciences (SPSS) version 18.0. A statistician cleaned and analysed the data, using the same version of SPSS. Statistical calculations were done for both descriptive and inferential statistics. The results were presented in the form of graphs, pie charts and tables (see chapters 4 and 5). Since data was collected using a tool based on ordinal scale (Likert scale), Spearman's *rho* rank order correlations ( $r_s$ ) were used to measure the association between two key variables (Polit & Beck 2008:766).



### **1.8.2 Level 2 of the study**

Level 2 of the study followed qualitative research methodology and the study populations were health services managers involved in human resource management at district, hospital, and health sub-district levels from the districts of Kumi, Mbale, Sironko and Tororo. The health service managers at the research sites were purposively selected for inclusion. Purposive sampling is a non-probability sampling method in which the researcher uses his/her own judgement regarding the participant from whom information is to be collected (Polit & Beck 2008:355). Level 2 of this study involved collection of qualitative data using a semi-structured interview guide (see annexure I) through face-to-face interviews. A tape recorder was used. The data collected was transcribed, coded, and analysed manually. Analysis involved creating categories, refining them and grouping them into themes and sub-themes before presentation, interpretation, and discussion. The researcher used the qualitative approach in order to get in-depth information on why performance is managed the way it is and to explore the views of health workers and managers on how their performance can be improved (see chapter 3 for details).

### **1.8.3 Design validity and reliability of level 1**

Validity and reliability are important notions for determining the suitability of the research instrument.

#### **Validity**

Validity is the suitability of instrument while reliability to its consistency in measuring whatever it is intended to measure (Polit & Beck 2008:457). In this study, the researcher used face, construct, and content validity (see details in chapter 3).

## **Reliability**

Saunders et al (2009:156 & 373) refer to reliability as “the extent to which data collection technique or analysis procedure yields consistent findings”. In this study, reliability was equated to clarity, quality, stability, consistency, adequacy and accuracy of the study instruments. Reliability was ensured through pre-testing of the questionnaires to ensure clarity of the questionnaire items and by ensuring anonymity of the participants to the questionnaires. Additionally, reliability of questionnaire items was tested by means of Chronbach’s coefficient Alpha ( $\alpha$ ), which is an index for testing internal consistency of the test items using SPSS. The Chronbach’s coefficient for all the questionnaire constructs was 0.70 and above except for one construct (question 30) which was 0.61 (see Table 4.2). As a rule, Alpha ( $\alpha$ ) should be at least 0.70 or higher (Amin 2005:298-302; Polit & Beck 2008:454-456). The details of validity and reliability of level 1 questionnaire are discussed in chapters 3 and 4.

### **1.8.4 Trustworthiness of the data obtained during level 2**

Lincoln and Guba (1985) cited in Polit and Beck (2008:539) propose four constructs for measuring the trustworthiness or soundness of the qualitative research approach. These include credibility, transferability, dependability and confirmability. In this study the researcher used these constructs to ensure trustworthiness of the study findings. The details of these four constructs are discussed in chapter 3.

### **1.8.5 Ethical considerations**

Polit and Beck (2008:753) describe ethics as ‘a system of moral values concerned with the degree to which research procedures adhere to professional, legal and social obligations of the participants’. Ethical consideration in research should consider fairness, honesty, openness, disclosure of methods, and the purpose for which the research is being carried out. Based on this

understanding, the researcher used the following ethical standards during the process of this study.

- Approval was obtained from the Research and Ethics Committee at the Department of Health Studies of UNISA (annexure A).
- Approval was obtained from the Uganda National Council for Science and Technology, the body responsible for ethical clearance for all research conducted in Uganda (annexure B & C).
- Permission to carry out data collection was requested from the district officials, hospital superintendents, and heads of the health sub-districts (annexure D & G).
- Informed written consent was obtained from all the health workers and their managers who participated in the study (annexure E).
- Privacy of the participants was respected at all levels.
- Confidentiality was maintained by protecting data collected from unauthorised access.
- The participants of this study remained anonymous by ensuring that their responses are not in any way linked to particular individuals.
- In addition to the questionnaires, the participants were provided with all the relevant information regarding the details of the study and the benefits of this study. The researcher also provided all the respondents his contact details (annexure F).
- The researcher respected the work of others through acknowledging the sources of information.
- The researcher reported what the data collected revealed and not what the researcher wanted to achieve. Hence, there was no distortion of data at any moment during this study.

The details of the ethical considerations are discussed in chapter 3.

## **1.9 SCOPE AND LIMITATIONS OF THE STUDY**

This study was conducted in four (4) districts in Eastern Uganda. Since the 1990s all districts are operating under decentralisation. The main focus of this study was limited to doctors, clinical officers and professional nurses. Other health professional cadres were not represented although they form part of the health workforce. This probably excluded some important findings from cadres of health workers that were not represented. Although stratified sampling by district, cadre, and level of health facility was used, the researcher observed that some districts had more staff in some strata than others. This was overcome by using proportionate stratified sampling (sampling ratio of 40%) to ensure representation of the target population.

The researcher used a structured self-administered questionnaire which was delivered by the researcher or research assistant and collected after one to two week. Some health workers were not able to fill the questionnaires and return them to the collection points on time. The researcher tried to overcome this by constantly reminding the health workers by phone to complete their questionnaires. However, since the researcher did not attain 100% response rate, some vital findings from non responders may have been left out. In addition, a structured questionnaire used to collect data from health workers does not permit probing, therefore, it was not possible to ask follow-up questions to achieve in depth inquiry about the research problem.

Lastly, at the time of the study, the researcher was working in Malawi, while the study was conducted in Uganda; therefore, a lot of travel was required. The researcher overcame this by applying for a special leave at the time of data collection and analysis.

## **1.10 STRUCTURE OF THE THESIS**

Chapter one presents the introduction and the background to the research problem. The statement of the problem, significance, aim and objectives, and

foundations of this study are put forward. Lastly, the research design and methodology, ethical considerations, scope and limitations of this research have been outlined.

Chapter two presents the review of relevant literature on the subject of performance of health workers. The conceptual framework is discussed in detail. The concept analysis of decentralisation and performance are also outlined.

Chapter three discusses in detail the research design and methodologies used in this study.

Chapter four deals with quantitative data analysis, interpretation, and discussion of the research findings.

Chapter five outlines qualitative data analysis, interpretation and discussion.

Chapter six presents the conclusions, limitation and recommendations arising from this study. In the same chapter the proposed performance management framework that was developed from the findings of the study is presented.

## **1.11 CONCLUSION**

Chapter one is the first stride to a comprehensive study about the performance of health workers in decentralised services in Uganda. In this chapter the researcher outlined the source and background to the research problem. The researcher presented the study aims and objectives; significance of the study, and has described the theoretical model that was used to guide this study. In addition, a brief account of the methodological orientation of this study is outlined. The researcher is optimistic that the outcome of this study will be beneficial to all parties concerned while at the same time contributing to the body of knowledge in the field of HRH.

## **CHAPTER 2 LITERATURE REVIEW**

### **2.1 INTRODUCTION**

Health workers' performance is a complex area to address because of a variety of influencing issues at different levels of health care. These issues are rooted in the ministries of health, districts, health facilities, individual health workers, and the communities. Health care delivery is highly dependent on manual labour. It needs skilled, competent, committed, responsive, and productive workers to achieve the mission and goals. As such, health workers are crucial to the delivery of health services. They manage other resources and a big percentage of the annual national health budget is spent on them (JLI 2004:21). Despite the achievements made since the introduction of market reforms in Uganda, little is known and published about the performance of health workers. Most of the studies done worldwide are focusing on performance of health systems and are not specifically targeted to health workers. In order to improve the health status of Ugandans and performance of health workers, policymakers need evidence to make informed decisions.

This research aims at developing a performance management framework that health sector stakeholders can use to improve service delivery. Its main contribution is geared towards the formulation of a framework for performance management that is specific to health workers. Performance management in the health sector is still deficient in Uganda and its implementation is not well documented. The performance management and appraisal guidelines used by health workers are similar to those used by other professionals in public service. Therefore, there is a need to have guidelines that are specific to health profession due to the complexity involved in health service delivery.

This chapter presents a review of existing literature relevant to the study. The review is aimed at identifying what is already known about performance of health workers in order to assist in identifying the grey areas that could be addressed by this study. The researcher identified and clarified the various determinants

that influence performance of health workers. Since there is insufficient information about performance of health workers in Uganda, this review presented performance from a general perspective. The following are the main areas of focus:

- The description of the components of the theoretical model which is illustrated in Figure 1.2.
- The concept of decentralisation of health services.
- The importance of human resources management practices as tools for managing performance.
- The discussion of the health workforce performance dimensions which include health workers availability, competence, productivity, and responsiveness.
- Performance management and appraisal of health workers.
- The role of leadership in guiding performance of health workers.

## **2.2 DESCRIPTION OF THE THEORETICAL FRAMEWORK**

The researcher based this study on the 'strategic performance model' adapted from Noe et al (2008:345) as illustrated in Figure 1.2. The 'strategic performance model' guided literature review, data analysis and presentation of results. The model makes reference mainly to the following concepts: individual attributes and behaviours, organisational strategy, performance dimensions and situational constraints. Noe et al (2008:345) describe individual attributes as key drivers of performance. These attributes must be translated into individual behaviours for performance to occur. The individual attributes and behaviours are influenced among other things by the organisational strategy and the situational constraints.

### **2.2.1 Individual attributes**

These are characteristics that make individuals unique and differentiate them from others. These can be related to what Armstrong (2009:300) and Baines, Asch, Hadfield, Mason, Fletcher and Kay (2005:496) describe as factors that influence individual performance since they are unique for every individual. Such factors include skills and abilities, self-monitoring abilities, intrinsic motivation, organisational commitment, worker experience, values and beliefs. Further attributes include personality, demographics, physiology and cognition. These factors influence performance in a number of ways. For example, skills and abilities dictate the capability of an individual to perform tasks as required (Kahya 2007:517). The extent to which an employee keeps his performance in check (self-monitoring) and his ability to take corrective action when performance falls below acceptable standards is vital. The cognitive ability can contribute directly to overall job performance through its effects on knowledge and skills acquisition (Kahya 2009:101; Ree, Earles & Teachout 1994:518). Additionally, Hackman and Oldham (1976:255) mention that the state of motivation such as job satisfaction is positively related to individual performance.

Authors like Baines et al (2005:499), Kahya (2007:515), and Viswesvaren and Ones (2000:223) emphasise that general cognitive ability and personality dimension of precision are strongly related to work performance. Moreover, they indicate that personality traits such as interpersonal skills, training and turnover are essential for performance of workers. Other writers such as Suliman and Iles (2000:415) and Van Scotter (2000:93) argue that in addition to the individual characteristics, several circumstantial and attitudinal factors are positively associated with work performance through motivation. Organisational commitment, job satisfaction and work-related attitudes, values and beliefs are particularly important factors for performance. The demographics and physiological factors such as age and gender are also relevant for work performance (Baines et al 2005:498; Kahya 2007:516).



### **2.2.2 Individual behaviour**

Behaviour is the way individuals conduct themselves in a specific situation and at a particular point in time. Armstrong (2009:301) emphasises that individual behaviour at work is dependent on both the personal characteristics (abilities, intelligence, personality, attitudes, and emotions) and the situation in which they work. Individual behaviours have a crucial role to play in determining work role performance (Kahya 2009:96). Health workers need specific behaviours to contribute to the desired health outcomes. Such behaviours are not directly under the control of central or local governments but are controlled at both the individual and organisational levels. These behaviours are directly related to performing job tasks (work roles) (Fritzen 2007:[2]; Perkins, Jensen, Jaccard, Gollwitzer, Oettingen, Pappadopulos & Hoagwood 2007:343).

In this study, the researcher investigated the work role performance behaviour of health workers as individuals (individual task behaviour), members of teams and organisations (team and organisation membership behaviours), and client-oriented behaviour. Murphy and Jackson (1999:335) and Kahya (2009:96) describe work roles as '...the total set of performance responsibilities associated with one's employment'. These responsibilities are carried out in conjunction with the behaviours just listed. Based on this definition, Griffin, Neal and Parker (2007:330) proposed a model of positive work role performance behaviours which address effectiveness in uncertain and interdependent organisational contexts. Griffin et al (2007:330), cross-classified the three levels at which work role behaviours contribute to effectiveness (individual, team, and organisation) and the three different forms of behaviour (proficiency, adaptability, and pro-activity) into sub-dimensions of work role performance. The researcher would like to use a similar approach in this study since it is a grey area especially in public health.

Individual task proficiency describes behaviours which fulfils the known expectations and requirements of the roles of an individual. Team proficiency behaviour reflects the degree to which the individual meets the expectations and

requirements of his roles as a member of a group. Organisation proficiency behaviours refer to how the individual contributes to the expectations and requirements as a member of the organisation (Griffin et al 2007:331). Kahya (2009:102) notes that behaviours involving cooperation, creativity, and self development contribute to performance.

Individual task adaptability describes the degree to which employees cope with or respond to changes that affect their roles. On the other hand, team member task adaptability, reflects how the individuals respond to changes that affect their roles as members of the group. Organisation member adaptability describes how the individuals cope with changes that affect their roles in an organisation (Griffin et al 2007:331-332).

Task pro-activity refers to extent to which individuals themselves or within a teams and organisation engage in self-directed and future oriented behaviour and toward changes in work situations. Such behaviour ensures that the organisation as a whole develops and innovates rather than promote change only within a department (Griffin et al 2007:332). Kahya (2009:102) explains the strong relationship that exists between creative performance and innovative effectiveness. The workers who score highly on creative performance generally obtain high outcomes in innovative effectiveness (Kahya 2009:102).

Another important variable for individual behaviour is the client-oriented (customer-oriented) behaviour. The term client orientation has been used constantly in marketing literature to explain an organisational posture in which the clients are main focus for the organisational strategy design (Noor & Muhamad 2005:126; Saura, Contri, Berenguer, Taulet & Velázquez 2005:497). At individual level client orientation is the willingness of the service providers to adjust their services delivery according to the needs, problems, and circumstances of the customers (Daniel & Darby 1997:272; Lanjananda & Patterson 2009:8). On the other hand, Hartline, Maxham and McKee (2000:35) and Noor and Muhamad (2005:126) define client (customer)-orientation at the

organisational level as ‘...the set of standards that puts the clients’ interests at the forefront , in order to develop a sustainable and profitable enterprise’.

Other scholars like Lanjananda and Patterson (2009:8) refer to client-oriented behaviour as ‘...the specific behaviours displayed by employees during service encounters that lead to satisfied customers. These behaviours may include empathy, assurance, responsiveness, authenticity, listening, dedication and civility (Lanjananda & Patterson 2009:9). According to Berry and Bendapudi (2007:111), health care is perhaps the most personalised service that clients search for. However, many studies document variations in the quality of care provided. Hence, the behaviours of front-line health workers such as nurses, clinical officers and medical doctors are critical for both patient satisfaction and successful health outcomes. It is therefore important to understand what behaviours predict the performance of health workers. This research, attempted to explain the performance of front-line health workers by simultaneously examining the individual attributes and behaviours, the situational constraints, and the organisational strategy.

### **2.2.3 Performance**

Performance has many dimensions. It involves delivering favourable results on time, within budget, and according to set standards (Department of Industrial Relations, Public Sector & Employee Relations (DIRPSER) 2005:5). Armstrong (2009:136) mentions that the notion of performance covers what has been achieved and how it is achieved. In this study, performance refers to availability, productivity, competence and responsiveness of the health workers (WHO 2006:68).

Whereas producing better health outcomes is important so is the aptitude to respond efficiently and effectively to the emerging challenges in the health sector. Since client satisfaction is a critical component of performance, it is important to create and maintain this ability. Performance management is concerned with the management of key relationships with clientele, work-mates,

higher-ranking managers and legislators. The realisation of performance targets and client satisfaction are both dependent upon employee performance. Therefore, performance is composed of efficiency and effectiveness of internal organisational procedures and ultimately depends on individual employee commitment. Managing health workers' performance, obtaining feedback regularly about workers' satisfaction with management procedures as well as monitoring the institutional environment are all crucial performance dimensions (DIRPSER 2005:5). The dimensions of health workers' performance are discussed in detail in sub-section 2.5.

#### **2.2.4 Organisational strategy**

This refers to the direction the organisation wants to take to achieve its goals (Noe et al 2008:69). Thompson, Strickland and Gamble (2010:6) define a strategy as '...the management's action plans for running the business and conducting operations'. Performance management is critical in supporting the formulation and implementation of the organisational strategy. The formulation of a strategy involves the establishment of five major components which include the organisation's mission, strategic goals, external analysis, internal analysis and the strategic choice (Noe et al 2008:75). The organisation's mission specifies the reason for existence and the strategic goals reflect on what the organisation intends to achieve. External analysis provides information about the threats and opportunities that exist within the organisation's environment whereas the internal analysis provides information about the organisation's strengths and weaknesses. Lastly, the strategic choice is the organisation's chosen plan that stipulates the way the mission and strategic goals will be achieved (Noe et al 2008:77). Hence, employee input and alignment of organisational activities to the mission is vital to strategy formulation and implementation.

Noe et al (2008:80) mention five variables that influence the success of strategy implementation. These include organisation structure, type of information and information systems, task design, selection, training and development, and employee reward systems. The last three variables are the direct responsibility

of human resource management function and the first two variables are influenced by human resources. Therefore, a performance management system provides a mechanism for steering organisations towards achieving their goals by facilitating the monitoring of existing strategies to ascertain the achievement of desired outcomes. When circumstances warrant change, performance management systems provide managers with a powerful tool to ensure the rapid change implementation (DIRPSEER 2005:5).

### **2.2.5 Situational constraints**

Situational constraints are contextual factors within and outside the organisation that are likely to affect the performance of health workers. These factors may also influence individual characteristics and behaviours (Noe et al 2008:346). Situational constraints may include organisation factors, working environment, and economic factors. Therefore, when evaluating performance of health workers, it is important to scrutinise situational factors that are likely to positively or negatively affect performance. These factors may either motivate or demotivate health workers. As illustrated in Figure 1.2, the researcher's focus is on the following situational constraints: organisational culture, community expectations, performance management style, working environment, leadership, rewards and sanctions, and decentralisation. For example, Kahya (2007:515) reports that poor working conditions (physical efforts, environmental conditions and hazards) may decrease employee performance. Such factors may consist of rigid organisational rules, lack of cooperation among co-workers in solving complex tasks, and absenteeism among others.

### **2.2.6 Justification for using the chosen theoretical framework**

The 'strategic performance' model provides a strong conceptual basis for this study as it emanates from the strategic management process. This model is built on the premise that a clear link must be established between the overall organisation's strategy and its human resource management strategy. The result of this endeavour is human resource practices geared towards the attainment

of the organisation's goals and objectives. Similarly, human resource management practices must be aligned to performance (Armstrong 2009:146). Human resources management practitioners like Armstrong (2009:147) have established that well executed human resources management (HRM) practices positively influence employee performance.

The use of the 'strategic performance model' is justified in this study because it guided the researcher's quest to achieve the research objectives. The model helped the researcher answer the question of what factors impede or enhance the performance of health workers. Could it be that health workers do not understand the mission, goals and objectives of their organisation or the top management does not support employee skills advancement through training, development and proper employee retention policies?

Perhaps the organisational culture contradicts with expected health outcomes, or the community expectations and health objectives are not in harmony? It could be that the human resource management practices such as performance management style, leadership, rewards and sanctions as well as the working environment are impediments to the desirable performance.

In addition, individual attributes such as skills, abilities, self monitoring, intrinsic motivation, commitment to the organisation, work experience, values and beliefs can all either promote acceptable performance or hamper it. If individual health worker's behaviours do not support the overall health service provision goals, poor performance is to be expected. However, when the health workers portray positive individual task behaviours, team membership behaviours, organisation membership behaviours and client centred behaviours, performance could be enhanced.

Indeed the strategic performance model assisted the researcher to develop a viable performance management framework which will guide performance management practices to ensure availability, productivity, responsiveness and competence of health workers. Additionally, the opinions and suggestions of

health workers were sought on how to improve performance of health workers specifically in line with organisational strategy, situational constraints, individual attributes and behaviour.

Overall the theoretical model presented is very useful because it describes performance enhancing dimensions which the researcher would like to explore at length. This model aided the researcher to determine and maintain the focus of the study. The model also assisted the researcher in organising literature review, data collection instruments, presentation and discussion of the findings as well as the formulation of recommendations.

### **2.3 THE CONCEPT OF DECENTRALISATION OF HEALTH SERVICES**

The term 'decentralisation' in the context of health services, is used to label a variety of reforms characterised by the transfer of fiscal, administrative, and political authority for planning, management, or service delivery from the central Ministry of Health (MoH) to alternate institutions (Mitchell 2009:216). These recipient institutions may be regional or local offices of the same ministry, local governments (such as the districts), autonomous public service agencies (such as Health Service Commission (HSC) and DSCs), or private sector organisations (Bossert & Beauvais 2002:14; Mitchell 2009:216). During its implementation in Uganda, it was anticipated that decentralisation would enhance performance in the health sector in the following ways:

- efficiency in resource allocation by allowing the services and expenditure to be determined by preferences of the clients ;
- enhanced technical effectiveness through increased cost realisation at grassroots level;
- innovative delivery of service tailored to local client needs by way of ongoing trials ;
- better service quality and transparency due to participative decision making;

- equitable resource distribution catering for the needs of previously disadvantaged places and populations (Bossert & Beauvais 2002:14; Mitchell 2009:217).

Internationally, there is considerable interest in revitalising primary health care (PHC) and strengthening health systems especially in low and middle-income countries (WHO 2008:xiii). Recent reports suggest the need for expansion of access to PHC services and organisational reforms to attain 'close-to-client' approaches that make services more relevant and responsive to the needs of communities. Decentralisation in particular, has been promoted as a means for improving the responsiveness and effectiveness of health systems in developing countries. Advocates for decentralisation argue that shifting financial and administrative control of health services to local authorities can improve efficiency in allocation ('doing the right things'), as distinct from technical efficiency ('doing things right'). Decentralisation increases accountability, responsiveness to the recipients of health services, and facilitate the mobilisation of local resources (Mitchell 2009:217). In the case of primary health care, further arguments for decentralisation include potentially improved community participation and integration with specialised hospital care, and more effective collaboration between health and non-health sectors (Guanais & Macinko 2009:1127). On the contrary, critics point out that decentralisation can instead lead to increased fragmentation of services and management practices that provide political or financial gains to local authorities. Furthermore, decentralisation may weaken the central ministries of health, and increase inequities in health care among regions or districts (Bryant 1999:12; Guanais & Macinko 2009:1127).

### **2.3.1 The approaches to decentralisation**

Mills (1994:282-283) and Munga, Songstad, Blystad and Maestad (2009:[2]), describe a four-fold typology of different forms of decentralisation that can be applied to community health, these include: **deconcentration, delegation, devolution, and privatisation.**



- *Deconcentration* is the shifting of power from the central government to the district offices within the structure of MoH.
- *Delegation* shifts responsibility and authority to autonomous and semi-autonomous institutions (such as HSC and DSC).
- *Devolution* is the shifting of responsibility and authority from the central offices of the MoH to local government (such as districts, health sub-districts and sub-counties).
- *Privatisation* relinquishes operating responsibilities and sometimes ownership, to private service providers with clearly defined contracts of what is expected in return for public funding (Bossert & Beauvais 2002:14; Kolehmainen-Aitken 2004:[2]; Mills 1994:282-283; Munga et al 2009:[2]).

### **2.3.2 Decentralisation of health services in Uganda**

The form of decentralisation in the public health sector in Uganda can be described as devolution. There is 'shifting of authority away from the central government to local administrative and political structures. Decentralisation reforms involved three main components namely political, administrative, and financial. Decentralisation in Uganda has transferred all political and administrative powers from the central government to the local governments. The districts now have the responsibility to deliver health services and manage the health personnel (Bossert & Beauvais 2002:16; Mitchell 2009:222-223).

Decentralisation of the public health sector is an integral part of Uganda's government reforms. Politically, the district health sector is governed by the District Health Committee (DHC), whose membership is drawn from the LC V. The non-hospital-based care is headed by the DHO, previously known as the District Director of Health Services (DDHS). The DHO reports to the Chief Administrative Officer (CAO), who is the civil servant in charge of the whole district administration. The DHO is assisted by the District Health Management Team (DHMT), comprising technical officers in that office. Since the fiscal year 1998/99, the management responsibilities of district hospitals have also been

transferred to the districts under the DHO. The national and regional hospitals, however, are still directly under the MoH (Jeppsson 2004:23).

Several reforms have taken place in line with the decentralisation policy during the last 17 years. They were aimed at establishing a single, coordinated, comprehensive district health system. The District councils (LC Vs) are responsible for providing health services to their local area residents, and whoever provides health services in the district does it on their behalf. It is the responsibility of the DHO to ensure that all health care activities are coordinated, and health providers are supported. A more recent development is the introduction of Health Sub-Districts (HSDs). These are functional zones within the district health system, established around an existing hospital or Health Centre IV (HC IV). This is the lowest unit to employ staff physicians, and the lowest to offer elective surgery. The purpose of establishing HSDs is to bring qualified health care personnel closer to the people. However, the management structures at the HSD level remain unclear and are at present not supported by any central guidelines. Sub-county local councils (LC IIIs) have been established and are operational in all districts. The planning capacity of sub-counties in different districts (and even within one district) varies greatly. There are also large regional variations in the status of health infrastructure and staffing patterns (Jeppsson 2004:25).

Following the shift of managerial powers to the local governments, the recruitment, disciplining, and dismissal of staff are now under the jurisdiction of the DSC. Prior to decentralisation, this used to be the duty of the central MoH. Despite the fact that the MoH knew the country's needs, the distribution of health personnel was inequitable, and some marginalised districts had critical staff shortages. Following decentralisation, the vacant posts are now advertised, and recruitment is done by the DSC. However, the inequity between remote and centrally located districts remains a major challenge (Jeppsson 2004:25; Mitchell 2009:225; Munga et al 2009:[8]).

Under decentralisation, the functions of the central government are now directed towards policy formulation, planning, inspection, provision of technical supervision to local governments, and management of national health programmes and projects. The health services delivery now lies within the framework of the districts. Each district, through its DSC has the power to recruit, discipline, and dismiss health workers. In order to ensure uniformity in all the districts, the Ministry of Public service (MoPS) standing orders still govern the conditions of service in the country (Bossert & Beauvais 2002:16; Jeppsson 2004: 26; Mitchell 2009:216).

### **2.3.3 Decentralisation and human resources for health (HRH)**

The MoH in Uganda (2006:1) defines human resources for health (HRH) as ‘...all persons, with or without formal training, who contribute towards the improvement of health’. This includes all health workers, whether they are employed by the public service, non-governmental organisations or the private sector. In this study, the researcher has focused on medical doctors, clinical officers, and professional nurses.

The architects of decentralisation have focused more on the financial and structural reform measures but ignored the human resource implications. Kolehmainen-Aitken (2004:[1-2]) and Munga et al (2009:[7]) point out that in many countries technical health experts have not been adequately incorporated in designing and planning the decentralisation processes. Evidence shows that re-allocation of roles and responsibilities that usually occur during decentralisation always affect the health workers performance. This is true, irrespective of the extent to which health managers are allowed to shape decentralisation and the management structures (Munga et al 2009:[7]). Van Lerberghe, Adams and Ferrinho (2002:525) and Mitchell (2009:226) observe that there is no evidence to automatically link decentralisation to more effective management of human resources. In most low-resource countries, local managers do not have staff adequately trained in personnel administration and they know little about the

simple systems of managing workforce performance (Esmail, Cohen-Kohler & Djibuti 2007:[7]; Mitchell 2009:224-225).

Decentralisation raises a number of crucial human resource issues that often frustrate effective performance which may subsequently instigate substantial agitation among health workers. Kolehmainen-Aitken's (1999:39) findings indicate that numerous performance problems were experienced because human resources issues were inadequately addressed under decentralisation. Academics mention that the performance of health workers in countries such as Papua New Guinea, Philippines, Nicaragua, and Zambia has deteriorated due to unclear definition of roles between the central and local government workers; inappropriate human resource planning capacities; inadequate management training; and in consideration of the motivation of the workers (Bossert 2000:65; Bossert & Beauvais 2002:28; Kolehmainen-Aitken 1999:39; Mitchell 2009:227).

Kolehmainen-Aitken (2004:[4]) explains that in order to enhance the performance of health workers, the local government health service managers should be able to measure workforce performance, conduct employee support supervision, and effectively address the performance gaps identified. The health service managers must ensure that their workers have the essential resources and equipment required to execute their duties. Employee motivation directly influences performance. Therefore, it is often challenging to address all these issues under decentralisation where the management tasks are performed by managers with insufficient experience in managing human resource. Additionally, in most instances the tools used for performance appraisals are out-of-date and unclear to local personnel managers (Esmail et al 2007:[6-7]; Mitchell 2009:228; Tong, Straussman & Broadnax 1999:193). In countries like Tanzania and Mozambique decentralisation has led to confusion in supervision responsibility. This confusion has weakened technical supervision capabilities and consequently to reduction in the number of supervisory visits to the health facilities (Munga et al 2009:[8-9]; Saide & Stewart 2001:156).

Decentralisation usually requires a change in staffing requirements, such as the need for new management skills. Both decentralised and centralised levels need new roles, expertise, and job descriptions. The new powers and responsibilities devolved to health facilities dictate that health workers and managers assume new roles in order for them to coordinate, negotiate with local and national officials as well as make dependable decisions. This calls for training of existing employees in new skills and recruitment of new personnel with new skills and abilities (Bossert 2000:65; Mitchell 2009:225; Munga et al 2009:[9]).

Devolution has a devastating impact on employees as they are separated from the comfort and salary scales of the national civil service. The aim of decentralisation is to enable lower level managers to be in charge of hiring, firing and employee motivation. The ability to control human resource functions is vital for improving the quality and efficiency of health services. One of the key problems of public service is the propensity to use job security and patronage for political purposes. The result is usually the reduction in workers' efficiency. On the positive side, civil service protections and regular salary scales offer some security for technical workforce from the subjective personal and political criteria for hiring and firing. Health workers' unions have engaged in endless battles to establish safer jobs and salary gains through the national health system (Kolehmainen-Aitken 2004:[5]). For example, the Zambian health workforce has engaged in a process of 'de-linkage'. In this process some MoH employees have been successful in competing for positions offered by the local health boards, in some instances at higher salary scales. However, this process seems to have stopped recently (Bossert 2000:66). The other effect of this separation is the disruption of career development for health experts in a joint public service; leaving few options for career development for those at the devolved health facilities. In an integrated health system, health professionals normally commence their careers in primary health care facilities and gradually progress either into hospital services or into public health administration, beginning at the district level up to national level. The devolution of the primary health care facilities usually eliminates this direct career progression and confines the career development of the devolved workforce (Bossert 2000:66; Kolehmainen-Aitken 2004:[6]).

Health care experts, who are more familiar with central level managerial positions, frequently struggle to be held directly accountable to local politicians (Mitchell 2009:225; Munga et al 2009:[9]). For instance, in Chile and Bolivia, political leaders in some rural municipalities were considerably less educated than the local health facility physicians and nurses. Such scenario often created decision making conflicts. Physicians would usually resist duties assigned. Sometimes, in order to avoid potential conflicts the physicians would avoid recruitment by these local governments. The local politicians sometimes have their own agendas and want to exploit the health services for their own benefit and patronage such as 'recruiting supporters as health workers' (Bossert 2000:67).

Access to opportunities for career development is vital for performance. Health services managers mainly from the lower level health facilities have contradictory attitudes. Much as they may want to fill vacant positions with suitably trained health workers, they are usually hesitant to let them go for further studies. Workforce shortages may be so severe in such health facilities that there is no one to substitute the personnel who go for further training. Some studies have indicated that decentralisation has actually reduced the prospects of professional development and career mobility (Kolehmainen-Aitken 2004:[7]).

Lastly, the literature demonstrates a negative effect of decentralisation on staff motivation. This is mainly because of the perception the health workers have concerning the poor working conditions and the inadequate salaries that have resulted from the decentralisation (Esmail et al 2007:[7]; Kolehmainen-Aitken 2004:[7]). Bach (2001:1) and Hagopian, Zuyderduin, Kyobutungi, and Yumkella (2009:w863) emphasise that health service managers need to pay sufficient attention to handling issues surrounding the working conditions and professional development that may influence health workers' motivation and performance.

## 2.4 HUMAN RESOURCE MANAGEMENT

Human resource (HR) practitioners have different perspectives on the definition of human resource management (HRM). Different authors put emphasis on diverse aspects of HRM. Nel, Werner, Haasbroek, Poisat, Sono and Schultz (2008:6) describe human resources management as ‘...the productive use of people in achieving the organisation’s strategic objectives and the satisfactions of their individual needs’. Snell and Bohlander (2007:4) refer to human resource management as ‘...the process of managing human talent to achieve the organisation’s objective’. Other authors like Noe et al (2008:4) define the concept of HRM as ‘...those policies and practices that might influence the attitudes, behaviours, and subsequently the performance of workers’.

Buchan (2004:6) asserts that HRM function in the health sector has a number of distinctive features because:

- The health labour force is big and is divided into different professions (such as doctors, nurses, clinical officers, pharmacists among others) with varied expertise;
- the health personnel like doctors and professional nurses pay more allegiance to their profession and clients rather than to their managers;
- the entry into most health training institutions and programmes or service is based on strict criteria and standards determined by the respective professional associations or councils;
- the health sector is one main recipient of public funds with a lot of political involvement; and
- health service delivery involves a lot of manual labour and big proportions of the annual national health budgets are spent on health personnel as compared to the expenditure on non-health workforce.

In order to achieve workforce performance, Nel et al (2008:6-8) emphasise the need for human resource management to create a fit between the dynamic components of the organisation which are:

- the individual employee;
- the job;
- the organisation itself; and
- the environment.

Human resource management practises are so highly interrelated that if executed well, can contribute not only to individual success but also to the overall success of the organisation. The sequence with which the HR practises are carried out plays an essential part to their success. Ideally human resource managers must begin by identifying the HR strategy that is, how the HR function will be organised in the quest to achieve organisational mission. It follows therefore, that HR strategy must be properly aligned to the overall organisational strategy.

Secondly, the HR department embarks on human resource planning to determine future demand and supply for human resources. This is followed by recruitment, selection and induction. The new recruits must undergo training to help them attain optimum performance in their jobs. They also need to be prepared for future jobs through continuous development. At this stage the employer has done the prerequisites and therefore expects better performance. This is where performance management becomes useful. Employee compensation is largely dependent on how well they perform. If the employer is pleased with the employee's performance he may go to an extent of providing lucrative benefits, services, and career planning opportunities to keep the morale high.

#### **2.4.1 The value of human resource management in performance**

For many years, HR experts believed that their function enhances performance. Liu, Combs, Ketchen and Ireland (2007:504), mention that human resource management practices mould performance through three main channels namely:

- raising the workers' knowledge, skills and abilities;



- motivating workers to leverage their knowledge, skills and abilities; and
- empowering workers to achieve the desired results.

Liu et al (2007:507) argue that high level of knowledge, skills and abilities among workers are prerequisites for effective performance. When the workers only know the regular tasks of their jobs, they cannot contribute productively to the organisation outside their allocated tasks. Additionally, when workers have the essential knowledge, skills and abilities that enable them to work beyond their regular functions they are not likely to do so unless they are adequately motivated. Furthermore, well-informed, skilled and inspired employees will not use their valuable time and capacities without favourable organisational structure and job designs..

#### **2.4.1.1 Enhancing worker's knowledge, skills and abilities**

The performance of health workers is crucial because it has an instant effect on health care delivery and eventually on the health of the population. According to World Health Organization (2006:67), the performing health workforce is one that functions in responsive, reasonable and proficient ways to achieve the superior health results. Proper selection, training and development, and compensation practices can enhance health workers' performance.

##### **2.4.1.1.1 Selection of workers**

Selection of employees is the critical step towards building a productive health workforce. Snell and Bohlander (2007:234) define selection as '...the process of choosing individuals who have relevant qualifications to fill existing or projected job openings'. Selection involves choosing the best applicants to fill a position (Grobler, Wörnich, Carrell, Elbert & Hatfield 2006:182). Thoroughly planned selection procedure assists in identifying the precise set of knowledge, skills and abilities required for the jobs (Liu et al 2007:505). It is very important during the selection process to identify the fit between the individual and the job as well as

between the worker and the organisation's culture and values. The lack of the fit between the job and the candidate as well as between the candidate and the organisational culture may lead to poor performance and lack of commitment (Kristof-Brown, Zimmerman & Johnson 2005:315). Studies have demonstrated that good selection practices contribute greatly to job satisfaction, organisational commitment, and reduce staff turnovers (Saks & Ashforth 1997:395).

#### **2.4.1.1.2 Training of health workers**

Training is defined by Noe et al (2008:267) as '...the planned effort by an organisation to facilitate employees' learning of job-related competencies'. These competencies include knowledge, skills and behaviour that are critical for successful work performance (Kahya 2009:102).

The health workforce needs the latest knowledge and skills to execute their duties well. Insufficient knowledge, skills and improper attitudes can be impediments to quality health care. Advances in medical field such as treatment and diagnosis, and the changing roles and responsibilities within the health sector require continuous professional development (Dieleman & Harnmeijer 2006:16). The WHO (2006:82) suggests that constant learning process must be developed at the commencement of a health profession career. Various methods are used to upgrade the skills and knowledge of health workers. Low cadre health workers (such as nursing assistant) who attend a few weeks or months of pre-service education have varying learning requirements from high cadre staff (such as doctors or professional nurses) with long duration of training and experience. Despite these differences, there are some common principles which underlie any approaches to health professional development. The approaches that may be used for professional development may be categorised either as individual or organisation-wide. The individual approaches are training courses, continuous professional development and web-based training and access to information. The team or organisation based approaches include retreats, teleconferencing, and collaborating workspaces (WHO 2006:83).

In low resource settings like Uganda, the commonly used methods are training courses and seminars that are organised away from the duty stations. Some writers however doubt the usefulness of these learning interventions since there is no evidence to prove their effectiveness (Rowe et al 2005:1028; WHO 2006:83). This is possibly due to lack of problem analysis and training needs assessment (Potter & Brough 2004:336). Additionally, it may be due to the mismatch between the training content, skills required, the choice of target group, and the training methods used (Mathauer & Imhoff 2006:[11]; Morgan & Deutschmann 2003:21). Apart from training subjects and methods, access to training opportunities among health workers also vary, with rural areas at a disadvantage (Dieleman et al 2006:[6]; Mathauer & Imhoff 2006:[11]). The WHO (2006:82), however, points out that the formal training courses organised outside the duty stations are known to be inadequate in modifying the clinical practice of the health professionals. In-service training courses can successfully transform the practices and behaviours of health personnel when it is interactive, using real-life situation, and when followed by ongoing support supervision.

#### **2.4.1.1.3 Compensation level**

Grobler et al (2006:35) emphasise that ‘...compensation does not only refer to extrinsic rewards such as salary and benefits but also to intrinsic reward such as achieving personal goals, autonomy and more challenging job opportunities’. Indeed, Noe et al (2008:486) point out the need to align the compensation policy with the overall organisation strategy. Compensation level is one of the most important dynamics affecting job choice. It determines whether the prospective worker will accept or reject the job. Ideally, the compensation system should promote the organisational culture and employee behaviours necessary for achievement of the organisation’s strategic goals. Liu et al (2007:506) maintain that attractive compensation helps to build the organisation’s image as an employer of choice and further leads to attraction and retention of high quality workers. In highly routinised work such as health care delivery, staff with high level of knowledge, skills and abilities has less opportunity to make improvements. Additionally, paying extra to have knowledgeable and skilled

employees is of little value if there is lack of motivation or workers confront problems in applying their skills. While investing in higher compensation pays off, managers have to ensure that they are able to take advantage of the higher knowledge, skills and abilities, which such compensation generate (Liu et al 2007:506).

#### **2.4.1.2 Motivation problems and enhancing practices**

Armstrong (2009:317) describes the term motivation as ‘...the goals individuals have, the ways in which individuals choose their goals and the ways in which others try to change their behaviours’. Therefore, motivation is about getting individuals to move in the right direction in order to achieve the desired results. Workforce literature has put a lot of focus on the relationships between the conditions in which health personnel operate and performance. According Fritzen (2007:[3-4]) one useful way to think about how to boost health workers’ ability to perform maximally, is to think of what they ‘can do’ (the skills and training that enables them to perform) and what they ‘will do’ (motivation and empowerment). On the ‘will do’ side, literature emphasises the need to consider a wide range of factors that affect health workers’ motivation. Fritzen (2007:[5-6]) classifies these factors into those that are obvious (day-light factors) and those that are hidden (shadow-side factors). The day-light factors include the workers’ terms of service, managerial goal setting, performance management, and prospects for career growth. The shadow aspects include informal organisation culture and expectations, alternative source of income, and the strength of professional ethics and social expectations. All these can influence the motivation and performance of health workers (Fritzen 2007:[6]).

Manongi, Marchant and Bygbjerg (2006:[6]) report that incentives for positive performance are very weak and even non-existent in most health sectors of developing countries. In their study in Tanzania, Manongi et al (2006:[5-6]), found that workers felt that they had very little to gain from working hard or being responsive to either the patients or superiors. The poor career paths and promotion opportunities led to health workers feeling stuck, while their salaries

are very meagre to meet most of their needs. Hence, health workers ended up engaging in part-time work in the private sector or in totally different informal occupations in order to improve their income. Liu et al (2007:506) established a positive link between incentives compensation and performance of workers. The WHO (2006:75) maintains that three aspects of compensation have a bearing on the performance of the health personnel. These include the level and steadiness of pay; the system used for payment; and the presence of other motivators. The health personnel should be compensated, rationally for the duties they perform. Poor remuneration and a sense of inequality negatively affect their performance.

Several authors such as Kolehmainen-Aitken (2004:[5]) and Fort and Voltero (2004:[4-5]) report that performance management and strategic planning systems for health workers are very weak or even non-existent in most low income countries. For example, a study done in Cambodia by Men, Grundy, Rasmey, An, Soeung, Jenkinson, Boreland, Maynard and Biggs (2005:12) found lack of effective systems for performance management of health workers. There was no system linking the individual performance goals and functions to the organisational strategy or rewarding strategy. There was also lack of compensation or rewards for appropriate initiative and behaviours (Men et al 2005:10). Some of the reasons for lack of effective performance systems in public services of developing countries include prerequisites such as living wage and availability of drugs. When such necessities are lacking, one cannot hold health workers accountable for poor performance in their jobs (Kolehmainen-Aitken 2004:[6]). According to Liu et al (2007:506) strategies that encourage promotion of workers from within the organisation are becoming more popular nowadays due to their motivating effects. Internal promotion procedures aid the employees to envisage clear prospect concerning their potential which inspires them to perform better and increase their skills and abilities for successive positions.

The 'shadow aspects' of the health systems have been found to reduce the morale of health workers. Kyadondo and Whyte (2003:338-340), mention that informal organisational norms and work ethics of some front-line health workers

in rural locations in Uganda are more oriented towards alternative livelihood strategies for survival than they are towards high standard of service delivery. In Vietnam for example, Dieleman, Cuong, Anh and Martineau (2003:[9]) report that maintaining the sense of professionalism of health workers is weak, especially in rural areas, where workers feel that commitment of the central and local governments to attend to their problems and social expectations is lacking. A strong and positive organisational culture can be as effective as incentives in motivating health workers.

While remuneration and job security are important determinants of morale, many organisations in low resource settings are found to significantly improve performance of health workers by cultivating a participatory and open performance oriented culture. In culturally oriented organisations the results of all the group members should be evaluated regularly against comparable performance objectives and indicators (Krogstad, Hofoss, Veenstra & Hjortdahl 2006:[7]).

#### **2.4.1.3 Employee empowerment and enhancing practices**

Heizer and Render (2008:199) refer to employee empowerment as ‘...the involvement of the workforce in every step of decision making process’. The designs of work processes that consistently produce the desired quality services require involvement of those who understand the weaknesses of the system.

Employee empowerment techniques include:

- nurturing open communication systems that engage the workers;
- promotion of open supportive supervision;
- shifting responsibility from top managers to service level (operation level) workers;
- developing high morale in organisation; and
- building recognised structures such as quality circles and teams (Heizer & Render 2008:200).

Liu et al (2007:507) emphasise the link between employee participation and performance. Employee participation is the extent to which workers can influence decisions. In institutions that support employee involvement, the workforce is allowed discretionary initiatives, contribute to decision making, and share views related to their employment. This gives a chance to the employees who are more conversant and competent about their duties than their supervisors to spot and correct mistakes. Furthermore, employee participation supports efforts for continuous innovation within the organisations (Liu et al 2007:507). Wright, McCormick, Sherman, and MacMahan (1999:551) point out that the complete benefits of workers' involvement are only realisable if the workers have the knowledge, skills and abilities to make good decisions and have the right motivation..

Researchers have reported a positive relationship between flexitime and individual performance (Liu et al 2007:507). Many organisations in the developed world are offering flexitime as a way to attract and retain workers. Similarly, job-sharing, telecommuting and part-time work allows workers to have greater control over their schedules. Such practices allow workers to remain focused and fulfil their responsibilities both at their workplace and at home (Liu et al 2007:507).

Some authors report that grievance procedure has an effect on performance of employees. Grievance procedures provide a formal avenue for employees' voices to be heard in case they are not satisfied with their work environment. Grievance procedures are said to empower workers by offering an opportunity for resolving disagreements with managers and other employees. If the workers realise that complaints procedures are fair and efficient, then they are more likely to be contented with the results or outcomes (Liu et al 2007:507; Peterson & Lewin 2000:395).

Employment security is another employee empowerment practice. Employment security is thought to enhance the level of commitment of the employee to the organisation. Ahmad and Schroeder (2003:19) and Liu et al (2007:507)

emphasise that devoted workers usually subscribe to the organisation's strategy. Moreover, a stable engagement helps the workers to build long-term and broad view of their employment.

## **2.5 PERFORMANCE OF HEALTH WORKERS**

Performance has many dimensions. It involves using the available resources to deliver timely results based on the standard procedures and circumstances (Armstrong 2009:136; DIRPSEER 2005:5; Langdon 2000:12; Noe et al 2008:344-345). While delivering results is of current importance, it is crucial for the organisations to have the potential to effectively respond to future challenges. Creating and sustaining this potential is vital for performance. Client satisfaction is the fundamental aspect of performance. Thus, performance of health personnel is important because of its direct impact on health service delivery and on the wellbeing of the population (WHO 2006:67).

Performance is about managing vital relationships with all stakeholders including the clients, contractors, managers, and community leaders. The attainment of results and meeting the patients' expectations depends on the way the health workers carry out their duties. Therefore, performance involves good organisation of the tasks and adding value to internal management procedures. Good performance depends on the dedication of the employees. Ongoing support supervision of the workers; obtaining regular feedback from the workers concerning the organisations management actions; and the regular review of organisational environment are all essential performance variables (DIRPSEER 2005:3; Noe et al 2008:344).

The WHO (2006:67) defines a well-performing workforce as '...one that works in ways that are responsive, reasonable and proficient to achieve the paramount health outcomes'. Poor performance of health workers leads to lack of access to quality health care. This results in inadequate health outcomes because the clients may not use the services due to neglect by the health personnel (Dieleman & Harnmeijer 2006:5).



## **2.5.1 Dimensions of health workforce performance**

The WHO (2006:68) suggests four dimensions that determine how health workers perform. These dimensions include availability, responsiveness, productivity and competence. In this study, the researcher looks at the performance of health workers in terms of these four (4) dimensions.

### **2.5.1.1 Availability of health workers**

Availability refers to having the right numbers of health workers, in the right locations, at the right moment and with the necessary expertise (Buchan 2005:3-5). Another author (Manuwa-Olumide 2009:5), refers to availability as ‘...the distribution and attendance of health workers’. Health workers form the backbone of the health system. They assist in the execution of health service delivery (Anyangwe & Mtonga 2007:93). It is the responsibility of the respective governments to facilitate access of its citizens to affordable and appropriate health care, however in many developing countries the health systems are faced with a range of personnel problems. Some of these challenges include lack of and inequitable distribution, as well as attrition of skilled health personnel (Stilwell 2004:21).

Internationally, there is increasing recognition that health worker shortages affect nearly all countries. Amidst the shortages, there is also a challenge of global mal-distribution of the available workers. Chen, Evans, Anand, Boufford, Brown, Chowdhury, Cueto, Dare, Dussault and Elzinga (2004:1984) observe that in order to achieve the health related MDGs, the minimum level of health workers required is estimated to be 2.5 health workers per 1000 people. In sub-Saharan Africa, the health workforce averages to only 0.8 health workers per 1000 people, which is considerably lower compared to other regions of the world (Chen et al 2004:1984).

Anyangwe and Mtonga (2007:94) observe that availability of health workers is one of the indicators that distinguish the developing from the developed

countries. In ideal situations, the poor countries (like most of the sub-Saharan countries) with the highest burden of disease should have the largest health workforce. Regrettably, most sub-Saharan African countries have the lowest concentration of health workers. Studies have reported disparities in the distribution of health workers even within the same country, with large concentrations of well qualified health personnel in urban areas (Anyangwe & Mtonga 2007:95).

Shortages of health workers affect performance of the existing staff because health care delivery is a labour-intensive industry. There is need to have sufficient health care providers to treat and care for the patients (Anyangwe & Mtonga 2007:97). Studies have revealed positive correlations between availability and concentration of health workers and the quality of health care. Therefore, as the number of health workers drops, the ability of health care systems to deliver quality services is compromised (Awofeso, Schelokova & Dalhatu 2008:[1]; JLI 2004:23; Mercer & Dal Poz 2002:1).

In Malawi and Zambia for example, the growth in the number of health facilities has surpassed the capacity of governments to staff them (Dovlo & Martineau 2004:40). Consequently the rural population suffers the impact of reduction in health personnel since they are least preferred by health workers. Health workforce shortages in health facilities increase the workload on those who remain. The shortage also limits access and reduces the quality of health care. Furthermore, waiting times are longer and often facilities are staffed with unqualified health personnel. Sometimes even clients seen by qualified personnel are put at risk due to time constraints and fatigue of health workers (Padarath, Chamberlain, McCoy, Ntuli, Rowson & Loewenson 2003:26). It is therefore imperative for governments to focus on the availability of health workers by providing some incentives as one way to attract and retain them in their jobs. This, coupled with other actions will help to improve the performance of health workers.

### **2.5.1.2 Responsiveness of health workers**

Heizer and Render (2008:212) define responsiveness as ‘...the willingness or readiness of employees to provide a service’. The Department for International Development (DFID) (2006:1) describes responsiveness as ‘...the extent to which service providers demonstrate receptiveness to the opinions, grievances and propositions of the clients by transforming its organisational strategy.’ Responsiveness is indicated by the appropriateness of the services. The provision of quality health services requires more resources (such as drugs and medical equipment) in addition to augmenting the numbers of health personnel. Thus, it is important to pay particular attention to those aspects that affect the efficiency and receptiveness of health workers. The health workforce must have the skills and enthusiasm to appreciate and deal with the health needs of their clients. Freedman (2005:19) maintains that focusing on health workers’ receptiveness allows for a more holistic approach to quality service provision by taking into consideration the technical aspects and client satisfaction.

A number of factors impede the responsiveness of health workers. These may be the social, cultural, and political economy. These factors might prevent health workers from providing quality care to the clients and may ultimately affect motivation. According to DFID (2006:3), health worker responsiveness may be hampered by;

- lack of professional support and management,
- lack of training and professional development programmes,
- lack of awareness of the clients’ and workers’ rights,
- inability to communicate in local languages, and
- inability to contribute to decision making process within the health systems.

Others factors that could hinder health worker responsiveness include lack of interpersonal communication skills, lack of public recognition for the value of health workers, and poor terms and conditions of services. Lastly, the inability of the health workers to provide appropriate care may be hampered by lack of skills

and adequate equipment and supplies which limits their sense of achievement and performance. Given the fore-mentioned factors, the responsiveness of health workers can be improved through a number of mechanisms. These may include, increase in remuneration and provision of other types of incentives such as hardship allowance for health workers in the hard-to-reach areas. These could eventually contribute to improved health worker performance and retention (Ammassari 2005:10; DFID 2006:6).

Monetary incentives are not the only measures that can be used to improve health workers' performance. In some countries like Ghana, the decentralisation of health service functions, the empowerment and recognition of local staff are said to be essential if retention and performance strategies are to be successful. Health workers should be consulted, their professional associations should be brought on board and their opinions represented in the policy outcomes (Sagoe 2005:2). For example, in Uganda, the relatively good performance of health workers in the religious private not for profit (PNFP) health facilities is attributed to the favourable working environment made by the decentralised health clinics with more decision-making powers over their facilities, budgets, and expenditures (DFID 2006:7; Reinikka & Svensson 2003:30).

Another effective tool for enhancing performance of health workers, improving their skills, capacity building, and raising awareness is through training. This approach is deemed successful when combined with organisational transformations that guarantee that acquired knowledge and skills are utilised by health personnel to improve the quality of services. The Indonesian experience indicates that performance and the quality of health care resonates more with what health workers know and achieve than the remuneration offered (DFID 2006:7).

Performance of health workers can also be improved through provision of better infrastructure, equipment, and materials such that the employees can apply and develop their professional skills. For example, in Ethiopia Lindelow, Serneels, and Lemma (2005:12) report that even though monetary incentives are the main

pull factor of health workers to private sector, the availability of better equipment and infrastructure also play a big role in attracting health workers.

### **2.5.1.3 Productivity of health workers**

Productivity is defined as ‘...the ratio of outputs to inputs or the relationships between inputs and outputs’ (Heizer & Render 2008:13; Nayeri, Nazari, Salsali & Ahmadi 2005:[2]). The JLI (2004:146) defines productivity as ‘...the outputs extracted from given inputs, such as patients seen per worker or number of procedures per provider’. This is perceived to be an economic measure of productivity and is dependent on the accessibility of information on personnel’s contribution to the organisation’s goals (such as man hours) and health care outputs (such as number clients attended to) (Buchan 2005:4). The above definitions of productivity do not overtly address the quality of service, and the health outcomes resulting from the care provided. In addition they are dependent on availability of information on both inputs and outputs. Other authors, such as Kurowski, Wyss, Abdulla and Mills (2007:116) define productivity based on two concepts of productivity. They define health worker productivity as ‘...the time spent on health service related activities such as patient care or staff meetings’. They also define service productivity as ‘...the proportion of useful staff time used in provision health priority interventions’. Manuwa-Olumide (2009:5) also describes productivity as ‘...the ability of health workers to provide efficient services and favourable outcomes’. In this study, productivity is about achieving improved ‘health outcomes’ from the current ‘contributions’ of the health workforce without compromising quality of care provided.

Although the performance of health workers may not be easy to quantify and monitor, this could be done by using suitable indicators. Hornby and Forte (2002:2) and Manuwa-Olumide (2009:5) describe human resource indicators that can be used to monitor health workforce performance. These indicators include interventions delivered per health worker such as outpatient or home visits, bed occupancy rates, and patients’ contacts among others.

The productivity of a health worker is affected by a myriad of factors. These factors may include inadequate medical equipment and supplies; poor health management structures; inadequate knowledge and skills; and insufficient receptiveness of workers (Dieleman & Harnmeijer 2006:16; Hagopian et al 2009:w867-869). The inadequate performance of workers emanates from a number of multifaceted yet interrelated variables. For instance, inadequate wages may result in increased rate absenteeism, since workers will be looking for work elsewhere to earn extra income. Studies also report that poor salaries may lead to low motivation of the workforce which generally hinders performance (Dieleman & Harnmeijer 2006:16).

A study carried out among nurses in Iran (Nayeri et al 2005:[5]) reports that the productivity of nurses is limited mainly by human resource factors. The human resource issues that promote or hinder the productivity of nurses in Iran include informed selection procedures of new workers based on proven standards; regular appraisal of employees; reliable staffing levels; full involvement of the ward nurses during patients' admissions; and open communication among the health teams. The authors further report that factors such as nursing standards, nurses' skills and experiences, and organisational strategies and procedures, availability of equipment, and the activities of the other members within the health care team determine the workload and the productivity of nurses (Nayeri et al 2005:[7]). Therefore, addressing these issues of human resources management can improve productivity.

#### **2.5.1.4 Competence of health workers**

Armstrong (2009:202) mentions that competence related to performance. Competence is a generic term referring to '...a person's overall ability'. It refers to the specific capabilities, such as leadership, and comprises knowledge, skills and attitudes (Armstrong 2009:202; Victorian Government Department of Human Resources 2009:3). Armstrong (2009:203) adds that competence is an individual ability that results in the actions that meet the requirements of the job.

Competence is important when assessing someone's work attributes and generally includes multiple actions and responsibilities (Miner, Childers, Alperin, Cioffi & Hunt 2005:11). The Joint Learning Initiative (2004:143) defines competencies as '...knowledge, skills, and attitudes that an individual acquires and develops through learning and work experiences'. Competence essentially takes into account what workers achieve in different situations including the readily observable and measurable behaviours, as well as unobservable traits (such as attitudes and values).

Generally, workforce competencies are frequently utilised to generate job descriptions (Miner et al 2005:11). Worldwide, health workers are gradually accepting competence standards as one way of communication with each other. Hornby and Forte (2002:2), Manuwa-Olumide (2009:5), and the WHO (2006:71) point out some human resources indicators that may be used to measure the health workers' performance dimension of competence. These include individual indicators and institutional indicators. The individual indicators embrace aspects like prescribing practices while the institutional ones are patient re-admission rates, number of live births, and number cross-infections (Ntoburi, Wagai, Irimu & English 2008:445).

The improvements in quality of health services mandates health workers to understand the objectives they have to achieve and how they are to achieve them. Quality enhancement initiatives require health personnel to direct their efforts towards receptiveness and efficiency of the services they offer. Health professionals should have up-to-date knowledge and skills to use advanced technologies to support health service delivery. This can be applied through the health information management systems that are essential in monitoring the health outcomes. Communication systems like mobile and fixed telephones, internet, and paging devices can facilitate information sharing and consultations regarding patients with other services providers in different locations (telemedicine) (Ntoburi et al 2008:445-446; Pruitt & Epping-Jordan 2005:637).

Insufficient knowledge and skills, and improper attitudes towards clients can be a hindrance to quality health care. Therefore, because of the frequent changes in the trends of diseases, diagnosis, and treatment protocols health workers need continuous professional development. According to WHO (2006:77), continuous learning practice has to initiate at the commencement of any career in the health profession. Bossyns and Van Lerberghe (2004:[3-4]) in their study, in Niger, report lack of competence among rural nurses, which led to delays in the referral of patients to higher levels of management. The rural nurses had insufficient technical and organisational competence to effectively determine which patients to refer. They also lacked counselling and communication skills to convince patients who are referred to go to the referral hospitals. Such incompetence leads to inappropriate health care and hence poor performance of health workers (Bossyns & Van Lerberghe 2004:[5]). Another contrasting study done in rural India (Iyengar & Iyengar 2009:15) reports that with good skills in identifying complicated obstetric cases, good counselling and communication skills leads to improved maternal health outcomes. This implies that improving the skills of midwives and access of mothers to skilled health care during and after childbirth is crucial in reducing maternal mortality rates.

### **2.5.2 Determinants of health worker performance**

The national health care systems cannot function efficiently without adequate skilled health personnel. Health workers have a vital role to play in the proper functioning of these health systems (JLI 2004:21). Unfortunately, several challenges avert health workers' performance efforts. Consequently, poor health outcomes are observed in most of the developing countries. Unless there are radical changes in performance of health workers, most developing countries might fail to attain the health related MDGs by 2015. Generally, the attainment of an effective health workforce requires the recruitment of potentially effective personnel, optimising the performance of the existing health workers, and retaining them (Manuwa-Olumide 2009:3; WHO 2006:67). The four dimensions of health workforce performance (availability, competence, productivity and responsiveness) are influenced by factors within and outside the health systems.



These factors are categorised into individual, organisational, health system, and broad environmental factors (Dussault 2006:6). The main factors are shown in Table 2.1.

**Table 2.1: Determinants of health workers' performance**

<b>Category</b>	<b>Determinants</b>
Individual	Age, sex, marital status, geographical origin, religion; Education, training received; Competence level; Personal values, preferences and interests.
Organisational	Structure and culture; Management capacities, capabilities, style, practices; Working conditions, occupational safety, workloads, availability of other inputs, state of infrastructures and equipment.
Health sector	Health policies, and human resource for health (HRH) policies (terms of employment, career, placements, transfers, promotions) Organisation of services; Regulation, labour relations mechanisms; Dominant values, objectives; Degree of centralisation, of bureaucratisation; Role of interest groups (unions, councils, user groups, pharmaceutical, equipment companies).
Broader environment	Policy priorities (finance, civil service, planning, education), representations; Economic growth, security, quality of governance.

Source: Dussault (2006:7)

Over the years it was believed that the principal cause of poor performance of health workers was insufficient knowledge and skills. Presently however, this perception seems to be changing. According to the WHO (2006:70-71), health workers may perform poorly because of their personal characteristics such as their socio-cultural background, knowledge, experiences, motivation and work ethics. In addition, their performance may be impeded by the characteristics of the population they serve such as their level of education, their knowledge, attitude, and beliefs about health and disease, and the economic characteristics such as income levels, and the availability of resources.

Furthermore, the characteristic of the health sector itself and the wider environment may also determine the conditions under which health workers perform. Such characteristic may include allocation of resources for health workers to do their job, the internal environment, the organisational culture, how workers are compensated, supervised, and managed, and their personal safety (Manuwa-Olumide 2009:6; WHO 2006:71).

Health policies define the regulation and management of work and duties of the health workers. These policies also determine the budgets for health workers and other inputs required for service delivery. Often, there is a tendency among the health managers to spend more funds on medical equipment and infrastructures instead of securing a continuous supply of drugs and providing incentives to the health workers. External policies such as those from ministries or departments of finance, and public service significantly impact on the working conditions of the health workforce. A good example of this is the fact that public service career development structures are applied to the health workers with less consideration of the uniqueness, the needs, and the prospect of the health workforce (Dussault 2006:7-8).

### **2.5.3 Strategies to optimise the performance of health workers**

Optimising the performance of existing health workers is crucial due to its immediate impact on service delivery. Thus, understanding the aspects that influence how health personnel execute their duties is critical to strategy formulation. Knowledge of the determinants of performance informs the formulation of strategy for improving the performance of health workers. The instruments available to support the performance of health workers are classified as job-related, support system related, and the enabling work environment-related strategies (WHO 2006:71). These strategies may be directed at individual health workers, at the health teams or the entire health system (Ferlie & Shortell 2001:281). Therefore, improvement in workforce performance and productivity usually results from a package of linked interventions rather than the uncoordinated ones (Buchan 2005:15).

#### **2.5.3.1 Job-related strategies**

These are strategies that are particularly relevant to the jobs or professions. The strategies include having comprehensible job descriptions, having professional norms and codes of conduct, matching appropriate skills to the work roles, and

support supervision (Dieleman et al 2003:[6-8]; Rowe et al 2005:1028; WHO 2006:72).

#### **2.5.3.1.1 Having comprehensible job descriptions**

The WHO (2006:72) reports that health workers in many developing countries lack proper job descriptions. Studies show that the use of written job descriptions with clearly stated objectives, responsibilities, authority and lines of accountability are consistently associated with improved achievement of work goals (Franco, Bennett & Kanfer 2002:1255). Job descriptions have been used effectively in many public health systems of developing countries with good performance results. For example, in Indonesia one study demonstrated that using job descriptions with clear standards along with better in-service training can enhance job satisfaction and compliance with standards among nurses and midwives (Dolea & Zurn 2004:1).

#### **2.5.3.1.2 Formation of professional norms and codes of conduct**

The health workers' sense of professional identity, vocation, and work ethics influence performance in terms of competence and responsiveness. For example, there are instances where health workers continue to provide services despite difficult and sometimes dangerous conditions (WHO 2006:72).

Health workers are expected to conduct themselves with integrity, to selflessly apply their technical knowledge, and to put the interest of patients above their own (Blumenthal 2002:525; Miettinen 1999:107). Usually the professional values are nurtured through written codes of conduct and regulations set by the professional associations (Manuwa-Olumide 2009:7). Wibulpolprasert and Pengpaibon (2003:[13-14]) assert that the professional associations foster health workers' sense of valued identity, responsibility and higher morale. Therefore, creation of the professional associations may be desirable in the long run, but they take time to establish. Recently employers are establishing clear written codes of conduct for their workers. However, the effectiveness of such codes

has not been proven (WHO 2006:73). The enforcement of the codes of conduct is still poor especially in developing countries. For example, due to difficult living conditions health workers in low resourced countries adopt some coping strategies which may compromise the maintenance of professional ethics (Ferrinho, Omar, de Jesus Fernandes, Blaise, Bugalho & Van Lerberghe 2004:[2-3]). In order to be successful the regulations and codes of conduct need to be well publicised and actions taken when they are broken.

### **2.5.3.1.3 Matching appropriate skills to the work roles**

Health workers are likely to perform well when their tasks are congruent with their skills (Hagopian et al 2009:w867). Across the globe, there are numerous examples of the inefficient use of the skills of individual health workers. For example, sometimes the tasks do not match the individual skills of health workers (nurses doing clerical work, untrained health workers carrying out deliveries on the wards). Certain tasks consume excessive amount of time (such as hosting visiting missions) such that the workers are not available at work at the time when the workload is high. A study done in Tanzania found that about 40-50% of the district medical officer's time was used on report writing, and about 20% on hosting missions. In Uganda the district health managers spend an estimated 70-80% of their time on planning, reporting, and training workshops (WHO 2006:73). This leaves little time for implementation of health activities.

Buchan (2005:14-15) suggests that harmonising review missions, training courses, and overlapping reporting demands can actually reduce the amount of time wasted. Hence, this time can be put to important use to match the skills of workers to the right activities. Additionally, shift patterns and time flexibility may also be used to increase health worker productivity. This can help to achieve a better match between staffing and workload at limited costs.

Task shifting is another way that can be used to enhance the performance of the health workers (Buchan & Hinton 2005:2). The task shifting requires the development of standardised protocols, including basic and simplified clinical,

recording, reporting, and monitoring and evaluation guidelines. Task shifting provides opportunities to improve access to life-saving treatment and stimulates creation of multidisciplinary health teams with better strategic skills mix to cope with growing patient loads (Zachariah, Ford, Philips, Lynch, Massaquoi, Janssens & Harries 2009:550). For example, in Malawi, Lesotho, Lusikisiki, and South Africa, nurses initiate and manage antiretroviral therapy (ART) at rural primary health clinics with support from mobile medical teams who provide clinical mentoring. This enables access for patients who otherwise might not have received the treatment they need (Zachariah et al 2009:550).

Task shifting may also provide health benefits for patients and health systems. For example, the costs of initial training of medical assistants and clinical officers are lower than for doctors, especially because the pre-service training periods are shorter (Zachariah et al 2009:551). In addition, task shifting increases retention, and reduces the risk of international 'brain drain'. This is because, through task shifting, new cadres of staff are established that are better retained in rural and hardship areas as their qualifications are generally not recognised internationally (Zachariah et al 2009:552).

#### **2.5.3.1.4 Implementing effective support supervision**

Studies demonstrate that supportive supervision when combined with appraisal and feedback to health workers has been found to improve performance (Rowe et al 2005:1029). Support supervision helps to solve specific problems, can improve performance, job satisfaction and motivation (Hagopian et al 2009:w871). For example, in Ghana good supervision made a difference in staff motivation and performance between public hospitals and quasi-autonomous hospitals (Dovlo, Sagoe, Ntow & Wellington 1998:4). In Afghanistan Edward, Dwivedi, Mustafa, Hansen, Peters and Burnham (2009:942) report that support supervision and training in Integrated Management of Childhood Illnesses (IMCI) improves the quality of case management of children under the age of 5 years. When support supervisory visits are seen as fault-finding and punitive, they have negative impact on performance of health workers (WHO 2006:75).

### **2.5.3.2 Support system related strategies**

Health workers require support from their organisations to enhance performance. The key support features include but are not limited to remuneration, adequate information, and infrastructure including equipment and supplies (WHO 2006:75).

#### **2.5.3.2.1 Regular and satisfactory remuneration**

It is believed that remuneration influences the behaviours of health workers. The level of remuneration, the way health workers are paid, and presence of other incentive always have an impact on performance of health workers (Hagopian et al 2009:w869). The WHO (2006:75) emphasises that health workers must be paid reasonably well for the work they do. All health workers should receive a living wage which corresponds to their tasks. At the same time, the wages must be paid regularly and timely. If this is not done then other forms of coping mechanisms will result such as absenteeism, migration, creation of ghost workers and referring patients from public to private clinics where some public health workers also hold part-time jobs (Ferrinho et al 2004:[5]; Macq & Van Lerberghe 2000:180; McPake, Asiimwe, Mwesigye, Ofumbi, Ortenblad, Streefland & Turinde 1999:849).

Some countries in Africa have tried to raise the salaries of health workers as a mechanism to improve their performance and retention. In Tanzania and Uganda for example, salaries of all health workers were increased in recent years following the job evaluation exercises. This meant that the salary of low cadre nurses almost doubled and became equivalent to the salary of a new university graduate. In Uganda however, the salary increment for health workers in the public sector led to the migration of health personnel from the religious private not for profit (PNFP) hospitals to public hospitals. This contributed to understaffing in those facilities. In Ghana and Zambia, the governments tried to remove the health workers from the regular civil service structure in order to improve their remuneration. However, this exercise was resisted by other non-

health professional bodies which led to its failure (High-Level Forum on the Health Millennium Development Goals 2004:2). Some studies report delays or lack of payment of salaries in some developing countries. For instance in Chad, salaries remain unpaid for long time which leads to absenteeism as health workers are looking for other ways to earn a living (Zachariah, Lange & D'Altilia 2001:332).

The way health workers are compensated is a major determinant of their performance and productivity. Service based methods (fee-for-service) are found to be more effective in increasing performance and productivity than time-based methods such as salaries and fixed budgets (Langenbrunner, Orosz, Kutzin & Wiley 2005:242). Accordingly, the performance-related payment methods are increasingly being applied in many developed countries (Isaac 2001:111; Manuwa-Olumide 2009:8; WHO 2006:78). Although performance-related payment system is gaining more popularity in some developing countries, its application still remains limited.

The use of incentives to improve performance of health workers is documented by many writers. The application of various types of allowances and bonuses has been proved to be effective in enhancing performance of health workers (Hagopian et al 2009:w870). Examples of such allowances include rural or hardship allowances, lunch allowance, and stipends for outreach services such as immunisations (Arrowsmith, French, Gilman & Richardson 2001:114; Hagopian et al 2009:w870). In Thailand, for example, payment of extra allowances to health workers in rural areas proved to be effective in increasing the availability of health personnel in those areas (Nityarumphong, Srivanichankorn & Pongsupap 2000:55).

#### **2.5.3.2.2 Develop a functional communications system to facilitate flow of health information**

A functional national health information system is a key component for improving the performance of health workers. Rowe et al (2005:1032) point out that having information helps health workers to do their jobs better. This information must be relevant to the job, available when needed, be of good quality, and easy to understand. Health workers at different levels require different types of information from various sources such as medical records, facility activity reports, health workforce inventories, and financial accounts. The overall productivity of workers should be based on reliable data concerning workforce levels, distribution, skills mix, and information about the factors that impede performance (WHO 2006:80).

Although information and communication are important in improving performance of health workers, unfortunately health personnel often lack adequate feedback on their performance. Most national health systems need to improve their health information management in order to make the required information available. Additionally, there is a need to develop a culture of monitoring and evaluation, and feedback systems to enhance performance of health workers (Manuwa-Olumide 2009:8; Rowe et al 2005:1032). Particular attention must be drawn to the use of modern communication technology (such as internet, mobile telephony) to improve data management, services delivery, and productivity in developing countries (Brimberry 1988:397; WHO 2006:80-81).

#### **2.5.3.2.3 Expand the health infrastructure and improve supply chain management**

Regardless of how skilled health workers are, very little can be achieved without the basic infrastructure such as clean water, working equipment, essential drugs, and other supplies (Manuwa-Olumide 2009:8; Stekelenburg, Kyanamina, & Wolffers 2003:109; Rese, Balabanova, Danishevski, McKee & Sheaff 2005:204;



WHO 2006:18). Drug stock-outs are reported in a number of developing countries particularly in Africa and Asia (WHO 2006:81). In Niger, Bossyns and Van Lerberghe (2004:[3]) point out that nurses in rural health centres are reluctant to refer patients to district hospitals because only a few of them provide surgical care, most do not even provide blood transfusions or oxygen. There is also lack laboratory and x-ray facilities. Another study in Kyrgyzstan reports that health workers providing care to diabetic patients lacked testing strips, glucometers, had poorly equipped laboratories, and irregular supply of insulin. This hampers the performance and productivity of health workers (Hopkinson, Balabanova, McKee & Kutzin 2004:43). Therefore, the availability of health infrastructure and other supplies contributes significantly to the productivity of health workers (Edward et al 2009:942; Kelly 2001:111).

A safe working environment is just as important. Health workers need to be provided with health care when sick. At the same time improving basic infrastructure such as paying utility bills for electricity may make a quicker difference to productivity than any other specific performance tool (WHO 2006:81). There is a need to recognise the importance of other support staff if performance of health workers is to improve. Particular attention should be paid to stores and supplies managers, account clerks, procurement managers. These workers are critical in the scaling up of the health service delivery (Manuwa-Olumide 2009:8; WHO 2006:81).

### **2.5.3.3 Work environment related strategies**

Enabling work environment can promote performance of health workers. Enabling environment mostly involves managerial, cultural and organisational arrangements. The researcher focused on continuous professional learning, team work and management , and full delegation of responsibilities and accountability.

### **2.5.3.3.1 Encourage continuous professional education and development**

The knowledge and skills of health practitioners need to be updated constantly to keep up with the rapid changes in knowledge and practices in public health. Continuous professional development is necessary for health practitioners at all levels of care, specifically those at the lowest level who go through the shortest periods of training (Manuwa-Olumide 2009:9; Mbindyo, Gilson, Blaauw & English 2009:[7]; WHO 2006:82). Continuous professional development is defined by the London Institute of Health Management (2004:1) as ‘...a systematic ongoing cyclical process of self-directed learning for individuals’. Such approaches include career paths, feedback from others, mentoring, and secondment. Experience shows that interactive hands-on experiential training with continuing supervision and support is more effective than training without practice (Davis, Thomson, Oxman & Haynes 1995:700; Davis, O’Brien, Freemantle, Wolf, Mazmanian & Tylor-Vaisey 1999:870; Egger, Travis, Dovlo & Hawken 2005:1). Some writers like Garcia, Hughes, Carcamo and Holmes (2003:807) mention that such methods improve prescribing and dispensing behaviours and also the clinical skills of health workers (WHO 2006:83).

Distance education is increasingly being used and has proven to be effective. Distance education increases knowledge and knowledge seeking behaviour, self-confidence, and positive attitudes towards the patients (Harris, Kutob, Suprenant, Maiuro & Delate 2002:287; WHO 2006:83). For example, in Guatemala a study by Flores, Robles and Burkhalter (2002:48) demonstrates that a 10-months distance education course supported by at least two contacts with tutors significantly increase the correct assessment and management of diarrhoea cases. Overall, care has to be taken to choose the training and development approaches that are likely to be effective for specific level of health care.

### **2.5.3.3.2 Institute proper and effective management skills among the health teams**

Over the years attention about the performance of health workers has focused on knowledge and skills for clinical services rather than the skills needed for the health systems to work. In order to stimulate better performance of health workers, the whole range of basic HRM strategies must be routinely implemented. These strategies include those for effective manpower planning, procurement, preparation and maintenance with emphasis on leadership and team-building. Human resource for health supervisors need to establish a work environment where the needs of health workers are harmonised with organisational demands, leading to the creation of a purposeful, willing, harmonious and well-motivated work team (Manuwa-Olumide 2009:9; Mbindyo et al 2009:[5]). This is not an easy task especially in districts where many cadres of staff from different backgrounds have to work together. Hence, managers must give priority to ensure that health practitioners understand the vision, mission and objectives, feel recognised and valued, participate in decision making, work as a team, develop through mentoring, coaching, training, advance in their careers, are supervised supportively and are constantly monitored and evaluated, are given feedback, and rewarded or sanctioned as appropriate (Boyne & Walker 2005:485; Mbindyo et al 2009:[9]; WHO 2006:85).

The assessment of facility performance is becoming more common, but experience is still scarce in low income settings. For example, Malawi introduced the performance contract scheme while Zambia introduced the performance improvement review system. In both cases the effectiveness of the performance audit and feedback is not well known (Shaw 2005:98). A study on performance management of district health managers in nine Latin American countries reports that teamwork is difficult to introduce into a health system that promotes hierarchical structure and favours an authoritative management style (Diaz-Monsalve 2003:301).

### **2.5.3.3.3 Empower middle and lower level managers to take full responsibility of health service delivery**

Giving local health managers the liberty to allocate resources can contribute to positive personnel and health facility performance. In Uganda, although decentralisation of health services has taken place and local health facility managers have been given responsibility for service delivery, they are not given enough power over funds and human resources. This often affects local performance. High level managers have to ensure that the culture of accountability is developed at all levels. This is a difficult task, given the current culture of corruption in many African countries including Uganda. There is a need to start by educating the communities to know what they should expect from their health providers and that the communities have the right to hold health workers accountable for their actions (de Savigny, Kasale, Mbuya & Reid 2004:3; George 2002:1; Manuwa-Olumide 2009:10). In Uganda for example, the performance of the health districts is ranked and the results are published in the annual health sector reports (WHO 2006:86). Formal mechanisms for handling allegations against health providers can also be effective but are very difficult to implement successfully in developing countries (Bhat 1996:265; Mbindyo et al 2009:[9]).

## **2.6 PERFORMANCE MANAGEMENT**

Performance management has been adopted recently into the health sector. It is one of the crucial functions of HRM. Performance management meant to establish a system that can help managers to improve the effectiveness of their workforce. Recently the competitiveness of many institutions and business enterprises is based on the capability of employees to apply their knowledge and skills to produce favourable results (Luecke 2006: xii-xiii).

Authors attach different meanings to performance management. Luecke (2006:140) defines performance management as ‘...the methods used to measure and improve the effectiveness of workers in their institutions’. Noe et al

(2008:343) define performance management as ‘...the process through which managers ensure that the activities and outputs of the workers are aligned with the organisation’s strategy’. This definition emphasises the need for performance management to support the strategy of the organisation. Another scholar (Aguinis 2009:1) describes performance management as ‘...a continuous process of identifying, measuring, and developing the performance of individuals and teams and aligning that performance with the strategic goals of the organisation’. Armstrong (2009:618) describes performance management as ‘...a systematic process for improving organisational performance by developing the performance of individuals and teams’. It is widely believed that performance management systems are based on consideration of both the behaviours and results.

Armstrong (2009:618) emphasises three main concerns of performance management and these are:

- matching individual and organisational objectives as well as encouraging workers to support the core values of the organisation;
- enabling the expectations of the managers and their subordinates to be defined and agreed in terms of roles, responsibilities, accountabilities, skills, and behaviours; and
- providing individuals with prospects to realise their own goals and develop their professional careers.

### **2.6.1 The functions of performance management**

Noe et al (2008:346) asserts that a performance management system has three (3) main functions which include:

- strategic;
- administrative; and
- developmental functions.

### **2.6.1.1 Strategic function**

Performance management system serves to link the workers' performance to the overall organisational strategy and objectives. However, research shows that few institutions understand and utilise performance management to support the organisational strategy. This strategic purpose may be achieved through designing an evaluation system that defines the performance of health workers in terms of the organisation's strategies and goals. Nevertheless, performance management systems should be sufficiently flexible to adjust to the changes that may occur in the organisation's strategic goals (Armstrong 2009:619; Noe et al 2008:346).

### **2.6.1.2 Administrative function**

Performance management provides useful information which may assist organisations in decision-making. For example, organisations may use the performance information derived during staff appraisals to decide on things like salary increments, promotions and terminations in service, lay-offs, and recognition of achievements (Noe et al 2008:347). Despite the importance of these decisions, some managers in the health sectors see performance appraisal as a compulsory burden through which they must go to fulfil their job requirements. Some health service managers may feel uncomfortable evaluating others and giving them feedback. Hence, these health service managers may highly rate every worker or at least rate them the same, rendering performance appraisal information worthless (Armstrong 2009:618; Longenecker 1987:183; Noe et al 2008:347).

### **2.6.1.3 Developmental function**

Performance management provides information about the strengths and weaknesses of health workers. By so doing, the workers' development needs are identified. When the workers are not performing according to the

expectations, performance management seeks to improve their performance. The feedback given during performance evaluation often identifies the weaknesses of workers. Not only does the performance evaluation identify weaknesses but also the causes of those deficiencies such as skills and motivational inadequacies (Armstrong 2009:620; Noe et al 2008:348).

Bernardin, Hagan, Kane and Villanova (1998:15), Lawler and McDermott (2003:49-50), and Noe et al (2008:348-351), mention that in order for performance management systems to effectively meet the strategic, administrative and developmental functions the following should occur:

- Ensure that the organisational doctrines are incorporated into the system.
- There should be noticeable senior management support.
- The key organisation performance measures should be clearly defined.
- Job descriptions should be linked to the performance management system.
- Ensure that performance management system assesses workers fairly and objectively based on clearly understood standards.
- Managers should be trained on how to use the performance management tools and how to effectively give feedback.
- Link appraisal to total rewards and recognition system.
- Personnel training and development plans should be linked to the results of performance appraisals.
- Performance management system should be evaluated for its effectiveness in transforming organisations..
- Based on the evaluations, the performance management system should be adjusted as required.

Authors like Luecke (2006:xiii) point out that everyone in the organisation benefits when there is effective performance management. For example;

- Clients and patients will observe better health outcomes and results because the health workers are of top-quality and working in unison towards key strategic goals.

- Supervisors are more successful, because their subordinates are doing the right things.
- The workers experience greater job security, career improvement, and better remunerations, thanks to outstanding performance.

### **2.6.2 Performance management process**

Performance management process is essentially about measuring, analysing, and improving the performance of workers as a contribution to the overall organisational performance. While staff and organisational performance are closely inter-related, the nature of the relationship is complex and subject to many external variables (Armstrong 2009:621; Landrum & Baker 2004:14; Martinez 2001:4).

Aguinis and Pierce (2008:141) describe the performance management process as ‘...an ongoing process that involves the following stages: prerequisites, performance planning, performance execution, performance assessment, performance review, and performance renewal and re-contracting’. Luecke (2006: xii) on the other hand describes performance management process as composed of several activities including goal setting, tracking changes, coaching, motivation, appraisal, and employee development. These processes usually take place in a cyclical and on-going approach.

Aguinis and Pierce (2008:141) mention that the first stage of prerequisites refers to having the knowledge of the organisation’s mission, strategic goals, and the job in question. Performance planning stage involves a discussion and agreements between the appraiser or supervisor and the worker (appraisee), regarding what needs to be done and how it should be done (consideration of both behaviours and results) as well as the development plan of workers. During the performance execution stage, the worker strives to produce results and display behaviours that were agreed upon earlier during the planning phase as well as to work on the developmental needs (Aguinis & Pierce 2008:141).



Performance assessment is a two way process that engages both the supervisors and their subordinates. This assessment is aimed at reviewing whether the targeted outcomes have been achieved and examining the extent to which the desired behaviours have been displayed. Many sources can be used to collect the performance information (such as peers, clients, managers, and suppliers), in most cases the immediate supervisor provides the information. This also includes an evaluation of the extent to which the goals stated in the organisation's development plan have been achieved (Aguinis & Pierce 2008:141).

During the performance review stage, a meeting takes place between the workers and their superiors to review their assessments. This meeting is referred to as 'appraisal meeting or discussion'. The meeting provides an official setting through which the employee receives feedback about his or her performance. The final stage of performance process is the renewal or re-contracting. This stage is almost similar to the initial planning component. The only difference is that renewal and re-contracting stage uses information gained from other phases of the performance management process (Aguinis & Pierce 2008:141; Armstrong 2009:626).

### **2.6.3 Performance appraisal**

Performance appraisal is defined by Luecke (2006:78) as '...a formal method for assessing how well an employee is doing with respect to assigned goals'. Üstünlüoğlu (2009:118) also describes performance appraisal and evaluation as '...the identification, measurement and management of employee performance in organisations which provides individuals with useful feedback and coaches them to higher levels of performance'. Armstrong (2009:618) describes performance appraisal as a formal assessment and rating of individuals by their managers at and after a review meeting. The primary goal of performance appraisal is to provide feedback to employees on how well they are doing their work and to provide direction for future development and accomplishments. Performance appraisal is generally conducted annually, with follow-ups as

required. Just like a physical examination conducted by a doctor, this annual check-up gives the manager an opportunity to spot the performance problems before they become serious and to encourage the continuation of good work. Additionally, performance appraisal also helps the workers and managers to focus on the goals and performance expectations that affect salary, merit increase, and promotions (Luecke 2006:79).

### **2.6.3.1 The purpose of performance appraisals**

Various authors (Armstrong 2009:629; Hornby & Forte 2002:2; Luecke 2006:79; Üstünlüoğlu 2009:119) discuss the main reasons for measuring performance. Performance appraisal serves as a tool for managers to:

- identify who is eligible for promotions and salary increments;
- recognise training and development needs for the workers;
- provide feedback required for improvement;
- place workers according to their ability;
- document the reasons for punitive actions, and in some situations assist in defence of actions which may be legally challenged;
- encourage goal setting for future accomplishments and measure attainment. This assists employees to advance their job skills and knowledge; and
- inspire workers in their routine work.

### **2.6.3.2 The differences between performance management and performance appraisals**

There are many differences between performance management and performance appraisal. First, in contrast to performance management, performance appraisal does not generally include strategic business consideration. Second, performance appraisal usually does not include wide-ranging and on-going feedback that employee worker can exploit to improve performance. Third, performance appraisal is normally an annual event that is often driven by the HR departments, while performance management is a

constant way of managing business that is driven by managers (Aguinis & Pierce 2008:140; Armstrong 2009:619). Generally, performance appraisal is seen as a prerequisite for the HR department. It does not characteristically include business and strategic consideration, while performance management can be a tool that helps organisational performance.

Noe et al (2008:343) emphasise that performance appraisal is only a component of performance management since it involves the administrative and relatively isolated duty of measuring aspects of the worker's performance. Performance management is a broader than performance appraisal because it provides not only for the measurement of performance but also defines performance according to organisational goals as well as providing performance feedback.

### **2.6.3.3 The characteristics of an effective performance appraisal system**

Noe et al (2008:354) mention the following characteristics of a good appraisal programme. The appraisal system should have:

- a system for evaluating specific job roles;
- recognised performance standard for all the rated tasks;
- standards that are specific, clear, and measurable;
- statement of expected standards of every worker at the beginning of the appraisal period;
- a mechanism of recording performance to show why standards were attained or not;
- a plan for training supervisors in defining, preparing and using the performance appraisal tools;
- a procedure which can be used by the workers to respond to appraisal results;
- a mechanism for supervisors to acknowledge that the rationale of the appraisal is to motivate workers and guide them in their quest for personal improvement, and help them resolve problems; and

- a procedure that does not necessarily overstrain the managers (Noe et al 2008:354).

#### **2.6.4 Performance measurement**

Measurement and evaluation are often used to strengthen and improve performance practices. Kruk and Freedman (2008:265) describe performance measurement as ‘...the periodic assessment of progress toward explicit short and long term objectives and the reporting of the results to decision-makers in attempt to improve performance’. Performance measurement provides quality information to decision-makers so that they can determine whether their efforts are on course, and inform the political leadership and citizens who are entitled to regular reports on the performance (Kruk & Freedman 2008:264).

Performance measurement helps managers to understand whether their health programmes are succeeding or failing by pointing out potential management challenges when the performance indicators do not show the desired results. Performance measurement encourages managers to take initiatives, to be responsible, and to explain the expectations and desires of the policy-makers (Armstrong 2009:623; Cook, Vansant, Stewart & Adrian 1995:1304; Kruk & Freedman 2008: 265).

Usually health and development programmes require timely and quality information. However, most performance reports in the health sector continue to focus on the amount of resources spent and the quantity of services given rather than the quality and the results achieved. Some writers like Kruk and Freedman (2008:270) and Wholey and Hatry (1992:604) mention that performance measurement should focus mainly on programme quality and on the results achieved through the use of public funds and other resources.

The recognition that new and fundamental changes in the management of health care are essential for the achievement of higher levels of performance has increased the importance of performance measurement. Most of these changes

were brought by the health sector reforms. The reinforcement of reform in the management of health workforce is the basis for successful health sector performance. This reinforcement also referred to as human resource development (HRD) is focussed on improving the institutional performance through the establishment of a dependable health workforce (Hornby & Forte 2002:2; Kruk & Freedman 2008:269).

#### **2.6.4.1 The uses of performance measurement**

Effective performance measurement systems have a number of applications. Cook et al (1995:1304), Kruk and Freedman (2008:263), and Smith, Mossialos and Papanicolas (2008:1) point out that performance measurement system is used to formulate budgets, distribute resources, encourage workers, improve services, and facilitate information flow between the people and governments. These authors further argue that performance measurement can help to improve integrity and in acquiring resources needed to maintain and enhance health programmes. The authors emphasise that performance measurement should be used for self-assessment and improvement, not simply auditing and monitoring. Additionally, performance measurement needs focus on how to improve the health programmes, and not dwell excessively on individual job performance.

Performance measurement enables an organisation to monitor its successes in achieving the strategic goals and objectives, and in achieving desirable outcomes. Performance measurement is closely linked to organisation's strategic plans, goals and objectives, and information analysis for decision-making (Cook et al 1995:1304; Kruk & Freedman 2008:268; Smith et al 2008:1).

There is no dearth of opinions concerning the significance of performance measurement in strategic management. As Cannon and Fry (1992:3) said, '...what gets measured gets managed'. It is a good management practice to find out how well the workforce and the programmes are performing, and to use this information for programme planning, implementation, and improvement. The key assumption of this argument is that performance measurement makes good

sense if the tools for doing it are available, and such tools are used to gather information. Getting managers to use performance data to manage their programmes is a big challenge in many organisations including health sectors. Therefore, for performance appraisal to be successful the organisation must commit the necessary financial and human resources. This will facilitate successful achievement of the desired outcomes, and ensure that all stakeholders know the goals and objectives to be achieved (Halachmi 2002:232; Kruk & Freedman 2008:273; Smith et al 2008:1).

#### **2.6.4.2 Performance standards**

The American Correctional Academy (ACA) (2010:5) describes a performance standard as ‘...a statement that clearly defines the required or essential condition to be achieved and maintained’. Katz and Green (1997:9) define a standard as ‘...a written value statement of rules, conditions, and actions in patient care that is sanctioned by an appropriate authority’. Therefore, a performance standard describes a state of being and activities or practices that might be necessary to achieve compliance. Performance standards reflect the organisation’s overall mission and purpose and contribute to the realisation of the articulated goals (American Correctional Academy 2010:2). Nocochea and Fort (2003:13) mention that standards should be based on solid foundation of evidence and should be developed with input from various stakeholders, management cadres, and health workers themselves. It is however observed that most developing countries are constrained by lack of standard practice, outdated norms and standards. In addition, institutional capacity to provide evidence-based information to guide the development of performance standards (Nocochea & Fort 2003:9).

The processes used to evaluate and improve the quality of health care have evolved from techniques used to manage quality in other industries such as Total Quality Management (TQM). Just as product quality and cost are the primary concerns assessed in industrial settings, measures of accessibility and appropriateness of health care, technical competence, patient satisfaction,

medical costs, and medical outcomes are objects of quality improvement efforts in health sector (Heizer & Render 2008:212; Panzer & Cronin 1993:85). Quality and performance information can also be used to guide consumer choice, to satisfy regulatory requirements, and to identify best practices, and priorities for improvement (Adair, Simpson, Casebeer, Birdsell, Hayden & Lewis 2006:92). To evaluate medical care systems, many health service researchers utilise a model that groups data about health care delivery into three dimensions: structural, processes, and outcomes. The characteristics of health care in each of these dimensions can be analysed separately according to specific measures. The combination of these types of data provides a complete picture of the quality of care within a health care system (Adair et al 2006:92; Pransky, Benjamin & Dembe 2001:296; Smith et al 2008:9).

Overall, the performance standards should be measurable and known to both the supervisor and employee. Three types of standards are identified namely; structural, process and outcome standards.

- **Structural standards**

Structural standards refer to the material and social instruments used to provide care. Structural attributes of health care delivery include: the organisation and setting of care; financial, regulatory and administrative systems; available resources; and the composition of the provider networks (Pransky et al 2001:296; Smith et al 2008:3).

- **Process standards**

Processes in health care are those activities involving the delivery of health services, including the actual procedures involved in providing care, patient-provider relationships, diagnostic and treatment choices, accessibility as well as the aptness of care. Thus, process norms are written standards that transform the organisation's value into interventions and actions (Adair et al 2006:92; Pransky et al 2001:296; Smith et al 2008:5).

- **Outcome standards**

Smith et al (2008:4) describe treatment outcomes as the changes that occur in health status of individuals or communities as direct results of the health care processes or its structures. Structures and processes must be measured since no medical care could be provided without them. However, the ultimate assessment of quality is the outcome of treatment offered to patients. Therefore, the outcome standards deal with the expected or desired outcomes of interventions or results that must be achieved, for example, the change in patient status after treatment (Adair et al 2006:92; Pransky et al 2001:296; Smith et al 2008:4-5).

Rafferty, Maben, West and Robinson (2005:16) stress that until the 1990s, quality improvement efforts were directed towards structural and process standards. However, there has been a gradual change to emphasise patient outcome standards. It is important to ensure that all performance standards are described precisely so that they contain all the key components of what is being assessed and the criteria upon which the assessment is based. Rafferty et al (2005:17) state that the agreed description of standards should be '**SMART**'.

**S** - Stated concretely and specifically,

**M** - Meaningful and practically measurable,

**A** - Agreed upon between the managers and workers,

**R** - Realistic, achievable, and based on sound rationale,

**T** - Time related and achievable in a defined period.

#### **2.6.4.3 Performance indicators**

Indicators are necessary to measure performance of health systems. Bankauskaite and Dargent (2007:126) mention that performance indicators are employed for four basic functions: facilitating accountability; monitoring health care systems and services as a regulatory responsibility; modifying the behaviour of professionals and organisations at both macro (population) and



micro (patient) level; and forming policy initiatives. The indicators are mainly outcome measures and less frequently process measures (Arah, Klazinga, Delnoij, Ten-Asbroek & Custers 2003:377; Bankauskaite & Dargent 2007:126). The WHO (2000:24) emphasises the importance of health systems as being more outcome-oriented. In view of this, Katz and Green (1997:106) describe performance indicators as specific type of performance outcomes based on reliable, quantitative process or outcome measure. These are related to one of the dimensions of performance such as efficiency, effectiveness, efficacy, appropriateness, timeliness, availability, continuity, safety, and responsiveness. Hence, the performance of the health system depends on the knowledge, skills and motivation of the people responsible for delivering the services (WHO 2003:7).

Boyce (2002:229) describes healthcare performance indicators as ‘...statistics or other units of information which reflect, directly or indirectly the performance of health care system in maintaining or increasing the well-being of its target population’. Hornby and Forte (2002:1) go further to describe performance indicators ‘...as tools that monitor and enhance the performance of an organisation in general, including at the clinical level’. The indicators that are related to patient care are called clinical indicators (Katz & Green 1997:106). A clinical indicator is ‘...a quantitative measure that can be used to measure and evaluate the quality of patient care and support services’ (Katz & Green 1997:106). Nonetheless, this is not a direct measure of quality; rather it is a flag that points to specific issues that require intensive review. The WHO (2005a:13) mentions that these performance indicators quantitatively measure whether an initiative has achieved the stated goals for the performance of the health systems.

Human resource performance indicators on the other hand are concerned with the development and utilisation of staff in an organisation. These indicators are designed to monitor the levels of organisational and workers’ performance. Hornby and Forte (2002:1) explain the usefulness of performance indicators in modern health care management. These include:

- Achieving business-oriented and objective-based management techniques.
- Building organisations that learn through measuring and supervising their performance.
- Initiating management processes that support the core values of the organisation.
- Relating achievements, outputs and outcomes to available resources.
- Empowering the workforce to improve their performance through performance management (Awases 2006:66; Hornby & Forte 2002:2; Smith et al 2008:5).

Evaluating performance involves setting goals and targets to be achieved by managers and their subordinates. By design, it is believed that measuring performance of health systems leads to performance improvement (WHO 2005b:5). Realistically this may not always be true. Mullen (2004:217) mentions that there is proof indicating that some performance indicators that endorse employee judgement may be a disincentive and detrimental to performance. On the positive note, indicators that promote professional values, learning, investigations, and trust have a desirable impact on performance. It follows that, approaches that involve judgement, obligatory performance improvement, table ratings, and mistrust have negative effects on performance (Awases 2006:66; Mullen 2004:226).

### **2.6.5 Approaches to measuring performance**

Noe et al (2008:355) describe the five main approaches for measuring performance of workers. These include:

- comparative approach;
- attribute approach;
- behavioural approach;
- results approach; and
- quality approach.

All these approaches to performance measurement have their own strengths and weaknesses.

### **2.6.5.1 Comparative approach**

This approach measures employee's performance by comparing his/her performance to the performance of others. There are three techniques in this category. The first is ranking, '...where the appraiser ranks his subordinates from the best performer to the worst'. Second is forced distribution '...where employees are ranked in groups. Third is the paired comparison '...where the supervisor compares every employee with every other employee in the work group, giving an employee a score of one every time she/he is considered to be a higher performer'. The main strength of the comparative approach is that it is useful when employee performance needs to be differentiated. It also eliminates the problems of leniency, strictness, and central tendency (Armstrong 2009:632; Noe et al 2008:359).

Despite its strength this approach has its drawbacks which are:

- The techniques are not linked to the overall strategy of the organisation.
- The ratings are subjective and therefore the validity and the reliability of the assessment are dependent on the appraiser.
- The techniques do not provide specific information necessary for feedback purposes.
- The techniques do not measure performance against absolute standards of performance (Noe et al 2008:359).

### **2.6.5.2 The attribute approach**

Noe et al (2008:359-360) mention that this approach focuses on identification of employee characteristics necessary for the organisational success and the employee performance is measured according to those features. This approach include the graphic rating scale where the supervisor rates the subordinate on a particular trait and characteristic and the mixed standard scales. The strengths of the attribute-based approaches are:

- They are easy to develop and apply across a range of jobs.
- If designed properly, they can be reliable and valid (Noe et al 2008:362).

The weaknesses of attribute-based approaches for measuring performance include:

- The techniques provide little strategic congruence.
- Performance standards are usually vague and may be interpreted differently by different appraisers (hence low validity and reliability).
- The techniques do not provide specific and relevant performance feedback information.
- The techniques may bring defensiveness in employees (Noe et al 2008:362).

### **2.6.5.3 The behavioural approach**

This appraisal technique defines behaviours necessary for effective performance in a particular job. When the supervisor is assessing performance, he/she identifies the extent to which the subordinate has exhibited the required behaviours. Examples of behavioural approaches include: critical incidents, behaviour anchored rating scales, behaviour observation scales, organisational behaviour modification and assessment centres (Noe et al 2008:362-366).

The strengths of the behavioural approach include:

- It provides the linkage between the organisational strategy and the behaviours required of the employee for strategy implementation.
- It provides employees with specific feedback about their performance.
- Acceptability of this approach by employees and managers is usually high.
- The techniques used rely on thorough job analysis which ensures reliability and validity (Noe et al 2008:366).

The weaknesses of the behavioural approach include:

- Behaviours measured need to be monitored and revised regularly to ensure that they are linked to the organisational strategy;
- It assumes that there is one best way to do the job; and
- It is least suited to complex jobs (Noe et al 2008:366).

#### **2.6.5.4 The results approach**

The results approach is based on the premise that results are the best indicators of how worker's performance has contributed to the organisational success (Noe et al 2008:367). The results-based techniques include: management by objectives (MBO) '...where goal setting is cascaded down throughout the organisation and the goals become the standards against which an employee's performance is measured'. Another type is the productivity measurement and evaluation systems (ProMES) '...which involves a process of motivating employees to higher productivity' (Noe et al 2008:367). The last technique is the balanced scorecard (BSC) method.

The BSC concept was first introduced by Kaplan and Norton (1992:71) in Harvard Business Review. The concept of balanced scorecard is very relevant in the present era of emerging global competition where the organisations are facing increasingly knowledgeable and demanding customers. The BSC method gives an insight into the organisational performance by integrating financial measures with other key indicators around the client perspectives, internal business processes, and organisational growth, learning and innovation. It enables the organisation to track short-term financial and operating results while monitoring progress for future growth, development, and success. The balanced scorecard is a strategic management system that enables organisations to clarify their vision and strategy and translate them into action. When fully deployed the balanced scorecard transforms strategic planning from an academic exercise into a nerve centre for the organisation (Ghosh & Mukherjee 2006:61-62; Popa 2009:215-216).

In Afghanistan, for example, the BSC has proved to be a useful tool for the Ministry and NGOs working in the health sector. It has become one of the foundations of the government's monitoring and evaluation system. The BSC has helped health stakeholders to focus on specific areas where performance is inadequate. The national performance results, the provincial results are disseminated to all the stakeholders in order to compare their performance. This guides the provincial medical directors to recognise the weak areas and to establish performance targets. The BSC provides a powerful tool that signals how efficient the delivery of the essential health package is at all levels. However, some of the shortcomings that were identified in Afghanistan with regard to the use of BSC approach is that it is expensive and does not offer explanations for the observed differences in performance across the provinces (Peters, Noor, Singh, Kakar, Hansen & Burnham 2007:149).

Snell and Bohlander (2007:358-359) point out that the BSC method enables managers to translate organisational goals into business units, teams, and individual employee goals. The appraiser considers four related categories that include financial, customer, process and learning. Kaplan and Norton (1992:79) argue that the success of the BSC is that it is the first management approach that links vision and strategy to employees' everyday actions by translating the abstract strategy into clear priorities and initiatives and relating them to comprehensible and tangible outcomes. Therefore, the organisation and its employees have to strive for satisfied shareholders, delighted customers, efficient and effective processes, and a motivated workforce. Hence, the BSC 'makes strategy everyone's job' (De Waal 2003:31; Peters et al 2007:148).

In an interview with De Waal (2003:31), Kaplan argues that the BSC will still be in use even in 10 years (2013) following the interview which is documented in the journal article. However, he point outs that it is likely that the BSC will increasingly be used together with the 'strategic map' which will assist the organisations and employees to fully understand and implement their strategy (De Waal 2003:33). According to De Waal (2003:34) the strategy map is '...a logical architecture that defines strategy by specifying the relationships between

shareholders, customers, business processes and competencies'. The strategic map makes sure that the BSC is linked to the organisation's strategy.

The results approach has a number of strengths which include:

- Minimisation of subjectivity as objectives and quantifiable indicators are used.
- It is highly acceptable to both supervisors and subordinates.
- Employee performance is linked to organisational strategy (Noe et al 2008:369).

The disadvantages of the results approach include:

- Objective measurements may be influenced by external factors that are beyond the control of the worker.
- The workers may only focus on the performance criteria against which they are to be evaluated (Noe et al 2008:369).

#### **2.6.5.5 The quality approach**

The focus of the quality approach is to improve customer satisfaction through customer-orientation and the prevention of errors (Noe et al 2008:370). The design of a quality-based performance management system focuses on:

- the assessment of employee and system factors;
- the relationship between the managers and employees in solving performance problems;
- internal and external customers in setting standards and measuring performance; and
- using a number of sources to evaluate employee and system factors (Noe et al 2008: 374).

The strengths of quality approach include:

- it incorporates and capitalises on the strengths of both the attribute and results approaches for performance measurement; and
- it adopts a systems approach to performance measurement.

One of the possible shortcomings of this approach is that the organisations may be reluctant to implement it due to their long established use of the traditional approaches (Noe et al 2008:374).

#### **2.6.5.6 The multi-rater approach (360-degree feedback)**

The multi-rater approach is also referred to as '360-degree feedback system'. According to Luecke (2006:140), the 360-degree feedback is '...a personal assessment tool used to systematically collect information about employee's behaviour and performance from key people who interact with him/her. Armstrong (2009:644) defines 360-degree feedback as '...a process in which someone's performance is assessed and feedback given by a number of people'. These people may include managers, peers, patients, and suppliers. The objective is to establish what it is like working for the organisations or with the individuals and to identify his strengths and weaknesses.

Armstrong (2009:644) mentions that 360-degree feedback is important in:

- supporting the workers' training and development plans;
- supporting HR procedures such as appraisal and planning for the scarce resources; and
- supporting compensation resolutions.

Snell and Bohlander (2007:343) explain that many organisations adopt a 360-degree feedback approach to performance measurement where information on an employee's performance is not provided by the employee's immediate supervisors, but by those he deals with on a daily basis such as clients, subordinates, co-workers, and suppliers. Nel et al (2008:497) mention that the 360-degree approach involves the administration of a questionnaire to



individuals with whom the employee interacts, in which they indicate how well the employee performs in number behavioural areas. This approach allows employees to receive an accurate view of their performance as 'different people see different things'.

The strengths of the 360-degree feedback approach are:

- it is comprehensive since the employee is appraised from multiple perspectives;
- the data produced is of high quality;
- it emphasises the use of both the internal and external clients in the appraisal;
- bias and prejudice are minimised as the appraisal reports are not dependent on one person's analysis; and
- feedback from people other than supervisors contributes considerably to a worker's development (Armstrong 2009:646; Snell & Bohlander 2007:345).

The weaknesses of the 360-degree feedback approach include:

- it is a complex system in that numerous appraisals need to be combined;
- it can be frightening, resulting in resentment from the worker being assessed;
- appraisals from differing individuals may be different and confusing
- considerable training is required to ensure that the system works as it should;
- employees could undermine the reliability of the approach through colluding in terms of the appraisal which they are to give to each other; and
- over-reliance on technology and lack of action following feedback (Armstrong 2009:646; Snell & Bohlander 2007:345).

#### **2.6.5.7 Mistakes made by appraisers during performance measurement**

Human beings have limitations in processing information which may result in distortion of performance appraisal results. Once this happens, the performance

appraisals lose their effectiveness. Noe et al (2008:377-379) points out the following common appraiser mistakes:

- *Recent events*: the appraiser recalls recent events rather than summing up events in the entire appraisal period.
- *First impression*: the appraiser remembers only the initial impression.
- *Halo and horns effects*: the appraisers fail to distinguish among different aspects of performance. The appraiser may rate a worker low or high on all items because of one attribute. Halo mistake leads to workers thinking that no aspects of their performance need improvement. Horns mistake leads to frustration and defensiveness among the workers.
- *Central tendency*: this is the reluctance of the appraisers to rate workers at either end of the spectrum but to rate the workers as average or satisfactory.
- *Similar to me effect*: this occurs when the appraisers rate workers with similar attributes higher than justified by performance.
- *Contrast effect*: the appraiser compares an individual worker's performance with that of others when it should be an individual performance.
- *Stereotyping*: this is a tendency to judge individuals on the basis of perceptions about the group.
- Failure to define the expected standards of performance which leads to differences on how workers and supervisors perceive the appraisals.
- Evaluating the aspects that are not part of the work or position.
- Rushing through the appraisal with the worker and not giving the worker a the chance to ask or answer questions.
- Evaluating the worker on aspects over which she/he has no control ,
- *Appraisal politics*: the appraiser purposefully distorts rating to achieve personal goals. This is likely to occur if the top management in an organisation tolerate distortion or are complacent to it (Noe et al 2008:377-378).

Although it is very difficult to completely eliminate these mistakes in performance appraisal or measurement, Noe et al (2008:380) and Armstrong (2009:631-632) propose the following ways for managers minimise them:

- Train supervisors on proper use of the appraisal tools.
- Encourage top management support for appraisal systems and vigorously discourage distortion.
- Give appraisers some autonomy to modify performance objectives and the criteria for their appraisees.
- Recognise the workers' accomplishments that are not self-promoted.
- Ensure that constraints such as the lack of funds do not drive the appraisal process.
- Ensure that appraisal procedures are consistent throughout the organisation.
- Promote a climate of openness to encourage workers to be honest about their weaknesses (Armstrong 2009:631; Noe et al 2008:380).

#### **2.6.5.8 The causes of failure in performance appraisal**

According to Luecke (2006:79), performance appraisals are meant to communicate personal goals, motivate good performance, provide constructive feedback, and set the stage for an effective development plan. On many occasions, however, performance appraisals fail to achieve their intended objectives.

Authors like Hornby and Forte (2002:1), Luecke (2006:79), and McConnell (2002:183-185) point out the following reasons that lead to failure of appraisals:

- *Feeling of guilt*: some supervisors are not confident in making judgement about the performance of their subordinates.. This might make the supervisors nervous and which results in giving high ratings to all the workers. This could potentially have a negative effect compensation, promotions and job security of the workers. In order to avoid the potential liabilities supervisors must prevail over their personal feelings and give honest performance ratings.
- *Ineffective use of performance standards*: Over-estimating of performance occurs when the appraisers do not have a clear understanding of the job

requirements and the standards applied. Some supervisors often view ratings of 'satisfactory' or average as being negative. In order to have an effective appraisal system, the supervisor and the worker must understand the job requirements, understand the meaning of each rating, and must be willing to make the tough decisions to ensure honest and accurate performance ratings.

- *Lack of responsibility for accurate performance results:* some supervisors appraise their workers without considering the rationale of the appraisal process simply because they are not held answerable for the accurateness of the appraisal results. This may result in high ratings for all workers. It is imperative that supervisors conduct truthful appraisals, set goals and coach their workforce based on the performance appraisal results. Every supervisor must be held responsible for preparing accurate performance appraisals. Effective performance appraisal takes time and energy, and should be ongoing.
- *Lack of impartiality and fear to hurt feelings of others:* some supervisors feel uncomfortable to point out the worker's performance deficiencies for the fear of comprising their relationship. However, it has to be remembered that performance appraisal systems are intended to provide accurate and honest feedback to workers. Inaccurate rating of workers may fail to recognise the areas where employees need assistance in growth and development. This would therefore hamper the worker's chances for promotions and compensation in future.
- *Incomplete data:* incomplete appraisal information gathering and using limited criteria for assessment can create a false representation of performance.
- *Unfocused criticisms:* some supervisors may give general comments about performance and may evaluate an employee on aspects over which she/he has no control (Hornby & Forte 2002:1; Luecke 2006:79; McConnell 2002:183-185).

### **2.6.6 Performance appraisal feedback**

Noe et al (2008:380) define feedback as "...the information that employees receive while they are performing concerning how well they are meeting the

objectives'. Therefore, performance management provides an opportunity for feedback to be presented to workers so that they can correct any deficiency in their performance. Giving and receiving performance feedback is an essential part of coaching and management in general (Luecke 2006:55). The performance feedback process is complex and provokes anxiety for both the managers and employees. Researchers like Adams (2005:24), Luecke (2006:55), Rafferty et al (2005:30), and Rowe et al (2005:1030), emphasise the importance of feedback on both success and failure of reinforcing the performance behaviour. They further highlight the need for effective and immediate feedback. Feedback works well when it related to specific performance standards and should be given as soon as the behaviour has been observed. At the same time, it should be provided in a way that will contribute to improvement in performance (Luecke 2006:55). The nature of feedback varies with the situation. It may take the form of an interview between the supervisor and the employee. The other forms of giving performance feedback include written communication such as incident reports, oral communication such as counselling and coaching (Luecke 2006:55).

The role of managers in providing effective performance feedback cannot be overlooked. Rowe et al (2005:1028) and Martinez (2003:210) point out that some supervisors or managers lack the skills to effectively communicate performance appraisal results to their subordinates. In some situations the performance appraisal results are kept confidential and not communicated to the staff member concerned. If employees are not made aware of how their performance is not meeting expectations, their performance will certainly not improve. In fact it may get worse.

Noe et al (2008:382-383), Luecke (2006:56), and Armstrong (2009:627-629), describe the following as the most effective way of dealing with performance feedback:

- *Feedback should be given constantly and not only once a year.* This enables employees to correct the mistakes immediately and helps them to know how their final evaluation is likely to be.

- *Create the right environment for discussion:* managers choose a neutral position when giving the feedback and at the same time conducting the meeting in form of dialogue and not confrontation.
- *Recognise effective performance through praise:* the purpose of the feedback is to give precise performance information which includes recognising effective as well as poor performance. Praising therefore provides reinforcement of some good performance behaviours (Armstrong 2009:628).
- *Encourage self-evaluation from the employee prior to the feedback:* self-assessment before the feedback can be very productive. It encourages the workers to think of their weaknesses (Armstrong 2009:628).
- *Encourage the employee to participate in the feedback session:* when the workers actively participate in the feedback sessions they are always satisfied with the process. Participation includes giving the workers a chance to voice their opinions of the performance evaluation and to discuss their performance goals.
- *Focus on solving problems:* the feedback sessions should not be used for criticising poor performance, rather, the session is meant finding solutions to fixing unsatisfactory performance. It is equally important to reinforce feedback on good performance. This helps to build confidence among the workers (Armstrong 2009:628; Luecke 2006:56).
- *Focus on behaviour or results and not character, attitude, or personality:* this practice minimises the feeling that the worker is personally attacked. A person who feels under attack will not learn.
- *Minimise criticisms:* an effective manager should resist the temptation of focusing on condemnations.
- *Jointly agree with the subordinate on specific goals and set a date for the next review meeting:* setting goals is one of the most effective motivators of performance. Research has demonstrated that this results in increased satisfaction, motivation to improve, and performance improvement (Armstrong 2009:629; Klein, Snell & Wexley 1987:267). Besides setting goals the supervisor must also be specific about the follow-up date to review performance towards achieving the goal. This provides added incentive for

the employee to take the goals seriously and work towards achieving them (Noe et al 2008:383).

### **2.6.7 Performance Improvement**

Performance improvement is one way managers can handle the gaps identified during the appraisal and feedback processes. According to Katz and Green (1997:28), performance improvement should address the question of how to enhance the health workers performance levels. Performance improvement is a response to make services of an organisation better, affordable, and faster. It also seeks to rectify the existing performance problems and build upon those performance levels that are already good (Katz & Green 1997:28). It is therefore important to have a performance improvement plan as part of performance management. Katz and Green (1997:200) assert that performance improvement involves the elimination of problems and the exploitation of the performance opportunities. The performance problems may be related to service, practice or governance, while opportunities are factors that can be outside the organisation but can be harnessed to improve performance.

Staff performance improvement is an important function of the organisation. Performance monitoring and appraisal results can be used to manage and enhance performance through staff training, counselling, and development (Smith et al 2008:14-15). Grobler et al (2006:300) identify training as being task oriented and focused on improving the worker's job performance. Development is directed towards 'creating ongoing learning opportunities so that employees can improve over longer period of time and learn skills other than those required for the current job' (Kleynhans, Markham, Meyer, Van Aswegen & Pilbean 2007:117). Other authors like Snell and Bohlander (2007:282) argue that training tends to be more narrowly focused and oriented towards short-term performance concerns while development is future-oriented and focuses on broadening individual's skills for future responsibilities. Since the functions of the organisations are oriented towards performance, then, performance monitoring is a management function that attempts to ensure that productivity and staff

performance are kept up to standard through formal or informal staff training and development activities.

### **2.6.7.1 Staff training**

Noe et al (2008:267) define training as the ‘...planned effort by an organisation to facilitate employees’ learning of job-related competencies’. These competencies include knowledge, skills, and behaviours that are critical for successful job performance. Training involves the application of formal processes to impact on and help employees acquire the skills necessary to perform their jobs satisfactorily (Armstrong 2009:665). Since the human resources are the most important assets for any organisation, it is important that their intellectual capital is maintained through training. In-service training is one of commonly used methods in the health sector to boost the performance of health workers. In-service training is about facilitating learning and development of an employee while rendering a service to an organisation. Armstrong (2009:667) and Swansburg and Swansburg (1999:571) maintain that in-service training provides a learning experience in the workplace for the purpose of refining new skills. Hence, in an organisation managers and supervisors are responsible for developing employee’s potential and abilities to perform and help them adjust to the rapidly changing job requirement. The WHO (2006:82), points out that in-service training is most likely to change behaviour when it is interactive, based on real problems, and coupled with continuing or intermittent support.

There are various forms and methods of in-service training. These include:

- *Presentation methods*: where learners are passive recipients of information. These include classroom instruction (such as lectures), distance learning, audiovisual techniques (such as video and overheads) (Noe et al 2008:291).
- *Hands on methods*: where the learner is actively involved in learning. This category includes on-the-job training (employees is taught in clinical units or



- observes peers and supervisors), simulations, case studies, and web-based training (training delivered over internet or intranet) (Noe et al 2008:294-295).
- *Group building methods*: where learners work together to build team identity. This includes adventure learning (development of team work & leadership skills using structured outdoor activities), team training (promotes ability of members to work together), and action learning (problem solving) (Noe et al 2008:303).

Brinkerhoff (2006:303-304) notes that the impact of training is dependent on the manner in which the training is implemented. Therefore, the key challenge which the organisations face is how to quickly and consistently take advantage of training to improve performance.

#### **2.6.7.2 Staff development**

Kleynhans et al (2007:117) describe staff development as ‘...a process directed towards creating ongoing learning opportunities so that employees can improve over longer period of time and learn more skills over and above those required for the job’. Armstrong (2009:674) adds that development takes the form of learning activities that prepare staff to exercise wider responsibilities. Usually staff development interventions are future oriented and serve to expand skills within employees which will enable them to move into jobs that do not exist yet (Nel et al 2008:446). The staff development interventions in an organisation include: formal education programmes, assessment, job experiences, and interpersonal relations (Noe et al 2008:389).

- *Formal education programmes*: this includes off-site and in-house training programmes that are customised to the organisation’s employee (Noe et al 2008:389). Such as, IMCI training courses, tuberculosis (TB) management courses or workshops.
- *Assessment*: according to Noe et al (2008:409) assessment involves ‘...collecting information and providing feedback to employees about their behaviour, and communication styles or skills’. The most popular methods

include performance appraisals, 360-degree feedback system, the assessment centre, benchmarks, and the Myers-Briggs Type Indicator (MBTI). Assessment is frequently used to determine employees with managerial potential.

- *Job experiences*: this refers to ‘...relationships, problems, demands, and tasks, or other features that employee face in their jobs’ (Noe et al 2008:417). Job experiences can be used for employee development in various ways such as:
  - *Job enlargement*: where the employee’s existing job is expanded horizontally so as to include a greater number of activities.
  - *Job enrichment*: where the employee’s job is expanded vertically to provide employee with more challenges.
  - *Job rotation*: where the employee moves among jobs within a particular department
  - *Others include transfers, promotions and temporally assignments with other organisations* (Noe et al 2008:420).
  
- *Interpersonal relations*: development can occur through establishment of interpersonal relationships. Methods used to enhance interpersonal relationships include **mentoring** and **coaching**. Noe et al (2008:424) refers to a mentor as an experienced, productive employee who helps to develop less experienced employees. A mentor may provide career support and psychosocial support to the employees (Noe et al 2008:426). A coach on the other hand, is a peer or manager who works with an employee to motivate him, help him develop skills, and provide reinforcement and feedback. Coaching is usually one-to-one session with an employee for the purpose giving feedback or pairing an employee with an expert in the area where there is deficiency (Noe et al 2008:427).

## 2.7 THE ROLE OF LEADERSHIP IN PERFORMANCE MANAGEMENT

The WHO (2008:xii) recognises the mismatch between expectations and performance as a cause for concern among health authorities in the quest to renew primary health care (PHC). Given the growing economic weight and social significance of the health sector, the performance of health workers creates anxiety among politicians. Different groups have a role to play in revitalising PHC and these include: national politicians and local governments, the health professionals, the scientific community, the private sector, and civil society organisations as well as the global health community (WHO 2008:82).

Armstrong (2009:376) defines leadership as ‘...the process of inspiring people to do their best to achieve the desired results’. Leaders play two important roles in organisations. First, leaders must achieve the results. Second, leaders must maintain effective and harmonious relationships within the organisation, and between individual members of the organisation. In order to fulfil their roles, leaders need to satisfy the following needs: task, group maintenance, and individual needs (Armstrong 2009:376). Ruth (1996:27) goes ahead to describe the main qualities of leadership as abilities for long-term strategic thinking, good communication skills, integrity, and ambition. Therefore, leadership generally refers to motivating and committing people to perform.

Performance management is one way organisations can communicate their mission and vision to all the stakeholders (Ukko, Tenhunen & Rantanen 2007:40). A well designed performance management system supports leaders in their crucial roles of providing overall direction and a strong focus for action in their organisations, and managing key internal and external relationships. Within the organisation, performance management provides leaders with assurance that the strategic decisions are being implemented and that the intended targets are being achieved. At the same time, performance management enables leaders to identify areas where the expected targets are not being achieved, thereby opening the way for timely remedial action (DIRPSER 2005:9; Khaleghian & Das Gupta 2005:1091-1093; Ukko et al 2007:40).

Indeed DIRPSER (2005:9) and Ukko et al (2007:41) emphasise that performance management systems should focus attention on the matters that are critical for the achievement of desired results and help attain alignment of priorities across all levels within the organisation. Leadership helps in identifying issues that require collaboration across different sectors and departments through the performance management process. Similarly, leadership assists in the analysis of the performance drivers which ultimately leads to a detailed understanding of performance issues. This therefore provides valuable input into decisions about the allocation of resources including the human resources (WHO 2008:84).

In organisations where discussions regarding performance are encouraged and ongoing, all members of the team are aware of how their roles contribute to achieving the organisational strategic goals. With this knowledge, leaders can exercise their decision-making powers to introduce new ideas and work practices. It is widely acknowledged that effective leadership use dialogue to motivate, and provide on-going support to the workers as they strive to achieve better outcomes. Performance appraisal data should form the basis for a dialogue between leaders and workers. The leadership should focus on creating an atmosphere where the workers are recognised and supported for their contributions towards achieving the organisation's strategic objectives. This calls for good interpersonal and communication skills, and the need to understand and appreciate social and cultural differences among the workers (DIRPSER 2005:9; Ukko et al 2007:46). Khaleghian and Das Gupta (2005:1096), and Ukko et al (2007:46-47) maintain that a good performance management system is a powerful tool for achieving change in an organisation. Therefore, by the revising performance criteria, managers provide staff with a clear message about the need for and the direction of changes in the priority areas. By closely monitoring the new criteria, managers can ensure that the desired change occurs (Luecke 2006:43).

The WHO (2008:86-91) explains performance information as a tool used by governments for accountability. However, the accountability of leaders extends beyond financial honesty and the delivery of outputs. Leaders are responsible for advancing the capacity of their organisations to engage constructively with future challenges through the development of their intellectual capital, and the creation of a genuine future-oriented performance culture which actively supports organisational learning and innovation. Leaders should also sustain the reputation of their organisations in the eyes of their clients, their workforce, and other stakeholders (Khaleghian & Das Gupta 2005:1093-1094; WHO 2006:86).

## **2.8 CONCLUSION**

In this chapter the researcher has reviewed the relevant literature on the performance and performance management of health workers. The researcher has discussed in detail the 'strategic performance model'. The components of the theoretical model, which include: individual attributes and behaviours, organisational strategy, situational constraints, and the dimensions of performance are described in a more detailed way. The researcher has also justified the use of the strategic performance theoretical framework to guide this study.

The researcher has discussed the concepts, types, and benefits of decentralisation in health services. Also discussed is the link between decentralisation and management of human resources for health.

In this literature review the researcher focused on human resource management and the need to improve health worker performance by creating a fit between the individual worker, the job, the organisation, and the environment. The researcher further discussed the value of human resource management practises in enhancing performance of workers through increasing employee's knowledge, skills and abilities; motivating employees to leverage their individual attributes and behaviours; and motivation of employees to perform.

This chapter further looked at the concepts of performance and the dimensions of health workers' performance that include staff availability, productivity, availability, competence and responsiveness. The determinants of health workers' performance and the strategies that may be used to enhance health workers' performance were presented in detail.

The researcher has also discussed the concept, functions, and the process of performance management. The differences between performance management and performance appraisal were presented in detail. The discussion of performance measurement and the approaches used to measure performance were put forward.

Lastly, the researcher discussed the concepts of performance feedback and strategies that may be used in performance improvement of health workers. The role of leadership in guiding performance of health workers is outlined. In the next chapter the researcher presents a detailed account for the research design and methodologies that were used in the study.

## **CHAPTER 3 RESEARCH DESIGN AND METHODOLOGY**

### **3.1 INTRODUCTION**

This chapter describes the research design and methods that were used to conduct this study. The chapter re-states the rationale of the research, describes the study design, study populations, sampling and sampling techniques, research instruments, data collection procedures and analysis. The procedures for ensuring validity, reliability and trustworthiness of the research findings are outlined. The ethical considerations followed during this research are also discussed. Additionally, the mixed methods approach as well as the research designs appropriate to this study are presented. The two levels at which this study was conducted are detailed. In this study the descriptive research design was used during data collection, analysis and interpretation.

### **3.2 RATIONALE OF THE STUDY**

As stated in chapter 1, the purpose of this study was to investigate the performance of health workers in Uganda in order to design a framework that may be used by stakeholders to improve performance in the decentralised health services. The researcher envisages that this study will add to the existing body of knowledge and understanding of performance management in the health sector. This, the researcher hopes to achieve through the contribution towards the formulation of the performance management framework specific to the health profession. Furthermore, this study will generate greater awareness among the public health sector managers on the importance of having a practical performance management framework as a vehicle for organisational effectiveness. For these reasons, this study is very important not only in Uganda but also in Africa and elsewhere.

### **3.3 THE SCOPE OF THE STUDY**

The researcher selected the sample from health workers and their managers working in four (4) districts located in Eastern Uganda namely: Kumi, Mbale, Sironko and Tororo. These districts were selected purposively based on their performance on the district league table during the past two financial years (FY) (FY 2006/07 & FY 2007/08) under the second health sector strategic plan (HSSP II). The assumption was that the performance of health workers, to a great extent, influences overall district performance. On the district league table, Tororo district has been amongst the best 15 performers for the consecutive 2 years and Kumi district has moved from the mid-table in FY 2006/07 to the best 10 performers during the financial year 2007/08. Furthermore, Mbale district dropped from being amongst the best 10 performers in FY 2006/07 to the mid-table during the FY 2007/08 and Sironko district has persistently been occupying the mid-table for the two years (Ministry of Health Uganda 2008:37). The main focus of this study was limited to doctors, clinical officers and professional nurses. The other health professionals were not represented although they form part of the workforce.

### **3.4 RESEARCH DESIGN**

Burns and Grove (2007:38) and Saunders et al (2009:136) define research design as ‘...the detailed plan of how the study is to be conducted with full advantage of control over factors that could interfere with the desired outcomes’. Polit and Beck (2008:66) also define research design as ‘...the overall plan for obtaining answers to questions being studied and for handling some of the difficulties encountered during the research processes’. Creswell and Plano-Clark (2007:58) emphasise that research design is a procedure for collecting, analysing, interpreting and reporting data in a study. Amin (2005:210) describes research design as an outline of what the researcher will do right from the formulation of the research questions to the final analysis of data. A research design is important because it facilitates smooth running of the various research operations thereby making the study more efficient. In deciding which research



design to use, the researcher has to consider a number of factors. These include the focus or orientation of the research, the units of analysis and the time dimension (Saunders et al 2009:137). Therefore, in order to obtain a full picture regarding the performance of health workers in decentralised services, the researcher used the mixed methods approach, using a survey design for the quantitative strand. In the mixed methods approach both quantitative and qualitative research methods are used at the same time or series of studies (Creswell & Plano-Clark 2007:58).

### **3.4.1 Mixed methods research approach**

As already stated, the researcher used the mixed methods approach to conduct this study. According to Creswell, Plano-Clark and Garrett (2008:66) mixed methods research approach is ‘...a plan for collecting, analysing and combining both quantitative and qualitative research methods or data in a single study or a series of studies in order to understand the research problem’. The mixed methods research approach brings together the quantitative and qualitative data either simultaneously or sequentially. In this study, the research problem is the performance of health workers in decentralised services.

The rationale for combining both kinds of data within one study is grounded in the fact that neither quantitative nor qualitative methods are sufficient by themselves to capture the trends and details of the situation. When used in combination, qualitative and quantitative methods can complement each other and allow for more robust analysis, by leveraging the strengths of each other and limiting the weaknesses (Hanson, Plano-Clark, Petska, Creswell & Creswell 2005:226).

Polit and Beck (2008:309) describe the following advantages of mixed methods approach which include: complementarity, incrementality, and enhanced validity.

- *Complementarity*: using mixed methods approach allows the researcher to use numbers (quantitative data) and words (qualitative data) in order to minimise the limitations of a single approach.

- *Incrementality*: the progress on research topic tends to be gradual, relying on feedback loops. Therefore, by using qualitative findings one can generate hypotheses that can be tested quantitatively, and quantitative findings that sometimes need clarification through in-depth probing.
- *Enhanced validity*: when a model is supported by multiple and complementary types of data, the researcher will be more confident about the validity of the results (Polit & Beck 2008:309).

It is for these merits that the researcher decided to use the mixed methods approach, in order to generate findings concerning the performance of health workers in Uganda that are supported by both qualitative and quantitative research approaches, hence, enhancing the credibility of this study.

Creswell et al (2008:68) classify mixed methods research approach into two major categories. These include concurrent and sequential triangulation designs. In the concurrent designs both qualitative and quantitative data is collected at the same time or within the same period. In sequential designs one category of data (quantitative or qualitative) builds on the other with emphasis put on one set of data. Sequential designs include explanatory, exploratory and sequential embedded designs.

Although it is thought to be more inclusive, mixed methods approach has its challenges. For example, it requires extensive data collection, time-intensive analysis, decisions on which research methods to combine, and how to integrate and interpret the research findings (Creswell et al 2008:72; Stewart, Makwarimba, Barnfather, Letourneau & Neufeld 2008:1407). For the purpose of this study, the researcher used the 'concurrent triangulation design' to investigate the performance of health workers in the decentralised services in Uganda.

### 3.4.1.1 Triangulation design

Polit and Beck (2008:768) define triangulation as ‘...the use of multiple methods to collect and interpret data about a phenomenon, in order to arrive at an accurate representation of reality’. Saunders et al (2009:146) assert that triangulation refers to ‘...use of different data collection techniques within one study in order to ensure that the data is telling you what you think they are telling you’.

The purpose of triangulation is to obtain different but complementary data sets on the same topic, with the intention of bringing together the differing strengths and minimise the weaknesses of quantitative and qualitative research methods (Polit & Beck 2008:196). In triangulation, simultaneous but separate quantitative and qualitative data collection and analysis is carried out. The researcher then attempts to merge the two sets of data by bringing the separate results together during interpretation or by transforming data to facilitate the integration of the two categories of data during analysis. This enables the investigator to understand the research problem better (Creswell & Plano-Clark 2007:64).

In this study, the researcher collected data about performance of health workers using different methods (*methodological triangulation*) from workers themselves (appraisees) and their health service managers (appraisers), working in different districts(*space triangulation and person triangulation*), during the same period and integrated the findings during interpretation (*data triangulation*).

- *Methodological triangulation* involves using multiple research methods or data collection techniques about the same phenomenon, which in this case is the performance of health workers. In this study, researcher used structured questionnaires to collect quantitative data and semi-structured interviews to collect qualitative data (Amin 2005:65; Polit & Beck 2008:543).
- *Space triangulation* involves collecting data on the same topic from different sites to test for cross-site consistency. In this study, the researcher collected

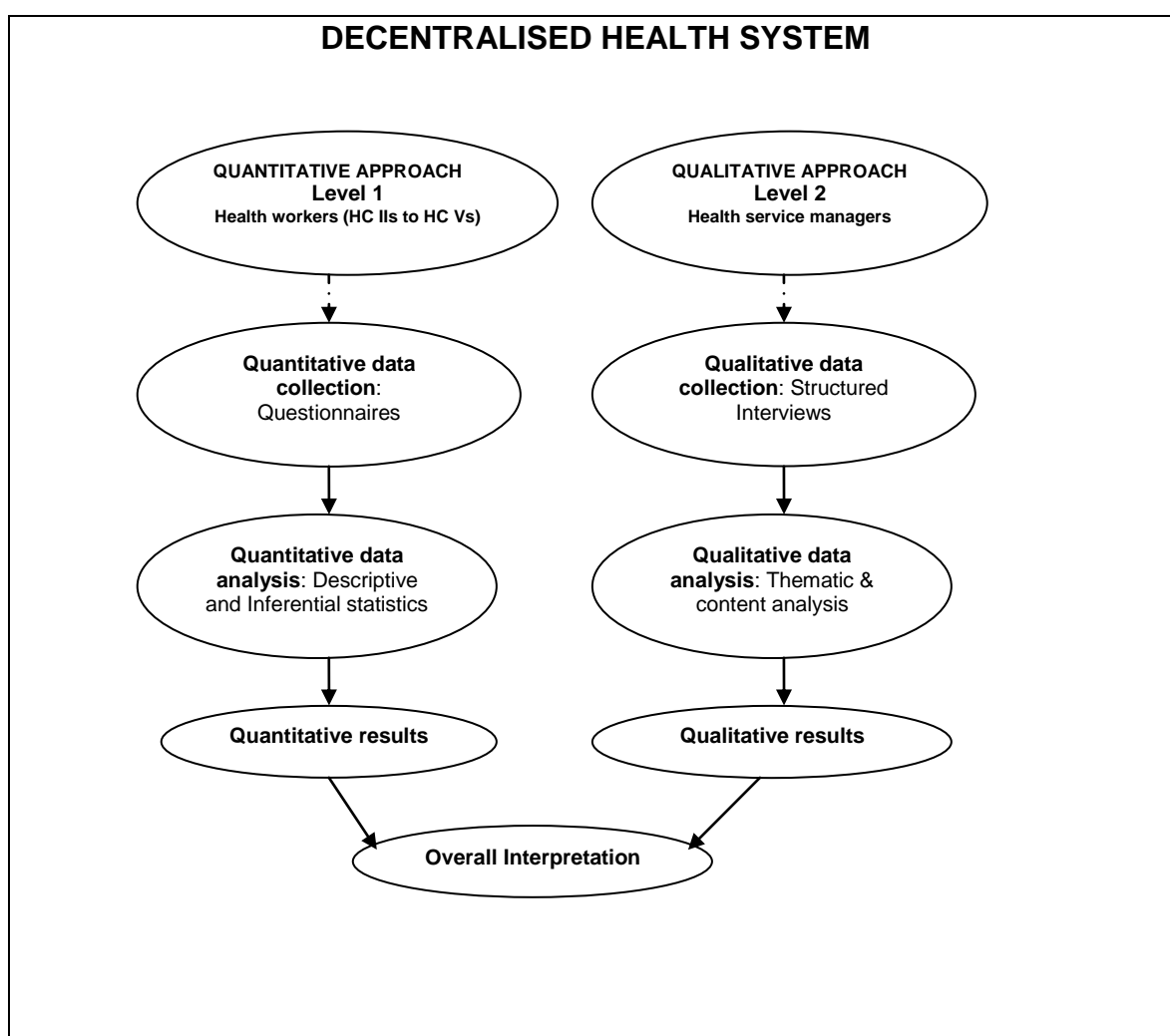
data from four (4) districts of Eastern Uganda with different levels of health workers' performance (Amin 2005:65; Polit & Beck 2008:543).

- *Person triangulation* involves collecting data from different types or levels of people. This is aimed at validating data through multiple perspectives on the topic. In this study, the researcher collected data from health workers (appraisees) and from health service managers (appraisers) (Polit & Beck 2008:543).
- *Data triangulation* involves the use of multiple sources of data with the same focus to obtain various views through a range of data on a given topic in order to enhance validity. The data collected can be analysed using different strategies for validation (Amin 2005:65; Polit & Beck 2008:543). In this study the researcher collected data from health workers and health service managers at different levels of health care (HC II, HC III, HCIV & district hospitals (HC V). The different sources of information provide insights about the phenomenon, provide an enriched explanation of the problem, and assist in validating conclusions (De Vos, Strydom, Fouche & Delpont 2005:362).
- *Investigator triangulation* refers to a situation where two or more investigators with diverse background examine the same phenomenon with each having a specific role to play in the study (Amin 2005:65). This removes the potential bias which is likely to occur if there is only one investigator. In this study, the researcher used the services of four trained research assistants with background in public health and social sciences to interview the health service managers during the qualitative phase. The aim was to reduce the potential bias since the research assistants would not be involved in the other stages of the study. The researcher employed services of an experienced statistician to analyse the quantitative data and to cross check the analysis and coding of the qualitative data. All these were aimed at enhancing the validity, reliability, and trustworthiness of the research findings.

#### **3.4.1.1.1 Variants of triangulation design**

According to Creswell and Plano-Clark (2007:64), there are four main variants of the triangulation design. These include the convergence model, the data

transformation model, the data validating quantitative model, and the multilevel model. For the purpose of this study, the researcher used the 'multilevel model'. In the multilevel model, different research methods (quantitative & qualitative) are used to collect and analyse data from different levels within the health system. The findings for each level are then merged together into one overall interpretation (Creswell & Plano-Clark 2007:64). Figure 3.1 illustrates the 'multilevel model', where level 1 represents the health workers within their facilities (appraisees), and level 2 represents the health service managers/supervisors at district and health sub-district level (appraisers).



**Figure 3.1: The visual multilevel triangulation model (Adapted from Creswell & Plano-Clark 2007:64).**

As shown in Figure 3.1, this study used the 'multilevel model' of triangulation with data collected, analysed and results presented for the two levels. In this

model, different but complementary data sets were collected on the same topic by means of both quantitative and qualitative techniques with equal priority. The data was analysed in parallel and then merged to develop a more complete understanding about the performance of health workers (Creswell et al 2008:68). A survey design using self-administered questionnaires was used to collect quantitative data on factors that enhance or impede performance of health workers (appraisees), and the current ways their performance is managed in the selected districts. Qualitative data was collected using semi-structured interviews with health service managers (appraisers) at the district and health sub-district levels to explore the phenomenon of performance of health workers, and performance management in general. The reason for collecting quantitative and qualitative data in the same study is to combine the strengths of both types of research, hence, generating more credible results.

### **3.4.3 The quantitative research approach (Level 1)**

Quantitative research approach was used to collect data from health workers (appraisees) at the facility level. Amin (2005:210) describes quantitative approach as ‘...a plan for carrying out research oriented towards data quantification, and is applied in order to describe or investigate the current conditions and relationships’. Polit and Beck (2008:16), add that the quantitative approach involves the use of a general set of organised and controlled procedures to gather information. In quantitative research, evidence is generated according to the specified plan, using formal instruments such as questionnaires to collect the needed information. The data collected is generally numerical and is analysed using statistical procedures in order to enhance objectivity (Polit & Beck 2008:16; Somekh & Lewin 2005:215).

According to Polit and Beck (2008:63), a quantitative approach can be experimental, quasi-experimental, or non-experimental and may use descriptive and inferential statistics. The design can be cross-sectional or longitudinal. This study was cross-sectional and non-experimental because data was collected at a specific point in time in the natural environment of the health workers.

Therefore, the researcher used quantitative non-experimental cross-sectional designs to identify and collect numerical data on several factors influencing the performance health workers and the current practices used to manage their performance. By so doing the researcher wanted to understand and describe the predictors of health workers' performance, hoping that this would assist in the development of the performance management framework.

#### **3.4.4 The qualitative research approach (Level 2)**

According to Amin (2005:43), a qualitative research approach is '...one whose data is basically descriptive in nature'. Amin (2005:45) outlines the characteristics that define qualitative research. These are:

- comprehensive explanation of the events;
- explicit explanation of data collection and analysis;
- inductive reasoning applied to evidence gathered from sources;
- synthesised interpretation; and
- extension of understanding by others.

In this research, qualitative research approach was used to collect data from the health service managers/supervisors (appraisers) at district and health sub-district levels. The data obtained using qualitative methods are mostly expressed in non-numerical terms, although sometimes it can be transformed into numerical variables. Even though description is emphasised, this does not mean that numerical figures cannot be used. In qualitative methodology, the researcher usually collects data using open-ended questions with the primary intent of developing themes from the data.

This study used a semi-structure interview technique for data collection. The advantages of using semi-structured interview technique to this study are: providing depth to the data, allowing for probing, and improving the confirmation of quantitative data. A potential disadvantage of the interview technique is the

perceived lack of anonymity by the participants (Polit & Beck 2008:424). For this reason, the participants were assured of their anonymity throughout the study.

In this study, the researcher collected qualitative data from the health service managers using semi-structured interview guide. The qualitative interview procedures can identify experiences in an attempt to understand or interpret phenomena in terms of the meaning people bring to it. Hence, qualitative data assumes that reality is subjective and is constructed by participants involved in the study. The researcher investigated and explained the reasons for sub-optimal performance of health workers. This methodology also enabled the researcher to get in-depth information on why performance is managed the way it is. Lastly, the researcher used this method to collect the views of health workers and health service managers on how performance can be improved.

#### **3.4.5 Descriptive research design**

Descriptive research is a broad class of non-experimental studies (Polit & Beck 2008:274). Saks and Allsop (2007:6) assert that descriptive studies provide current information or intelligence regarding the research problem. Polit and Beck (2008:274) add that in descriptive study the researcher observes, relates, and describes measurable attributes of the phenomenon in a natural environment. The purpose of descriptive studies is to generate precise measurement of the phenomena being studied that can be explained by accumulation of statistical data (Burns & Grove 2007:34; Saunders et al 2009:140).

In this study, the researcher intended to describe and categorise the factors that positively and negatively affect the performance of health workers, and relate them to the organisational strategy in the current working environment. In addition, the researcher wanted to describe the various approaches that are currently used to manage the performance of health workers. This enabled the researcher to identify the strengths and weaknesses which in turn formed the basis for designing the performance management framework.



### **3.4.6 Survey research design**

The researcher utilised a survey design to collect quantitative data. Amin (2005:212) defines a survey as ‘...a research activity that is used to gather data from a sample of a population’. A survey design may be used in descriptive, explanatory, and exploratory studies. According to Polit and Beck (2008:323) a survey is designed to obtain information about the prevalence, distribution, and interrelations of variables within a population. Babbie (2001:238) argues that a survey is probably the best method available for researchers who are interested in collecting original data for describing a given population. The purpose of a survey is to generalise data from a sample to the population so that inferences can be produced about their characteristics. Surveys are mainly used in studies where individuals are the units of analysis.

During this study, the researcher used the survey design because of its cost effectiveness and its ability to can cover a large population. A survey is an excellent way to gain knowledge from the target population of this study. It allows the health workers to answer questions comfortably and more truthfully since their answers are handled anonymously. Additionally, a survey helps the researcher to be creative in shaping the areas for further research (Saunders et al 2009:144).

Although it is advantageous, a survey design has some shortcomings. First, a survey does not provide an in-depth picture of why certain features are there or not and why stakeholders hold different perspectives. Second, in a survey participants may sometimes want to portray themselves in a better light. Third, a survey may lead to bias since people who respond to them are usually extremes of the continuum, mostly the opinionated, generally better educated, and wealthier. Fourth, a survey may lead to less representation of the minority groups (Lange 2002:78; Saunders et al 2009:145).

### **3.5 LEVEL 1: QUANTITATIVE RESEARCH METHODS**

A quantitative and descriptive research methodology was used at this level (level 1) to collect data from the health workers (appraisees) in their facilities. The research objectives guided the investigations regarding the unknown aspects of the performance of health workers. Responses to quantitative research objectives are usually presented in statistical form.

#### **3.5.1 Population and sampling at level 1 (Health facility level)**

The research methods that were used in sampling and collection of data from the health workers during the quantitative strand are described in the following sections.

##### **3.5.1.1 Study population for level 1**

Amin (2005:235) defines a study population as ‘...a complete collection of all elements or individuals that are of interest in a particular investigation and where inferences are to be made’. Trochim (2006:32) describes study population as a group to which the results of the study are generalised. According to Saunders et al (2009:212) a study population is ‘...a full set of cases from which a sample is taken’. The study population may include study objects such as individuals, groups, organisations, human products, and events to which they are exposed. Taking this into account, the study population at this level (health facility level) were all health workers (appraisees) working in decentralised services in Uganda.

##### **3.5.1.2 Target population for level 1**

Polit and Beck (2008:338) define target population as ‘...the aggregate of cases about which the researcher would like to make generalisations’. A target population according to Burns and Grove (2007:324) is the entire set of

individuals or units that meet the sampling criteria. Amin (2005:235) describes target population as one to which the researcher would wish to generalise the results. For the purpose of this study, the target population at level 1 constituted the health workers (appraisees) working in Eastern region of Uganda.

### 3.5.1.3 Accessible population for level 1

According to Burns and Grove (2007:324) an accessible population is ‘...the portion of the target population to which the researcher has access’. Polit and Beck (2008:338) also define accessible population as ‘...the aggregate that conforms to the designated criteria and are accessible as participants of the study’. Amin (2005:235) describes accessible population as one from which the sample is actually drawn. This implies that results from the sample should only be generalised to the sampled population and generalisation to the target population will depend on the similarity that exist across the population. In this study, the researcher selected the sample from health workers working in the selected four (4) districts of Eastern Uganda namely: Kumi, Mbale, Sironko and Tororo. At the time of this study, there were 828 health workers (doctors, clinical officers and professional nurses) working in the 4 districts. The distribution of health workers in the four districts is shown in Table 3.1.

**Table 3.1: Distribution of health workers in the four districts of Eastern Uganda (N=828)**

District	Distribution of health workers by Cadres			Distribution of health workers by level of health facility				Total (%)
	Doctors	Clinical Officers	Nurses & Midwives	Hospital	HC IV	HC III	HC II	
Kumi	17	44	112	101	0	53	19	173 (20.9%)
Mbale	38	72	198	174	55	62	17	308 (37.2%)
Tororo	22	59	137	107	43	59	9	218 (26.3%)
Sironko	0	36	93	0	54	63	12	129 (15.6%)
<b>Total (%)</b>	<b>77 (9.3%)</b>	<b>211 (25.5%)</b>	<b>540 (65.2%)</b>	<b>382 (46.1%)</b>	<b>152 (18.4%)</b>	<b>237 (28.6%)</b>	<b>57 (6.9%)</b>	<b>828 (100%)</b>

Sources: Health workers' registers at the Kumi, Mbale, Sironko and Tororo DHO's offices, April 2010

Table 3.1 presents the distribution of health workers targeted for quantitative study (level 1). From this table, it can be noted that professional nurses and midwives form the dominant group (n=540; 65.2%), followed by clinical officers (n=211; 25.5%) and doctors (n=77; 9.3%). The distribution by the level of health facility indicates that there were more health workers in hospitals (n=382; 46.1%), HC III had 237 (28.6%) health workers, HC IV had 152 (18.4%), and HC II had 57 (6.9%) health workers.

#### **3.5.1.4 Sampling frame for level 1**

Saunders et al (2009:214) and Trochim (2006:32) describe the sampling frame as ‘...a list of elements from which the probability sample is selected’. In this study, the sampling frame for the quantitative approach was the lists of all health workers namely: doctors, nurses, and clinical officers working in the four selected districts. Each DHO maintains a register of health workers in his jurisdictions. These registers include the name, age, gender, cadre, location, and date of appointment among others. The numbers of each category of health workers are indicated in Table 3.1.

#### **3.5.1.5 Sample size determination for health workers**

After establishing the number of individuals in the target population, the researcher used the tables developed by Krejcie and Morgan (1970:608) to determine the required sample size for the quantitative study. The sample size is dependent on the accuracy required and the likely variations in target population.

According to the DHOs’ registers in the four districts, there were 828 health workers (doctors, clinical officers and nurses and midwives) as of April 2010 working in the health facilities. Based on this information and using the tables developed by Krejcie and Morgan (1970:608), at 95% confidence interval the minimum sample size required for this study is approximately 265 health workers. Polit and Beck (2008:351) point out that not everybody invited to

participate will cooperate; hence, the research anticipated lack of cooperation or attrition from about 25% of the sampled population. Therefore, instead of taking the actual sample size, the researcher decided to increase the sample size by at least 25% ( $265 + 25/100 \times 265 = 265 + 66 = 331$ ). The final sample size for this study was 331 health workers drawn from the four districts in eastern Uganda. Saks and Allsop (2007:219) assert that the larger the sample size, the smaller the error in estimating the characteristics of the target population but the more costly it becomes to conduct the study.

### **3.5.1.6 Sampling and sampling techniques of health workers**

A sample is a portion of population whose results can be generalised to the entire population for the particular study (Polit & Beck 2008:339). Therefore, sampling is the process of extracting a portion of the population from which generalisation of the findings can be made (Amin 2005:237; Polit & Beck 2008:339). Sampling is useful because it is more practical and economical. The use of sampling economises on costs and time spent on the sample as compared to the larger populations. Furthermore, sampling ensures completeness and high degree of accuracy due to the limited area of operation. The main disadvantage of sampling is that the selected units may not be representative of the population, even when the best statistical methods have been applied, especially when the sample size is small. In addition, accessible population is not usually 100% representative since elements that are not accessible might be different from the accessible ones (Amin 2005:239; Burns & Grove 2007:327).

A sample may be selected using probability or non-probability sampling methods. A probability sample is one that is selected randomly such that all the elements in each sampling frame have an equal chance of being chosen. Probability sampling methods include: simple random sampling, stratified sampling, systematic sampling, cluster sampling and panel sampling (Amin 2005:244; Polit & Beck 2008:340; Saunders et al 2009:222).

For the purpose of this study, the researcher used probability stratified random sampling to select participants for the quantitative strand. In stratified sampling the population is divided into two or more strata such that the elements within each sub-population are homogeneous. Then using random sampling, the samples are selected independently from each sub-group (Amin 2005:246; Saks & Allsop 2007:159; Saunders et al 2009:228).

In each district, the researcher stratified the target population by cadre and level of health facility (hospital, HC IV, HC III & HC II). In order to get a representative sample, the researcher followed the Neuman's rule of thumb to achieve the appropriate proportions of the sample from each stratum. Neuman's rule of thumb states that for a small population (under 1,000) a larger sampling ratio is needed (about 30%) and for a larger population (about 10,000) a smaller ratio is needed (10%) (Neuman 2006:241-242). In this study the target population was under 1000 health workers, therefore the researcher applied a big sampling ratio of 40% on each stratum to obtain the required sample of 331 participants. The resultant distribution of the sample is shown in Table 3.2.

**Table 3.2: Proportional distribution of the participants in the sample (N=331)**

District	Distribution of health workers by Cadres			Distribution of health workers by level of health facility				Total (%)
	Doctors	Clinical officers	Nurses & Midwives	Hospital	HC IV	HC III	HC II	
Kumi	7	17	45	40	0	21	8	69 (20.8%)
Mbale	15	29	79	69	22	25	7	123 (37.2%)
Tororo	9	23	55	43	17	24	3	87 (26.3%)
Sironko	0	15	37	0	22	25	5	52 (15.7%)
<b>Total (%)</b>	<b>31 (9.4%)</b>	<b>84 (25.4%)</b>	<b>216 (65.2%)</b>	<b>152 (45.9%)</b>	<b>61 (18.4%)</b>	<b>95 (28.7%)</b>	<b>23 (6.9%)</b>	<b>331 (100%)</b>

After categorising the members of the population as elements of one of the identified sub-groups, the researcher allocated numbers (starting from 001) against the names of the health workers and by use of the tables of random numbers, the required sample for each category was selected. Replacement was done using the same procedure for the selected individuals who were found

to be out their stations during the start of data collection. Authors like Amin (2005:246) and Saks and Allsop (2007:159) mention that the desired number of units from each stratum is selected proportionately. Hence, the selection of sample from each stratum depends on its size. This implies that large samples were selected from big strata and small samples from the smaller strata. This ensured representativeness of all the strata.

Table 3.2 summarises the distribution of the participants from the established sample size (N=331). From the table it is noted that 20.8% (n=69) were drawn from Kumi district; 37.2% (n=123) from Mbale district; 26.3% (n=87) from Tororo district; and 15.7% (n=52) from Sironko district. With respect to the distribution by cadre, 9.4% (n=31) were doctors; 25.4% (n=84) clinical officers; and 65.2% (n=216) were professional nurses and midwives. With respect to the health facilities, 45.9% (n=152) were hospital based; 18.4% (n=61) from HC IV; 28.7% (n=95) from HC III; and 6.9% (n=23) from HC II.

### **3.5.2 Data collection during the quantitative study (level 1)**

Burns and Grove (2007:536) define data collection as ‘...identification of respondents and systematic gathering of information relevant to the aim and objectives of the study’. Saunders et al (2009:256) describe data collection as the gathering of information required to address the research problem. In case of concurrent mixed methodology both quantitative and qualitative data is collected simultaneously with equal priority given to both types of data. In this study, the researcher used structured data collection methods. During the quantitative approach, the researcher used self-administered questionnaires (Amin 2005:281; Saunders et al 2009:400).

### **3.5.2.1 Data collection approach and method for health workers**

Since this study followed a concurrent mixed methods approach, the researcher collected data (quantitative and qualitative) simultaneously using a self-administered structured questionnaire. Structured data collection involves the use of formal instruments composed of pre-defined items and response options (Polit & Beck 2008:371; Saunders et al 2009:601).

The questionnaire items consisted of mainly closed-ended questions. The development of the questionnaire was guided by the objectives of the study and the theoretical model (Saunders et al 2009:362). The structured methods yield data that are relatively easy to quantify and analyse. Polit and Beck (2008:369) state that '...structured self-report data collection method is strong in respect to its directness, versatility, content coverage, and yields information that would otherwise be difficult to obtain through other means'.

Burns and Grove (2007:551) define a questionnaire as '...a printed, structured self report form designed to collect information through written or verbal responses'. Amin (2005:269) agrees that a questionnaire is a form consisting of interrelated questions prepared by the researcher concerning the problem under investigation. It is assumed that if a questionnaire is to be used the participants must be able to read and understand the items, possess information to answer the questions, and be willing to answer questions honestly.

The researcher opted to use the questionnaire during this study because of its advantages. Questionnaires are less costly compared to other methods and usually offer greater assurance of anonymity. Additionally, questionnaires can cover a wider geographical area since the researcher can approach respondents more easily than any other method. Although the use of questionnaire is advantageous, it has its own drawbacks, since it does not allow for probing, prompting and clarification. At the same time, it does not give the researcher an opportunity to motivate respondents to participate in the process of filling the questionnaires; the identity of individual is concealed and hence, it is uncertain



whether the questions are answered by the targeted population. Furthermore, questionnaire items are fixed, and due to lack of supervision some items in the questionnaire are sometimes partially filled (Amin 2005:270; Polit & Beck 2008:369; Saunders et al 2009:365).

### **3.5.2.2 Construction of the questionnaire**

In mixed methods approach, the researcher uses different tools to collect data on the same topic (Saunders et al 2009:146). In this case, the researcher developed two separate tools one for each level of the data collection process (quantitative & qualitative). A self-administered questionnaire was developed for quantitative strand and a structured interview guide for the qualitative strand. A questionnaire must be clear, simple, and unambiguous. It ought to be arranged in an orderly manner in such a way that data analysis is easy (Polit & Beck 2008:425; Saunders et al 2009:387). The researcher developed the structured questionnaire for health workers (appraisees) with items based on a 5-point Likert scale-style (strongly agree, agree, undecided, disagree, and strongly disagree). The questionnaire was developed based on the literature review, the research objectives, and the theoretical model. The researcher also looked at the other tools that have been used by other investigators in similar studies and adapted some of the questions that are appropriate for this study.

Almost all questionnaire items were close-ended and worded in such a way that the participants were limited to specified mutually exclusive response options. Closed options facilitate coding and statistical analysis of data. It also ensures that the researcher obtains the desired information, which can increase the reliability of the study (Saunders et al 2009:374). Therefore, the assistance of the study promoters and statistician was sought in this regard. The questionnaires were in English.

### 3.5.2.3 Structure of the questionnaire

The self-administered questionnaire (Annexure H) was divided into six sections (A-F). These questions were designed to elicit information about the factors that enhance or impede the performance of health workers and the current practices for managing performance in the decentralised services. All questionnaire items were closed-ended and on a 5-point Likert scale except section A which deals with the demographic characteristics of the participants and question number 38 which was open-ended.

**Section A** consisted of nine items about the personal and health facility information such as gender, age, marital status, current profession, highest qualifications, years of experience, type of health facility, and district of employment.

**Section B** consisted of five questions concerning individual attributes presented on a 5-point Likert scale such as skills and abilities, self-monitoring ability, intrinsic motivation, organisational commitment, as well as values and beliefs.

**Section C** consisted of four questions, also on a 5-point Likert scale, on individual behaviours for performance such as proficiency, adaptive, and proactive behaviours for performance.

**Section D** consisted of five questions on the situational and organisational factors that might influence performance such as clarity of organisational strategy, working environment, staffing issues, work schedules, and organisational culture.

**Section E** consisted of four questions investigating the health workers' performance dimensions (availability, competence, productivity, and responsiveness) on a 5-point Likert scale.

**Section F** consisted of ten questions concerning the current performance management practices in the districts. Eight questions used a 5-point Likert scale, while one question (question number 30) made use of “yes” and “no” answers, while the question on suggestions of health workers on how to improve their own performance (question 38) was open-ended. The items in this section included those on performance reviews and standards, performance reporting, performance improvement, rewarding system, staff development, and the suggestion on how performance can be improved.

#### **3.5.2.4 Pre-testing of the data collection tools**

Polit and Beck (2008:762) define pre-test as ‘...the trial demonstration of a newly developed instrument to identify flaws or assess time requirements’. Pre-testing is conducted in order to identify possible weaknesses in the research instruments. Polit and Beck (2008:214) and Saunders et al (2009:394) mention that pre-testing a questionnaire assists the researcher to find out:

- the time it will take to fill the questionnaire;
- the comprehensibility of the instructions;
- if items on the questionnaire are ambiguous;
- whether there are any major omissions in the questionnaires;
- whether the layout is clear and attractive; and
- potential confounding variables that may necessitate control.

In this study the pre-testing of the questionnaires was done at two levels. The first level was with the experts in the field of study and the second level was with the health workers and their managers.

##### **3.5.2.4.1 Expert review of the data collection tools**

Following the design and construction of the questionnaires, the researcher requested and sent the data collection tools to five experts and two promoters to assess the relevancy and content of the questionnaire items. These experts

included two with human resources management background; two public health experts; and one statistician. In addition the two promoters for this research also thoroughly reviewed the questionnaire.

The general view of the experts was that the data collection tools were comprehensive enough to cover all the variables indicated in the theoretical framework. All the questionnaire items were relevant to the study, and the length of the questionnaire was acceptable. The following were the recommendations from the experts and promoters for improvement on the questionnaire:

- In section A, to include whether facility is rural or urban. This led to the inclusion of question 10 (Annexure H) which was not initially in the questionnaire.
- For question 7 (option 1) of the self administered questionnaire (Annexure H), the word 'district' was removed, and left to read as 'hospital'. This is because some districts might have more than one hospital.
- It was recommended that some questionnaire items should be 'positively' worded from the initial 'negative' statements. These items (Annexure H) included; 12.1, 12.2, 21.9, 21.10, 21.11, 24.4, 26.6, 26.8, 26.9, 26.10, 27.5, and 27.6. Hence, all the items in the questionnaire are now positively worded.
- For question 24 (item 24.7) it was suggested that the word 'district' be dropped in favour of 'local political leadership'.
- For question 33 (items 33.1, 33.2, 33.4) and question 34 (item 34.5), the word 'district' was replaced by the word 'organisation'.

All these suggestions were incorporated in the final draft of self-administered questionnaire (annexure H).

For the interview schedule (Annexure I), the experts indicated that all the questions were straight forward, inclusive and clear. Therefore no modifications were made.

#### **3.5.2.4.2 Pre-testing with the health workers and health services managers**

Following incorporation of the suggestions of the experts and after obtaining permission from the relevant authorities, the researcher pre-tested the draft questionnaire with 12 experienced participants/health workers (7 professional nurses/midwives, 3 clinical officers, and 2 doctors). These were selected from Mbale hospital in Mbale district and Atatur hospital in Kumi District using convenience sampling. The questionnaire was delivered by the researcher himself accompanied by a letter explaining the purpose of the pre-test. The participants were requested to give constructive feedback regarding the clarity of the questions and the time required to complete the questionnaires.

Generally, the health workers indicated that the questions were clear and easy to answer since most of it was structured. However, they complained that the self-administered questionnaire was long but the questions were interesting and relevant. The health workers indicated that the questionnaires took them between 40 and 55 minutes to complete. The health workers who participated in the pre-testing were not included in the main study.

#### **3.5.2.5 Administration of the questionnaire**

Once the questionnaire was designed, pre-tested, and amended, it was copied and used to collect data from the sampled participants. The researcher and the research assistants delivered the self-administered questionnaires to 331 participants, and collected them after one to two weeks. Delivering the questionnaires to the participants and collecting them after that period, allowed sufficient time to answer the questions (Amin 2005:281; Saunders et al 2009:400). The researcher used this method because postal services in Uganda are unreliable, and because this method is known to achieve high response rates. Saunders et al (2009:400) point out that although this method adds costs, the response rates as high as 98% could be achieved.

Table 3.3 shows the number of usable questionnaires that were returned and used during the analysis.

**Table 3.3: Number of questionnaires sent and returned in usable state**

District	Number (n) of questionnaires sent out for distribution	Number (n) and percentage (%) of usable questionnaire returned
Kumi	69	55 (79.7%)
Mbale	123	106 (86.2%)
Tororo	87	65 (74.7%)
Sironko	52	50 (96.2%)

Table 3.3 shows that slightly over 96% (n=50; 96.2%) of the questionnaires sent, were returned from Sironko district in usable state. Tororo district had the lowest number of usable questionnaires returned (n=65; 74.7%). Overall, the response from the districts was good.

### **3.5.3 Validity and reliability of the questionnaire**

Validity and reliability are two important concepts in the usability of an instrument for research purposes.

#### **3.5.3.1 Validity of the questionnaire**

Validity is the suitability of instrument while reliability refers to its consistency in measuring whatever it is intended to measure (Polit & Beck 2008:457). Amin (2005:285) describes validity as the ability to produce findings that are in agreement with theoretical or conceptual values. A research instrument is said to be valid if it actually measures what it is supposed to measure. Burns and Grove (2007:365) assert that validity of a research instrument is the determination of how well the instrument reflects the theoretical concept being examined. Several writers (De Vos et al 2005:160; Polit & Beck 2008:458; Saunders et al 2009:372) identify four main approaches for measuring the validity of research instruments, these include: face, construct, content and criterion-related validity.

In this study, the researcher made use of face, construct and content validity. Saunders et al (2009:373) define construct validity as the extent to which the questions actually measure the presence of the variables one intends measure. The researcher ensured construct validity by rooting the measures in a wide literature search that defines meanings of the construct and its elements. The researcher also ensured that categories of meaning are relevant to the participant in their natural setting. Content validity on the other hand refers to the extent to which the measurement tool provides adequate coverage of the research questions (Saunders et al 2009:373). In this study, content validity was ensured through careful sampling and good formulation of the research instrument items. This ensured that the questionnaire items are relevant to the study. The experts in the field of study such as the promoters of this study, human resources management lecturers, public health experts and a stastician were called upon to assess whether or not the instrument items were relevant and adequately covered the known content of the subject (De Vos et al 2005:161; Polit & Beck 2008:482-483). Despite all these, the researcher observed that using these methods might introduce bias due to their subjectivity. The validity of the research instruments can be external or internal.

- **External Validity**

External validity is the degree to which the research findings can be generalised to the wider population (Polit & Beck 2008:287; Saunders et al 2009:216). In this study, external validity was ensured through the use of probability sampling, specifically stratified sampling in order to have adequate representation from the major categories of health workers. In addition, the researcher tried as much as possible to get the correct composition and adequate sample size for the study. The researcher selected constructs relevant to the study population in general and not only a portion of the target population. Furthermore, the researcher selected participants from all levels of health facilities including the hospitals, HC IV, HC III, and HC IIs.

- **Internal validity**

Internal validity is intended to reveal that the reasons for a particular event or set of data derived from the research can actually be sustained by data; in other words the findings of the study must describe accurately the phenomena being researched (Polit & Beck 2008:295). In this study, internal validity was ensured through construction of questionnaires in line with study objectives, and voluntary participations of respondents.

### **3.5.3.2 Reliability of the questionnaire**

Saunders et al (2009:156 & 373) refer to reliability as ‘...the extent to which data collection and analysis techniques yield consistent findings’. Polit and Beck (2008:452) define reliability as ‘...the consistency with which the research instruments measure the targeted attributes’. Hence, when a research instrument is administered by various researchers, it should provide similar results under comparable conditions (De Vos et al 2005:163). In this study, reliability was equated to clarity, quality, stability, consistency, adequacy, and accuracy of the research instruments. For purpose of this study, reliability was ensured through pre-testing of the questionnaires to ensure clarity of the test items. In addition, reliability of test items was tested by means of Cronbach’s coefficient Alpha ( $\alpha$ ), which is an index for testing internal consistence of the test items using SPSS. All the constructs except one, had Cronbach’s alpha of 0.70 and above except one construct (question 30) which had an alpha of 0.61 (see Table 4.2). As a rule, Alpha ( $\alpha$ ) should be at least 0.70 or higher (Amin 2005:298; Polit & Beck 2008:454-456).

### **3.5.4 Quantitative data analysis**

Amin (2005:306) refers to data analysis as ‘...closely related operations which are performed for the purpose of summarising the collected information and organising it in such a way that they answer the research questions’. In this study, the researcher used computer software called Statistical Package for



Social Sciences (SPSS) for data entry and analysis of quantitative data. Analysis of closed-ended questions was done using descriptive statistics and inferential statistics (Spearman's *rho* rank order correlation statistics). The analysed data was presented in the form of frequency tables, charts, and text where appropriate. The researcher analysed open-ended questions using qualitative content analysis, with the aim of quantifying the emerging characteristics and concepts. Polit and Beck (2008:517) describe content analysis as the process of analysing the substance of narrative data to identify prominent themes and patterns among the themes. It involves breaking down data into smaller units, coding, and naming the units according to the content they represent, and grouping coded material based on shared concepts. The researcher employed the services of a statistician to help with data entry and analysis.

### **3.6 LEVEL 2: QUALITATIVE RESEARCH METHODS**

The researcher collected data from the health service managers (appraisers) using qualitative research methods. This method enabled the researcher to explore and explain the performance of health workers, and to get in-depth analysis on why performance is managed the way it is. Furthermore, the researcher used this method to collect the views of the health service managers on how performance can be improved.

#### **3.6.1 The target population and sampling for level 2**

During this study, the target population for the qualitative strand constituted the health service managers (appraisers) working in the four selected districts of Eastern Uganda.

##### **3.6.1.1 Sampling of health service managers**

The researcher selected managers/supervisors (appraisers) of health workers to participate in qualitative study using purposeful or judgemental sampling method. Purposive sampling is a non-probability sampling method in which the

researcher uses his own judgement regarding the participants from whom information is collected (Polit & Beck 2008:355). The researcher usually chooses the sample based on his knowledge of the group to be sampled and is certain that respondents have the information required. The main disadvantage of this method is its potential for inaccuracy in the researcher's criteria and the resulting sample selection (Amin 2005:242; Saunders et al 2009:237).

During this study the inclusion criteria was health managers who have worked in the selected districts for at least 6 months, and were involved in supervising, and appraising health workers. Both the male and female managers were included. Additionally, participants had to voluntarily consent to participate in the study. The political leaders who are members of the DHMT were excluded.

### **3.6.1.2 Sample size for health service managers**

Polit and Beck (2008:357) suggest that the sample for qualitative study should be determined based on the information needs. Hence, the guiding principle in sampling is data saturation (sampling to the point at which no new information is obtained, and redundancy is achieved). In this study, a total of 24 health services managers were invited to participate, however, only 21 managers accepted to be interviewed. This gave a response rate of 87.5% from the managers. Teddlie and Yu (2007:88) emphasise that a sample size of least 20 to 30 is adequate to achieve representativeness, and reach the saturation level in a qualitative study.

### **3.6.2 Data collection during the qualitative study (level 2)**

The researcher used a semi-structured interview guide (annexure I) to collect data from the health service managers.

### **3.6.2.1 Data collection approach and method for health service managers**

As already stated, the researcher used a semi-structured interview guide (annexure I) for the qualitative strand of this study in order to have uniformity in the questions. According to Saunders et al (2009:320) structured interviews are based on identical set of questions. The interview technique is unique in that it involves the collection of data through direct verbal interaction. The response rates are usually high during face-to-face interactions given that many people cannot easily fill out the questionnaires. The interview situation permits the researcher to follow verbal leads and thus obtain more data and greater clarity of the questions which seem to be ambiguous or confusing to the participants. The interview situation also permits greater depth than other methods data collection such as the questionnaires (Amin 2005:274; Polit & Beck 2008:424).

Indeed Polit and Beck (2008:424) emphasise that the strengths of interviews outweigh those of questionnaires, although they are costly, prevent anonymity and bear the risk of interviewer bias. In addition, the interviewees are less likely to give 'I don't know' answers, hence missing information is minimised. In an interview the order of the questioning does not matter a lot, since the interviewer is at liberty to change the order in which the questions are asked. Interviews also help to control the sample since the researcher knows whether the participants are the intended target. Lastly, with face-to-face interviews additional information such as understanding and the level of cooperation can be obtained through direct observations (Polit & Beck 2008:425).

### **3.6.2.2 Development of the interview schedule**

The interview guide for the health service managers (appraisers) was developed based on the theoretical framework, literature review, and the objectives of the study. The structured interview guide was meant to solicit in-depth information about performance of health workers and the current practices used to manage their performance.

### **3.6.2.3 Structure of the interview schedule**

The semi-structured interview guide (Annexure I) consisted mainly of open-ended questions. The interview guide had two main parts namely sections A and B.

**Section A** consisted of seven questions or items about the biographic data of the participants such as the gender, age, district of employment, whether they have qualification in management, and opportunities for discussing performance. This section has a mixture of closed and open-ended questions.

**Section B** consisted of eight open-ended questions. These questions were meant to probe about factors that enhance or impede the performance of health workers and how decentralisation has affected performance of health workers. Other questions probe about the health workers' behaviours towards their patients. The manager's perspective of adaptive, proactive, and proficiency performance behaviours of the health workers within their respective districts were explored. Furthermore, the interview guide consists of probing questions concerning the dimensions of performance of health workers namely availability, competence, productivity, and responsiveness. There are also questions to investigate how performance appraisal is planned, measured, reported, recognised, and how the appraisal information is utilised. Lastly, the researcher elicited the views of the health services managers on how they wish to see performance of health workers improved in their districts.

### **3.6.2.4 Training of the research assistants**

The researcher recruited four research assistants to assist in data collection during both the quantitative and the qualitative phases. The research assistants participated in distributing and collecting the questionnaires in the quantitative phase and were also involved in collecting data from health service managers in the respective districts. The researcher recruited research assistants with background training in public health and social sciences at post graduate level, and with prior experience in conducting research. They had good communication

skills, and were fluent in both written and spoken English. Training was conducted in order to ensure standardisation of data collection process. Depending on the prior experience of the research assistants, training covered both the general procedures (such as how to conduct an interview), and those specific to this study (such as how to administer particular questions) as well as the ethical standards for conducting research (Polit & Beck 2008:382). The training covered topics and discussion on interview techniques. This was followed by rehearsals and role plays, until the research assistants mastered the skills (Polit & Beck 2008:383). The training took two days and was facilitated among others by one consultant on qualitative research methodology from Makerere University Institute of Social Research.

### **3.6.2.5 Administration of the interviews**

The structured interviews use formal and written questions which are asked face-to-face with interactions between the interviewers and the participants (Polit & Beck 2008:428). Polit and Beck (2008:429) point out that administering interview schedules requires different skills. The quality of interview data relies heavily on interviewer's proficiency. During this study, the researcher together trained research assistants tried as much as possible to put the participants at ease so that they feel comfortable in expressing their opinions. The interviews were conducted at the respective offices of the participants. The interviewers kept time of the appointments, and attempted to be unbiased (Polit & Beck 2008:429). Questions were asked orally in English, as they appear on the interview schedule and the responses were recorded both in audio and writing.

By probing and repeating the questions when required, the interviewers elicited more useful information about the study topic. Before the interview commenced, the interviewers explained the purpose and procedure for the interview, and requested for permission to use an audio tape recorder (Polit & Beck 2008:386). The participants were assured that all the information they were to provide would be treated with utmost confidentiality. The interviews only commenced after an informed written consent. The participants were assured that they were free to

withdraw from the interview at any time even if they had earlier consented. The participants were also given an option to stop the tape at any time during the interview. The interviews were transcribed in full, and participants were asked to review the transcription after each interview (Saunders et al 2009:485). The participants were encouraged to make additional notes directly on the transcribed page which were returned to the researcher. This process was important for those participants who were comfortable with written versus oral expression (Troiano 2003:406).

### **3.6.2.6 Criteria for enhancing quality and integrity of qualitative data**

Polit and Beck (2008:763) define qualitative research as ‘...the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research designs’. Both qualitative and quantitative researchers need to test and demonstrate that their studies are credible. While credibility in quantitative research depends on instrument construction, in qualitative research the researcher is the instrument (Patton 2002:14; Saunders et al 2009:182). Although reliability and validity are treated separately in quantitative studies, these terms are not viewed separately in qualitative research. Instead the terminology that encompasses both such as credibility, transferability, and trustworthiness is used instead (Golafshani 2003:600; Polit & Beck 2008:196).

Lincoln and Guba (1985) cited in Polit and Beck (2008:539) propose four constructs for measuring the trustworthiness or soundness of the qualitative research design. These include credibility, transferability, dependability and confirmability. In this study the researcher made use of these constructs to ensure the trustworthiness of the findings. A variety of techniques were used to ensure that these four qualitative dimensions are tested and met.

- **Credibility** refers to how accurately the subject of the study is identified and described by the inquiry (Troiano 2003:407). Polit and Beck (2008:539) refer to credibility as the confidence in truth of data and its interpretation. In this

study, credibility was ensured through memoing, member checking, and peer debriefing (Polit & Beck 2008:545-548). In addition, the researcher took comprehensive field notes; audio taped the interviews, and transcribed the interviews verbatim.

- **Dependability** refers to the stability (reliability) of data over time and conditions (Polit & Beck 2008:539). Troiano (2003:407) mentions that dependability measures the researcher's ability to account for changes in the phenomenon under study. In this study, the researcher strengthened dependability through checking and re-checking for the presence or absence of the phenomenon by careful documentation of the interviews. In addition, dependability was ensured through space, person, investigator, and methodological integration (triangulation) of data (Polit & Beck 2008:549).
- **Confirmability** refers to the congruence between two or more independent people about the accuracy, relevance and meaning of data (Polit & Beck 2008:539). In other words confirmability is a measure of the researcher's objectivity. In this study, confirmability was reinforced through inter-coder checks, peer review and through debriefing sessions (Polit & Beck 2008:544).
- **Transferability** refers to extent to which the findings can be applied or have applicability in other settings or groups (Polit & Beck 2008:539). In this study, the applicability of one set of data was achieved through triangulation of data by use of multiple informants and multiple data collection methods. The applicability was also ensured by taking comprehensive field notes and ensuring that an adequate sample for data saturation was reached (Polit & Beck 2008:544; Troiano 2003:407). Indeed, by the 17<sup>th</sup> interview, the researcher had started getting almost no new information from the respondent which was an indication of data saturation.
- **Authenticity** refers to the extent to which the researcher fairly and faithfully showed a range of different realities. According to Polit and Beck (2008:540), authenticity emerges in a report when it conveys the tone of participants. In this study, authenticity was ensured through audio taping and verbatim transcription of the interviews. In addition, authenticity was also achieved through prolonged engagement with the participants.

### **3.6.3 Qualitative data analysis**

Qualitative research is increasingly becoming common in health service research (Bradley, Curry & Devers 2007:1758). The analysis of qualitative data is labour intensive. It requires creativity, and conceptual sensitivity (Polit & Beck 2008:507). The analysis of qualitative data is an active and interactive process. Generally, qualitative data is challenging even to experienced researchers because there is lack of universal rules for data analysis and enormous amount of work is required to reduce data for reporting purposes (Polit & Beck 2008:507). Data analysis in qualitative research usually begins during the process of data collection, mainly because the results of early data collection guide the subsequent field work and allow timely theorising of the results (Polit & Beck 2008:508).

#### **3.6.3.1 Processing and analysing interview data**

Bradley et al (2007:1758) and Polit and Beck (2008:509) mention that the analysis of interview data involves a systematic approach for discovering and categorising ideas that are conveyed by the participants. The first step in data analysis is data-coding process. It is almost impossible to interpret qualitative data unless one codes them. The codes define categories by pooling a wealth of ideas into some order and structure. The codes are tags or labels which are assigned to the whole document or segments of the document to help categorise key concepts while preserving the context in which these concepts occur (Bradley et al 2007:1761). In this study, once the categories were identified and given names, the researcher related them to the main phenomenon or idea (performance of health workers). The coded results provided a comprehensive summary of the content of the interviews.

Saunders et al (2009:490-497) suggest the following procedures for generating meaning from transcribed and interview data:



- counting frequencies of occurrences of themes;
- noting patterns of the themes, which may originate from repeated themes;
- considering plausibility by making sense out of the data collected to reach a conclusion;
- clustering by setting items into categories;
- identifying and noting relationships between themes;
- building a logical chain of evidence by noting causality and making conclusions; and
- making conceptual coherence by moving from constructs to theories to explain the phenomena.

In this study, the researcher followed the following steps when processing the data from the transcriptions of the audio taped interviews and field notes. In case of each interview question the researcher:

- read the data from each set without writing down anything;
- read the data the second time and noted the themes and patterns emerging as characteristics about performance of health workers;
- wrote down the themes and categories as they appeared in each set of data. These themes were laid out on a chart such that the information from each case was visible. Codes were then developed for the themes that are related to the research objectives;
- used the codes from each theme, to enable the researcher to revisit the data sets and coded the relevant segment in each theme; and
- from the data recorded against each theme, the answers to the relevant research objectives were obtained. This data was then crosschecked by the statistician to ensure that there was consistency between the themes, subthemes and the categories.

### **3.7 ETHICAL CONSIDERATIONS**

According to De Vos et al (2005:57) ethics means ‘...preferences that influence behaviour in relations’. Ethics is mostly associated with morality, to deal with issues of rights and wrong among societies. Therefore, ethics in the use of human subject for research should not go without careful examination. Amin (2005:28) adds that ethics refers to ‘...well based standards of right and wrong that prescribe what humans ought to do usually in terms of rights, obligations, benefits to society, fairness, or specific virtues’. Polit and Beck (2008:753) also describe ethics as a system of moral values concerned with the degree to which research procedures adhere to professional, legal and social obligations of the participants. Therefore, ethical consideration in research should uphold fairness, honesty, openness, disclosure of methods, and the purpose for which the research is being carried out. Based on this understanding, the researcher followed the following ethical standards during the process of this study.

#### **3.7.1 Protecting the participants**

Every individual is entitled to the right to privacy and dignity. In this study, the researcher treated the respondents with respect and sought their cooperation through an informed written consent (Annexure E) (Polit & Beck 2008:171). Amin (2005:40) and Saunders et al (2009:187) argue that participants should be told of the research interest and should give permission to proceed. The researcher ensured that the participants’ identities are protected so that the information collected does not harm them in any way. No participant’s names were recorded in any form on the questionnaires to ensure anonymity and confidentiality (Polit & Beck 2008:170). The researcher did not at any point relate any information collected to any particular individual. The researcher only collected data relevant to this study and made the necessary effort to disclose and explain how the participants would benefit from the results of this study. It was important for the participants to understand the value of the study and how the information would be used before giving their consent. Participation in this study was voluntary and participants were informed of their right to withdraw from the study even if they

had initially given their consent. No form of coercion was used for those individuals who did not show interest to participate in the study (Polit & Beck 2008:172).

### **3.7.2 Protecting the right of the institution**

The researcher requested and received ethical clearance of the study from the Research and Ethics Committee at the Department of Health Studies of the University of South Africa (Annexure A). The researcher presented the certificate of ethical clearance of UNISA to Uganda National Council for Science and Technology (UNCST) to get clearance to collect data in Uganda (Annexure B). The researcher also requested for permission from the Ministry of Health in Uganda to conduct the study in the public health facilities (Annexure C). At the district and health facility levels permission was sought from DHOs and the respective heads of the hospitals and health centres (Annexure G). The researcher promised to abide by the agreements made during the negotiations for permission to conduct the study (Polit & Beck 2008:188). Furthermore, the facilities from where the participants were drawn were identified by level of health facility and not by name.

### **3.7.3 Scientific integrity of the research**

The researcher respected the work of others by acknowledging all the sources that were referred to in this study. The researcher used objective methods to collect, analyse and report the study findings. Therefore, the researcher chose the methodology to use based on the research objectives and not any other reason. The data was interpreted according to the methodological standards and not the researcher's fancy. The researcher maintained honesty when writing and reporting the findings by properly explaining the methods used and the reasons for doing so. No fabrication or distortion of data was done to fit what the researcher wanted to achieve (Polit & Beck 2008:188). The researcher only reported what the data revealed (Amin 2005:30; Saunders et al 2009:199). The

researcher honoured the participant's privacy. This study was low risk since it did not involve collection of any specimen from the respondents and the researcher did not have any contact with patients. Therefore, there was no harm this study caused to the participants.

### **3.8 CONCLUSION**

In this chapter the researcher has presented the research design and methodology that was used to conduct this study. The mixed methods approach was presented in detail. The sampling and sampling techniques used in this study were outlined. The structure of the data collection instruments was presented. Also presented are the strategies that were employed to ensure validity, reliability and trustworthiness of study findings. Lastly the researcher outlined the methods that were used to ensure that data was collected, analysed and reported ethically. In the next chapter, the researcher presents the analysis, presentation, and description of the quantitative research findings.

## **CHAPTER 4 ANALYSIS, INTERPRETATION AND DISCUSSION OF QUANTITATIVE DATA (LEVEL 1)**

### **4.1 INTRODUCTION**

This chapter discusses the quantitative data analysis and interpretation. Kruger, De Vos, Fouche and Venter (2005:218) mention that the purpose of quantitative data analysis is to categorise, order, manipulate, and summarise data to an intelligible and interpretable form in order to provide answers to the research objectives and be able to draw conclusions from the data.

The objectives of this study were to

- identify factors that impede or enhance the performance of health workers
- assess the current practices used to manage performance of health workers
- determine the views of health workers and their managers on how to improve performance
- develop a performance management framework for health workers based on the research findings

In this chapter, the data was analysed according to the objectives of the study. This implies that the results are not necessarily presented or discussed in the sequence of the theoretical framework or that of the questionnaire. This chapter is organised as follows: response rate, data analysis including testing for normality of the data, and the reliability of the scale used. The descriptive and inferential statistics that were used are briefly discussed. This is followed by the presentation of the demographic characteristics of the participants and the research findings. Finally the chapter summary is presented.

## 4.2 RESPONSE RATE

The response rate is the rate of participation in the study. According to Polit and Beck (2008:765) the response rate is calculated by dividing the number of persons participating in the study by the number of persons sampled. Table 4.1 shows the response rate for this study.

**Table 4.1: Response rate for the study**

<b>Descriptive information</b>	<b>Number of questionnaires</b>	<b>Percentage (%)</b>
Total number of questionnaire sent out	331	100
Total number of questionnaires returned	282	85.2
<b>Total number of usable questionnaires</b>	<b>276</b>	<b>83.4</b>

As shown in the Table 4.1, the response rate for this study was 83.4%, which is considered to be very good. This good participation is probably an indication that the study was interesting to the participants given that the questionnaire items were many. Using a similar approach to data collection in their study about perceptions of the working conditions of health workers in Nigeria, Chirdan, Akosu, Ejembi, Bassi, and Zoakah (2009:245) obtained a comparable response rate of about 85.4%. Murphy-Black (2006:378) points out that studies that use representative sample are dependent on a good response rate.

## 4.3 DATA ANALYSIS

Data analysis is the ability to breakdown data and to clarify the nature of the factors and the relationships between them (Saunders et al 2009:587). Polit and Beck (2008:751) describe data analysis as the systematic organisation, synthesis of research data, and testing of the hypothesis using those data. The purpose of data analysis is to provide answers to the research questions or objectives. The plan for data analysis comes from the research objectives, the research design, the methods of data collection used, and the level of measurement of data (Wood & Ross-Kerr 2006:243).

#### **4.3.1 Statistical analysis programme**

The software that was used to analyse the data for this study was the SPSS Version 18. The researcher collaborated with the statistician to analyse data. Data analysis was done using both descriptive and inferential statistics. The researcher set the p-value at less than 0.05 ( $p < .05$ ) as the level of statistical significance for the tests performed.

#### **4.3.2 Testing for the normality of data**

Following data entry and cleaning but before statistical analysis was carried out, the researcher together with the statistician tested the data for normality. This was done in order to determine the suitable statistical tests to use. The data for the 26 constructs was tested for normality using the Kolmogorov-Smirnov test. This test revealed that all the data was not normally distributed ( $p < .001$ ) (see annexure J). Therefore, since Likert scales produce ordinal data as opposed to interval data, and given that the data was not normally distributed the non parametric statistical tests were used (McCrum-Gardner 2008:39).

#### **4.3.3 Reliability of the data collection scale**

Reliability is the degree of consistence with which a research instrument measures a given attribute (Polit & Beck 2008:764). Hence, reliability test measures how consistent the participants were in answering a group of related questions. Therefore, before calculating the average of each respondent, one has to ascertain whether the responses were reliable.

The Cronbach alpha is the most widely used reliability index that estimates the internal consistency of a measure composed of several subscales. The Cronbach alpha ranges from .00 to 1.00. A measure of 1.00 signifies a perfect reliability.

George and Mallery (2003:231) provide the following rule of thumb for interpreting the Cronbach alpha: “>.90 – Excellent; >.80 – Good; >.70 – Acceptable; >.60 – Questionable; >.50 – Poor; and <.50 – Unacceptable”. Ideally, an alpha of .70 and above is acceptable and is considered a reasonable goal.

Table 4.2 present a summary of the reliability coefficients of the 26 constructs or questions used in this study.

**Table 4.2: Reliability coefficients for the 26 construct**

<b>Questions (Items)</b>	<b>Item or construct description</b>	<b>Number of items</b>	<b>Cronbach alpha (<math>\alpha</math>)</b>
11.1 - 11.10	Job related skills and abilities	10	.790
12.1 - 12.4	Self-monitoring ability	4	.865
13.1 - 13.9	Self motivation (intrinsic motivation)	9	.962
14.1 - 14.11	Commitment to organisation	11	.926
15.1 - 15.11	Individual values and beliefs	11	.849
16.1 - 16.5	Individual proficiency behaviour	5	.805
17.1 - 17.4	Individual adaptive behaviour	4	.818
18.1 - 18.3	Individual proactive behaviour	3	.763
19.1 - 19.10	Client-oriented behaviour	10	.860
20.1 - 20.9	Clarity of organisation strategy	9	.833
21.1 - 21.13	Working environment	13	.899
22.1 - 22.4	Staffing in the organisation	4	.920
23.1 - 23.5	Work schedule	5	.725
24.1 - 24.11	Organisational culture	11	.936
25.1 - 25.9	Responsiveness	9	.910
26.1 - 26.10	Availability	10	.890
27.1 - 27.6	Productivity	6	.761
28.1 - 28.9	Competence	9	.874
30.1 - 30.6	How performance review results utilised	6	.613
31.1 - 31.8	Setting performance standards	8	.952
32.1 - 32.9	Performance measurement	9	.973
33.1 - 33.6	Performance reporting	6	.787
34.1 - 34.10	Performance improvement	10	.933
35.1 - 35.6	Rewarding system	6	.807
36.1 - 36.9	Staff training and development	9	.942
37.1 - 37.6	Overall performance	6	.828

Table 4.2 shows that twenty-five (25) out of the twenty-six (26) constructs have Cronbach alpha ( $\alpha$ ) of at least 0.70 and above. Only 1 construct (question 30) has Cronbach alpha ( $\alpha$ ) of 0.61. Overall, this indicates that questionnaire was reliable.



#### **4.3.4 Descriptive statistics**

Descriptive statistics are the various methods used to describe and summarise data. The descriptive statistics include the means, median, and percentages. For the purpose of this study, the researcher presented data in terms of frequencies and percentages. The participants had to select only one response option from a list of options provided by the researcher. All the percentages are expressed to one decimal place in the text and in the graphical presentations. However, not all percentages add up to 100% due to the rounding off to the nearest one decimal. Hence, the percentages range between 99.9% and 100.1%. The responses categories strongly agree, agree, undecided, disagree and strongly disagree were used in the questionnaire to enable the participants respond to a specific statement according to their personal views. For the purpose of the analysis and discussion, the categories strongly agree and agree were grouped together to form a category called 'agree', likewise the strongly disagree and disagree were grouped together to form category 'disagree'. Additionally, categories very good and good were grouped to form category called 'good' and very poor and poor were grouped together to form category called 'poor'. Where the responses were very clear and clear, these were grouped together to form a category called 'clear', likewise where the response was very unclear and unclear, these formed a category called 'unclear'. The categorical data is displayed using tables and either bar charts or pie diagrams where appropriate.

#### **4.3.5 Inferential statistics**

According to Polit and Beck (2008:755) inferential statistics is that type of statistics that permit deductions about whether the results observed in a sample are likely to occur in the larger population. In this study, since the data was ordinal and not normally distributed, the association between two variables was investigated using the non parametric Spearman's *rho* rank order correlation coefficient ( $r_s$ ) (McCrum-Gardner 2008:41). The Spearman's *rho* rank order correlation coefficient ( $r_s$ ) indicates the magnitude and the direction of a relationship between two variables measured on ordinal scale (Polit & Beck

2008:766). The correlation coefficient can take any value between -1 and +1. A value of +1 represents a perfectly positive correlation and a value of -1 represents a perfectly negative correlation (Saunders et al 2009:459).

The Spearman's *rho* correlation coefficient ( $r_s$ ) was interpreted using the rule of thumb suggested by Hinkle, Wiersma and Jurs (1998:120), Larose (2006:45), and Nevid (2007: A-10) as shown in Table 4.3.

**Table 4.3: Rule of thumb for interpreting the size of a correlation coefficient ( $r$ )**

<b>Size of the correlation</b>	<b>Interpretation</b>
.90 to 1.00 (-.90 to -1.00)	Very high positive (negative) correlation
.70 to .90 (-.70 to -.90)	High positive (negative) correlation
.50 to .70 (-.50 to -.70)	Moderate positive (negative) correlation
.30 to .50 (-.30 to -.50)	Low positive (negative) correlation
.00 to .30 (.00 to -.30)	Little if any correlation

*Source: Hinkle, Wiersma and Jurs (1998:120), Larose (2006:45), and Nevid (2007: A-10)*

#### **4.4 DEMOGRAPHIC INFORMATION OF THE PARTICIPANTS**

This section presents the description of the biographic information of the participants involved in this study. This information includes the gender, age, marital status, current profession, highest professional qualification, and years of experience as health professional. This section also presents the type of health facility where the participants are working, the duration of their service in those particular health facilities, the district of work, and the location of the health facility. Table 4.4 presents the summary of the demographic characteristics of the participants.

**Table 4.4: Demographic characteristic of the participants (N=276)**

<b>Demographic characteristics</b>	<b>Number</b>	<b>Percentage (%)</b>
<b>Gender</b>	<b>(N=276)</b>	<b>(100)</b>
Female	176	63.8
Male	100	36.2
<b>Age</b>	<b>(N=276)</b>	<b>(100)</b>
20 - 29 years	50	18.1
30 – 39 years	115	41.7
40 – 49 years	57	20.7
50 – 59 years	54	19.6
60 and above	0	0.0
<b>Marital status</b>	<b>(N=276)</b>	<b>(100)</b>
Married	182	66.0
Single	92	33.3
Unknown	2	0.7
<b>Current profession</b>	<b>(N=276)</b>	<b>(100)</b>
Medical doctor	19	6.9
Clinical officer	51	18.5
Registered nurse/midwife	111	40.2
Enrolled nurse/midwife	95	34.4
<b>Highest qualification</b>	<b>(N=276)</b>	<b>(100)</b>
Doctoral degree	2	0.7
Master degree	4	1.4
Postgraduate certificate/diploma	5	1.8
Bachelors degree	23	8.3
Diploma	148	53.6
Certificate	94	34.1
<b>Years of experience in health profession</b>	<b>(N=276)</b>	<b>(100)</b>
0 – 5 years	73	26.4
6 – 10 years	68	24.6
11 –15 years	43	15.6
16 – 20 years	26	9.4
21 years and above	66	23.9
<b>Type of health facility</b>	<b>(N=276)</b>	<b>(100)</b>
Hospital	119	43.1
Health centre IV	56	20.3
Health centre III	80	29.0
Health centre II	21	7.6
<b>Duration of service in the facility</b>	<b>(N=276)</b>	<b>(100)</b>
0 – 11 months	53	19.2
1 – 5 years	99	35.9
6 -10 years	51	18.5
11- 15 years	22	8.0
16 – 20 years	28	10.1
21 years and above	23	8.3
<b>District of work</b>	<b>(N=276)</b>	<b>(100)</b>
Kumi	55	19.9
Mbale	106	38.4
Sironko	50	18.1
Tororo	65	23.6
<b>Location of health facility</b>	<b>(N=276)</b>	<b>(100)</b>
Urban	111	40.2
Rural	165	59.8

single includes the 'never married, separated, divorced and widowed.

Table 4.4 shows that the majority of health workers that participated in the study were female (n=176; 63.8%). Most of the participants (n=172; 62.3%) were aged

between 30 years to 49 years. There were no participants aged 60 years and above. With regard to marital status, 66.0% (n=182) were married and 33.3% (n=92) were single and 0.7% (n=2) did not indicate their marital status. The category for 'single' included those who were never married, divorced, separated, and the widowed. There were more professional nurses and midwives (n=204; 74.6%) who participated in the study than the rest of the targeted cadres of health workers. This is consistent with what is already known that the nursing cadre constitutes the biggest proportion of the human resources for health in most of the health systems. The clinical officers were 18.5% (n=51), and the medical doctors were 6.9% (n=19). Most of the participants were diploma holders (n=148; 53.6%), these were followed by the certificate holders (n=95; 34.1%), and the bachelors degree holders (n=23; 8.3%). There were fewer participants (n=11; 4.0%) with post graduate qualifications (certificate, diploma, master degrees, and doctorate degrees). This is mainly because this cadre of staff is rare to get at the district level; they are mainly working at regional or national referral hospitals.

Overall, the majority of the participants (n=203; 73.5%) had more than 5 years of professional experience. This indicates that most of the health workers who participated in this study were experienced. With regard to the types of health facility where the participants were drawn or working, most of the participants (n=157; 56.9%) were from the various levels of health centres (II, III, IV) and 43.1% (n=119) were hospital based. Out of the 276 participants, 59.8% (n=165) were working in rural areas, and 40.2% (n=111) in urban areas. With respect to the duration of working in those particular health facilities, 55.1% (n=152) had worked for 5 years or less and the rest (n=124; 44.9%) had worked in those facilities for more than 5 years. Regarding the distribution by districts of work, most participants (n=106; 38.4%) were from Mbale district, followed by Tororo district (n=65; 23.6%), Kumi district (n=55; 19.9%), and Sironko district (n=50; 18.1%). This indicated good representation of participants across the 4 districts.

## **4.5 FINDINGS RELATED TO OBJECTIVE ONE**

The first objective of this study was to identify the factors that enhance or impede the performance of health workers. The researcher investigated these factors by looking at the individual health workers' attributes, individual behaviours for performance, organisational factors, and the performance dimensions. The researcher used the Likert scale format type of questions to collect data from the participants. The results from data analysis are presented in the following sub-sections (4.5.1 to 4.5.5). The descriptive statistics is presented first followed by the inferential statistics (correlations).

### **4.5.1 Individual attributes**

This section presents the responses of the participants concerning their attributes. The results are presented according to the following subheadings: job related skills and abilities, self-monitoring ability, self-motivation (intrinsic motivation), commitment to the organisation, and individual values and beliefs.

#### **4.5.1.1 Job related skills and abilities**

Table 4.5 presents the results of the analysis of the responses of the participants concerning their job related skills and abilities.

**Table 4.5: Job related skills and abilities of the participants (N=276)**

Item description	Poor		Average		Good		Very good		Total	
	n	%	n	%	n	%	n	%	N	%
My skills in assessing clients are	0	0.0	0	0.0	138	50.0	138	50.0	276	100.0
My abilities in delivering health education are	0	0.0	54	19.6	112	40.6	110	39.9	276	100.1
My clinical competences are	0	0.0	28	10.1	138	50.0	110	39.9	276	100.0
My skills in counselling clients are	0	0.0	55	19.9	138	50.0	83	30.1	276	100.0
My interpersonal relations are	0	0.0	27	9.8	112	40.6	137	49.5	276	99.9
My abilities in providing in-service training are	27	9.8	84	30.4	82	29.7	83	30.1	276	100.0
My time management abilities are	0	0.0	110	39.9	111	40.2	55	19.9	276	100.0
My skills in supervising other health workers are	0	0.0	55	19.9	139	50.4	82	29.7	276	100.0
My skills in maintaining health facility equipment are	0	0.0	54	19.6	167	60.5	55	19.9	276	100.0
My abilities to implement the Uganda National Minimum Health Care Package (UNMHCP) are	28	10.1	54	19.6	84	30.4	110	39.9	276	100.0

It is evident from Table 4.5 that the participants have good or very good skills and abilities in assessing clients (n=276; 100.0%), have good interpersonal relations (n=249; 90.1%), have good clinical competences (n=248; 89.9%), have good skills and abilities in delivering health education (n=222; 80.5%), good skills in maintaining health facility equipment (n=222; 80.4%), have good skills in counselling clients (n=221; 80.1%), and skills in supervising other health workers (n=221; 80.1%). In addition, the participants have good skills and abilities in implementing the UNMHCP (n=194; 70.3%), have good time management abilities (n=166; 60.1%) and good abilities in providing in-service training (n=165; 59.8%).

From these results it appears that the health workers have the skills and abilities to enable them perform their duties satisfactorily. However, it has to be noted that time management was average for a big proportion of the participants (n=110; 39.9%), and a big proportion of health workers (n=27; 9.8%) had poor abilities in providing in-service training. This is worrisome because time management and in-service training are vital for good performance. Kahya (2007:517) mentions that skills and abilities dictate the capability of individuals to perform tasks as required. The findings of this study indicate that health workers

are knowledgeable, skilled, and are able to perform well. McKeon, Forgarty, and Hegney (2006:119) report that higher level of knowledge and skills are associated with lower levels of violations of patients' safety procedures. Therefore, the high level of skills and abilities can act as a buffer against unsafe practices in the health facilities. This finding is in line with previous research by Meurier (2000:202) which identifies lack of knowledge as one of the most common system failures contributing to unsafe practices in health facilities. However, health workers may sometimes be let down by other factors such as organisational factors. Lundstrom, Pugliese, Bartley, Cox, and Guither (2002:93) mention that environmental and organisational factors can influence the well-being of health workers, and ultimately the satisfaction, safety, and quality of care provided to the patients.

#### 4.5.1.2 Aspects of self-monitoring ability

Table 4.6 presents the responses regarding the aspects of self-monitoring ability of the participants. All the participants answered the questions on the self-monitoring ability scale. They had to indicate whether they strongly disagree, disagree, undecided, agree or strongly agree with the statements. For the purpose of analysis and discussion both strongly disagree and disagree were combined to give a response of 'disagree' and strongly agree and agree were reported as 'agree'.

**Table 4.6: Self-monitoring ability of the participants (N =276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
It is easy for me to copy the behaviour of others	54	19.6	110	39.9	0	0.0	84	30.4	28	10.1	276	100.0
I always defend the ideas that I already believe in	0	0.0	28	10.1	28	10.1	136	49.3	84	30.4	276	99.9
I am able to adapt myself to different situations and different people	0	0.0	0	0.0	0	0.0	85	30.8	191	69.2	276	100.0
I can be friendly towards others even though I really dislike them	0	0.0	56	20.3	0	0.0	193	69.9	27	9.8	276	100.0

As shown in Table 4.6, most of the participants (n=164; 59.5%) disagreed that they find it easy to copy behaviours of others while 40.5% (n=112) agreed that they find it easy to copy the behaviours. This can be interpreted in two ways. On the one hand this characteristic may be good for performance because some health workers may not copy bad behaviours such as poor time management and being rude to patients. On the other hand some health workers can copy the good behaviours within their organisations that can actually enhance their performance.

Two hundred and twenty participants (79.7%) agreed that they always defend the ideas they already believe in. This can be both good and at the same time detrimental to performance. Some health workers may defend performance boosting ideas such as voluntarily performing one's duties even after official working hours. However, when health workers defend negative ideas such as unnecessary absenteeism, it follows that performance will be compromised. All the participants (n=276; 100.0%) agreed that they can adapt themselves to different situations and to different people. Most respondents (n=220; 79.7%) agreed that they can be friendly towards others even though they really dislike them, and 20.3% (n=56) disagreed. These results indicate considerable levels of flexibility and professionalism among the participants which in turn can improve performance.

Barrick, Park, and Mount (2005:763) assert that high self monitoring ability may have an important effect on jobs for which interpersonal performance is required such as health care delivery. Barrick et al (2005:764) mention that self-monitoring has important work-related implications and suggest that self monitoring should be considered as an important moderator when examining the relationship between personality and performance.

#### **4.5.1.3 Dimensions of self motivation**

Table 4.7 shows the participants' responses regarding the aspects of self motivation.



**Table 4.7: Dimensions concerning self motivation of health workers (N =276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
I feel satisfied when I do my job well	0	0.0	27	9.8	0	0.0	57	20.7	192	69.6	276	100.1
When I do my work well it contributes to my personal growth and development	28	10.1	27	9.8	0	0.0	84	30.4	137	49.6	276	99.9
I get a sense of accomplishment when I perform my work well	0	0.0	55	19.9	0	0.0	28	10.1	193	69.9	276	99.9
My job increases my feeling of self esteem	0	0.0	27	9.8	0	0.0	195	70.7	54	19.6	276	100.1
I have considerable freedom on how to do my work	0	0.0	56	20.3	4	1.4	184	66.7	32	11.6	276	100.0
I feel satisfied when I help others to achieve their goals	0	0.0	27	9.8	0	0.0	56	20.3	193	69.9	276	100.0
I feel satisfied when others recognise my achievements	0	0.0	27	9.8	0	0.0	140	50.7	109	39.5	276	100.0
I achieve my goals by satisfying my clients' needs	0	0.0	27	9.8	0	0.0	85	30.8	164	59.4	276	100.0
Overall I am satisfied with my job	0	0.0	55	19.9	29	10.5	110	39.9	82	29.7	276	100.0

From Table 4.7, the majority of the participants (n=249; 90.2%) agreed that they felt satisfied when they do their work well, when others recognise their achievements, and when they help others to achieve their goals. Two hundred and forty nine (90.2%) agreed that their job increases the feeling of self esteem, and they achieve their goals by satisfying their clients' needs. Additionally, 80.0% (n=221) of the participants agreed that when they do their work well it contributes to their personal growth and development and that they get a sense of accomplishment when they perform their work well. Others (n=216; 78.3%) agreed that they have considerable freedom to do their work. Overall, 69.6% (n=192) of the participants agreed that they were satisfied with their job. These findings indicate that the health workers are self motivated and indeed willing to perform their duties.

A study done in Nigeria (Chirdan et al 2009:247) reports that over two-thirds of the health workers were generally satisfied with their current jobs. This is

comparable to the results of this study. Willis-Shattuck, Bidwell, Thomas, Wyness, Blaauw, and Ditlopo (2008:[5]) report that recognition and/or appreciation from managers, colleagues, or community is one of the most important motivating factors to health workers in many developing countries. Dieleman et al (2006:[5]) also found that in Mali health workers are encouraged by getting results from their work, being useful to the society and taking care of the people. Similarly, Mathauer and Imhoff (2006:[9-10]) report that in Kenya and Benin, health workers are motivated by their desire to help patients, professional advancement, and the recognition they get from the clients and managers. Therefore, increasing health workers' intrinsic motivation serves to improve job satisfaction, and attainment of personal objectives. This improves performance of health workers.

#### **4.5.1.4 Aspects concerning individual commitment to the organisation**

Table 4.8 shows the responses of health workers concerning their commitment to the organisations.

**Table 4.8: Dimensions of the participants' commitment to the organisation (N=276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
I am willing to put more effort than what is normally expected to help my organisation become successful	0	0.0	0	0.0	0	0.0	139	50.4	137	49.6	276	100.0
I am willing to accept almost any type of work in order to continue working in this organisation	0	0.0	84	30.4	0	0.0	138	50.0	54	19.6	276	100.0
My organisation inspires me to perform to the best of my ability	0	0.0	56	20.3	28	10.1	164	59.4	28	10.1	276	99.9
I talk highly about this organisation to my friends as a great place to work for	0	0.0	84	30.4	28	10.1	56	20.3	108	39.1	276	99.9
I would encourage my friends and family to seek health care from this facility	0	0.0	0	0.0	57	20.7	192	69.6	27	9.8	276	100.1
My supervisor takes personal interest in my career	0	0.0	55	19.9	29	10.5	110	39.9	82	29.7	276	100.0
My organisation strongly acknowledges my goals and values	28	10.1	56	20.3	28	10.1	109	39.5	55	19.9	276	99.9
I would be very happy to spend the rest of my life with this organisation	0	0.0	84	30.4	28	10.1	109	39.5	55	19.9	276	99.9
It would be very hard for me to leave this organisation right now even if I wanted to	29	10.5	83	30.1	27	9.8	82	29.7	55	19.9	276	100.0
I think that moving from one organisation to another would interfere with my career development	57	20.7	55	19.9	27	9.8	28	10.1	109	39.5	276	100.0
Overall, I am committed to this health facility	0	0.0	27	9.8	55	19.9	112	40.6	82	29.7	276	100.0

Table 4.8 shows that all the participants (n=276; 100.0%) agreed that they are willing to put more effort than what is normally expected to make their organisations successful. Two hundred and nineteen participants (79.4%) agreed that they would encourage their friends and family to seek health care from their facilities. About 70% (n=194; 70.3%) of the participants agreed that

overall they are committed to their respective health facilities. One hundred and ninety two (69.6%) of the participants agreed that their organisations inspire them to perform to the best of their abilities, and are willing to accept almost any type of work in order to continue working in the organisation.

Similarly, 69.6% (n=192) of the participants, agreed that their supervisors take personal interest in their careers. About 59% (n=164; 59.4%) agreed that they talked highly about their facilities, that their organisations strongly acknowledges their goals and values and that they would be very happy to spend the rest of their career lives working for the organisation. However, 30.4% (n=84) of the participants, disagreed that their organisations acknowledge their goals and values and were unwilling to spend the rest of their working period with the organisation. Slightly less than 50% (n=137; 49.6%) agreed that it would be very hard for them to leave their organisations right now even if they wanted to and also agreed that moving from one organisation to another would interfere with their career development. However, for both these variables (n=112; 40.6%) disagreed.

Overall, all these findings indicate that the health workers are considerably committed to work for their respective health facilities. Hence, organisational commitment is an important factor that can either enhance or impede the performance of health workers. Managers and management researchers have long believed that organisational goals are unattainable without enduring commitment of the organisation members (Tella, Ayeni & Popoola 2007:2). According to Huang, Chen, Tsai and Lin (2006:10), members of the organisation who have high level of commitment always show better job performance, job satisfaction, and productivity as well as lower levels of absenteeism and tardiness. Armstrong (2009:345) proposes the following steps to create commitment: initiatives to increase involvement and ownership, communication, leadership development, developing a sense of excitement in the job, and developing various human resource policies and practice initiatives.

#### 4.5.1.5 Aspects concerning the individual values and beliefs

Table 4.9 presents the responses concerning the individual values and beliefs of health workers.

**Table 4.9: Dimensions of individual values and beliefs (N= 276)**

Item description	Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	N	%
I communicate openly with everyone in this organisation	56	20.3	0	0.0	193	69.9	27	9.8	276	100.0
When I make a mistake I honestly admit and try to rectify it	28	10.1	0	0.0	167	60.5	81	29.3	276	99.9
I think it is better to work as a team in order to realise my potential and get work done	28	10.1	0	0.0	55	19.9	193	69.9	276	99.9
Safety of patients is very important to me	0	0.0	0	0.0	83	30.1	193	69.9	276	100.0
I am in support of continuous improvement in patient care	0	0.0	0	0.0	83	30.1	193	69.9	276	100.0
I put a lot of effort to achieve positive health outcomes for my patients	0	0.0	28	10.1	140	50.7	108	39.1	276	99.9
I believe in provision of client driven services	27	9.8	28	10.1	113	40.9	108	39.1	276	99.9
I believe in respect of the patients	0	0.0	0	0.0	112	40.6	164	59.4	276	100.0
I believe organisational loyalty should be encouraged and rewarded	27	9.8	0	0.0	112	40.6	137	49.6	276	100.0
I believe promotions should be based on individual performance	0	0.0	0	0.0	28	10.1	248	89.9	276	100.0
I believe team work is valuable and should be rewarded	0	0.0	0	0.0	83	30.1	193	69.9	276	100.0

From Table 4.9, all the participants (n=276; 100.0%) agreed that they believed in respect for the patient, that safety of patients was very important to them, and were in support of continuous improvement in patient care. All participants (n=276; 100.0%) believed that teamwork was valuable and should be rewarded, and they also believed that promotions in service should be based on individual performance. About ninety percent [90.2% (n=249)] of the participants, agreed that organisational loyalty should be encouraged and rewarded. Most of the participants (n=248; 89.9%) agreed that they put in a lot of effort to achieve positive health outcomes for their patients and when they make mistakes they honestly admit and try to rectify them. Likewise, most of the participants (n=248; 89.8%) also think that it is better to work as a team in order to realise their

potential and get work done. Lastly, the majority of the participants (n=221; 80.0%) agreed that they believed in the provision of the client driven services.

Given the responses from the participants it can be said that the health workers possess the individual values and beliefs that are conducive to good performance. Suliman and Iles (2000:415) and Van Scotter (2000:93) mention that individual work-related attitudes, values and beliefs, job satisfaction, and organisation commitment are important factors for performance. Mugisha (2009:56-57) adds that employees' norms, beliefs, and values can be used to support development of appropriate behaviours, organisational commitment, and organisational strategy. Therefore, individual values and beliefs can be used to create organisational integration and if well managed it can translate into an effective key managerial success in the area of health workers' performance.

#### **4.5.2 Individual behaviours for performance**

The individual behaviours that were investigated in this study include: proficiency behaviour, adaptive behaviour, proactive behaviour and client-oriented behaviours. The findings for each of these behaviours are indicated in the following sub-sections (4.5.2.1 to 4.5.2.4).

##### **4.5.2.1 Dimensions of individual proficiency behaviours of health workers**

Table 4.10 shows the responses of health workers concerning their proficiency behaviours.

**Table 4.10: Dimensions concerning the individual proficiency behaviours of health workers (N = 276)**

Item description	Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	N	%
I always use standard procedures to ensure that my core tasks are completed properly	55	19.9	0	0.0	139	50.4	82	29.7	276	100.0
I coordinate my work with my co-workers	0	0.0	0	0.0	140	50.7	136	49.3	276	100.0
I communicate openly with my co-workers	0	0.0	0	0.0	141	51.1	135	48.9	276	100.0
I provide help to my co-workers when asked	0	0.0	0	0.0	113	40.9	135	59.1	276	100.0
I portray a positive image of my organisation to others such as the patients	28	10.1	28	10.1	84	30.4	136	49.3	276	99.9

Table 4.10 shows that all the participants (n=276; 100.0%) agreed that they communicate openly with each other and coordinate their work well amongst themselves and provide help to co-workers when asked. Two hundred and twenty-one (80.1%) of the health workers agreed that they use standard procedures to ensure that their core tasks are properly done, and 19.9% (n=55) of the participants disagreed. Furthermore, 79.9% (n=220) of the participants agreed that they portray a positive image of their organisations to the stakeholders and 10.1% (n=28) either disagreed or were undecided.

Overall, the participants displayed satisfactory proficiency behaviours which are likely to support good performance. This finding is contrary to what Nzinga, Mbindyo, Mbaabu, Warira and English (2009:[5]) found in Kenya. In their study they established that health workers working in the hospital paediatric departments were not cooperating and communicating openly with each other and this was affecting their performance and the quality of care given to patients. According to Kahya (2009:102), behaviours that involve cooperation, creativity, and self development contribute to job performance. Griffin et al (2007:340) mention that role clarity is one of the strongest predictors of individual, team, and organisation task proficiency behaviours for performance.

#### 4.5.2.2 Dimensions of individual adaptive behaviours

The following table presents the results of the individual adaptive behaviours for the health workers.

**Table 4.11: Dimensions concerning the adaptive behaviours of health workers (N=276)**

Item description	Disagree		Agree		Strongly agree		Total	
	n	%	n	%	n	%	N	%
I adjust well to changes in my core tasks	0	0.0	138	50.0	138	50.0	276	100.0
I have learned new skills to help me adjust to changes in my core tasks	0	0.0	221	80.1	55	19.9	276	100.0
I respond constructively to changes in the way my team works	55	19.9	167	60.5	54	19.6	276	100.0
I am flexible with regard to the overall changes in my organisation	28	10.1	194	70.3	54	19.6	276	100.0

Table 4.11 shows that all the participants in the study (n=276; 100.0%) agreed that they adjust well to changes in their core tasks and have learned new skills to help them to adjust to the changes that come up in their core tasks. A significant number of participants (n=248; 89.9%) agreed that they are flexible with regard to the overall changes within their organisations and 10.1% (n=28) participants disagreed. Similarly, 80.1% (n=221) of the participants agreed that they respond constructively to changes in the way their teams work.

In general these results indicate that the participants display positive individual adaptive behaviours which are likely to contribute to good performance. Nzinga et al (2009:[6-7]) report that in Kenya there were inadequacies in adapting or responding to new clinical practices or guidelines due to lack of the perceived benefits linked to their uptake. In that study, senior and older health workers were often reported to be stuck in the patterns of previous clinical practice although there were some exceptions. This problem was attributed to the lack of experience of being compelled to change by emerging knowledge. Griffin et al (2007:341) assert that openness to change is a strong predictor for adaptive



behaviours. This can enhance task performance for an individual, a team and the organisation.

#### 4.5.2.3 Dimensions concerning individual proactive behaviours

Table 4.12 shows the responses from the participants regarding their individual proactive behaviours.

**Table 4.12: Dimensions for individual proactive behaviours (N = 276)**

Item description	Strongly disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	N	%
I have initiated better ways of performing my core tasks	0	0.0	0	0.0	221	80.1	55	19.9	276	100.0
I have developed new and improved methods to help my work unit perform better	27	9.8	0	0.0	194	70.3	55	19.9	276	100.0
I have made suggestions to improve the overall performance of the organisation	27	9.8	28	10.1	139	50.4	82	29.7	276	100.0

From Table 4.12, it is clear that all the participants (n=276; 100.0%) agreed that they have initiated better ways of performing their core tasks. Two hundred and forty nine (90.2%) agreed that they have developed new and improved methods to help their work unit or team perform better and 9.8% (n=27) of the participants disagreed. Of the participants, 80.1% (n=221) indicated that they have made suggestions to improve the overall performance in their organisations, 10.1% (n=28) were undecided, and 9.8% (n=27) disagreed.

The results clearly indicate that the health workers are proactive and this is likely to enhance their performance. Kahya (2009:102) observes that workers who score highly on creative performance or are proactive achieve high outcomes in innovative effectiveness. This is good for individual, team, and organisational performance. Griffin et al (2007:332) maintain that proactive behaviours ensure that the whole organisation develops rather than only individual departments.

#### 4.5.2.4 Dimensions concerning the individual client oriented behaviour

Table 4.13 shows the responses from the participants concerning their client oriented behaviours

**Table 4.13: Dimensions concerning the client oriented behaviours (N =276)**

Item description	Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	N	%
I try to assess what the clients' needs are	0	0.0	2	0.7	173	62.7	101	36.6	276	100.0
I have the clients best interest in mind	0	0.0	0	0.0	140	50.7	136	49.3	276	100.0
I try to address the clients' needs with the appropriate treatment available	0	0.0	28	10.1	138	50.0	110	39.9	276	100.0
I am aware that my task is to serve my clients to the best of my ability	0	0.0	0	0.0	140	50.7	136	49.3	276	100.0
I respect what the patients have to say	0	0.0	0	0.0	85	30.8	191	69.2	276	100.0
I have respect for my clients	27	9.8	0	0.0	112	40.6	137	49.6	276	100.0
I give clients opportunity to express their needs with me	0	0.0	0	0.0	139	50.4	137	49.6	276	100.0
I take a problem solving approach to care for my clients	0	0.0	0	0.0	167	60.5	109	39.5	276	100.0
I always take time to perform my clinical work	28	10.1	0	0.0	112	40.6	136	49.3	276	100.0
I always behave in a professional manner	0	0.0	0	0.0	140	50.7	136	49.3	276	100.0

Table 4.13 indicates that all the participants (n=276; 100.0%) are aware of their task of serving the clients to the best of their ability, have the clients' interest in mind, and respect what their patients say. All the participants (n=276; 100.0%) indicated that they always behave professionally, take a problem solving approach to care for their clients, and give the clients opportunity to express their needs. Almost all the participants (n=274; 99.3%) agreed that they try to assess what their clients' needs are and 90.2% (n=249) of the participants have respect for their clients. Close to ninety percent (n=248; 89.9%) of the participants indicated that they always take time to perform their clinical work and try to address their clients' needs with the appropriate treatment available.

These results demonstrate that the participants were generally more inclined to display client-oriented behaviours. Lanjananda and Patterson (2009:9) explains that the client oriented behaviours include attributes such as empathy, assurance, responsiveness, authenticity, listening, dedication, and civility which the health workers in this study seem to display. The behaviours of frontline health workers like doctors, nurses and clinical officers are critical to both patient satisfaction and successful health outcomes.

### **4.5.3 Organisational factors**

The organisational factors that were investigated include the clarity of the organisational strategy, work environment, staffing, work schedule, and organisational culture. This sub-section therefore presents the results concerning the organisation factors.

#### **4.5.3.1 Dimensions concerning the clarity of the organisational strategy**

The health workers had to indicate whether the following dimensions were very clear, clear, neutral, unclear and very unclear. For the purpose of analysis and discussion the categories very clear and clear were grouped together and reported as 'clear' and the very unclear and unclear were reported as 'unclear'. Table 4.14 shows the responses from the health workers concerning the clarity of the organisational strategy.

**Table 4.14: Dimensions concerning the clarity of the organisational strategy (N = 276)**

Item description	Vey unclear		Unclear		Neutral		Clear		Very clear		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
My organisation's mission is	0	0.0	0	0.0	0	0.0	139	50.4	137	49.6	276	100.0
My duties and responsibilities are	0	0.0	0	0.0	0	0.0	111	40.2	165	59.8	276	100.0
The goals and objectives of the job are	0	0.0	0	0.0	0	0.0	138	50.0	138	50.0	276	100.0
The way my work is related to the overall objective of the organisation is	0	0.0	27	9.8	0	0.0	139	50.4	110	39.9	276	100.1
The expected results of my work are	0	0.0	28	10.1	0	0.0	139	50.4	109	39.5	276	100.0
The way I divide my time among tasks required for my job is	0	0.0	82	29.7	0	0.0	165	59.8	29	10.5	276	100.0
The way to determine the appropriate procedures for each work assignment is	0	0.0	83	30.1	0	0.0	139	50.4	54	19.6	276	100.1
The way performance is measured is	0	0.0	111	40.2	28	10.1	110	39.9	27	9.8	276	100.0
The way performance appraisal results are utilised is	27	9.8	83	30.1	56	20.3	83	30.1	27	9.8	276	100.1

The results from Table 4.14 show that all the participants (n=276; 100.0%) were clear about their organisation's mission, their duties and responsibilities as well as the goals and objectives of the job. Most of the participants (n=249; 90.2%) clearly know how their work is related to the overall objective of the organisation and 89.9% (n=248) clearly know the expected results from their work. Most participants (n=194; 70.3%) were clear about the way they divided their time amongst the tasks required for the job, and 29.7% (n=82) were unclear.

Similarly, of the participants 69.9% (n=193) indicated that the way to determine appropriate procedures for each work assignment was clear while 30.1% (n=83) indicated that it was not clear. About 40% (n=111; 40.2%) of the participants were not clear about the way performance is measured in their organisations, 49.6% (n=137) of the participants indicated that it was clear to them, and 10.1% (n=28) were undecided. An equal number of participants (n=110; 39.9%) had

opposing views regarding the clarity of how performance appraisal results are utilised. They indicated that they were either clear or unclear on how the performance results are utilised in their organisations and about 20.3% (n=56) of the participants were undecided.

Generally, from the results presented it seems as though the organisational strategy is clear to most of the health workers. However, when it comes to the way the performance is measured and how the results of the performance appraisals are utilised, there is still considerable weakness and this may impact negatively on the performance of health workers. According to Ntoburi et al (2008:445) improvement in quality of health services requires that the health workforce is clear about the expectation and outcomes of the organisation they are working for.

In this study the results show that the health workers are clear about the mission and the objectives of their organisation, this is good for performance. However, it was disturbing to note that the health workers were not clear about how their performance is measured and how the performance results are utilised. A study done in Malawi by Manafa, McAuliffe, Maseko, Bowie, MacLachlan, and Normand (2009:[4]) reports that most health workers do not have job descriptions. Hence, they do not have clear expectations of performance. This results in some health workers being given roles for which they are not adequately prepared for and expected to perform. This therefore affects their performance. Thompson et al (2010:6) assert that performance management is crucial in supporting the formulation and implementation of the organisational strategy. Hence, there should be an alignment between performance management and the organisational strategy.

#### **4.5.3.2 Dimensions concerning the work environment**

Table 4.15 shows the results on the aspects of the work environment as perceived by the health workers.

**Table 4.15: Dimensions concerning the work environment (N = 276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
My working environment is considerably safe	55	19.9	27	9.8	28	10.1	166	60.1	0	0.0	276	99.9
My health facility has a good working space arrangement	28	10.1	54	19.6	0	0.0	167	60.5	27	9.8	276	100.0
All the necessary equipment are available	54	19.6	112	40.6	27	9.8	83	30.1	0	0.0	276	100.1
The health facility equipment are in good working condition	27	9.8	167	60.5	27	9.8	27	9.8	28	10.1	276	100.0
Drugs and supplies are sufficient	56	20.3	81	29.3	55	19.9	84	30.4	0	0.0	276	99.9
There are clear infection control guidelines	0	0.0	0	0.0	83	30.1	166	60.1	27	9.8	276	100.0
I participate in decision making concerning patients' care	0	0.0	55	19.9	28	10.1	166	60.1	27	9.8	276	99.9
I am satisfied with my opportunity to participate in decision making	0	0.0	55	19.9	0	0.0	194	70.3	27	9.8	276	100.0
I receive constructive comments from my supervisors	0	0.0	55	19.9	28	10.1	139	50.4	54	19.6	276	100.0
I receive constructive comments from my co-workers	0	0.0	56	20.3	0	0.0	165	59.8	55	19.9	276	100
I receive constructive comments from the patients/their relatives	0	0.0	28	10.1	28	10.1	193	69.9	27	9.8	276	99.9
My opinion is respected at work	0	0.0	28	10.1	27	9.8	194	70.3	27	9.8	276	100.0
I feel my job is secure	0	0.0	28	10.1	0	0.0	166	60.1	82	29.7	276	99.9

Table 4.15 shows that most participants (n=248; 89.9%) had a sense of job security. About 80% (n=221; 80.1%) of the participants indicated that their opinions are respected at work and are satisfied with the opportunity to participate in decision making. Most of the participants (n=220; 79.7%) indicated that they receive constructive comments from their co-workers, patients or their

relatives, and about 70.0% (n=193; 69.9%) receive constructive comments from their supervisors.

About 70% (n=193; 69.9%) of the participants agreed that there are clear infection control guidelines and about 30% (n=83; 30.1%) were undecided. Similarly, close to 70% (n=193; 69.9%) agreed that they participate in decision making concerning patient care while 19.9% (n=55) disagree and the rest 10.1% (n=28) were undecided. The results also show that most of the participants (n=194; 70.3%) agreed that their health facilities have good working space arrangement and 29.7% (n=82) disagreed. About 60% (n=166; 60.1%) of the participants considered their working environment to be considerably safe and 82 (29.7%) thought it was unsafe, while 10.1% (n=28) were undecided.

About 60% (n=166; 60.1%) of the participants disagreed that they have all the necessary equipment necessary to do their work, about 30% (n=83; 30.1%) agreed and almost 10% (n=27; 9.8%) were undecided. Of the participants, 70.3% (n=194) disagreed that the health facility equipment were in good working condition, 19.9% (n=55) agreed and 9.8% (n=27) were undecided. With regard to the drugs and supplies, about 50% (n=137; 49.6%) of the participants disagreed that they had sufficient stocks of drugs, 30% (n=84; 30.4%) agreed and close to 20% (n=55; 19.9%) were undecided.

The results here show mixed reactions about the working environment of the health workers. Majority of the health workers seem to be contented with most of the aspects of their working environment. However, most of the health workers seem to be unhappy about the availability of medical equipment as well as the drugs and supplies. As indicated by most of the health workers even some of the equipment that is available is not in good working condition. The interpretation is that while some aspects of the working environment may be conducive, lack of adequate medical supplies and non-functional equipment may hinder the performance of health workers.

It was important to learn that the majority of health workers are secure in their jobs and participate in decision making concerning the patients. This is consistent to what Huang et al (2006:11) found in their study in Taiwan. In that study they report that most nurses believe that job security is automatically provided by their organisations and they were given opportunity to participate in decision making concerning patient management. Chirdan et al (2009:246) also mention that in Nigeria, health workers find their workplace inspiring and were happy with supervision, interpersonal relationships, and the openness as well as support they get from their managers.

The researcher found that health workers in this study felt that their work environment was safe and had clear infection prevention guidelines. However, another study done in Uganda by Hagopian et al (2009:w869) points out that a sizeable proportion of health workers felt that their managers do not take any specific measures to protect them from infections like HIV/AIDS. Most health workers lacked the necessary equipment, drugs, and supplies to carry out their duties effectively. This is consistent with most of the studies done in most developing countries. The performance of health workers in most health systems in developing countries is constrained by lack of adequate supplies of drugs and equipment. This affects the health workers' motivation and job satisfaction (Fauveau, Sherratt & de Bernis 2008:[9]; Hagopian et al 2009:w867-w868; Mbindyo, Blaauw, Gilson & English 2009:[8]; Willis-Shattuck et al 2008:[5]).

#### **4.5.3.3 Dimensions concerning staff in the organisation**

Table 4.16 presents the results concerning the staffing of the organisations.



**Table 4.16: Dimensions concerning the staffing in the organisation (N=276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
The allocated staff in this facility are sufficient to cover the current workload	54	19.6	84	30.4	55	19.9	83	30.1	0	0.0	276	100.0
Support of staff in form of counselling at workplace is available	55	19.9	56	20.3	28	10.1	137	49.6	0	0.0	276	99.9
I have opportunity to make inputs into staffing policies and procedures	27	9.8	110	39.9	28	10.1	84	30.4	27	9.8	276	100.0
There is a good balance between health workers and their supervisors	27	9.8	112	40.6	0	0.0	110	39.9	27	9.8	276	100.1

Table 4.16 shows that there were mixed views concerning the staffing within the health facilities. Fifty percent (n=138) of the health workers disagreed that the allocated staff in their respective facilities was sufficient to cover the current work load, 30.1% (n=83) agreed and 19.9% (n=55) were undecided. Almost 50% (n=137; 49.6%) of the participants disagreed that they have opportunity to provide input into staffing policies and procedures, 40.2% (n=111) agreed and 10.1% (n=28) were undecided. Slightly over fifty percent (n=139; 50.4%) of the participants disagreed that there was a good balance between health workers and their supervisors and 49.6% (n=137) agreed. The results show that 49.6% (n=137) of the participants agreed that there was support to staff in form of counselling at the workplace, 40.2% (n=111) disagreed and 10.1% (n=28) were undecided.

Overall, the staffing within the health facilities is not satisfactory. This can negatively affect the performance of health workers. However, it is important to note that there is some form of support in terms of workplace counselling for staff, which may assist in improving the performance of health workers, though not satisfactory. The findings of this study are consistent with many other studies done in developing countries. For example in Malawi, there is an acute shortage of health workers which affects delivery of health services (Manafa et al

2009:[5]). Studies demonstrate a negative correlation between health worker density and poor health outcomes (Awofeso et al 2008:[4]; Awofeso 2010:1319). Hence, the shortages of health workers can affect the performance of the existing staff. Armstrong (2009:960) explains that the importance of health and safety practices is often underestimated by the managers. Prevention of accidents and elimination of health and safety hazards is a prime responsibility of management.

#### 4.5.3.4 Dimensions concerning the work schedule of health workers

The results in Table 4.17 present the responses from the health workers concerning their work schedule.

**Table 4.17: Dimensions concerning the work schedule of health workers (N =276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Total	
	n	%	n	%	n	%	n	%	N	%
I have opportunities for a flexible work schedule	28	10.1	27	9.8	0	0.0	221	80.1	276	100.0
Overall I perceive my work schedule to be fair	28	10.1	28	10.1	0	0.0	220	79.7	276	99.9
I am always compensated when I work overtime	193	69.9	28	10.1	28	10.1	27	9.8	276	99.9
My workload is manageable	0	0.0	166	60.1	0	0.0	110	39.9	276	100.0
I am able to balance the demands of my work with my personal life	27	9.8	111	40.2	28	10.1	110	39.9	276	100.0

Table 4.17 shows that of the participants, 80.1% (n=221) agreed that they have opportunities for flexible work schedule and 19.9% (n=55) disagreed. Slightly less than 80% (n=220; 79.7%) of the participants agreed that they perceive their work schedule to be fair. About 80% (n=221; 80.1%) of the participants disagreed that they are always compensated when they work overtime and about 10.1% (n=28) participants were undecided or had agreed that they are compensated. About 60% (n=166; 60.1%) of the participants disagreed that their workload is manageable and 39.9% (n=110) participants agreed. Fifty percent (n=138) of the participants disagreed that they are able to balance the demands of work with their personal lives, about 40% (n=110; 39.9%) agreed and 10.1% (n=28) were undecided. These results show that generally the work schedule can either enhance or impede the performance of health workers. The health

workers were not happy with the workload, lack of compensation for overtime work, and lack of work-life balance. However, the health workers seemed happy with the fairness and flexibility of their work schedules.

This study found that health workers have a flexible work schedule and the perception that the work schedule was fair. This seems to be consistent with what Huang et al (2006:11) found in Taiwan. The researcher found that slightly over 60% of the participants said that their workload is not manageable. This confirms Hagopian et al's (2009:w867) findings in Uganda. On the contrary, in Nigeria, Chirdan et al (2009:246) report that about two-thirds of health workers were happy with their workload. It is possible that there are probably more health workers in Nigeria than there are in Uganda. This study revealed that although there was flexibility in the work schedules; the health workers lack work-life balance. Armstrong (2009:978) emphasises that good work-life balance policies can lower absence, help to tackle the low morale and high degree of stress that can lead to retention problems as employees tire of juggling work and life responsibilities.

Furthermore, this study found that there was no compensation for working overtime. This is a common practice in most of the African health systems. In Tanzania Manongi, Marchant, and Bygbjerg (2006:[6]) mention that health workers felt that they had very little to gain from working hard or being responsive to the patients or superiors. This has contributed to absenteeism and poor performance. Liu et al (2007:504) report that there is a positive link between incentives compensation and performance of workers.

#### **4.5.3.5 Dimensions concerning the organisational culture**

This section presents the results of the health workers' opinions regarding the organisational culture. Table 4.18 shows the distribution of the responses from the health workers.

**Table 4.18: Dimensions concerning the organisational culture (N=276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
Members of this organisation share a common purpose	0	0.0	57	20.7	28	10.1	136	49.3	55	19.9	276	100.0
My performance is assessed according to how best I execute my duties	0	0.0	28	10.1	28	10.1	139	50.4	81	29.3	276	99.9
Employees of this organisation try hard to identify problems and solve them accordingly	27	9.8	55	19.9	28	10.1	139	50.4	27	9.8	276	100.0
The policies of this organisation are consistent with the cultural belief of the community	27	9.8	110	39.9	28	10.1	84	30.4	27	9.8	276	100.0
Recruitment of new health workers is done based on qualifications	0	0.0	28	10.1	0	0.0	139	50.4	109	39.5	276	100.0
Promotions of health workers is based on merit	0	0.0	62	22.5	63	22.8	122	44.2	29	10.5	276	100.0
The local political leadership is supportive of health workers	56	20.3	83	30.1	55	19.9	55	19.9	27	9.8	276	100.0
Decentralisation has led to improvement in performance of health workers	27	9.8	112	40.6	28	10.1	109	39.5	0	0.0	276	100.0
Decentralisation has improved my chances for career progression	82	29.7	57	20.7	82	29.7	28	10.1	27	9.8	276	100.0
My co-workers have adequate skills for their job	28	10.1	83	30.1	0	0.0	138	50.0	27	9.8	276	100.0
My health facility manager is competent in his/her duties	0	0.0	56	20.3	41	14.9	143	51.8	36	13.0	276	100.0

The results in Table 4.18 show that the majority of the participants (n=248; 89.9%) agreed that recruitment of new health workers is done based on qualifications. Close to 80% (n=220; 79.7%) of the participants agreed that their performance is assessed according to how best they execute their duties. Similarly, a significant proportion 69.2% (n=191) of the participants agreed that the members of their organisation share a common purpose and about 20.7%

(n=57) disagreed. Most of the participants (n=179; 64.8%) agreed that their managers are competent in executing their duties. About 60% (n=166; 60.1%) of the participants indicated that the employees in their organisations try hard to identify problems and solve them accordingly. Most of the participants 59.8% (n=165) agreed that their co-workers have adequate skills for their jobs and 40.2% (n=111) of participants disagreed. Close to 55% (n=151; 54.7%) of the participants agreed that promotions of the health workers is merit based, 22.5% (n=62) disagreed, and 22.8% (n=63) were undecided.

Slightly over fifty percent (n=139; 50.4%) disagreed that political leadership is supportive of health workers; that decentralisation has led to improvement in the performance of the health workers, and that decentralisation has improved their career progression. Furthermore, many health workers (n=137; 49.7%) thought that the policies of their organisations were not consistent with the cultural beliefs of the community and about 40.2% (n=111) agreed while 10.1% (n=28) were undecided.

The results illustrate that the health workers share a common purpose; both they and their managers are competent at their jobs; the recruitments and promotions are done on merit. However, the political leadership is not supportive of health workers and this may impede their performance. Likewise the participants indicated that decentralisation has minimised their chances for career progression and that decentralisation has led to deterioration in the performance of health workers.

Brown and Harvey (2006:11) assert that some patterns of organisational culture may be functional and may facilitate the accomplishment of the organisational goals. Other patterns of behaviour or cultural norms may actually inhibit or restrict the accomplishment of the organisational goals. In many low resource countries like Uganda, local governments do not have staff adequately trained in personnel administration or know little about the system of managing workforce performance (Esmail et al 2007:[7]; Mitchell 2009:224). This has a big impact on performance.

The lack of political support for health workers is regrettable since these leaders are supposed to be the supervisors of the health services in their respective localities. The political interference reported by this study is similar to what was found in Chile and Bolivia (Bossert 2000:67). This is indeed detrimental to performance and retention of health workers in the districts. Researchers like Ssenooba, Rahman, Hongoro, Rutebemberwa, Mustafa, Kielmann and McPake (2007:[10]) report similar political interference in the management of health services in Uganda with district local leaders always intimidating health workers and practicing nepotism during the recruitment and promotion processes. In Mozambique district officials under decentralisation interfere with transfers of health staff and in China health managers are faced with pressures from the local authorities to recruit their relatives despite them not possessing the right qualifications (Dieleman et al 2009:[5]).

World Health Organization (2007:4) emphasises that leadership and governance must ensure that strategic policy frameworks exist and are combined with effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system-design, and accountability. This study also noted that decentralisation had reduced the chances of career progression for the health workers. Supporting studies have been published by Kolehmainen-Aitken (2004:[6]) and Munga et al (2009:[7]).

#### **4.5.4 Performance dimensions**

The research investigated the performance of health workers using four variables including responsiveness, availability, productivity and competence of health workers. These formed the dependent variables. This section (4.5.4.1 to 4.5.4.4) presents the findings from the health workers concerning these performance dimensions.

#### 4.5.4.1 Dimensions concerning responsiveness of services

Table 4.19 presents the responses concerning responsiveness of health workers and the services they provide.

**Table 4.19: Dimensions concerning responsiveness of health workers (N=276)**

Item description	Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	N	%
Clients are always satisfied with the friendly services offered by health workers	28	10.1	0	0.0	221	80.1	27	9.8	276	100.0
Clients are satisfied with the quality of services we provide	112	40.6	0	0.0	137	49.6	27	9.8	276	100.0
Clients are satisfied with the timeliness of the services	166	60.1	28	10.1	82	29.7	0	0.0	276	99.9
The complaints from stakeholders towards individual health workers are rare	55	19.9	83	30.1	138	50.0	0	0.0	276	100.0
The stakeholders are satisfied with the health workers' cooperation	84	30.4	28	10.1	164	59.4	0	0.0	276	99.9
The health workers clearly know who they serve	82	29.7	0	0.0	167	60.5	27	9.8	276	100.0
Health workers are always willing to address the clinical and emotional demands of the patients	55	19.9	28	10.1	166	60.1	27	9.8	276	99.9
Health workers get professional support to improve their performance	56	20.3	0	0.0	138	50.0	82	29.7	276	100.0
When at work I know what is expected of me	0	0.0	0	0.0	140	50.7	136	49.3	276	100.0

From Table 4.19, it is clear that all the participants (n=276; 100.0%) agreed that when they are at work they know what is expected of them. Most participants (n=248; 89.9%) agreed that the clients are always satisfied with the friendliness of the services that health workers provide. The majority of the participants (n=220; 79.7%) indicated that they get professional support to improve their performance. Most of the health workers (n=194; 70.3%) clearly know who they serve and most of them (n=193; 69.9%) are always willing to address the clinical and emotional demands of the patients. About 60% (n=164; 59.4%) of the participants agreed the stakeholders are satisfied with the health workers' cooperation and the quality of service they provide. About 41% (n=112; 40.6%) indicated that clients were not satisfied with the quality of service the health workers provide and about 30% (n=84; 30.4%) were not satisfied with the

cooperation of health workers. Fifty percent (n=138) of the participants indicated that complaints from the stakeholders towards individual health workers are rare, 30.1% (n=83) were undecided and 19.9% (n=55) of the participants disagreed. It is however important to note that about 60% (n=166; 60.1%) of the participants disagreed that the patients were satisfied with the timeliness of the services and 29.7% (n=82) indicated that the clients were satisfied and 10.1% (n=28) were undecided.

Generally, the respondents demonstrated satisfactory levels of service and responsiveness towards the patients. However, the services are not provided in a timely manner. Health workers must have the ability and willingness to understand and address both the clinical and emotional demands of clients (DFID 2006:1; Heizer & Render 2008:212). According to Freedman (2005:19), health workers' responsiveness enables a more holistic consideration of the quality of health service provision by taking into consideration both the technical aspects and client satisfaction. The researcher found that the health workers were not providing timely services. This can be explained by organisational constraints such as the low staffing levels, heavy workload, poor work flow structures, and probably lack of some of the drugs, and equipment necessary for them to perform (Nzinga et al 2009:[5]).

#### **4.5.4.2 Dimensions regarding the availability of health workers in the health facility**

Table 4.20 shows the responses of the health workers concerning their availability in the districts or health facilities.



**Table 4.20: Dimensions concerning the availability of health workers (N=276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
This organisation has a retention policy with clear strategies	27	9.8	28	10.1	55	19.9	84	30.4	82	29.7	276	99.9
I am always available when my services are required	0	0.0	28	10.1	0	0.0	139	50.4	109	39.5	276	100.0
This facility has adequate numbers of health workers to deliver the services	0	0.0	138	50.0	28	10.1	83	30.1	27	9.8	276	100.0
The rural facilities are as well staffed as the urban ones	28	10.1	193	69.9	27	9.8	28	10.1	0	0.0	276	99.9
This facility has an attendance register which is filled by every staff member	0	0.0	27	9.8	0	0.0	167	60.5	82	29.7	276	100.0
I am always present during the official working hours	0	0.0	82	29.7	28	10.1	112	40.6	54	19.6	276	100.0
I put in much effort when I am on duty	0	0.0	27	9.8	0	0.0	167	60.5	82	29.7	276	100.0
Staff attendance in this organisation is good	0	0.0	111	40.2	0	0.0	138	50.0	27	9.8	276	100.0
The workload in this facility is manageable	0	0.0	111	40.2	56	20.3	109	39.5	0	0.0	276	100.0
In this facility the patient waiting time is short	0	0.0	109	39.5	55	19.9	112	40.6	0	0.0	276	100.0

Table 4.20 shows that most of the participants (n=249; 90.2%) indicated that their health facilities have attendance registers that are filled by all staff members and a similar percentage 90.2% (n=249) agreed that they put in much effort when they are on duty. About 90% (n=248; 89.9%) of the participants indicated that they are always available when their services are required. About 60% (n=166; 60.1%) of the participants indicated that they are always present at work during the official working hours and also indicated that their organisation has a retention policy with clear strategies. Slightly less than 60% (n=165; 59.8%) of the participants agreed that the staff attendance in their organisations was good and 40.2% (n=111) disagreed. There were mixed views in the responses from the health workers concerning the patients' waiting time. One hundred and

twelve (40.6%) of the participants agreed that the patients' waiting time was short, while 39.5% (n=109) disagreed and 19.9% (n=55) were undecided.

The majority of the health workers (n=221; 80.0%) disagreed that the rural facilities are as well staffed as the urban ones. Fifty percent (n=138) of the participants disagreed that their health facilities had adequate numbers of health workers to deliver the services, about 40% (n=110; 39.9%) agreed and 10.1% (n=28) were undecided. There were also mixed views in the responses of health workers concerning the workload with 40.2% (n=111) of the participants disagreeing that the workload at their facilities was manageable while 39.5% (n=109) of the participants agreed that their workload was manageable and 20.3% (n=56) of the participants were undecided.

These results demonstrate that participants were more likely to take initiative as individuals to ensure availability. However, the reported lack of adequate staffing may probably be an explanation for high workload and long patient waiting time (Nzinga et al 2009:[5]). Some authors like Huicho, Dieleman, Campbell, Codjia, Balabanova, Dussault and Dolea (2010:360) mention that availability of health workers itself cannot directly improve the health outcomes in absence of effective components such as drug supply and functioning facilities and good clinical practice. However, a well performing health workforce is a significant component of a strong health system that together with other social determinants can lead to improved health status of the population. The JLI (2004:23) mentions that as the numbers of health workers drop, the ability of systems to deliver health services also reduces. Hence, the maldistribution of health workers between rural and urban health facilities as reported by this study, this affects the quality of health care and waiting time may be longer (Padarath et al 2003:26).

#### **4.5.4.3 Dimensions regarding the productivity of health workers**

Table 4.21 shows the responses concerning the productivity of health workers.

**Table 4.21: Dimensions concerning the productivity of health workers (N=276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
My productivity is measured according to the number of patients I attend to	54	19.6	55	19.9	0	0.0	140	50.7	27	9.8	276	100.0
This organisation has indicators to measuring staff productivity	27	9.8	112	40.6	27	9.8	56	20.3	54	19.6	276	100.1
I spend most of my time at work attending to patients	0	0.0	81	29.3	28	10.1	140	50.7	27	9.8	276	99.9
My skills are suited for the type of work I do	0	0.0	28	10.1	27	9.8	166	60.1	55	19.9	276	99.9
My productivity is increased by the availability of drugs and equipment	0	0.0	0	0.0	56	20.3	112	40.6	108	39.1	276	100.0
The management structures in this facility encourage the performance of health workers	0	0.0	54	19.6	28	10.1	194	70.3	0	0.0	276	100.0

The results from Table 4.21 show that most of the participants (n=221; 80.0%) agreed that their skills are suited for the type of work they do. The majority of workers (n=220; 79.7%) indicated that their productivity is increased by the availability of drugs and equipment. Most of the participants (n=194; 70.3%) indicated that their health facility management structures encourage the performance of health workers. Slightly over 60% (n=167; 60.5%) of the participants agreed that they spend most of their time attending to the patients and that their productivity is measured according to the number of the patients they attend to. About 40% (n=109; 39.5%) of the participants disagreed that their productivity is measured according to the number of patients they attend to and 29.3% (n=81) disagreed that they spend most to their time attending to patients while 10.1% (n=28) participants were not decided. With regard to indicators for measuring performance slightly over 50% (n=139; 50.4%) of the participants indicated that the organisation does not have indicators for measuring productivity of health workers, 39.9% (n=110) agreed that there were indicators and 9.8 % (n=27) were undecided. In general, the participants possessed

adequate skills necessary to perform their jobs. They emphasised the importance of adequate supplies of materials to support productivity and performance. However, the results showed that the measurement of productivity of health workers was generally lacking in most health facilities.

Although the health workers may have the skills, their productivity can be limited by a host of factors like lack of equipment, supplies, drugs, poor management structures and low salaries among others (Dieleman & Harnmeijer 2006:16; Hagopian et al 2009:w868). It was also noted that the health worker were almost evenly divided on how their productivity is measured. Thus, there is need to develop and communicate clear indicators for measuring productivity.

#### 4.5.4.4 Dimensions regarding competence of health workers

Table 4.22 shows the responses of the health workers concerning their competences.

**Table 4.22: Dimensions concerning the competence of health workers (N=276)**

Item description	Disagree		Agree		Strongly agree		Total	
	n	%	n	%	n	%	N	%
I am confident my ability to do my job	28	10.1	113	40.9	135	48.9	276	99.9
I have mastered the skills necessary to do my job	0	0.0	222	80.4	54	19.6	276	100.0
I am confident about my prescribing practices	0	0.0	222	80.4	54	19.6	276	100.0
I always improve my knowledge and skills through continuous professional education	0	0.0	139	50.4	137	49.6	276	100.0
My attitude toward the care of patients is good	0	0.0	140	50.7	136	49.3	276	100.0
I use my knowledge and skills to improve safety of patients	0	0.0	194	70.3	82	29.7	276	100.0
I always make timely referral of patients that are in need of specialised treatment	0	0.0	140	50.7	136	49.3	276	100.0
I have good communication skills	0	0.0	194	70.3	82	29.7	276	100.0
I am able to use the available communication technology to support patient care	0	0.0	221	80.1	55	19.9	276	100.0

Table 4.22 indicates that all the health workers (n=276; 100.0%) have mastered the skills necessary to do their work and are confident about their prescribing practices. All the participants (n=276; 100.0%) said that they improve their knowledge and skills through continuous professional education and use their knowledge and skills to improve the safety of the patients. All the health workers (n=276; 100.0%) agreed that their attitude towards patient care is good and always make timely referrals of patients in need of specialised treatment.

All the health workers (n=276; 100.0%) indicated that they have good communication skills and are able to use the available technology to support patient care. It is also important to note that about 90% (n=248; 89.9%) of the participants agreed that they are confident about their ability to perform their job. Generally, the results show that the health workers are competent and this is highly likely to enhance their performance. Liu et al (2007:507) assert that high level of knowledge, skills and abilities among workers are necessary for effective performance. Health workers also reported that they have good communication skills. This is very important because listening, guidance, clear expectations and feedback are prerequisites for better performance (Huang et al 2006:11).

The health workers in this study reported that they make timely referral when required. Iyengar and Iyengar (2009:15) mention that good skills in identifying complicated obstetric cases, good counselling and communication skills results in improved maternal health outcomes in India. This finding is contrary to what is reported in Niger by Bossyns and Van Lerberghe (2004:[5]) where rural health workers lack the competence to communicate, counsel and convince patients with complications for referral to higher level facilities.

#### **4.5.5 Association statistics**

Correlation statistic was used to determine if there was any association between the various factors that influence the performance of health workers and the performance dimensions. The performance dimensions include responsiveness, availability, productivity and competence of health workers. The results of the

correlations are provided in Tables 4.23 to 4.25. Since the data was ordinal and not normally distributed, the researcher computed correlations using the non parametric Spearman's *rho* rank order correlation ( $r_s$ ) statistic. The interpretation of the strength of the correlation coefficient ( $r_s$ ) is shown in Table 4.3. The detailed correlation matrices are provided in annexures K, L and M.

#### 4.5.5.1 Correlation between the individual attributes and performance

Table 4.23 shows the correlation matrix of the associations between the individual health workers' attributes and the performance dimensions. The individual attributes include skills and abilities, self monitoring ability, self motivation, organisational commitment and individual values and beliefs (see annexure K for the detailed correlation matrix).

**Table 4.23: Correlation between the individual health workers' attributes and the dimensions of performance (N=276)**

Spearman's <i>rho</i> rank order Non parametric correlations		Responsiveness	Availability	Productivity	Competence
<b>Skills and abilities</b>	Correlations	.180**	.018	.453**	.998**
	Sig. (2-tailed)	.003	.770	.000	.000
	N	276	276	276	276
<b>Self monitoring ability</b>	Correlations	.391**	.642**	.067	.316**
	Sig. (2-tailed)	.000	.000	.269	.000
	N	276	276	276	276
<b>Self motivation</b>	Correlations	.687**	.798**	.371**	.586**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276
<b>Commitment to the organisation</b>	Correlations	.794**	.820**	.439**	.452**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276
<b>Individual values and beliefs</b>	Correlations	.617**	.570**	.346**	.577**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276

\*\* Correlation is significant at the 0.01 level (2-tailed)

The correlation coefficients in Table 4.23 indicate that all the individual health workers' attributes are positively correlated to performance. There is a significant and high correlation between responsiveness and organisational commitment of health workers ( $r_s=.794$ ;  $p<.01$ ). Responsiveness is moderately correlated with self motivation ( $r_s=.687$ ;  $p<.01$ ) and individual values and beliefs ( $r_s=.617$ ;  $p<.01$ ). There is a significant but low correlation between responsiveness and self monitoring ability ( $r_s=.391$ ;  $p<.01$ ). There is little if any correlation between

responsiveness and skills and abilities of the health workers ( $r_s=.180$ ;  $p<.01$ ). Even though there is a low correlation between responsiveness and skills and abilities, overall, there is a positive association between responsiveness and the general individual attributes. This is an indication that committed, self-motivated, and self-monitoring health workers are highly likely to be responsive to the patient needs. They have the self-drive to serve the clients. According to Ammassari (2005:10) and DFID (2006:3) individual factors such as skills and abilities, self motivation, individual values and beliefs and commitment to organisation can affect the responsiveness of health workers.

The results show a significant and high positive correlation between availability of health workers and organisational commitment ( $r_s=.820$ ;  $p<.01$ ) and also self-motivation ( $r_s=.798$ ;  $p<.01$ ). There is a significant and moderate positive correlation between self monitoring ability ( $r_s=.642$ ;  $p<.01$ ), individual values and beliefs ( $r_s=.570$ ;  $p<.01$ ) and availability of health workers. There was no correlation between the skills and abilities and availability of health workers ( $r_s=.018$ ;  $p >.05$ ). From these correlations it can be deduced that availability of health workers is positively related to individual attributes meaning that health workers are more likely to be available for duty when they have significant levels of commitment, are self motivated, are able to self-monitor and possess strong values and beliefs. Notably, the lack of relationship between availability and skills and abilities is explainable because health workers may be available for duty whether or not they possess adequate skills and abilities.

Table 4.23 shows that there is a significant but low positive correlation between productivity of health workers and their skill and abilities ( $r_s=.453$ ;  $p<.01$ ), organisation commitment ( $r_s=.439$ ;  $p<.01$ ), self motivation ( $r_s=.371$ ;  $p<.01$ ) and individual values and beliefs ( $r_s=.346$ ;  $p<.01$ ). There is no correlation between productivity and self monitoring ability ( $r_s=.067$ ;  $p>.05$ ). This low positive association illustrates that although health workers may possess positive individual attributes; this may not necessarily translate into productivity and indeed the lack of correlation between productivity and individual self-monitoring provides a vivid explanation for this. Gambin, Green and Hogarth (2009:52)

report that in general there is evidence to suggest that skill levels are related to productivity: the highly skilled people efficiently produce higher value goods and services. But there are still substantial gaps in the evidence base. This is because it is not always clear what skills result in an increase in productivity, whether the hard skills (e.g. formal qualification) or soft skills (e.g. interpersonal skills, communication skills).

The results show a significant and very high positive correlation between competence and skills and abilities of health workers ( $r_s=.998$ ;  $p<.01$ ). The results further show that there is a significant and moderate positive correlation between self motivation ( $r_s=.586$ ;  $p<.01$ ), individual values and beliefs ( $r_s=.577$ ;  $p<.01$ ) and competence of health workers. There is a significant but low positive correlation between organisation commitments ( $r_s=.452$ ;  $p<.01$ ), self-monitoring ability ( $r_s=.316$ ;  $p<.01$ ) and competence of health workers. Clearly, competent health workers are more likely to have the required skills and abilities and to be self-motivated as well as hold strong values and beliefs conducive for performance. Liu et al (2007:507) mention that high levels of knowledge, skills and abilities are some of the determinants of competence of workers.

#### **4.5.5.2 Correlation between the individual performance behaviours and performance of health workers**

Table 4.24 presents the correlation matrix for the associations between the individual performance behaviours of the health workers and the performance dimensions (see detailed correlation matrix in annexure L).



**Table 4.24: Correlation between the individual performance behaviours and the dimensions of performance (N=276)**

Spearman's rho rank order Non parametric correlations		Responsiveness	Availability	Productivity	Competence
<b>Individual proficiency behaviours</b>	Correlations	.856**	.724**	.235**	.562**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276
<b>Individual adaptive behaviours</b>	Correlations	.623**	.659**	.343**	.643**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276
<b>Individual proactive behaviour</b>	Correlations	.598**	.759**	.262**	.359**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276
<b>Individual client-oriented behaviours</b>	Correlations	.669**	.537**	.396**	.449**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276

\*\* Correlation is significant at the 0.01 level (2-tailed)

Table 4.24 shows that all the individual performance behaviours are positively correlated to performance. There is a significant and high positive correlation between responsiveness and the individual proficiency behaviours of health workers ( $r_s=.856$ ;  $p<.01$ ). There are also significant and moderate correlations between individual client-oriented behaviours ( $r_s=.669$ ;  $p<.01$ ), individual adaptive behaviours ( $r_s=.623$ ;  $p<.01$ ), individual proactive behaviours ( $r_s=.598$ ;  $p<.01$ ) and the responsiveness of health workers. Indeed there is a high likelihood that health workers who are highly proficient, client oriented and display adaptive and proactive behaviours, will demonstrate high responsiveness towards clients. Kahya (2009:102) mentions that workers' behaviours that involve teamwork, innovativeness and self advancement contribute to performance.

The results also indicate significant and high positive correlations between the individual proactive behaviours ( $r_s=.759$ ;  $p<.01$ ), individual proficiency behaviours ( $r_s=.724$ ;  $p<.01$ ) and the availability of health workers. There are significant and moderate correlations between the individual adaptive behaviours ( $r_s=.659$ ;  $p<.01$ ), client oriented behaviours ( $r_s=.537$ ;  $p<.01$ ) and the availability of health workers. This demonstrates that proactive and proficient individuals are likely to be available to perform their duties. There are significant but low positive correlations between individual client-oriented behaviours, ( $r_s=.396$ ;  $p<.01$ ), individual adaptive behaviours ( $r_s=.343$ ;  $p<.01$ ), individual proactive behaviours ( $r_s=.262$ ;  $p<.01$ ), individual proficiency behaviours ( $r_s=.235$ ;  $p<.01$ ) and the

productivity of health workers. Indeed while adaptive, proactive and proficiency behaviours may facilitate individual productivity; it is not always certain that this will be the case.

The results in Table 4.24 further show that there are significant and moderate correlations between the individual adaptive behaviours ( $r_s=.643$ ;  $p<.01$ ), individual proficiency behaviours ( $r_s=.562$ ;  $p<.01$ ) and the competence of health workers. There are also significant but low correlations between the individual client-oriented behaviours ( $r_s=.449$ ;  $p<.01$ ), individual proactive behaviours ( $r_s=.359$ ;  $p<.01$ ) and the competence of health workers. This can be interpreted as follows: adaptive and proficient health workers are highly likely to be competent but this may not always hold since competent health workers may not always be adaptive. According to Kahya (2009:102) those workers who score highly on creative performance are likely to achieve high outcomes in creative effectiveness.

#### 4.5.5.3 Correlation between the organisation factors and performance of health workers

Table 4.25 presents the correlation matrix of the associations between the organisational factors and the performance dimensions of the health workers (see detailed correlation matrix in annexure M).

**Table 4.25: Correlation between the organisational factors and the dimensions of performance of health workers (N=276)**

Spearman's rho rank order Non parametric correlations		Responsiveness	Availability	Productivity	Competence
<b>Clarity of the organisation strategy</b>	Correlations	.747**	.756**	.600**	.473**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276
<b>Working environment</b>	Correlations	.889**	.963**	.451**	.332**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276
<b>Staffing of organisation</b>	Correlations	.814**	.908**	.592**	.176**
	Sig. (2-tailed)	.000	.000	.000	.003
	N	276	276	276	276
<b>Work schedule</b>	Correlations	.742**	.869**	.268**	.206**
	Sig. (2-tailed)	.000	.000	.000	.001
	N	276	276	276	276
<b>Organisation culture</b>	Correlations	.890**	.934**	.538**	.386**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276

\*\* Correlation is significant at the 0.01 level (2-tailed)

Table 4.25 shows that all the correlations between the organisational factors and the performance dimensions are positive. The results show significant and high positive correlations between organisational culture ( $r_s=.890$ ;  $p<.01$ ), working environment ( $r_s=.889$ ;  $p<.01$ ), staffing of the organisation ( $r_s=.814$ ;  $p<.01$ ), clarity of the organisation strategy ( $r_s=.747$ ;  $p<.01$ ), work schedule ( $r_s=.742$ ;  $p<.01$ ) and the responsiveness of the health workers. Clearly, a healthy organisation culture, working environment coupled with adequate staffing, flexible work schedules and clear strategies, are highly likely to stimulate responsiveness on the part of health workers. Brown and Harvey (2006:11) maintain that there are some aspects of the organisation such as culture that may facilitate the accomplishment of the organisational goals which in this case is the achievement of good health outcomes.

There are significant and very high correlations between work environment ( $r_s=.963$ ;  $p<.01$ ), organisational culture ( $r_s=.934$ ;  $p<.01$ ), staffing of the organisation ( $r_s=.908$ ;  $p<.01$ ) and the availability of health workers. There are also significant and high correlations between the work schedule ( $r_s=.869$ ;  $p<.01$ ), clarity of the organisational strategy ( $r_s=.756$ ;  $p<.01$ ) and the availability of health workers. In general, a positive organisational culture, adequate staff levels, staff availability, clear work schedules and strategies are likely to motivate health workers and thus promote availability. The WHO (2007:16) reports that there is a strong correlation between health workers density, services coverage and health outcomes. Awofeso (2010:1319) maintains that poor working and living conditions are some of the factors that impede performance of workers in rural and remote areas of Nigeria.

Table 4.25 shows that there are significant and moderate correlations between clarity of the organisation strategy ( $r_s=.600$ ;  $p<.01$ ), staffing of the organisation ( $r_s=.592$ ;  $p<.01$ ), organisational culture ( $r_s=.538$ ;  $p<.01$ ) and the productivity of health workers. There are significant but low positive correlations between the working environment ( $r_s=.451$ ;  $p<.01$ ), the work schedule ( $r_s=.268$ ;  $p<.01$ ) and the productivity of health workers. Indeed a clear strategy, sufficient staff level, a healthy culture are likely to enhance individual productivity. A study in Nigeria by

Taiwo (2010:306) maintains that a conducive work environment stimulates creativity among employees that may facilitate better methods to enhance productivity. Furthermore, improvement in work environment can result in higher productivity of employees while bad working conditions may contribute to low productivity.

The results from Table 4.25 indicate that there is a significant and moderate correlation between the clarity of the organisational strategy ( $r_s=.473$ ;  $p<.01$ ), organisational culture ( $r_s=.386$ ;  $p<.01$ ), working environment ( $r_s=.332$ ;  $p<.01$ ), and competence of health workers. There is little if any correlation between the work schedule ( $r_s=.206$ ;  $p<.01$ ), staffing of the organisation ( $r_s=.176$ ;  $p<.01$ ) and the competence of health workers. This moderate association may be due to the fact that clear organisational strategies, a positive culture and a favourable working environment may promote competence of health workers but this may not always be the case. The little relationship between the work schedules, staffing and competence may probably be because whether or not an organisation has flexible schedules and adequate staff levels this may not necessarily mean that its employees will be competent in their jobs.

## **4.6 FINDINGS RELATED TO OBJECTIVE TWO**

The second objective of this study was to assess the current practices used to manage performance of health workers. Under this objective the researcher investigated how the health workers' performance is reviewed and how the results from the performance appraisals are utilised. Also investigated were the following: how the performance standards are set, how performance is measured, reported, recognised and rewarded, and strategies for improving performance.

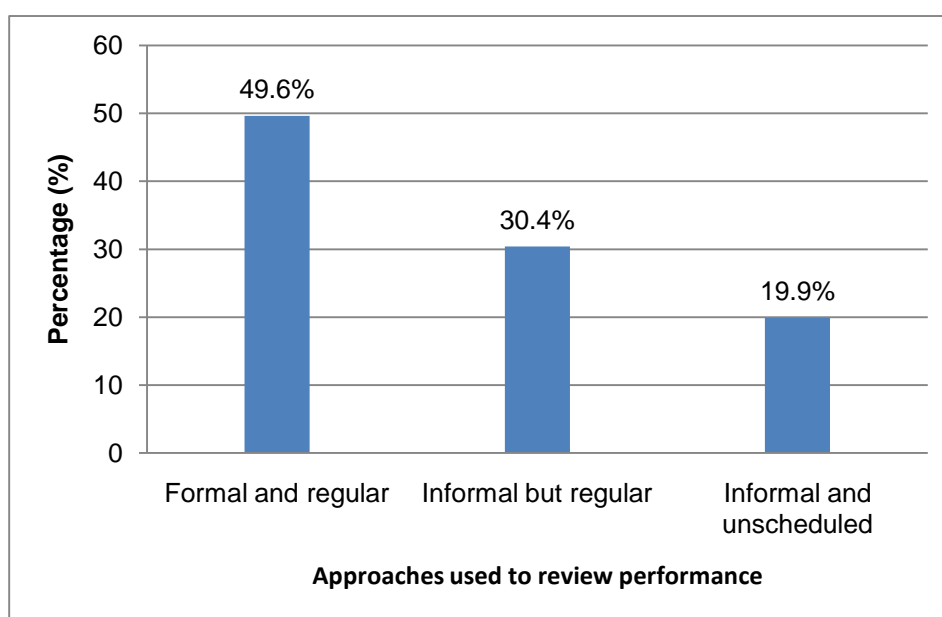
### **4.6.1 Performance management**

This section presents the analysis and interpretation of the finding concerning how performance is reviewed, and how the results of performance appraisal are

utilised. Also presented are the aspects for setting performance standards, performance measurement, performance reporting, performance improvement, the rewarding system and the dimensions concerning staff training and development.

#### 4.6.1.1 Approaches to reviewing the performance of health workers

Figure 4.1 shows the approaches used to review the performance of health workers in the districts.



**Figure 4.1: How performance of health workers is reviewed in the districts (N=276)**

Figure 4.1 shows that most of the health workers (n=137; 49.6%) indicated that there is a formal and regular system for reviewing performance. Eighty-four (30.4%) of health workers mentioned that there is an informal but regular performance review system and 19.9% (n=55) mentioned that there are informal and unscheduled performance reviews. The results depict that the methods of reviewing the performance of health workers exist even though some of them may be deficient as effective tools for performance review. According to Mathauer and Imhoff (2006:[12]) performance management tools serve to improve the performance of health workers. Performance management assists in setting, communicating and internalising the organisational goals. This study has

found that there were some forms of annual performance review. Similar results were also reported in Kenya. However, in Benin there was no such performance assessment for health workers (Mathauer & Imhoff 2006:[12]).

#### 4.6.1.2 How the results of performance review are utilised

Table 4.26 presents the responses from the health workers regarding how the information from the performance reviews is used.

**Table 4.26: The use of performance review results in the districts (N=276)**

Use of performance review information	Yes		No		Total	
	n	%	n	%	N	%
Training of staff	220	79.7	56	20.3	276	100
Promotion in service	222	80.4	54	19.6	276	100
Demotions of staff	55	19.9	221	80.1	276	100
Rotation of staff	193	69.9	83	30.1	276	100
Rewards	193	69.9	83	30.1	276	100
Not used at all	27	9.8	249	90.2	276	100

Table 4.26 shows that most of the participants (n=249; 90.2%) thought that at least the information from the performance appraisals is utilised in one way or the other to improve the performance of health workers. Two hundred and twenty-two participants (80.4%) indicated that it is used for promotion of workers in public service, and 79.7% (n=220) indicated that it is used for identifying the training needs of health workers. Close to 70% (n=193; 69.9%) of the participants indicated that performance review outcomes are used for rewarding and rotating staff. The results showed that most participants (n=221; 80.1%) do not think that the results of the staff appraisals are used for demoting staff.

It is apparent from these findings that the performance appraisal outcomes are largely utilised in good course. Proper use of performance appraisal results is expected to enhance performance management function and ultimately the performance of health workers. According to Kruk and Freedman (2008:263) and Smith et al (2008:1) effective performance measurement system should be used to allocate resources, motivate employees, improve services, self-assessment

and improvement. The systems should also focus on improving health programmes.

#### 4.6.1.3 Setting performance standards

Table 4.27 shows the aspects concerning the setting of performance standards in the organisations.

**Table 4.27: Dimensions concerning the setting of performance standards (N=276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
All health workers are familiar with the organisation's mission towards clients	0	0.0	28	10.1	55	19.9	139	50.4	54	19.6	276	100.0
I have a clear job description	0	0.0	82	29.7	0	0.0	112	40.6	82	29.7	276	100.0
The performance standards are clear	0	0.0	55	19.9	28	10.1	139	50.4	54	19.6	276	100.0
There are appropriate performance indicators to assess the health worker's performance	0	0.0	83	30.1	0	0.0	111	40.2	82	29.7	276	100.0
Targets are set for activities to be achieved in a given period	0	0.0	27	9.8	55	19.9	111	40.2	83	30.1	276	100.0
The performance standards, indicators, and targets are communicated to all departments to ensure that health workers understand them	27	9.8	28	10.1	55	19.9	138	50.0	28	10.1	276	99.9
This organisation regularly reports the performance of standards, indicators and targets to the external stakeholders	0	0.0	82	29.7	28	10.1	111	40.2	55	19.9	276	99.9
All the stakeholders in this organisation participate in setting performance standards	27	9.8	55	19.9	28	10.1	139	50.4	27	9.8	276	100.0

Table 4.27 indicates that out of the 276 participants, 194 (70.3%) agreed that they had clear job descriptions and also agreed that targets are set for activities to be achieved during a given period. Eighty-two (29.7%) participants disagreed about having clear job descriptions and about 20% (n=55; 19.9%) were undecided on whether targets are set for activities to be carried out in a given period. Franco et al (2002:1255) point out that job descriptions with clearly stated objectives, authority and lines of accountability are mostly associated with improved achievement of work goals.

About seventy percent (n=193; 69.9%) of the participants agreed that all health workers were familiar with the organisations' mission towards the clients, have clear performance standards and appropriate indicators to assess the health workers' performance. A study done in Indonesia (Dolea & Zurn 2004:1) reports that using clear job descriptions with clear standards along with better in-service training can enhance job satisfaction, compliance with standards and performance among nurses and midwives.

Close to sixty percent (n=166; 60.2%) of the participants agreed that all the stakeholders in the organisation participate in setting performance standards and that the performance standards, indicators and targets are communicated to all departments to ensure that all the health workers understand them. Similarly, 60.1% (n=166) participants indicated that their organisations regularly report performance standards, indicators and targets to the external stakeholders. It is however important to note that close to 30% (n=82; 29.7%) disagreed that all stakeholders are involved in setting performance standards and also disagreed that the organisations regularly report performance standards and indicators to the external stakeholders. Rowe et al (2005:1032) and Manuwa-Olumide (2009:8) mention that sharing information helps health workers perform better. Hence, the organisations need to develop a culture of monitoring, evaluation and feedback of health information to improve the performance of health workers.

The general understanding from these results is that the managers attempt to put in place yard-sticks against which the performance of health workers is to be



evaluated. Staff participation and staff involvement is an important human resource management function. It permits making the best use of the health workers' knowledge, hands-on experience and ideas for improvement. In addition, staff participation involves recognition and appreciation of their competencies. This has an important effect on motivation and performance of health workers (Mathauer & Imhoff 2006:[11]). Mathauer and Imhoff (2006:[12]) mention that in Benin and Kenya, many health workers (57% in Kenya and 80% in Benin) felt that they were not given chance to participate in decision making at their health facilities. Therefore, it is important to promote participation, for example, by holding regular meetings as forums for health workers to share ideas and suggestions for improvement and decision making on issues that concern their work and immediate environment (Mathauer & Imhoff 2006:[12]).

#### **4.6.1.4 Performance measurement**

Table 4.28 presents the responses from the health workers concerning the aspects of performance measurement in the districts.

**Table 4.28: Dimensions of performance measurement in the districts (N=276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
Objectives to be achieved are known by individuals to be assessed	0	0.0	55	19.9	0	0.0	194	70.3	27	9.8	276	100.0
The performance standards expected from the staff are clear and understood by all	0	0.0	83	30.1	0	0.0	138	50.0	55	19.9	276	100.0
The district clearly defines the way how to measure individual activity performance	27	9.8	56	20.3	0	0.0	138	50.0	55	19.9	276	100.0
This organisation has a system for collecting and tracking staff performance data	0	0.0	83	30.1	0	0.0	138	50.0	55	19.9	276	100.0
The organisation measures most of the established individual performance standards and targets	0	0.0	83	30.1	0	0.0	138	50.0	55	19.9	276	100.0
Individual health worker's performance is measured regularly	0	0.0	55	19.9	55	19.9	112	40.6	54	19.6	276	100.0
I am fully aware of the process used to measure my performance	0	0.0	56	20.3	54	19.6	112	40.6	54	19.6	276	100.1
My performance is evaluated based on my job description	0	0.0	28	10.1	27	9.8	167	60.5	54	19.6	276	100.0
My performance is fairly measured	0	0.0	28	10.1	55	19.9	166	60.1	27	9.8	276	99.9

Table 4.28 shows that most of the participants (n=221; 80.1%) agreed that their performance is evaluated based on their job descriptions and that the objectives to be achieved are known by the individual to be assessed. About 70% (n=193; 69.9%) of the participants agreed that the district clearly defines how to measure the individual activity performance and makes sure that the performance standards expected from the health workers are clear and understood by all. About 30% (n=83; 30.1%) of the participants disagreed. Similarly, about 70% (n=193; 69.9%) of the participants indicated that the organisation has a system for collecting and tracking staff performance and measures most of the established individual performance standards and targets. About 30% (n=83;

30.1%) of the participants were did not agree. Additionally, 69.9% (n=193) of the participants agreed that their performance is fairly measured and about 19.9% (n=55) were undecided while 10.1% (n=28) disagreed. Slightly over 60% (n=166; 60.2%) of the participants agreed that the individual health workers' performance is measured regularly and that they are fully aware of the processes involved in measuring their performance. In both cases about 20% (n=55; 19.9%) of the participants were either undecided or were in disagreement.

These results show that in general the health managers attempt to measure the performance of their subordinates. The results also show that not all participants seem to know what performance measurement is all about and which indicators are applied. This is consistent with what Mathauer and Imhoff (2006:[12-13]) found in Kenya. Kruk and Freedman (2008:264) point out that performance measurement provides quality information to decision makers so that they can determine whether their efforts are on course or not. Human resources indicators are designed to monitor the current levels of organisational as well as human resource performance in order to successfully attain the health sector reforms (Hornby & Forte 2002:2; Kruk & Freedman 2008:269).

#### **4.6.1.5 Performance reporting**

Table 4.29 illustrates the dimensions concerning the reporting of health workers' performance in the districts.

**Table 4.29: Dimensions concerning the reporting of performance of health workers (N=276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
This organisation documents the progress related to performance standards and targets	0	0.0	28	10.1	55	19.9	112	40.6	81	29.3	276	99.9
This organisation has a specific system that regularly reports the performance of health workers	0	0.0	55	19.9	0	0.0	194	70.3	27	9.8	276	100.0
Constructive feedback on performance appraisal is provided on a regular basis	0	0.0	84	30.4	27	9.8	110	39.9	55	19.9	276	100.0
This organisation always reports the health workers' performance information to the external stakeholders	0	0.0	83	30.1	81	29.3	84	30.4	28	10.1	276	99.9
The health workers' performance data is analysed and reviewed according to the set performance standards, indicators, and targets	27	9.8	28	10.1	54	19.6	112	40.6	55	19.9	276	100.0
The health workers are given opportunity to make comments on the results of their performance	0	0.0	0	0.0	54	19.6	195	70.7	27	9.8	276	100.1

Table 4.29 shows that the majority of the participants (n=221; 80.1%) agreed that the organisation has a specific system that regularly reports the performance of health workers. About 80% (n=222; 80.4%) of the participants agreed that they are given opportunity to make comments on the results of their performance. Close to 70% (n=193; 69.9%) of the participants indicated that the organisation documents progress related to the performance standards and targets. Slightly over 60% (n=167; 60.5%) agreed that the health workers' performance data is analysed and reviewed according to the set standards, indicators and targets. Of the participants, 59.8% (n=165) agreed they receive constructive feedback on performance appraisals regularly. There was uncertainty about reporting performance to the external stakeholders. Slightly over 40% (n=112; 40.6%) of the participants agreed that health workers'

performance data is reported to the external stakeholders, about 30% (n=83; 30.1%) disagreed and 29.3% (n=81) of the participants were undecided.

Although there are some few deviations, the findings indicate that to a great extent the managers report the results of performance appraisal process. This may assist in the implementation of appropriate measures for improving the performance. In their study in Kenya and Benin, Mathauer and Imhoff (2006:[13]) report that almost half of the participants in Kenya and one tenth of the participants in Benin claimed that they do not receive any personal feedback from their superiors. Rafferty et al (2005:30) and Rowe et al (2005:1030) mention the importance of feedback on both the successes and failures of reinforcing performance. These researchers emphasise that feedback needs to be effective and immediate for it to have a great impact on performance. Managers have a very important role in providing an effective feedback. However, Martinez (2003:210) and Rowe et al (2005:1028) point out that some supervisors lack the skills to effectively communicate performance appraisal results to their subordinates. In some situations performance appraisal results are kept confidential and not communicated to the staff member concerned. According to Luecke (2006:55) feedback works well when it is related to specific performance standards.

#### **4.6.1.6 Dimensions of performance improvement**

The following Table 4.30 presents the responses of the health workers concerning performance improvement in the district.

**Table 4.30: Dimensions concerning performance improvement in the districts (N=276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
Timely action is taken when performance falls below the acceptable levels	0	0.0	84	30.4	55	19.9	137	49.6	0	0.0	276	99.9
The performance reports are effectively used for decision making	0	0.0	57	20.7	110	39.9	109	39.5	0	0.0	276	100.1
The health workers' performance information is used to set priorities for personal development	0	0.0	57	20.7	82	29.7	137	49.6	0	0.0	276	100.0
The staff are involved in decision about performance improvement	0	0.0	56	20.3	27	9.8	165	59.8	28	10.1	276	100.0
The organisation has specific processes to manage changes in policies, programmes, or infrastructure	0	0.0	28	10.1	136	49.3	112	40.6	0	0.0	276	100.0
My supervisors encourage me to use different ways to improve my performance	0	0.0	55	19.9	28	10.1	166	60.1	27	9.8	276	99.9
Rewards and sanctions are based on performance results	0	0.0	85	30.8	54	19.6	110	39.9	27	9.8	276	100.1
The analysis of employees training needs is based on the performance appraisal reports	0	0.0	83	30.1	27	9.8	111	40.2	55	19.9	276	100.0
There are procedures to collect suggestions for performance improvement from the employees	27	9.8	83	30.1	27	9.8	111	40.2	28	10.1	276	100.0
I always have access to my supervisors when I need support	0	0.0	28	10.1	0	0.0	166	60.1	82	29.7	276	99.9

Table 4.30 shows that most of the participants (n=248; 89.8%) agreed that they always have access to their supervisors whenever they need support. One hundred and ninety-three (69.9%) participants agreed that their supervisors encourage them to use different ways to improve their performance and that the

staff themselves are involved in decisions about performance improvement. These findings are somehow similar to what Mathauer and Imhoff (2006:[13]) found in Kenya and Benin. In their study they report that health workers felt that their managers were accessible, however, they did not always provide encouragement and had insufficient consideration of the health workers' views for improving performance.

Slightly more than 60% (n=166; 60.1%) of the participants agreed that analysis of employees training needs is based on the performance appraisal reports and about 30% (n=83; 30.1%) disagreed. Slightly more than 50% (n=139; 50.4%) of the participants indicated that there are procedures to collect suggestions from employees about performance improvements but about 40% (n=110; 39.9%) disagreed.

Slightly less than 50% (n=137; 49.6%) of the participant agreed health workers' performance information is used to set priorities for personal development and that timely action is taken when performance falls below acceptable levels. However, about 50% (n=139; 50.4%) either disagreed or were undecided. Similarly, of the participants, 49.6% (n=137) agreed that rewards and sanctions are based on performance results, while 30.8% (n=85) were in disagreement and 19.6% (n=54) were undecided. About 49% (n=136; 49.3%) of the participants were uncertain about the existence of specific processes to manage changes policies, programmes and infrastructure for performance, 40.6% (n=112) agreed and 10.1% (n=28) disagreed. There was uncertainty about whether performance reports are effectively used for decision making. One hundred and ten participants (39.9%) were undecided as to whether performance appraisal reports are used to make decisions about performance, 39.5% (n=109) agreed and 20.7% (n=57) disagreed. According to Smith et al (2008:14-15) the performance monitoring and appraisal results can be used to manage and enhance performance through staff training, counselling and development.

The results of this study reveal that even though the organisational factors such as effective performance management systems are inadequate, there is a considerable effort by the health systems managers to improve the performance of health workers. Katz and Green (1997:200) point out that performance improvement should involve the elimination of problems and the exploitation of performance opportunities. The performance problem may be related to service, practice or governance.

#### 4.6.1.7 Dimensions regarding the rewarding system

The following Table 4.31 gives the responses of the health workers concerning the rewarding system in their districts or organisations.

**Table 4.31: Dimensions concerning the rewarding system (N=276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
I am paid according to my experience	27	9.8	57	20.7	83	30.1	82	29.7	27	9.8	276	100.1
My salary is according to my job responsibilities	0	0.0	82	29.7	0	0.0	139	50.4	55	19.9	276	100.0
Hard work is acknowledged and rewarded accordingly	0	0.0	84	30.4	109	39.5	83	30.1	0	0.0	276	100.0
All health workers know their fringe benefits	0	0.0	167	60.5	27	9.8	82	29.7	0	0.0	276	100.0
I am satisfied with the fringe benefits I get from my organisation	81	29.3	140	50.7	0	0.0	55	19.9	0	0.0	276	99.9
I feel my organisation offers sufficient opportunities for promotions	27	9.8	112	40.6	0	0.0	137	49.6	0	0.0	276	100.0

Table 4.31 shows that most of the participants (n=221; 80.0%) were not satisfied with the fringe benefits they receive from their organisations. Slightly over 70% (n=194; 70.3%) agreed that their salaries are in accordance with their job responsibilities and about 30% (n=82; 29.7%) disagreed. Of the participants 60.5% (n=167) disagreed that all health workers know their fringe benefits,



29.7% (n=82) agreed and 9.8% (n=27) were undecided. Slightly over 50% (n=139; 50.4%) of the participants indicated that their organisations do not offer them sufficient opportunities for promotions and 49.6% (n=137) felt that their organisations offer them promotional opportunities. There were mixed views from the health workers on whether their organisations acknowledge or reward hard work. About 40% (n=109; 39.5%) of the participants were uncertain, about 30% (n=83; 30.1%) agreed and another 30.4% (n=84) disagreed. Similarly, there were mixed views also about whether the health workers were paid according to their experience. About 40% (n=109; 39.5%) agreed that they are paid according to their experience while 30.4% (n=84) disagreed and another 30% (n=83; 30.1%) were undecided.

These results provide a clear picture of how deficient the rewarding system is in the decentralised health system. This is highly likely to have a negative bearing on the performance of health workers. According to Hagopian et al (2009:w869) the reward and remuneration systems are believed to influence the behaviours and performance of health workers. The WHO (2006:75) emphasises that health workers must be remunerated well for the work they perform. If health workers are not paid well, they are likely to adopt some sort of coping mechanisms such as absenteeism, migration, creation of ghost workers and referring patient to private sector where some health workers hold part-time job (McPake et al 1999:849). Langenbrunner et al (2005:242) argue that service based methods (fee-for-service) are more effective in increasing performance and productivity than time based methods such as salaries and fixed budgets. Performance related payment methods are increasingly being applied in many developed countries and some developing countries such as Rwanda have adapted such systems (Manuwa-Olumide 2009:8).

#### **4.6.1.8 Dimensions concerning staff training and development**

Table 4.32 shows the responses of health workers concerning staff training and development in their districts or organisation.

**Table 4.32: Dimensions concerning staff training and development (N=276)**

Item description	Strongly disagree		Disagree		Undecided		Agree		Strongly agree		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
This organisation has a staff training and development policy	28	10.1	82	29.7	55	19.9	83	30.1	28	10.1	276	99.9
Opportunities exist for career advancement in this organisation	0	0.0	110	39.9	0	0.0	138	50.0	28	10.1	276	100.0
Appropriate training is conducted to ensure that health workers carry out their duties well	0	0.0	56	20.3	0	0.0	192	69.6	28	10.1	276	100.0
Job specific refresher courses are provided on a regular basis	28	10.1	109	39.5	27	9.8	112	40.6	0	0.0	276	100.0
The in-service training provided is adequate in addressing the existing skills gap	28	10.1	109	39.5	28	10.1	111	40.2	0	0.0	276	99.9
Health workers who are less competent are provided with the necessary support to improve their knowledge and skills	0	0.0	83	30.1	54	19.6	139	50.4	0	0.0	276	100.1
Health workers participate in identifying their career development needs	0	0.0	28	10.1	55	19.9	193	69.9	0	0.0	276	99.9
In the last 6 months my supervisors discussed with me my career development prospects	55	19.9	111	40.2	0	0.0	110	39.9	0	0.0	276	100.0
I have received the training required to succeed in my position	0	0.0	27	9.8	0	0.0	221	80.1	28	10.1	276	100.0

Table 4.32 shows that the majority (n=249; 90.2%) of the health workers agreed that they have received the training required to succeed in their positions. About 80% (n=220; 79.7%) of the participants also agreed that appropriate training is conducted to ensure that health workers carry out their duties well. Nearly 70% (n=193; 69.9%) of health workers agreed that they participate in identifying their career development needs. About 60% (n=166; 60.1%) of the health workers agreed that opportunities exist for career advancement in their respective

organisations and about 40% (n=110; 39.9%) disagreed. The results show that nearly 60% (n=166; 60.1%) of the participants disagreed that in the past six months their supervisors had discussed with them their career development prospects and about 40% (n=110; 39.9%) agreed.

Slightly over 50% (n=139; 50.4%) of the participants indicated that health workers who are less competent are provided with the necessary support to improve their knowledge and skills, about 30% (n=83; 30.1%) disagreed and about 20% (n=54; 19.6%) were undecided. Slightly less than 50% (n=137; 49.6%) of the participants indicated that that the in-service training provided is inadequate for addressing the existing skills gap and that there was irregular job specific refresher courses; about 40% (n=112; 40.6%) thought there were regular job specific refresher courses and about 10% (n=27; 9.8%) were undecided. There were mixed views with regard to staff training and development policy. About 40% (n=111; 40.2%) agreed that there was a training and development policy for health workers; about 40% (n=110; 39.9%) disagreed and about 20% (n=55; 19.9%) were undecided.

From these results it can be deduced that the district managers attempt to address the short term training needs while the health workers' long term developmental needs may not be sufficiently addressed. Training and professional development are important motivation and performance determinants as they nurture the health workers' personal objectives and their value systems. Training can enable health workers to cope better with the requirements of their jobs, enable them to take on more demanding duties and positions and to achieve the personal goals of professional advancement (Mathauer & Imhoff 2006:[10]). In service training is one of the commonly used methods in the health sector to enhance performance of health workers. Armstrong (2009:667) and Swansburg and Swansburg (1999:571) mention that in-service training provides a learning experience in the workplace for the purpose of refining new skills and therefore developing the health workers' potential to perform and adjust rapidly to the changing job requirements.

#### 4.6.1.9 Dimensions concerning the overall performance of health workers

Table 4.33 shows the responses of the health workers concerning their overall performance.

**Table 4.33: Dimensions concerning the overall performance of health workers (N=276)**

Item description	Average		Good		Very good		Total	
	n	%	n	%	n	%	N	%
My overall performance is	0	0.0	195	70.7	81	29.3	276	100.0
My competence to deliver services is	0	0.0	167	60.5	109	39.5	276	100.0
The quality of service I provide is	57	20.7	137	49.6	82	29.7	276	100.0
My overall daily attendance is	83	30.1	85	30.8	108	39.1	276	100.0
My overall productivity is	28	10.1	166	60.1	82	29.7	276	100.0
The overall responsiveness of the service I provide is	1	0.4	139	50.4	136	49.3	276	100.1

From Table 4.33, it is very clear that all the participants (n=276; 100.0%) indicated that their overall performance and competence to deliver the services is good. Overall, the responsiveness for almost all the participants (n=275; 99.6%) was good. Close to 90% (n=248; 89.9%) of the participants indicated their overall productivity was good and about 10.1% (n=28) indicated that it was average. Overall, 79.3% (n=219) of the participants indicated that the quality of service they provide is good and 20.7% (n=57) indicated that quality was average. Overall the majority of the participants (n=193; 69.9%) indicated that their daily attendance to duties was good and 30.1% (n=83) indicated that it was average. These results show that the overall self-reported performance of the health workers was good.

#### 4.6.2 Association between the dimensions of performance management and the performance dimensions

Table 4.34 presents a summary of the correlation matrix of the associations between the dimensions of performance management and the performance of

health workers. The performance dimensions of health workers include responsiveness, availability, productivity and competence (see detailed correlation matrix in annexure N).

**Table 4.34: Correlation between performance management and the dimensions of performance (N=276)**

Spearman's rank order Non parametric correlations		Responsiveness	Availability	Productivity	Competence
<b>Setting of performance standards</b>	Correlations	.842**	.885**	.569**	.365**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276
<b>Performance measurement</b>	Correlations	.676**	.644**	.469**	.349**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276
<b>Performance reporting</b>	Correlations	.728**	.712**	.680**	.094
	Sig. (2-tailed)	.000	.000	.000	.120
	N	276	276	276	276
<b>Performance improvement</b>	Correlations	.874**	.861**	.349**	.195**
	Sig. (2-tailed)	.000	.000	.000	.001
	N	276	276	276	276
<b>Rewarding system</b>	Correlations	.735**	.871**	.435**	.319**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276
<b>Staff training and development</b>	Correlations	.799**	.801**	.387**	.842**
	Sig. (2-tailed)	.000	.000	.000	.000
	N	276	276	276	276

\*\* Correlation is significant at the 0.01 level (2-tailed)

Table 4.34 shows that all the correlations between the dimensions of performance and performance management are positive. The results show significant and positive high correlation between performance improvement ( $r_s=.874$ ;  $p<.01$ ), setting performance standards ( $r_s=.842$ ;  $p<.01$ ), performance reporting ( $r_s=.728$ ;  $p<.01$ ), rewarding system ( $r_s=.735$ ;  $p<.01$ ), staffing training and development ( $r_s=.799$ ;  $p<.01$ ) and responsiveness of health workers. There is also a significant and moderate correlation between performance measurement ( $r_s=.676$ ;  $p<.01$ ) and responsiveness of health workers. The interpretation of these correlations is that the health workers are more likely to be responsive when they have clear and specific performance expectations on how to execute their duties. An effective rewarding system motivates the health workers and hence is likely to generate satisfactory levels of responsiveness. Adequate staffing reduces the workload on health workers enabling them to manage their tasks effectively. In addition, when health workers are constantly given a feedback on how they are performing, they are more likely to execute

their duties efficiently in order to avoid falling behind expected levels of performance.

The results show significant and high positive correlations between setting performance standards ( $r_s=.885$ ;  $p<.01$ ), performance reporting ( $r_s=.712$ ;  $p<.01$ ), performance improvement ( $r_s=.861$ ;  $p<.01$ ), rewarding system ( $r_s=.871$ ;  $p<.01$ ), staff training and development ( $r_s=.801$ ;  $p<.01$ ) and availability of health workers. There is a significant and moderate positive relationship between availability of health workers and performance measurement ( $r_s=.644$ ;  $p<.01$ ). These can be interpreted thus: the health workers are more likely to be available for duty when they know that there are clear expectations on how they should perform.

The results show significant and moderately positive correlations between setting performance standards ( $r_s=.569$ ;  $p<.01$ ), performance reporting ( $r_s=.680$ ;  $p<.01$ ) and productivity of health workers. There are also significant and low positive correlations between performance measurements ( $r_s=.469$ ;  $p<.01$ ), performance improvement ( $r_s=.349$ ;  $p<.01$ ), rewarding system ( $r_s=.435$ ;  $p<.01$ ), staff training and development ( $r_s=.387$ ;  $p<.01$ ) and productivity of health workers. The results signify the high likelihood of increased productivity of the health workers following the presence of clear performance guidelines and a clear account of their work related activities. The low association between performance measurement; performance improvement; rewarding system; staff training and development and productivity indicates that there may be other factors which determine the motivation of the health workers to perform other than those mentioned.

Table 4.34 shows that there is a significant and high positive correlation between staff training and development ( $r_s=.842$ ;  $p<.01$ ) and competence of health workers. Indeed it is to be expected that with adequate training and continuous professional development, the health workers will be more capable of executing their tasks competently. The results further show significant and low positive correlations between setting performance standards ( $r_s=.365$ ;  $p<.01$ ), performance measurements ( $r_s=.349$ ;  $p<.01$ ) and rewarding system ( $r_s=.319$ ;

$p < .01$ ) and competence of health workers. This shows that no matter how stern the performance standards and the performance measurement system may be, the health workers will not automatically become competent. Moreover, an effective rewarding system may not necessarily translate into competence.

There was little if any correlations between performance reporting ( $r_s = .094$ ;  $p > .05$ ), performance improvement ( $r_s = .195$ ;  $p < .01$ ) and competence of health workers. These results indicate that effective performance reporting and performance improvement may not be primary determinants of competence. Perhaps the health managers may choose not to utilise performance appraisal results to identify training needs, resulting in ad hoc training programs which do not address the actual needs on the ground.

#### 4.7 FINDINGS RELATED TO OBJECTIVE THREE

The third objective of the study was to determine the views of health workers on how to improve performance. This objective was investigated using an open-ended question. The responses were entered in the computer, coded, and then analysed using the multiple response method. The results are shown in Table 4.35.

**Table 4.35: Health workers' responses on how to improve performance (N=261\*)**

Category of response	Frequency of responses (n)	Percentage (%)
Improve staff motivation such as increase in remuneration, equipment.	201	77.0
Provide opportunities for further formal studies/training.	150	57.5
Provide continuous refresher training courses.	137	52.5
Conduct regular meetings to discuss health worker's performance related issues.	68	26.1
Regular staff rotation in different health facilities.	18	6.9

\*15 participants did not respond to this question.

Table 4.35 shows that out of the 261 participants that responded to this question, the majority (n=201; 77.0%) reported that they wanted to see an improvement in

the staff motivation. Such motivation attributes that were mentioned include increase in remunerations; provision of equipment to facilitate easy execution of tasks; provision of uniforms since most health workers had to purchase their own uniforms instead of being provided by the organisation, and provision of accommodation for staff nearer to the health facilities. They thought this would help to improve motivation and hence the performance of health workers. The findings of this study are in agreement with what the health workers in Kenya and Benin suggested on how they can improve their motivation and performance (Mathauer & Imhoff 2006:[8]).

Hagopian et al (2009:w869) observe that the level of remunerations, the way health workers are paid and the presence of other incentives always have an impact on the performance of health workers. Writers like Manuwa-Olumide (2009:8), Rese et al (2005:204) and WHO (2006:18) argue that no matter how skilled health workers are, very little can be achieved without basic infrastructure such as working equipment, essential drugs, clean water and other supplies.

About 58% (n=150; 57.5%) of the participants suggested that there should be an improvement in opportunities for provision of further formal training for those health workers that want to advance their careers. Additionally, about 53% (n=137; 52.5%) of the participants suggested that they should be provided with continuous refresher courses. Dieleman and Harnmeijer (2006:16) argue that advances in medical field such as treatment and diagnosis and the changing roles within the health sector require continuous professional development. Health workers require up-to-date knowledge to perform well. Inadequate knowledge, skills and inappropriate attitudes may be an impediment to quality health care. Continuous professional development is essential for the health workers at all levels, especially those at the lowest levels who go through the shortest periods of training (Manuwa-Olumide 2009:9; Mbindyo et al 2009:[7]).

Slightly more than 26% (n=68; 26.1%) of the participants suggested that there should be regular staff meetings to discuss the health workers' performance related issues. Information and communication are very important aspects in



improving the performance of health workers. Health workers need to know how they are performing and if there are any obstacles to their performance these can be identified and addressed at an early stage. Rowe et al (2005:1032) point out that having information helps health workers to do their jobs better. This information must be relevant to the job, available when needed, be of good quality and easy to understand. According to WHO (2006:80) the productivity of health workers should be based on reliable data about the workforce level, distribution, skills mix and information about those aspects that impede their performance.

Lastly, only 6.9% (n=18) of the participants suggested regular rotation of staff to various health facilities. This can be useful since it may encourage transfer of skills from one health facility to the other and also for example those health workers working in rural areas can have an opportunity to move to urban areas. This can improve their motivation and subsequently their performance.

#### **4.8 CONCLUSION**

Chapter four presented the analysis and interpretation of quantitative data. The response rate for this study was satisfactory, standing close to 84%. Data was tested for normality before being analysed using SPSS Version 18. In order to determine the consistency of the responses from the participants the Cronbach's reliability coefficient tests were utilised. This study made use of frequencies and percentages to summarise the data. The extent to which association exists between two variables was determined by the Spearman's *rho* rank order correlation coefficient ( $r_s$ ).

The first objective of this study was to identify factors that either enhance or impede the performance of health workers. Five individual attributes namely job related skills and abilities, self-monitoring ability, self-motivation, commitment to the organisation, and individual values and beliefs were investigated. The general findings revealed that the health workers possessed positive attributes suitable for good performance.

Objective two assessed the current practices used to manage the performance of health workers. Of the main focus was how the performance of the health workers was reviewed as well as how the performance appraisal results were utilised. Of the participants 49.6% reported that the performance appraisals were formal and regular. Eighty percent of the participants indicated that the performance appraisal results are used for promotion in service.

The third objective investigated the views of the health workers on how to improve performance. The health workers recommended that both the intrinsic and the extrinsic motivational factors must be improved. The next chapter presents the analysis, interpretation, and discussion of the qualitative findings.

## **CHAPTER 5 ANALYSIS, INTERPRETATION AND DISCUSSION OF QUALITATIVE DATA (LEVEL 2)**

### **5.1 INTRODUCTION**

In this chapter, the analysis, interpretation and discussion of the findings for the qualitative data is presented. The qualitative data was collected from the health service managers in the districts of Kumi, Mbale, Sironko and Tororo. The qualitative data collection was meant to obtain in-depth information from the health service managers with respect to the following objectives which are to:

- identify the factors that enhance or impede the performance of health workers
- assess the current practices used to manage the performance of health workers
- determine the views of the managers on how to improve performance

### **5.2 RESEARCH METHODOLOGY**

This level of data collection used the qualitative data collection methodology. The details of qualitative data methodology are discussed in chapter 3. Data collection from the health service managers ran concurrently with the quantitative data collection from the health workers. The main purpose of qualitative data was to get the answers to the research objectives from the perspective of the district health service managers.

#### **5.2.1 Study population**

The study population was the health service managers working in the districts of Kumi, Mbale, Sironko and Tororo. These managers were directly involved in supervising and appraising health workers. They included the DHOs; district nursing officers (principal nursing officers); heads of the health the sub-districts (health centre IVs); hospital medical superintendents; hospital administrators and

the principal personnel officers. All the health service managers were working in the public sector.

### **5.2.2 Sampling**

The participants were selected by purposive sampling based on predetermined criteria such as hierarchy in the district health services and the level of involvement in supervision of health workers. A total of 24 managers were approached for the interviews. The aim was to have at least 6 interviews from each district. Two (2) managers declined the interview saying that they did not have time and one (1) was attending a training workshop. Ultimately, a total of 21 health service managers were interviewed. The distribution of the interviewees per district is shown in Figure 5.3.

## **5.3 DATA COLLECTION**

The researcher used one-to-one approach of interviewing using an interview guide (annexure I). The researcher together with the trained research assistants conducted the interviews. One of the research assistants was recording responses on audio tape cassettes, while the others were taking comprehensive notes of the interviews.

### **5.3.1 Permission to conduct interviews**

A written consent was obtained from each participant using a consent form (Annexure E). This consent form was given to the participant, who had to sign it and return it to the interviewers just before the interview commenced. All the managers who participated in the study signed this consent form. The consent form indicated the purpose of the study, rights of the participants and the purpose for which the data was to be used.

### **5.3.2 Interview guide**

The interview guide (Annexure I) was semi-structured and had two main sections. Section A contained the biographic information of the participants and that of their districts. Section B had eight open-ended questions related to the

objectives of the study. Where and when it was necessary, probes were used in order to get additional information.

### **5.3.3 Conducting interviews**

All the interviews were conducted in English using the semi-structures interview guide. The researcher gave a hard copy of the interview guide to the interviewees well before the interview commenced in order to give them a chance to follow the sequence of the questions. The researcher conducted the interviews and was assisted by the trained research assistants. Permission was sought from the participants before the interview commenced. Permission was also requested for the use of the audio tape recorder. Out of the 21 participants, only three declined to be audio tape recorded. In such cases comprehensive notes were written by the trained research assistants.

### **5.3.4 Transcription of interviews**

At the end of the interviews, the transcription of the interviews was done verbatim and captured on computer using Microsoft Word 2007. Two experienced transcribers were employed to transcribe the data from the audio tapes. After the transcriptions each interview was sent back to the participants to confirm whether what they said during the interview is what was indeed recorded. This process was meant to ensure confirmability and credibility of the findings. The transcriptions were confirmed by the researcher before the final version of transcribed information was made.

## **5.4 DATA ANALYSIS**

Data analysis commenced simultaneously with data collection and continued after transcribing the interviews. Data from section A was analysed using the SPSS version 18 and data from the opened-ended questions in section B of the interview schedule was coded and analysed manually. The researcher read the transcribed information at least three times. Following this, the themes and subthemes were identified. Subsequently, the categories for each subtheme

were identified. The researcher used the services of a stastician to crosscheck and confirm the coding. Where necessary during the presentation of the results the researcher used typical quotes from the participants.

## 5.5 PRESENTATION OF FINDINGS FROM SECTION A OF THE INTERVIEW GUIDE

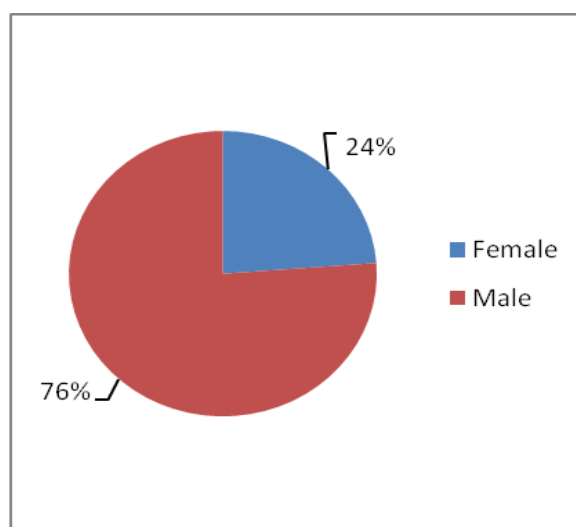
This section presents the results from section A of the interview guide which is about the demographic characteristics of the participants.

### 5.5.1 Demographic characteristics of the participants

The demographic characteristic of the participants are indicated in the subsequent subsections (5.5.1.1 to 5.5.1.6).

#### 5.5.1.1 Gender of the participants

Figure 5.1 shows the gender of the participants.

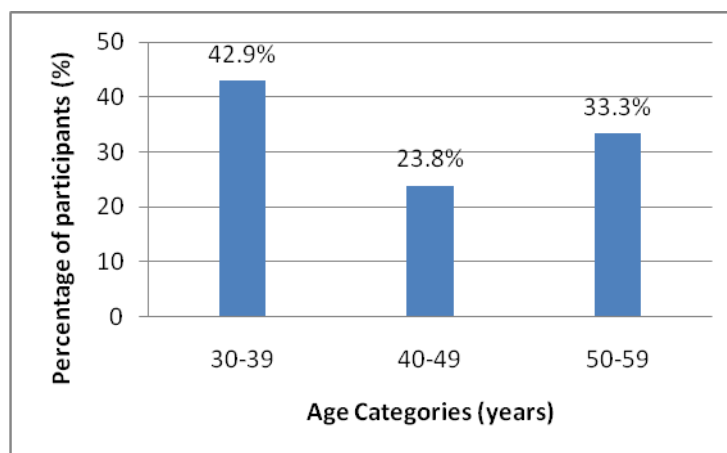


**Figure 5.1: Gender of the health service managers (N=21)**

Figure 5.1 shows that out of the 21 health service managers that interviewed, about 76% (n=16; 76.2%) were male, and about 24% (n=5; 23.8%) were female.

### 5.5.1.2 Age categories of the participants

Figure 5.2 presents the ages of the participants

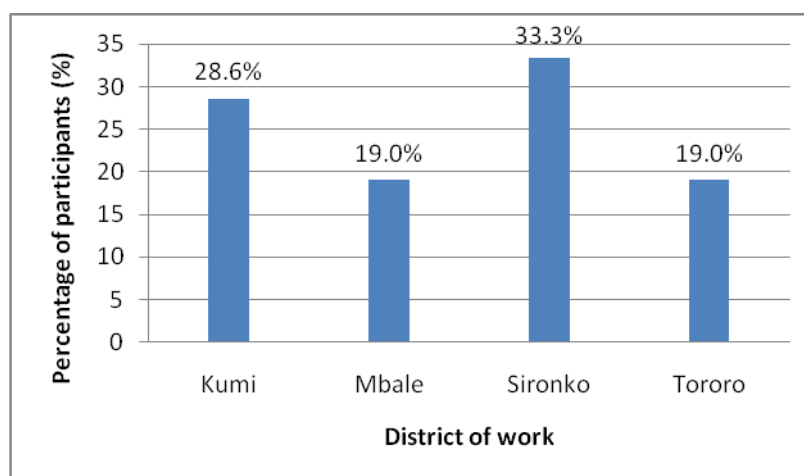


**Figure 5.2: Age of the health service managers (N=21)**

Figure 5.2 shows that most of the participants (n=14; 66.7%) were aged between 30 years to 49 years. This is an indication that all the managers were mature adults.

### 5.5.1.3 District of work of the participants

Figure 5.3 presents the distribution of health services managers by the districts.



**Figure 5.3: Districts where the health service managers work (N=21)**

There was a good representation of participants from all the four districts. Most of the managers interviewed were from Sironko district (n=7; 33.3%), followed by Kumi district (n=6; 28.6%). Both Mbale and Tororo districts were represented each by 4 (19.1%) participants.

#### 5.5.1.4 Duration of work in the district

Table 5.1 shows the years the managers have worked in their current positions in the districts.

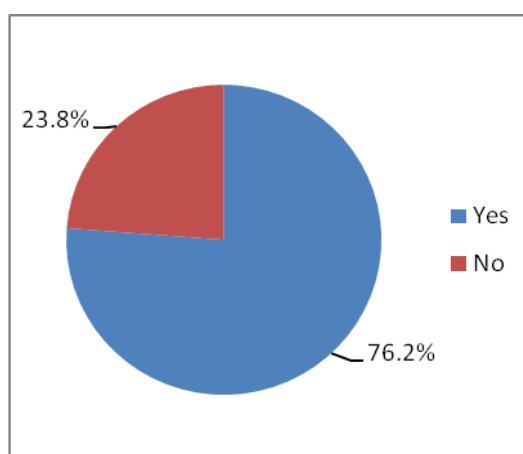
**Table 5.1: The number of years managers have worked in the district (N=21)**

Duration in Current position	Frequency (n)	Percentage (%)
0-5 years	4	19.1
6-10 years	10	47.6
11-15 years	4	19.1
16 years and above	3	14.2
<b>Total</b>	<b>21</b>	<b>100</b>

Table 5.1 shows that most of the health service managers (n=17; 80.9%) have been in their positions for more than 5 years. Only 4 (19.1%) managers have been in their current positions for up to 5 years.

#### 5.5.1.5 Training in human resource management or general management

Figure 5.4 presents the proportions of managers that have had some human resource and/or management training.



**Figure 5.4: Training in human resource or general management (N=21)**



Figure 5.4 shows that most of the managers (n=16; 76.2%) have had some form of training in human resource or general management.

#### 5.5.1.6 Type of training/programme in which the managers learnt human resource management

Table 5.2 shows the type of training during which the managers learnt about human resource management.

**Table 5.2: Type of training/programme attended by the managers (n=16)**

Type of Training	Frequency (n)	Percentage (%)
Master in public health	3	18.7
MSc health services management	2	12.5
MSc of human resource management	1	6.3
BA Public administration	1	6.3
BSc Health services management	6	37.5
Middle level managers training courses	3	18.7
<b>Total</b>	<b>16</b>	<b>100.0</b>

Out of the 16 managers who attended the training in management or human resources management, 37.5% (n=6) did so under their formal masters training courses such as Master in Public Health and Masters of Science for example in health services management and human resource management. About 45.8% (n=7) had training in management during their bachelor degrees and 18.7% (n=3) had such training during the middle level managers' training programmes.

#### 5.5.1.7 Forum for discussion of issues concerning the performance of health workers

All the managers interviewed (n=21), indicated that they have attended various forums during which HRH performance issues were discussed. Table 5.3 shows the list of forums where performance is discussed.

**Table 5.3: Forums where performance has been discussed (n=21)**

Forum level	Yes		No		Total	
	n	%	n	%	N	%
Ministry of Health	12	57.1	9	42.9	21	100
District	16	76.2	5	23.8	21	100
Health sub-district	12	57.1	9	42.9	21	100
Health facility level	14	66.7	7	33.3	21	100
One to one (individual basis)	11	52.4	10	47.6	21	100

Majority of the managers indicated that most of the performance related discussions take place at the district level (n=16; 76.2%) and health facility levels (n=14; 66.7%). An equal number of participants (n=12; 57.1%) indicated that health workers performance related issues are discussed at the ministry of health and health sub-district levels. About 52.4% of the health managers indicated that performance related issues are discussed on one-to-one basis.

## **5.6 PRESENTATION, INTERPRETATION AND DESCRIPTION OF FINDINGS FROM SECTION B OF THE INTERVIEW GUIDE**

This section deals with analysis of data obtained through the open-ended questions of the interview schedule (Annexure I). As mentioned earlier in chapter 3, the interviews were audio taped and transcribed verbatim. After reading and re-reading the transcripts from the 21 interviews, themes and subthemes were identified and classified into major categories. The coding was done manually by the researcher and was cross-checked and confirmed by an experienced scientist from University of Malawi with a master degree in applied statistics and with over 18 years of experience in the field of qualitative and quantitative research methodologies. Table 5.4 shows the themes, subthemes and categories that were identified.



			performance appraisal results		results are used (such as identifying training needs, promotions , redistribution of staff, support supervision , and not used)
4	Suggestions of managers on how to improve performance appraisal	4.1	Performance appraisal tool	4.1.1	Review appraisal tool
		4.2	Performance appraisal process	4.2.1	Nature and frequency of appraisal process
		4.3	Recognising performance	4.3.1	Rewarding good performance
		4.4	Performance appraisal feedback	4.4.1	Frequency of appraisal feedback
		4.5	Using performance appraisal results	4.5.1	Promotions Confirmation in the civil service Training
		4.6	Training of supervisors	4.6.1	How to conduct the appraisals and the Importance of appraisal process

As indicated in Table 5.4, the data collected from the health services managers had four major themes. The following subsections provide the detailed presentation and discussion of the results according to the themes and objectives of the study.

### 5.6.1 Theme 1: Factors that may enhance or impede the performance of health workers

One of the emerging themes from this study concerns factors that can either enhance or impede the performance of health workers. The following three sub-themes were identified: **organisational factors (health system)**, **individual factors**, and **institutional (local government) factors**. Out of these, several categories emerged as illustrated in Table 5.4. This section discusses organisational (health system) factors that influence the performance of health workers as illustrated in Table 5.5.

**Table 5.5: Organisational factors influencing the performance of health workers**

THEME		SUB-THEME		CATEGORIES	
1.	Factors that may enhance or impede the performance of health workers	1.1	Organisational (health systems) factors	1.1.1	Working environment
				1.1.2	Drugs, supplies. and equipment
				1.1.3	Remuneration
				1.1.4	Accommodation and living conditions
				1.1.5	Transport and referral system
				1.1.6	Support supervision
				1.1.7	Prospects for further studies
				1.1.8	Communication & interpersonal relations
				1.1.9	Experience sharing
				1.1.10	Promotion prospects/career movement
				1.1.11	Performance appraisal and recognition
				1.1.12	Working relationships
				1.1.13	Responsibility
				1.1.14	Clarity of organisation mission
				1.1.15	Mobility of health workers
				1.1.16	Staffing levels and turnover rates
				1.1.17	Primary Health Care (PHC) funding

### **5.6.1.1 Subtheme 1.1: Organisational (health system) factors**

Factors emanating from the organisational factors (health systems) can affect the performance of health workers both positively and negatively. The following categories present an outline of the factors identified by the managers as either enhancing or impeding the performance of their subordinates (health workers). It was noted from the interviews that all the factors but two identified by the participants were those that negatively affect performance.

#### **5.6.1.1.1 Working environment**

Most of the interviewees (n=19; 90.5%) alluded to the poor general working environment in the health facilities as a hindrance to good performance. The most recurring issues under working conditions were related to lack of adequate working space. Some of the participants stated:

*“...by the time these hospitals were built the population was low and of course the infrastructures here have remained the same. You find that you have the same space now like you had in the 1960s...”*

*“...work environment is a big problem here, you come to things like inpatient wards are too small, patients sleep on floors, the workspace is inadequate, it is really frustrating for us...”*

*“...the working environment here is not conducive at all...how do you expect me to work to the fullest...”*

Working environment plays a big role in the performance of health workers. A study done in Uganda (Hagopian et al 2009:w869) found that many health workers are unmotivated by the working conditions in their health facilities. This affects the motivation and morale of health workers and may consequently lead to poor performance. This is consistent with what the researcher has found in this study. El-Jardali et al (2007:[9]) emphasise the importance of working conditions that can either pull or push health workers and therefore affect their performance. Such conditions include unbearable working conditions, safety hazards and poor management practices.

#### **5.6.1.1.2 Drugs, supplies and equipment**

Nearly all the managers (n=20; 95.2%) mentioned that the lack of sufficient drugs and supplies such as gloves and equipment is a hindrance to performance. These seemed to create problems not only in the context of duty execution but also impacts on the relationships between health workers and the communities. Some of the managers (n=12; 57.1%) regrettably reported that some community members accuse them of hoarding the drugs to sell them for their own (health workers') personal gains.

*“...you find that our health workers perform their duties without any protective gear like gloves. You can have cases that require gloves but you can run out stock of gloves for months and therefore you have to depend on patient attendants to go a buy from the shops...”*

*“...there is an instance where one of my midwives here had to deliver a baby using these plastic bags ('buveera'), the baby was coming and she had no gloves so she had to improvise and save both the baby and mother...”*

*“...stock outs of drugs is a common occurrence here, and sometimes they accuse us of stealing drugs when actually the amount of drugs supplied to us cannot even last for a month...”*

A number of studies have reported similar findings. Willis-Shattuck et al (2008:[8]) report cases of frequent stock outs of materials like drugs, gloves and

even supplies like laboratory reagents in many health facilities in Africa. Hagopian et al (2009:w869) report that in Uganda health workers lack the necessary supplies needed to perform their jobs well and safely. Such supplies include gloves, needles, bandages and the equipment such as x-ray machines and films as well as blood pressure cuffs among others. This negatively affects the performance of health workers. Health facility resource availability should be a principal consideration since patient care cannot be effective without the proper and adequate resources.

#### **5.6.1.1.3 Remuneration**

There was a unanimous view (n=21; 100.0%) that low pay for health workers negatively impacts on the motivation of health workers, thereby resulting in poor performance. Health workers are tempted to engage in other money making activities besides their duties. This splits their attention and in due course compromises their availability for work.

*“...I don't really understand why we health workers are the least paid civil servant. Members of parliament are getting more and more allowances...”*

*“... why do you think health worker's go for part-time private practice? It is because their pay is pathetic...”*

*“...health workers in Uganda are the least paid in the whole east African region, that's why you see our doctors and nurses moving to other countries where pay is good...”*

Chirdan et al (2009:246) point out that in Nigeria, the health workers are also not happy with their remuneration. This is a common finding in many African and other developing countries including Uganda. The WHO (2006:75) emphasises that health workers should be paid well and timely for the work they do. Hagopian et al (2009:w869) report that in Uganda only 11% of health workers feel that their salaries are fair. Health workers find it very important to have remuneration package that includes health care for their dependants, terminal benefits, housing, food and transportation allowance. The way health workers are paid makes a big difference in their performance and productivity. McPake et al (1999:849) mention that where the health workers are not paid well they are

likely to develop some coping mechanisms such as migration, absenteeism and referring patients to private clinics where they hold part-time jobs in order to ensure survival. In general, poor compensation is more likely to impede the performance of health workers.

#### **5.6.1.1.4 Accommodation and living conditions**

All the managers (n=21; 100.0%) firmly complained that inadequate and substandard housing hinders the performance of health workers. Lack of accommodation near the duty stations forces the health workers to commute long distances. This is a disadvantage because the costs of commuting daily to work are high yet the salaries remain low. The available staff houses are dilapidated and there are no funds to maintain them.

*“...most health workers here do not have accommodation. They live very far from their health facilities...”*

*“...in this place you will never even get a house for rent..., this is a village, it is very difficult to work in such conditions, that’s why I think most of our health workers stay far way in towns...”*

*“...in our hospital a number of our staff are living outside the hospital, they have no accommodation within the health facilities.*

*“...I have made people in this hospital to share the few houses we have; hence, I am always solving disputes among those staff who are sharing accommodation. You can’t imagine putting two or three families in one house; they are married, with children and from different cultural backgrounds...”*

Living conditions of health workers affect their morale, motivation and consequently their performance. Hagopian et al (2009:w867) report that poor living conditions of health workers, with poor access to decent accommodation, lack of access to good schools for their children, poor access to entertainment and shopping centres affects their morale, motivation and may subsequently hamper their performance.



#### **5.6.1.1.5 Transport and referral system**

Most managers (n=18; 85.7%) indicated that health facilities have inadequate means of transport, if any, to meet their daily needs for patient referrals as well as carrying out routine support supervision visits, distribution of supplies like drugs, gas and other supplies. Inadequate transport affects the referral system and this compounds the logistical problems faced by health workers. It is important to note that transport plays an important role in facilitating the performance of health workers. Health workers need transport to travel to their places of work, conduct supervisions and also assist in the referral of patients. Lack of hospital infrastructure is an important de-motivator and affects the performance of health workers (Willis-Shattuck et al 2008:[5]). Lack of infrastructure like transport affects the responsiveness of health workers. Lindelow et al (2005:12) mention that in Ethiopia availability of better equipment and infrastructure like transport plays a big role in the attraction and performance of health workers in the private hospitals. Dieleman and Harnmeijer (2006:16) and Hagopian et al (2009:w867-w869) report that the productivity and performance of health workers is affected by lack of equipment like transport facilities that facilitate supervision visits and the referral of patients.

#### **5.6.1.1.6 Support supervision**

Insufficient support supervision is one of the recurring issues from the interviews that negatively affect the performance of health workers. Most managers (n=17; 81.0%) mentioned that inadequate funding and lack of transport facilities could be some of the contributory factors to the unsatisfactory support supervision. One manager (4.8%) explicitly mentioned that motivation of health workers does not only emanate from financial compensation but also from factors such as support supervision. Rowe et al (2005:1029) mention that supportive supervision when combined with audit and feedback to staff, consistently improves the performance of health workers. Findings from a study done in Afghanistan (Edward et al 2009:942) illustrate that with support supervision and training in integrated management of childhood illnesses (IMCI) there was significant

improvement in the quality of case management by the health workers managing the children under five years of age. World Health Organization (2006:75) argues that if support supervision is a sterile administrative event or is seen as fault finding and punitive, then it is likely to have a negative impact on the performance of health workers. Hagopian et al (2009:w871) point out that health workers in Uganda had slightly better than neutral relationship with their supervisors. This is almost consistent with the findings of this study.

#### **5.6.1.1.7 Prospects for further studies**

The concern of most managers (n=15; 71.4%) was that younger health workers needed opportunities to advance their careers through further studies. However, they are demoralised by lack of such opportunities. Where the opportunity emerges the criteria for selecting candidates to go for further studies is not clear. Nepotism seemed to play a part as one of the managers outlined:

*“...In this district the criteria used to select who should go for further studies is not clear. For example, I am pursuing a master degree in Public Health myself but I had to go to the bank for a loan; you know I am a man from another district myself...”*

Education and training opportunities have a strong motivation and performance effect. Training enables the health workers to take on more demanding duties and achieve their personal goals of professional development (Mathauer & Imhoff 2006:[10]; Willis-Shattuck et al 2008:[5]). In this study, the researcher established that the prospects for further training were not readily available and in most case health workers have to look for their own sponsorship. This, in one way, affects the performance of health workers since they get the feeling that they are probably not recognised by their superiors for the work they do. This is contrary to what is happening in other countries. In Kenya, for example, there are prospects of sponsorship in the public health system. This makes the jobs in public sector more attractive to health workers and hence improves performance of health works. Willis-Shattuck et al (2008:[4]) mentions that health workers are reluctant to work in rural areas because the opportunities for career development are less than in urban areas. This indicates that health workers take pride and

are motivated to perform when they feel that they have the opportunities to progress in their careers. In order to enhance the performance of health workers, it is important to create opportunities for further training and at the same time ensure equity in the selection of those who really deserve it.

#### **5.6.1.1.8 Communication and interpersonal relationships**

Slightly less than half of the managers (n=10; 47.6%) pointed out that one of the serious impediments to good performance of health workers was communication. Communication problems exist between the health workers themselves; between health workers and the patients and between health workers and the community members. This has been cited as the main cause of conflicts with a negative bearing on performance. Communication plays a very important role in the performance of health workers. First of all health workers need to communicate with each other in order to share information about their patients. Similarly, health workers must have the good skills to communicate effectively to the patients and their relatives. The DFID (2006:3) maintains that lack of interpersonal communication skills, lack of awareness of the clients' rights, and the inability to communicate in local languages impedes responsiveness of health workers is. All these can hinder the performance of health workers.

The WHO (2006:80) observes that information and communication are important in improving the performance of health workers. Unfortunately, health workers often do not receive adequate feedback on their performance. A study by Nzinga et al (2009:[5]) report that communication among health workers employed in paediatric wards in Kenya is poor. In general, there were few or no forums for hospital health workers in paediatric departments and all cadres of staff to meet and discuss issues concerning their patients. Hence, there was little opportunity to develop any widely supported goals for paediatric care in hospitals and there was also little self assessment, problem identification or solving at functional and organisational levels. Lipinge, Hofnie, van der Westhuizen and Pendukeni (2006:11) report that in Namibia, there are poor interpersonal

relations between health professionals at operational and ministry levels. Most of the communication is directive with no positive information sharing and formal feedback. This is consistent with what the researcher has established from this study.

#### **5.6.1.1.9 Experience sharing**

More than half of the managers (n=12; 57.1%) stated that increased interaction and sharing of information amongst themselves could enhance the performance of health workers. This would enable them to share experiences and possibly collaborate in managing complex cases. Yet, avenues for health workers to interact and exchange ideas seem to be wanting. Communication and sharing experiences are interrelated. Without proper communication the sharing of information about performance of health workers cannot be achieved.

Rowe et al (2005:1032) argue that having and sharing information helps health workers to perform better. The culture of sharing information can enhance the performance of health workers and improve their ability to work together as a team (Manuwa-Olumide 2009:8; Rowe et al 2005:1032). Nzinga et al (2009:[5]) report poor communication and team work among health workers in Kenya. There was little if any team work among health workers in the paediatric departments. This led to poor performance and implementation of clinical guidelines. To counteract this there was need for enhanced supervision and facilitation. This considerably improved cross-cadre and cross-department communication.

#### **5.6.1.1.10 Promotion prospects or career movement**

Decentralisation was mostly blamed by all the managers (n=21; 100.0%) for its rigidity in terms of promotion prospects of health workers. This is particularly true for those health workers who have managed to go further studies to improve on their qualifications. Upon their return they find that they do not fit into the district health system. This demotivates them and affects their performance.

Manafa et al (2009:[4-6]) report that in Malawi health workers also have very little if any prospects for promotions in service. The study observes that some enrolled nurses went for upgrading but ever since they completed their diploma training courses they neither received promotions nor bonuses. This seems to be de-motivating the staff and therefore affects their performance. Another study in Namibia (Lipinge et al 2006:7) report that there were limited prospects for career movement among the health workers due to the restructuring process that had taken place, the lack of performance appraisal system and favouritism seemed to be a common feature about who should be promoted or not. Crush (in Lipinge et al 2006:8) also reports that in Zimbabwe some of the reasons why health professionals were leaving the public sector were because of inadequate opportunities for promotion in civil service and lack of or limited opportunities for self improvement.

#### **5.6.1.1.11 Performance appraisal and recognition**

More than a quarter of the interviewees (n=6; 28.5%) stated that from their experience, some health workers become motivated to work when their performance is appraised. However, performance appraisal is not done adequately and when it is done, it is irregular and feedback is seldom given. One of the managers said:

*“...Of course appraising means you are discussing the strong and weak areas. So if people realise that you recognise their strong areas it can improve their performance but also when you tell them about their weak areas it can also motivate them...”*

Where performance appraisals are conducted, good performance is not rewarded and this may demoralise the health workers. Recognition and appreciation is a good motivator and can assist in enhancing performance of health workers. According to Manongi et al (2006:[5]) in Tanzania, although lack of physical infrastructure and equipment was de-motivating health workers, recognition and support by their superiors was a big motivator.

The government regulation is that all civil servants should be appraised at least once a year for those who are confirmed in service and twice a year for those health workers on probation. Although performance appraisal is done in one way or another, most of the time no rewards are given for good performance. A study done in Mali by Dieleman et al (2006:[5]) illustrate that there were infrequent performance appraisals which were mostly subjective and there were no formal strategies in place to show appreciation or give rewards for outstanding performance. This seems to affect the motivation and performance of health workers. Another study in Namibia (Lipinge et al 2006:8) reports that there was no positive re-enforcement of staff appraisal, motivation or reward in the public sector. Lack of recognition and appreciation is also reported by other studies from Kenya where health workers describe it as a big barrier to good clinical practice (Nzinga et al 2009:[5]).

#### **5.6.1.1.12 Working relationships**

Poor working relationships between the health workers themselves as well between health workers and their employer (District Council) have a negative impact on performance. It was noted by over half of the managers (n=12; 57.1%) that conflicts between the health workers occur even outside the work setting. One of the managers mentioned that some conflicts are caused by clashes that they have in their residence. Lack of adequate housing forces some of the health workers to share houses. As a result, personality clashes tend to create conflicts.

Lipinge et al (2006:11) mention that in Namibia, there was poor interpersonal relationships between health professionals at operational and management levels. They also demonstrate that communication from the ministry of health was top-down and instructional. This is almost similar to the findings of this study. This, in most cases, hinders the performance of health workers. Nzinga et al (2009:[5]) report poor working relations among health workers in Kenya to an extent that it affects the effective health service delivery. The findings of this study contradict what was found in Nigeria (Chirdan et al 2009:246). According to their finding, over 80% health workers in Nigeria felt that interpersonal and

working relations with their managers were open, at the same time over 90% felt that co-workers were supportive. Good working relationships can indeed enhance the performance of health workers.

#### **5.6.1.1.13 Responsibility**

Most of the managers (n=18; 85.7%) mentioned that one of the serious factors that impede performance is little or no responsibility given to health workers. This makes them feel unappreciated and unmotivated. If health workers are given more responsibility in the day-to-day running of the health facilities, this is likely to enhance their motivation and performance. Sagoe (2005:2) mentions that in Ghana decentralisation of the health services function, the empowerment and recognition of local staff were critical in the retention and enhanced performance of health workers. In addition, Reinikka and Svensson (2003:30) mention that in Uganda, health workers in the religious, private not-for-profit facilities were performing better because of the decentralisation of decision making authority over their facilities' budgets and expenditures. This is a motivator and it helps to increase performance of health workers. Huang et al (2006:11) point out that in Taiwan, the level of autonomy and responsibility given to nurses to control their practice and work schedules was an important factor which increased their organisational commitment and performance.

#### **5.6.1.1.14 Clarity of organisational mission**

The majority of the interviewees (n=15; 71.4%) reported that many lower cadre health workers do not understand the mission statement of their organisation. In fact, some of them do not even know that the mission statement exists. This means that these health workers do not share into what their organisation stands for and therefore less likely to contribute through good performance.

In order to perform, health workers need to understand and be clear of what they want to achieve. Quality health improvement can only be achieved when health workers know clearly the outcomes they are working towards as well as knowing

what changes can lead to improvements and how to evaluate their efforts (Ntoburi et al 2008:445). If the mission of the organisation is not known to the health workers, then it is almost impossible for them to set targets for achieving their goals. The health workers need to be clear about the organisational structure, the type of information and information systems, task design, selection, training and development and the reward system (Noe et al 2008:80). lack of clarity about all these may misdirect the performance of health worker. Therefore, it is the responsibility of the management to make sure that health workers know about the ministry of health's mission, goals and objectives in order to align their activities accordingly.

#### **5.6.1.1.15 Mobility of health workers**

Lack of mobility emerged from over half (n=12; 57.1%) of the interviews as a major factor causing low morale and performance among the health workers. The decentralisation system confines the health workers to one district. If one wants to move to another district he or she has to resign first and start at the entry level in a different district. This finding is consistent with what is reported by Ssenooba et al (2005:11) who mention that health workers felt a sense of entrapment under decentralisation in a particular district, without hope of moving across districts.

#### **5.6.1.1.16 Staffing levels and turnover rates**

Nearly all the managers (n=20; 95.2%) referred to the issue of low staffing levels coupled with high employee turnover as major factors that demotivate and hinder the performance of health workers. For example, one of the managers indicated that their staffing level in his district is about 40%. As a result, health workers experience increased workloads and low morale as their colleagues leave for better opportunities elsewhere.

Several studies in developing countries have documented issues of understaffing in the health systems. Manongi et al (2006:[4]) in Tanzania; Bradley and McAuliffe (2009:[6]) and Manafa et al (2009:[5]) in Malawi and



Lipinge et al (2006:9) in Namibia all report chronic shortages of human resources for health due to poor motivation and retention practices. According to Ssenooba et al (2005:8) shortage of staff is widely perceived as a major problem that, in many ways, affects performance of health workers in Uganda. For instance, the high workloads make it difficult to follow standard patient care such consultations time and the annual and study leave approvals may be delayed due to absence of replacements to absorb the workload (Ssenooba et al 2005:8).

#### **5.6.1.1.17 Primary Health Care (PHC) funding**

Lack of adequate funding for primary health care (PHC) activities poses challenges to health workers. While the funds are already insufficient for meeting the PHC requirements, all the managers (n=21; 100.0%) mentioned that the funds keep on decreasing every year. One of the managers pointed out that:

*“...Since I joined this district in 2003 I have noticed every year the PHC funds which go to health facilities has been reducing every year ... yet the population we are serving is increasing now and again...”*

During the period between the financial years 2002/2003 and 2005/2006, the trend was to budget and transfer more funds to decentralised services administered at the local government and district levels, as opposed to centralised funding. Although this decentralisation has continued, it has not resulted in significant improvement in delivery of services. The vast majority of spending at the decentralised level has gone towards employee costs. While the allocation of funds to decentralised facilities is meant to improve service provision, the transfer of funds has not translated into the expected improvement in the health services delivery (Fanaka Kwa Wote 2008:2).

#### **5.6.1.2 Subtheme 1.2: Individual factors**

These are the factors emanating from health workers as individuals. These are listed in Table 5.6.

**Table 5.6: Individual factors influencing the performance of health workers**

1.2	Individual Factors	1.2.1	Availability
		1.2.2	Competence
		1.2.3	Pro-activity
		1.2.4	Client-oriented behaviour
		1.2.5	Productivity

#### **5.6.1.2.1 Availability**

The health service managers' views were split (n=11; 52.4%) with regard to availability of health workers. Depending on the location of the health facility, some of the managers (n=11; 52.4%) indicated that the health workers were available. This was also subject to the approved staffing levels. Mostly, the easily accessible health centres had higher staffing levels of between 70% and 80% and hence more likely to report satisfactory levels of availability. Availability in these health centres is also enhanced by low levels of absenteeism. However, health centres located in hard-to-reach areas experience low availability. Apart from the low staffing levels some of the managers pointed out that the availability of health workers is heightened by absenteeism. Some of the managers (n=18; 85.7%) mentioned that majority of health workers commute long distances everyday since they lack accommodation at their facilities. They have to pay money for transport from their meagre salaries. When they do not have money for transport, they cannot go to work.

On the other hand availability depends on their individual attitudes towards work. One of the managers stated:

*"...this has to do with attitude, a lot to do with someone's drive to work, some people are lazy, and they just want to have excuses not to do work. And yet there are those who feel that they have an obligation to do their duties".*

In addition, it also emerged from over half of the interviews (n=13; 61.9%) that availability of health workers depends on the cadre. In general, lower cadre staff is available while highly skilled health workers like doctors are not.

Anyangwe and Mtonga (2007:93) argue that health workers are the backbone of any health systems and are important for the implementation of health policies. Several studies describe the maldistribution of health workers between rural and urban areas (Chen et al 2004:1984; Stilwell 2004:21). In Kenya Gondi, Otieno, and James (in Mullei, Mudhune, Wafula, Masamo, English, Goodman, Lagarde, & Blaauw 2010:S1) report acute understaffing in rural primary health care facilities. The vacancies in rural areas being considered less desirable. Urban settings have superior infrastructure and services while rural centres are associated with high workloads and poorly aligned incentive systems that disadvantage rural staff. This is comparable to the situation Uganda. Studies demonstrate positive correlations between quality of health care and good health outcomes with availability of health workers. As the number of health personnel reduces, the ability of the system to offer health services also reduces (Awofeso et al 2008:[2]; JLI 2004:23).

#### **5.6.1.2.2 Competence**

The general view of nearly all the health service managers (n=20; 95.2%) was that the health workers demonstrate satisfactory levels of competence. Some problems were identified though, for example, one of the interviewees stated that sometimes the ability of health workers seems inadequate simply because they are assigned to duties for which they are not trained.

Health workers can only be competent if they have the necessary knowledge, skills and equipment to do their work. Manongi et al (2006:[5]) assert that in Tanzania, due to understaffing, many low cadre health workers are compelled to handle cases for which they are not trained. For instance, an auxiliary nurse would do the work of pharmacist and that of clinicians. This generally results in inadequate or substandard health services.

Whereas in general the managers recognised that the health workers are knowledgeable enough to perform their jobs, some of them (n=17; 81.0%) indicated that the competence of health workers needs to be revamped through

refresher courses. It is important to observe that the health service managers trust the competence of health workers. However, competence alone without other resources may not automatically translate into performance.

Huicho et al (2010:360) argue that availability and competence of health workers by themselves cannot directly improve the health outcomes and performance of health workers in absence of effective health systems components such as drugs, supplies and functional equipment. Inadequate knowledge, skills and attitudes among health workers can create an obstacle good health care and may lead to poor performance of health workers (Bossynns & Van Lerberghe 2004:[3-4]).

#### **5.6.1.2.3 Pro-activity**

The general view of the managers was that the health workers are proactive. Majority of the managers (n=19; 90.1%) pointed out that high levels of innovativeness is seen among the health workers who are given authority and responsibility. It gives them a sense of control. Health workers also display innovativeness when there is scarcity.

*“... if you have a patient with chest problems like there is fluid in the chest cavity and you know the proper way to drain the fluid is to use complicated things like chest tubes but health workers just push the needle and they are able to drain the fluid out the chest...”*

Kahya (2009:102) argues that workers who are creative or innovative usually achieve high outcomes. This may be good for both individual and organisational performance. However, it is important to observe that people can only be innovative if they are well motivated and competent.

#### **5.6.1.2.4 Client oriented behaviour**

The behaviour of the health workers towards the clients was reported as generally good. However, slightly less than a quarter of the managers (n=5; 23.8%) noted that there are some instances where health workers display

undesirable conduct towards patients. This was largely attributed to acrimony arising from work related factors such as lack of adequate supplies, drugs and equipment. Yet, some managers (n=8; 38.1%) also mentioned that some of the health workers are simply not client-oriented and this may be due to their general ill-conduct (depending on their family backgrounds).

Berry and Bendapudi (2007:111) argue that health care is the most personal and important service that clients seek. Therefore, the behaviours of health workers such as nurses, clinical officers and doctors are essential for both patient satisfaction and successful health outcomes. A study in Bangladesh report that almost all patients expected respect and politeness from health workers irrespective of whether they use static or outreach facilities (Aldana, Piechulek & Al-Sabir 2001:514). It is therefore important to understand the behaviour of health workers in order to predict their performance.

#### **5.6.1.2.5 Productivity**

Most of the managers (n=13; 61.9%) indicated that on average the health workers are productive, though many factors hinder the desired levels of productivity. Individual drive and commitment was cited by many managers as an important determinant of productivity. Factors such as availability of health workers affect the productivity and performance. In health facilities with low staffing levels productivity tends to be sub-minimal because the available workers are overworked. General staff motivation also plays a part in determining productivity. Resource availability has a significant bearing on how productive the health workers will be. It was also established during the interviews that in some health facilities productivity was difficult to determine because there were no established indicators. Hence, productivity assessment was most likely to be subjective. A few health facilities had indicators which simplified the task of measuring productivity.

A study in Iran illustrates that productivity of nurses is affected mainly by human resources factors such as proper selection of workers, adequate numbers of

staff, full participation and involvement in the process on managing patients, financial security and sound communication among the team members (Nayeri et al 2005:9). These reported findings support the results of this study. Although it may be difficult to measure productivity of health workers, some writers like Buchan (2005:4), Manuwa-Olumide (2009:5), Hornby and Forte (2002:2) and JLI (2004:146) propose the indicators that can be used to measure productivity. These indicators include, for example, the number of patients attended to as outpatients, number of home visits made and bed occupancy rates among others. Other studies also identify factors such as lack of equipment, drugs and supplies and poor management practices are some of the causes of poor motivation and poor productivity among health workers (Dieleman & Harnmeijer 2006:16; Hagopian et al 2009:w867). According Forcheh and Fako (2007:103) productivity among service providers such as health workers highly depends on the routine activity that each is supposed to do. Hence, there is need to have proper indicators to closely monitor these activities. These seem to be inadequately practiced in the Ugandan health sector.

### **5.6.1.3 Subtheme 1.3: Institutional (local government) factors**

These are the factors which stem neither from the organisation nor from the individual health worker. Table 5.7 illustrate institutional factors influencing the performance of health workers.

**Table 5.7: Institutional factors affecting the performance of health workers**

1.3	Institutional (local government) factors	1.3.1	Decentralisation
		1.3.2	Government policies and guidelines
		1.3.3	Political interference
		1.3.4	Health seeking behaviours of communities

#### **5.6.1.3.1 Decentralisation**

The managers had divergent opinions concerning the effects of decentralisation on the performance of health workers. For those (n=14; 66.7%) who thought that decentralisation is detrimental to the performance of health workers the following reasons were given:

*“...there is delayed recruitment due to lack of funding and tools...the people under central government have tools yet in the districts they are not there...”*

*“...in other areas they do not have doctors...most doctors prefer areas like towns, they shun hard-to-reach areas...”*

*“...in fact the staffs have stagnated because the civil service structure of the district local government is rigid. The majority of the cadres who remain at the centre or regional hospital are actually ahead by two or three steps compared to those in local government...”*

On the contrary, the managers (n=7;33.3%) who were in favour of decentralisation stated that:

*“...decentralisation has brought services closer to the people and has facilitated community ownership of the health services that is our satisfaction”.*

In addition, one of the managers indicated that decentralisation has brought positive effects in the supervision of the health services. The capacity of district health management team has been improved to supervise health services instead of supervisors from the central administration having to conduct supervision all over the country.

Ssengooba et al (2005:14) argue that decentralisation and related organisational restructuring was meant to improve performance of the systems by empowering lower levels to make decisions that are most responsive to the needs of the people. Dieleman et al (2009:[5]) emphasise that decentralisation of human resource management functions could have positive impact but complementary interventions to create enabling environment are required. Such interventions include management training, changes in the bureaucratic procedures, appropriate preparation in staffing structures and staffing levels among others. According to Ssengooba et al (2007:[10]) under decentralisation the supervision of health workers and services in Uganda has taken a more human angle with the direct accountability of health staff to selected community members. Generally, the health workers seem to appreciate the new changes in their supervision since relationships to key community leaders improved through closer working relationships. This supports what some of the managers reported in this study.

A study by Liu, Martineau, Chen, Zhan, and Tang (in Dieleman et al 2009:[5]) report that in China decentralisation reforms led to inappropriate recruitments due to social pressure to recruit incompetent relatives and friends. Health service managers and workers were also faced with the organisational pressure to increase hospital income. The focus on increasing the hospital income led to over-treatment and over-prescriptions. This negatively affected the quality of care given to patients and hence the performance health workers.

The researcher found that some managers (n=15; 71.4%) complained of delays in the recruitment processes due to lack of funding and some other necessary resources for the DSCs to carry out their duties. This is contrary to what was found by Ssengooba et al (2007:[10]) that health workers thought that under decentralisation recruitments were a bit faster. However, the problem under decentralisation in Uganda is that the recruitment of health workers is threatened by nepotism whereby those who originate from the district are better preferred than those who are considered 'aliens'. This affects not only the motivation but also the performance of health workers. Health workers might be working under fear of losing their jobs in favour of the 'sons and daughters of the soil'.

Like other studies mention, health service managers thought that there were limited opportunities for promotions in public services. This is mainly because promotion to higher levels means an increase in salary which the districts may not afford due to the limited financial resources and also by the quota (civil service staffing ceiling) constraints (Bradley & McAuliffe 2009:[3-5]; Lipinge et al 2006:8; Manafa et al 2009:[6]).

#### **5.6.1.3.2 Government policies and guidelines**

One of the managers explicitly stated that government policies and guidelines are outright clear. The decentralisation policy is good in as far as bringing services closer to the communities. However, the implementation of the policy remains problematic. It seems as if some people do not understand the decentralisation concept. The fiscal decentralisation is not done properly and this



affects a host of other factors such as availability of health workers and other resources. The health management information system captures most of health related data from the health facilities. This means that the information needs of health workers should not be a hindrance to performance. However, the problems arise because the information system is largely manual and some of the health workers are not trained to use it. This then affects performance negatively.

Although the government has good policies, these are not known to all and therefore are not implemented. When new policies and guidelines come up, health workers have to be trained and oriented on them. Nzinga et al (2009:[4]) identify that in Kenya one of the barriers faced by health workers in implementation of the clinical guidelines is inadequate training coverage resulting in inadequate knowledge and skills. It is therefore important to train most of the health workers when new policies and guidelines are introduced. This helps to facilitate change and may assist in enhancing the performance of health workers. Sound policy, resources allocation and day-to-day management decisions in the health sectors require timely information from routine health information system. In most developing countries including Uganda the health information managements is inadequate in providing quality data and continuous information that can be used to improve health workers and systems performance (Hotchkiss, Aqil, Lippeveld & Mukooyo 2010:[1]). Although the researcher found that the policies and guidelines are available they are either not well designed or many health workers are not trained or oriented about their existence and implementation.

#### **5.6.1.3.3 Political interference**

This has been cited by the majority of the managers (n=19; 90.5%) as a serious hindrance to the performance of health workers. The politicians want to control the way health facilities are run and this creates a lot of conflict between themselves and the health workers as one manager noted:

*“There is also political influence and interference. Some of these people who are recruited may be related to some politicians and they want them to be working in certain areas, so it makes distribution of staff difficult”.*

Political interference seems to be a common occurrence in the districts. This is consistent with some other studies done in developing countries. In Mozambique, Saide and Stewart (in Dieleman et al 2009:[5]) mention that district administrators influenced transfers of health workers and administrative constraints often prevented adequate performance evaluation. In China, some health service managers were faced with the problem of addressing recruitments due to social pressure to recruit incompetent relatives and friends (Dieleman et al 2009:[5]). Ssenooba et al (2007:[10]) report that in Uganda because of political interference health workers with management responsibilities were fearful of their precarious relationships with local authorities. This was mainly because of local authorities claim to have decision-making power in dismissal of health workers. Hence, this fear among health workers for dismissal leads to job insecurity for health workers in the decentralised services and can impede the performance of health workers.

#### **5.6.1.3.4 Health seeking behaviours of the communities**

Although this was not a general view from many managers, one manager observed that because communities are very poor, sometimes people decide to come to hospitals when it is too late for health workers to save their lives. This reflects badly on the health workers because when patients die they feel that they could have done something to save lives. Communities may sometimes put the blame on health workers when their relatives die. This in general demoralises health workers and negatively affects their performance. This result is consistent with the findings of Hausmann-Muela, Ribera, and Nyamongo (2003:8) in Tanzania that due to their cultural beliefs community members delayed to refer serious illnesses to health facilities. Instead they preferred to treat the patients using traditional remedies. Yet those remedies do not always work. This leads to delay in seeking health services which would save the lives of the patients.

## 5.6.2 Theme 2: Views of managers on how to improve the performance of health workers

The second theme which was identified from the interviews relates to the views of health service managers on how the performance of health workers can be improved. The following three subthemes emerged: organisational initiative, institutional initiative and community initiative. Table 5.8 outlines the subtheme organisational initiative along with its categories.

**Table 5.8: Views of managers on how to improve the performance of health workers**

2	Views of managers on how to improve the performance of health workers	2.1	Organisational (health systems) initiatives	2.1.1 2.1.2 2.1.3 2.1.4 2.1.5	Improving remuneration Training of health workers Delegation of responsibility Hospital infrastructure, accommodation and transport Support supervision
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### 5.6.2.1 Subtheme 2.1: Organisational initiative

This subtheme spells out what the immediate organisation can do to improve the performance of its employees.

#### 5.6.2.1.1 Improving remuneration

All the managers (n=21; 100.0%) interviewed suggested that better remuneration of the health workers would boost their morale and thus improve their performance. The salaries should be increased, be paid regularly and in a timely manner. This quote is testimony to what some of the managers believed should be done:

*“...I can’t go without talking about the issues of salary... because that is making health workers not stay in one place is to make ends meet. Somebody cannot sit in this place from morning to evening when he is not sure whether his children will go to school or not...so improvement of staff remuneration is important...”*

Many countries in Africa are reporting poor remuneration of health workers as one of the causes of poor motivation, retention and performance. In many African countries health workers who work for government end up being poorly remunerated (Muula 2005:25). The WHO (2006:75) emphasises that health workers must be paid reasonably well and on regular and timely basis. Hagopian et al (2009:w869) maintain that the way health workers are remunerated influences their performance. The application of bonuses and allowances such as lunch, overtime and outreach allowances in Uganda has proved to be effective in enhancing the performance of health workers (Hagopian et al 2009:w870).

Some health service managers (n=9; 42.9%) were of the view that remuneration should be based on the performance results. In Namibia for example, Lipinge et al (2006:14) report that nurses suggested that salaries should be based on performance appraisals and market-related salaries based on qualification. Isaac (2001:111) and Manuwa-Olumide (2009:8) observe that performance related payments are being applied in many developed countries. However, without proper indicators for measuring productivity and performance it is always difficult to implement such a system.

#### **5.6.2.1.2 Training of health workers**

All the health service managers (n=21; 100.0%) recommended regular training for all cadres to equip them with up-to-date skills that will enhance their performance. This is what one manager had to say:

*“...then the refresher courses to new staff that are recruited... There are many clinical officers who heading health units but many of them do not know how to fill the monthly report forms...”*

Training and education opportunities have strong motivation effects on health workers. According to Mathauer and Imhoff (2006:[10]) training enables health workers to take on more challenging and demanding duties as well as assisting

them to achieve their personal goals of advancement. This can help them cope better with the requirements of their jobs. Cicciò, Makumbi and Sera (2010:1250) argue that adequate in-service training is necessary for quality health service delivery in primary health care settings. Policy changes, new clinical guidelines and general management tasks all require effective training of the highest number of health workers possible in order to reach the programme objectives. Rowe et al (2005:1027) emphasise that professional development can influence the health worker's motivation as well as performance. Mbindyo et al (2009:[7]) point out that continuous professional development is necessary for health workers at all levels in order to improve their performance.

In some countries such as Malawi, Manafa et al (2009:[4-5]) emphasise that in-service training which represents training on specific topics identified by the district team helps in enhancing performance of health workers. Such training is often organised in fulfilling the patients' needs. From the managers' perspectives the process appears to be fair and equitable. From the health workers' perspective, in-service training appeared to have improved their performance but some new skills acquired were sometimes never used. Unlike their managers, health workers in Malawi felt that there was favouritism with regards to who benefits from continuous education and in-service training (Manafa et al 2009:[5]).

According to Lipinge et al (2006:14) in Namibia some hospital managers are of the view that in order to enhance performance of health workers, compulsory continuous education should be enforced to encourage health professionals to acquire more knowledge and skills. They also recommend that each department should have a plan which includes staff refresher courses.

Researchers from Makerere University College of Health Sciences (Kaye, Mwanika & Sewankambo 2010:1372) emphasise that the formal community based training experience of medical and nursing graduates significantly influence their choice to work in rural and underserved areas. They therefore

conclude that while personal values may impact on the decision to work in the rural areas, training experience also shapes these personal values and choices.

### **5.6.2.1.3 Delegation of responsibility**

There was a general view among most managers (n=15; 71.4%) that the health workers would perform better if they are given significant authority and responsibility. The feeling of empowerment would increase their commitment and improve performance. One manager observed:

*“...Money motivates some people, but not everybody is motivated by money alone...others are motivated by the responsibility or assignments...additional assignments make somebody feel recognised...”*

Although decentralisation has taken place, not all health facilities have as much as necessary authority over funds and staff. This is known to affect the performance of health personnel. Health workers are motivated when they are delegated responsibilities and this is likely to enhance their performance. Therefore, giving district health managers freedom to allocate funds can make a big difference in staff and health facility performance.

Health workers need more authority and responsibility over their work and that of their co-workers. Responsibility encourages autonomy and promotes the sense of control over one's job, such as the ability to make decisions about health care practice (Tang 2003:8). Mrayyan (2004:333) reports that increased autonomy is influenced by supportive management, education and experience. Organisations that have autonomous and long serving workers provide quality care to patients, in a cost effective way (Lephalala 2006:46). One study in USA reports that where the nurses are autonomous and empowered the quality of patient care was consistently higher (Upenieks 2005:27). Khowaja, Merchant and Hirani (2005:33) mention that in Pakistan, the lack of autonomy, inadequate staffing and work overload has a significant impact on job satisfaction, performance and attrition of nurses.

#### **5.6.2.1.4 Hospital infrastructure, accommodation and transport**

All managers (n=21; 100%) proposed that provision of adequate housing near the duty stations could improve availability of the health workers. Absenteeism could be reduced and health workers would save a lot of money which they use to commute to and from work. They also suggested that health facility infrastructure should be improved and the old buildings should be renovated or if possible new ones put up for patient care. Lack of hospital infrastructure and supplies (drugs, equipment and other medical supplies) including accommodation and transport is a serious de-motivator to the health workers. Willis-Shattuck et al (2008:[5]) point out that hospital infrastructure and resource availability should be a principal consideration since patient care cannot be effective without the correct resources, like vehicles for patient referrals. Poor infrastructure does not inspire confidence among health workers working in a particular health facility as well as from the clients who use those facilities.

#### **5.6.2.1.5 Support supervision**

Support supervision emerged as an important factor which the managers believed would boost the performance levels. The majority of managers (n=18; 85.7%) pointed out that health workers need ongoing support supervision as this enables them to learn, identify problems and solve them accordingly.

Supportive supervision when conducted properly, followed by adequate feedback to health workers can actually improve their performance. Supportive supervision is usually used to identify and solve specific problems, can improve job satisfaction and motivation of health workers (Hagopian et al 2009:w871). Finnigan (2005:1) states that one of the greatest drivers of employees' decisions to stay or leave is relationship with their immediate supervisors. Edward et al (2009:942) report that in Afghanistan, by using support supervision and training of health workers in IMCI, there was improvement in the quality management of children less than five years of age.

On the contrary, a study in Tanzania reports that support supervision to health workers from their immediate superiors or the external supervisors from DHMT was irregular and not supportive and it was very rare to get a feedback report following the supervision (Manongi et al 2006:[5]). Joubert, Du Rand, and Van Wyk (2005:39) report that some supervisors tend to abuse their subordinates, for example doctors tend to show more aggression towards nurses. Uzun (2003:81) report that in 2003, more than 75% of South African and Turkish nurses reported verbal abuse. This impacts negatively on patient care, productivity, morale and job satisfaction.

### **5.6.2.2 Subtheme 2.2: Institutional initiative**

This describes the programmes that can be implemented by the local governments to enable the decentralised health systems function appropriately. These are indicated in Table 5.9.

**Table 5.9: Institutional initiative to improve performance of health workers**

2.2	Institutional (local government) initiative	2.2.1	Centralise district health office and the management of health workers
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#### **5.6.2.2.1 Centralise the district health office and the management of health workers**

This view did not recur during the interviews but it emerged as an interesting suggestion from three (14.3%) district managers. These managers suggested a drastic measure of removing the control of the DHO from the District Council to the central government just as they centralised the position and functions chief administrative officers (CAO). According to the managers, this would enable the DHOs to be easily transferred across districts. The managers, especially the DHOs, are sometimes put under a lot of pressure to comply with the directives from the district councils even if those directives may sometimes be inappropriate. The DHOs and health workers comply because they fear that they would be fired if they do not. They simply have to be in the 'good books' of their



supervisors (district council) to retain their jobs. This supports what another study that was conducted in Tanzania.

In Tanzania Munga et al (2009:[6-8]) extensively discuss the issues of decentralisation as opposed to centralisation of the recruitment and control of health workers. Their study reveals that decentralised recruitment and control was perceived to be more effective in improving retention of the lower cadre health workers within the districts. In contrast, the centralised arrangement was perceived to be more effective both in recruiting qualified staff (such as the DHOs), control and balancing their distribution across districts, but poor in ensuring their retention. This result show that the decentralised recruitment and control opened new avenues for political influences on technical decisions related to employment and performance of health workers.

In Uganda some districts have failed to attract and retain highly qualified cadres like doctors because of the perceived interference from the political leadership. Munga et al (2009:[10]) suggests that the governments should consider a hybrid of both centralised and decentralised management of human resources for health in order to ensure performance.

### **5.6.2.3 Subtheme 2.3: Community initiatives**

Community initiatives require that the community members who are served by the health workers weigh in to ensure that the health workers perform in a satisfactory manner. This is indicated in Table 5.10.

**Table 5.10: Community initiatives to improve performance of health workers**

2.3	Community initiatives	2.3.1	Community appreciation and support to health workers
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#### **5.6.2.3.1 Community appreciation and support for health workers**

Majority of the health service managers (n=16; 76.2%) believed that community members could assist the health workers improve their performance by demonstrating appreciation for the job they do under difficult circumstances. They also suggested that community support is important to boost the morale of health workers.

Appreciation from clients is seen as an indicator for successful professional conduct and achievement of health workers' goal to provide health care for the patients. According to Mathauer and Imhoff (2006:[9-10]) the importance of client appreciation stems primarily from the health workers' satisfaction and their professional goals of helping patients. This, in essence, motivates health workers to perform better even if their remuneration is not all that attractive. Lack of appreciation from clients and their families lead to poor intrinsic motivation and this can impede the performance of health workers. In one of the studies done in Kenya, Nzinga et al (2009:[5]) mention that the communities really appreciated health workers for what they were doing. However, the administration or management was not appreciating the work. Although community appreciation was a motivator to these health workers, the lack of appreciation from the management was a de-motivator. This is therefore likely to negatively affect the performance of health workers.

Ssengooba et al (2007:[11]) report that in Uganda following the health sector reforms, communities expected the quality of health services to improve especially after the abolition of fee- for- service. The increase in the utilisation of health services after the removal of fee-for-service put pressure on the health system especially with frequent shortages of drugs and supplies. Some community members were wrongly accusing health workers of siphoning drug from the health facilities.. This, in effect, can impede the performance of health workers.

### 5.6.3 Theme 3: Existing practises for managing the performance of health workers

The third theme of this study emerged as the existing practises used to manage the performance of health workers. Under this theme six subthemes were identified together with their own categories. Table 5.11 illustrates subtheme 3.1, which is planning for performance appraisal with its two categories.

**Table 5.11: Current practices for managing performance of health workers**

3	Existing practises for managing the performance of health workers	3.1	Planning for performance appraisal	3.1.1	Target setting and performance agreements
				3.1.2	Pre-appraisal planning meetings

#### 5.6.3.1 Subtheme 3.1: Planning for performance appraisal

This subtheme relates to activities that should be undertaken before the actual process of appraisal begins. Two categories were identified as shown in Table 5.11.

##### 5.6.3.1.1 Target setting and performance agreements

Few managers (n=6; 28.6%) indicated that the appraisers and appraisees sit together to set targets which health workers should strive to achieve while executing their duties. Still few managers noted that supervisors and their subordinates agree on expected performance standards. One manager stated that it is expected that target setting be done but he doubted if this was the case at lower levels. In general, although most of the managers acknowledge that clear performance appraisal guidelines exist, target setting was inadequately done. The following quote confirms this:

*“The biggest problem is actually setting targets. In fact what our staff put on their appraisal forms are not targets but are just statements”.*

The study revealed that there is some form of performance appraisal system in place; however, its implementation seems to be a big challenge to both the health workers and their supervisors. According to Aguinis and Pierce (2008:141) the first stage for performance management is for the employees to have a clear knowledge of the organisation's mission, strategic goals and the job in question. The performance planning stage involves a discussion and agreement between the appraiser or supervisor and the worker regarding what needs to be done and how it should be done. However, as indicated in sub-section 5.6.1.1.14 of this study, many health service managers were not sure whether the health workers at the lower levels are clear about the organisation's mission. Dovlo et al (1998:4) emphasise that it is important for each level of service delivery to know the core purpose and the objectives of the health unit and hospital. This could form the basis for discussions and feedback on the performance of the employees. With little knowledge about the organisation's strategy it becomes almost impossible to set targets.

#### **5.6.3.1.2 Pre- appraisal planning meetings**

Most of the managers (n=15; 71.4%) indicated that pre-appraisal meetings are not done as one manager stated:

*"We hardly plan for this ...I would say it is just a routine that you fill these appraisal forms, you don't even sit to discuss with the person concerned, you also just tick and evaluate without making realistic comments".*

*"...yes we have these meetings on paper but not in practice..."*

The pre-appraisal meetings are meant to discuss and agree on what is to be done, how it should be done and what behaviours are required to achieve the required results. According to the University of Northern Iowa (2000:4) a productive performance meeting serves as a collaborative planning session during which both the supervisor and employee can take an in-depth look at past and current performances and can together set new goals and objectives for the coming period. The performance meeting helps the supervisor and employee establish clear understanding of the employee's job duties, responsibilities and

priorities. It also provides an opportunity for the supervisor to coach the employee on how to become more proficient and productive. Establishing performance goals provides direction and helps the employee and supervisor to perform their duties appropriately.

### **5.6.3.2 Subtheme 3.2: Performance measurement**

The focus of this subtheme is on the approach employed by managers in measuring the performance of health workers. The categories of performance measurement are as indicated in Table 5.12.

**Table 5.12: Performance measurement of health workers**

3.2	Performance measurement	3.2.1	Performance measurement tools and indicators
		3.2.2	Frequency of performance measurement

#### **5.6.3.2.1 Performance measurement tools and indicators**

Slightly less than half of the managers (n=10; 47.6%) indicated that performance measurement is done in their facilities while others said that they do not measure performance. However, more than half (n=12; 57.1%) of the managers stated that there are no clear tools for doing so, for example, in some instances mere observations were used. The rest of the managers said that they used performance appraisal forms to measure the performance of health workers. It also became evident from the interviews that performance measurement is done just as a formality or obligation in most health facilities. In addition, the discussions revealed that performance measurement was deterred by absence of clear indicators.

The Ministry of Public Service in Uganda has an appraisal form that is used to measure the performance of health workers. All civil servants are obliged to complete this appraisal form at least once annually. Although this form lacks the

proper indicators to monitor the performance of health workers, it can serve as a tool to improve the performance of health workers. It is important to note that all health workers have job descriptions, which serve as a stable framework for evaluating and guiding staff while their daily task schedules provide more specific measures and measurable performance guide (Dovlo et al 1998:4). In addition to job descriptions, all hospitals and health facilities have treatment schedules, guidelines and standards as well as the health management information system in place. All these can be used as tools for measuring performance of health workers. However, many managers do not know that they can use them to measure performance of health workers (Dovlo et al 1998:4; Hotchkiss et al 2010:[3-4]).

Many health service managers (n=16; 76.2%) reported lack of clear indicators for measuring performance of health workers. Bankauskaite and Dargent (2007:126) state that performance indicators are used to facilitate accountability, monitoring health care systems and service, modifying behaviour of health workers and forming policy initiatives. This research almost supports Mathauer and Imhoff's (2006:[12]) study in Kenya illustrating that although health workers undergo an annual performance review, not everybody knows what it was all about and what indicators are applied.

#### **5.6.3.2.2 Frequency of performance measurement**

The managers (n=10; 47.6%) who reported that they measure performance of the health workers observed that it is not done as frequently and regularly as may be necessary. One of the managers clearly articulated:

*"Performance measurement is done here ...but to me this is really ad hoc".*

Performance measurement is supposed to be an ongoing process and should be done regularly. In Uganda, health workers who are on probation have their performance monitored once every 6 months while after permanent appointment in service they are appraised once a year. Armstrong (2009:618) affirms that the

primary goal of performance appraisal is to provide feedback to the employees on how they are doing and provide a direction for the future. Therefore, performance appraisal is generally conducted once annually, and with follow-ups if required. Mathauer and Imhoff (2006:[12]) report that in Kenya although health workers must pass an annual performance review every year in order to continue working in the public sector, the quality of these appraisals is questionable since some health workers and managers do not even know which indicators to apply.

### 5.6.3.3 Subtheme 3.3: Performance reporting and feedback

This subtheme uncovers the findings concerning the way performance of health workers is reported and whether or not the managers give performance feedback to their subordinates. The subtheme and its categories are shown in Table 5.13.

**Table 5.13: Performance reporting and feedback**

3.3	Performance reporting and feedback	3.3.1 3.3.2	Mode and frequency of reporting Mode and frequency of giving performance feedback
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#### 5.6.3.3.1 Mode and frequency of reporting

Two sets of responses emerged from the interviews regarding performance reporting. Some managers (n=11; 52.4%) stated that they report performance while other said that they do not report it. Among those who do not report the performance some indicated that the reason is because they do not measure performance. Some of the managers (n=5; 23.8%) stated that they measure performance of health workers but they do not report it. The dominant reason was that managers avoid creating conflicts with their subordinates especially where the performance is not good.

Among the managers (n=11; 52.4%) who report performance the majority of them admitted that they were faced with challenges in doing so. Some managers

(n=9; 42.9%) stated that the reporting was mostly generalised, reporting group performance and not individual performance. Individual performance is generally reported verbally apart from when there was indiscipline, only then would written reporting be done.

Despite the challenges a few managers (n=3; 14.3%) pointed out that they had a standard format of reporting performance. For some the reporting is done quarterly while it was done bi-annually in some facilities. According to the Uganda's HMIS, monthly reports are supposed to be completed by the individual health facilities and sent to the health sub-districts and from there to the district and finally a consolidated report about the performance is sent to the ministry of health (Hotchkiss et al 2010:[3]). These reports usually indicate the number of cases seen, the equipment available and some information concerning the health worker performance though it is very minimal with little feedback to the source of the information.

#### **5.6.3.3.2 Mode and frequency of giving performance feedback**

All the managers (n=21; 100.0%) expressed the need for supervisors to provide the health workers with the feedback every time the appraisal is done. They believed that face-to-face discussion of appraisal results is an appropriate way of showing the health workers their performance strengths and weaknesses. These findings are similar to many other studies done in Africa.

A number of research studies indicate inadequacies in reporting performance of health workers. In Malawi for example, although some form of performance appraisal for health workers is carried out, there is usually no feedback. Health workers do not receive feedback from their superiors about their performance either during the appraisals or supervisory visits (Bradley & McAuliffe 2009:[3]; Manafa et al 2009:[5-6]). Similar findings are reported in Tanzania (Manongi et al 2006:[5]) where health workers felt that it was useless for their superiors to keep on going for their appraisal and supervisory visits without giving them feedback on where they are wrong to help them correct their mistakes accordingly. Further



research studies in Kenya and Benin by Mathauer and Imhoff (2006:[9]) also report that most health workers do not receive any feedback from their superiors and therefore they feel a sense of neglect by their superiors. This indeed demotivates the health workers and may contribute to poor performance.

#### **5.6.3.4 Subtheme 3.4: Recognising performance**

The focus of this subtheme is on how the performance of health workers is recognised. Table 5.14 illustrates the subtheme and its category.

**Table 5.14: Recognising performance of health workers**

3.4	Recognising performance	3.4.1	Modes of recognising performance (such a issuing certificates, end of year parties, gifts, and words of praise)
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##### **5.6.3.4.1 Modes of recognising performance**

The most recurring ways of performance recognition that were put forward by the health services managers include the following:

- Issuing certificates
- End-of-year parties
- Gifts
- Words of praise

At least there is some form of recognition shown to the health workers for their performance, although it is not well spread to all the districts. Recognition of performance of health workers not only comes from the managers but also from the public. Khowaja et al (2005:35) point out that lack of appreciation by managers about the performance of registered nurses in Pakistan contributed to job dissatisfaction. Bradley and McAuliffe (2009:[3]),and Yumkella (2005:14) assert that performance management system in the public health sector in Malawi is weak and characterised by lack of transparency in performance assessment, lack job descriptions, weak supervisory systems and no recognition

for good performance. Although there are job descriptions for most of the health workers in Uganda, recognising performance for most of them is still lacking.

Recognition plays a major part in the motivation, job satisfaction and performance of health workers. Dieleman et al (2006:[6]) point out that in Mali like in most African countries there were no formal methods to show appreciations for good performance. In Uganda, some managers also congratulated and thanked personnel in public service. Some well performing health workers were assigned supervisory roles or training in order to gain extra income from allowances (Dieleman et al 2006:[6]; Hagopian et al 2009:w871).

### **5.6.3.5 Subtheme 3.5: Use of performance appraisal results**

Table 5.15 presents subtheme 3.5 which identifies ways in which performance appraisal results are utilised.

**Table 5.15: Use of performance appraisal results**

3.5	Use of performance appraisal results	3.5.1	Ways in which appraisal results are used (identifying training needs, promotions, redistribution of staff, support supervision, & not used)
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#### **5.6.3.5.1 Ways in which performance appraisal results are used**

The views of the managers were divided on this issue. Some of the managers (n=9; 42.9%) stated that the results of performance appraisals were not used in their facilities. Most of the managers (n=12; 57.1%) indicated that the results are used to identify training needs of the health workers. One manager regretted, however, that training needs are identified but this does not guarantee sponsorship for the candidates. Other managers (n=11; 52.4%) said they use the results for promotion, support supervision, confirmation and staff re-distribution purposes. Evidence from the discussions suggests that although performance appraisal results are not utilised in some facilities there was an attempt to utilise the results in other facilities. This would assist the managers to implement appropriate measures to improve the performance of health workers.

These findings support what Mathauer and Imhoff (2006:[14-15]) established in Kenya.

Kruk and Freedman (2008:263) and Smith et al (2008:1) suggest that the results for performance measurement system should be used to formulate budgets, allocate resources, motivate employees and improve services among others. It is good practice to find out how well the workforce and programmes are performing and use this information for programme planning, implementation and improvement. According to Armstrong (2009:629) and Üstünlüoğlu (2009:119) performance appraisal should serve to identify who is eligible for pay rises, promotions, placement according to the abilities, motivate employees in their jobs and give feedback for improvement. It is, therefore, important to develop the culture of using the information that has been collected through the process of performance management.

#### **5.6.4 Theme 4: Suggestions of managers on how to improve performance appraisal**

The fourth theme of this study is about the suggestions given by the health service managers on how performance appraisal could be improved. Six subthemes were identified under this theme. These are: performance appraisal tool, performance appraisal process, recognising performance, performance appraisal feedback, using performance appraisal results and training of the supervisors. The first subtheme is shown in Table 5.16 with its category.

##### **5.6.4.1 Subtheme 4.1: Performance appraisal tool**

This subtheme relates to the views of the managers on how the performance appraisal process can be improved through the appraisal tool. Table 5.16 shows this subtheme and its category.

**Table 5.16: Improving performance appraisal tool**

4.1	Performance appraisal tool	4.1.1	Review performance appraisal tool
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#### **5.6.4.1.1 Review the performance appraisal tool**

Majority of the health service managers (n=19; 90.5%) recommended that the existing performance appraisal tool be revised as it has some flaws. The tool is too long and this demotivates the health workers to complete it because it takes a long time to complete. Most managers (n=17; 81%) indicated that the appraisal tool falls short of performance indicators. These findings are similar to those of GTZ's (2009: IV) study in Malawi. GTZ (2009: IV) reports that in Malawi, performance appraisal forms are too long, not user friendly and lack clear indicators for measuring performance. This demotivates health workers to complete these appraisal forms since they are not clear how their performance is measured. Similarly, another study in Ghana report that performance appraisal forms were too long difficult and confusing for the staff members to fill. (Initiatives, Quality Health Partners & The Ghana Health Service 2005:14).

In addition, some of the managers (n=8; 38.1%) suggested that the appraisal tool be made available at all times. The managers reported that they lacked stationery to duplicate the tool to distribute to the health workers. When they fail to do so, the health workers have to photocopy the appraisal tools themselves in order to be appraised. Without constant supply of the performance appraisal form, it is most likely that health workers can make excuse not to complete their performance appraisals. It is the responsibility of the district manager to ensure that all the required materials are in place in order to ensure effective performance appraisal systems. The process should be clearly explained to the health workers and the indicators for measuring individual performance should be available and known to all the stakeholders.

#### **5.6.4.2 Subtheme 4.2: Performance appraisal process**

This subtheme reveals the opinions of the managers on how the appraisal process could be improved. The subtheme and its category is illustrated in Table 5.17.

**Table 5.17: Performance appraisal process**

4.2	Performance appraisal process	4.2.1	Nature and frequency of the appraisal process
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#### **5.6.4.2.1 Nature and frequency of appraisal process**

There was a general consensus from the managers (n=21; 100.0%) that the appraisal process should be continuous and interactive. The supervisors need to sit and discuss with their subordinates to agree on the objectives and set realistic targets. Some managers (n=18; 85.7%) also suggested that the appraisal process should be two-way. The subordinates must also appraise their supervisors. In other words, all the stakeholders including clients or patients who use the services should be involved in the process.

Initiatives et al (2005:16) recommend that performance appraisal should be conducted at least once a year with an abbreviated 6-month review. This system allows for two formal meetings between staff and supervisors and helps health workers to assess their progress and create new strategies if necessary. The GTZ (2009: VI) also suggests that any performance management framework should allow for regular, on-going and continuous implementation of appraisals. It should contain, as a pre-requisite, clear criteria for assessment and a sustainable rewards system as part of the incentive scheme. Some scholars suggest quarterly appraisals. However, a study done in Ghana reports that doing quarterly performance appraisals is too cumbersome for the health workers since it does not give them chance to have one-to-one meetings with their supervisors (Initiatives et al 2005:16).

#### **5.6.4.3 Subtheme 4.3: Recognising performance**

This subtheme relates to how performance appraisal could be enhanced by recognising performance. Table 5.18 presents the subtheme and its categories.

**Table 5.18: Recognising performance of health workers**

4.3	Recognising performance	4.3.1	Rewarding good performance
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#### **5.6.4.3.1 Rewarding good performance**

All managers (n=21; 100.0%) suggested that good performance of health workers should be rewarded in order to motivate them. It was discovered during the discussions that managers believed that when health workers are motivated they are highly likely to be enthusiastic about performance appraisal. The rewards that were proposed include recommendation for training, promotion in service, giving more responsibility, giving letters of recognition as well as certificates of achievement or recognition. This is likely to enhance the motivation and performance of health workers. Hagopian et al (2009:w869) report that rewards and remuneration systems are known to influence the behaviours as well as the performance of the health workers. Any performance management system should be linked to rewards or recognition. Without this the performance management system is incomplete.

Skinner and Green (2010:1) suggest that any actions agreed upon during the appraisal process, whether for further training, a raise in pay, promotion, or disciplinary action, should be followed through on as soon as possible. Any action discussed during performance appraisals, especially rewards, should only be offered as a result of improved performance and never as an empty promise in an attempt to motivate an employee for the future. The appraisal is not fully complete until both the manager and the employees have followed through on all of the elements that have been discussed as part of the process. A manager that does not follow through on promises will be perceived by employees as not taking their own recommendations or the needs of staff seriously. It is important that the appraiser be aware of any budgetary or time constraints to avoid promising something to the employee that cannot be delivered. Making promises that cannot be delivered seriously damages a manager's credibility.

Paul (2009:13) points out that the reward system has to be reworked so that the health workers who meet the needs of the individual communities and provide high quality care leading to client satisfaction get rewarded rather than those who fill up false reports to please their supervisors. For example, in Rwanda both the motivation and performance of health workers has increased as a result of performance based rewarding system. This motivation is reflected in the staff wanting to take up more responsibility and their willingness to participate actively in activities related to improving health care services. The improved motivation is also reflected in the availability of health workers and willingness to work supplementary hours even though they are not paid for it (Paul 2009:13).

#### **5.6.4.4 Subtheme 4.4: Performance appraisal feedback**

The focus of this subtheme was to describe the views of the managers on how performance feedback may improve performance appraisal. Table 5.19 illustrates the subtheme with its categories.

**Table 5.19: Frequency of performance appraisal feedback**

4.4	Performance appraisal feedback	4.4.1	Frequency of appraisal feedback
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##### **5.6.4.4.1 Frequency of performance appraisal feedback**

Most managers (n=19; 90.5%) recommended that performance feedback should be given regularly to health workers. This helps the health workers know how they are performing and may help to increase their keenness for performance appraisal.

Skinner and Green (2010:1) assert that in a well-rounded and healthy organisation, the appraiser should ask for employee feedback both on their own performance and that of the organisation. At the same time the employees should be given feedback related to their performance. The employees are not working in a vacuum. One of the major criticisms about performance appraisals is that they do not usually take into account the ways in which the environment

affects employee performance. It is important that performance appraisals be used as an evaluative tool in context rather than in an artificial realm in which employees are solely to blame for problems.

Paul (2009:21) adds that regular performance evaluation and feedback can provide management and health workers with the essential information on their strength and weaknesses and can also be formative and supportive. The health workers should be given opportunity to express and demonstrate their opinions and needs thereby improving the feedback mechanism. Therefore, in order to have great impact on performance the feedback needs to be immediate and should be related to specific performance standards (Luecke 2006:55; Rowe et al 2005:103).

#### **5.6.4.5 Subtheme 4.5: Using performance appraisal results**

Table 5.20 presents the subtheme 4.5. This is concerned with how the use of performance appraisal results can improve the process of performance appraisal.

**Table 5.20: Recommendations on use of performance appraisal results**

4.5	Using performance appraisal results	4.5.1	Promotion, confirmation in the civil service and training
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##### **5.6.4.5.1 Promotion, confirmation in civil service and training**

From the discussions and interviews it became evident that all the managers (n=21; 100.0%) valued the use of the results from performance appraisals. The most recurring areas where the manager believed the use of appraisal results would be mostly applicable are the following: training, promotions and confirmation in the civil service. Kruk and Freedman (2008:263) and Smith et al (2008:1) suggest that information from an effective appraisal system should be used to motivate employees, improve services, self-assessment and to allocate resources. Employees can be motivated through promotion, confirmation in service and giving them opportunity to go for further training. However, Initiatives et al (2005:17) mention that promotion alone should not be the reason for



performance appraisal but the process has to link to professional or career advancement. This will stop the staff from rushing to complete the performance appraisal forms only when they are called upon for promotional interview.

#### **5.6.4.6 Subtheme 4.6: Training of supervisors**

This subtheme is about the importance of training to performance appraisal. One category emerged from the discussions as shown in Table 5.21.

**Table 5.21: Training of supervisors**

4.6	Training of supervisors	4.6.1	Training managers about the importance of appraisal
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##### **5.6.4.6.1 Training of health managers on the importance of performance appraisal**

All the health service managers (n=21; 100.0%) believed that in order to improve performance appraisal, supervisors and their subordinates need to be sensitised and oriented on what performance appraisal is all about and why it is important. This not only equips the health workers with knowledge but also empowers the supervisors on conducting performance appraisal in a consistent and effective manner. One of the issues noted from the managers' suggestions is that ongoing support supervision is necessary in order to create a strong foundation upon which the appraisal process can be based. It is important to have both the supervisors and their subordinates to be oriented about the processes and importance of performance appraisals in order to ensure effectiveness. The GTZ (2009:19) recommends that resources should be set aside for orientation and training of health workers as well as their managers on performance management. Initiatives et al (2005:23) emphasise that in order to ensure sustainability of performance management the training should be integrated into the routine quarterly staff meetings at the district and health facility levels. This will reduce costs and establish a sustainable forum for building capacity in performance management.

## 5.7 CONCLUSION

This chapter presented the analysis, interpretation, and discussion of the qualitative data. The presentation began with an introduction to the chapter. The findings from the qualitative data collection were presented under the following four themes:

- The factors that influence the performance of health workers
- The views of managers on how to improve the performance of health workers
- Existing practices for managing the performance of health workers
- The recommendations of health service managers on how to improve the process of performance management.

Each theme was discussed under several subthemes which were also subdivided into numerous categories. The research findings indicate that there are more factors which impede the performance of health workers than there were those that enhance the performance. Of these factors, numerous emerged as organisational factors over which the health workers may have little if any ability to alter even if they so desired. Individual factors as well as institutional factors also had a role to play in either enhancing or impeding performance.

The health managers were generally of the view that improvement of both the intrinsic and the extrinsic motivational factors would boost the performance of health workers. Although the current practises for managing the performance of health workers are faced with a myriad of challenges, efforts exist to improve performance. These include performance improvement programmes such as performance appraisals and performance reporting.

On how the performance management process can be improved the managers suggested that all the factors which impede the performance of health workers need to be addressed, also the factors which enhance the performance must be strengthened. The next chapter presents the conclusions, limitations and recommendations of the study.

## **CHAPTER 6 CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS**

### **6.1 INTRODUCTION**

This chapter presents a summary of the key findings, implications of the findings, limitations, and conclusions of the study. Also presented are the recommendations for improving performance management in the health sector as well as areas for further research. The proposed performance management framework arising from the findings of this study is outlined.

### **6.2 THE AIM AND OBJECTIVES OF THE STUDY**

The conclusions are presented according to the aim and the objectives of the study. The overall aim of the study was to investigate the performance of health workers in the decentralised services in order to come up with a management framework that may be used to improve the performance in Uganda.

The objectives of this research were to

- identify factors that impede or enhance performance of health workers
- assess the current practices for managing performance of health workers
- determine the views of health workers and their managers on how to improve performance
- develop a performance management framework for health workers based on the findings of this research

### **6.3 RESEARCH DESIGN AND METHODOLOGY**

The study used both quantitative and qualitative research methodologies. Health workers at facility level constituted level 1 and health service managers constituted level 2. Level 1 utilised quantitative research methodology to collect

and analyse data from health workers at the health facility level. Level 2 used qualitative research methodology to collect and analyse data from the health service managers at the district, hospital, and health sub district levels. Data collection and analysis for level 1 and level 2 were done concurrently (see chapter 3).

### **6.3.1 Level 1**

The population for this level comprised professional nurses/midwives, clinical officers, and doctors working in the districts of Kumi, Mbale, Tororo and Sironko. Data was collected using a questionnaire with all items but one based on a 5-point Likert scale. The last item was an open-ended question (annexure H). Data was collected from 276 health workers out of the targeted 331. These participants were selected through stratified random sampling. The data analysis was done using SPSS version 18 and the results were presented in tables, figures and text (see chapter 4).

### **6.3.2 Level 2**

The population for level 2 were the health services managers from the districts of Kumi, Mbale, Tororo and Sironko. The health services managers included the DHOs, hospital administrators, medical superintendents, principal nursing officers, senior personnel officers and the heads of the health sub districts. These managers were selected purposively based on their positions and level of involvement in supervising health workers. A total of 21 managers were interviewed using a semi-structured questionnaire (annexure I). The data collected were analysed and coded manually. The results were presented in form of tables, figures as well as in text. Quotes were used where necessary (see chapter 5).

## **6.4 CONCLUSIONS**

The findings from the two levels are summarised according to the study objectives.

### **6.4.1 Identify the factors that enhance or impede the performance of health workers**

The findings indicated that a number of factors either enhance or impede the performance of health workers. The factors identified included the individual attributes, behaviours of health workers and organisational factors. The findings of this study showed that the health workers have the required skills and abilities to perform their work, although time management seems to be a problem (see Table 4.5). During the interviews, the health service managers concurred that health workers are competent and have the knowledge and skills to perform their duties (see sub section 5.6.1.2.2). Similarly, the results showed that health workers have values and beliefs that are favourable for desirable performance (see Table 4.9).

The findings further indicate that health workers exhibit considerable levels of flexibility and professionalism during the execution of their duties which can enhance their performance (see Table 4.6).

The results further demonstrated that despite some challenges, the health workers are self-motivated and willing to work (see Table 4.7). It was established that health workers were generally committed to their work and the organisations they work for (see Table 4.8). These are all important factors that may enhance their performance.

Generally, the findings revealed that health workers are proficient (see Table 4.10), adaptive (see Table 4.11), proactive (see Table 4.12) and are client-oriented (Table 4.13). These can indeed enhance their performance. This was also echoed by most health services managers who mentioned that health workers demonstrate satisfactory levels of competence (see subsection

5.6.1.2.2), they are proactive (see subsection 5.6.1.2.3) and generally exhibit good behaviours towards the patients, although there are instances when some workers display undesirable conduct towards patients (see subsection 5.6.1.2.4). The findings of this research revealed that health workers are generally clear about the strategies of their organisations (see Table 4.14). It was established that health workers and managers share a common purpose, they are competent and recruitments and promotions are done on merit. The health services managers however pointed out that much as the high cadre staffs like doctors, nurses and clinical officers are clear about the organisation's strategy, many low cadre health workers do not understand the mission of their organisations (see subsection 5.6.1.1.14). The results of the study indicated that most health workers and managers lacked support from the local political leadership (see Table 4.18; subsection 5.6.1.3.1 and 5.6.1.3.3). The health service managers complained of political interferences in their work both at technical and administrative levels leading to conflicts between health workers and the local leaders. This negatively affects the performance of health workers. The managers indicated that the government has good policies and guidelines, however, their implementation still remains a challenge (see section 5.6.1.3.2). The study further revealed that there were considerable weaknesses in the way performance is measured and how the results of the performance appraisals are utilised (see Table 4.14). This may impact negatively on the performance of health workers.

There were mixed reactions concerning the working environment. Most health workers seemed to be contented with the job security, working space, infection control measures, opportunity to participate in decision making concerning their clients and the feedback they receive from their supervisors. However, many health workers were not satisfied with availability and the condition of the medical equipment as well as the availability of drugs and other medical supplies (see Table 4.15). This implies that while the general working environment might be conducive, lack of adequate medical supplies to facilitate patient care can negatively affect the performance of health workers.

The health service managers alluded to the following as impediments to performance :

- poor general working environment,
- lack of drugs and other medical supplies,
- poor remunerations,
- lack of accommodation,
- lack of transport at the health facilities,
- insufficient support supervision,
- lack of prospects for academic progression and career movement,
- inadequate performance management including appraisals,
- insufficient rewarding and recognition system,
- poor communication, and
- poor interpersonal relationships among the health workers and the communities (see subsections 5.6.1.1.1 to 5.6.1.1.12).

The study established that overall, the staffing levels within the health facilities are below the minimum standards set by the ministry of health (see Table 4.16). The findings further revealed that there is increased workload for the existing health workers, inadequate or non-existent compensation for working overtime, and lack of work-life and personal life balance. This in many cases hinders the performance of health workers. On a positive note, the findings showed that health workers were happy with the fairness and flexibility of their work schedules (see Table 4.17).

The findings further indicated that nearly all the health service managers complained of low staffing levels and high turnover of health workers in the facilities, which increases the workload on the existing health workers and reduces their morale to perform (see subsection 5.6.1.1.16). The managers indicated that hard-to-reach areas usually have low availability of staff and usually have high turnover of staff. Although sometimes the health facilities may have adequate numbers of health workers, late coming and absenteeism seems to be a big challenge since many health workers have to commute long distances to their duty stations. Yet, they may not have sufficient money to

manage daily transport fares due to poor remuneration (see subsections 5.6.1.1.3; 5.6.1.2.1, and 5.6.2.1.5). The health workers on the other hand reported that they always take initiatives to ensure that they are available for work, although they may be let down by the low staffing levels which leads to increased workload (see Table 4.20).

The health services managers indicated that although health workers are generally productive, those facilities with low staffing levels tended to have low productivity and inadequate performance. This is mainly because the existing health workers are overworked. This coupled with lack of resources like transport, drugs and equipment tends to impede the productivity of health workers (see subsection 5.6.1.2.5). Despite these challenges, the findings show that health workers are responsive to the needs of their clients and patients, even if the services they provide are not timely (see Table 4.19).

From the researcher's point of view most the factors which hinder the performance of health workers emanate from the health system and those that facilitate performance come from the individual health workers themselves. Looking at the strategic performance model (Figure 1.2) it is evident that most of the situational constraints as well as the organisational strategy components play a part in hindering the performance of health workers. However, at the individual level, the health workers seem to possess necessary attributes and behaviours which support performance.

#### **6.4.2 Assess the current practices used to manage the performance of health workers**

The findings of the study showed that there are various methods used to review the performance of health workers and these include formal and regular reviews (49.6%), informal but regular reviews (30.4%) and some informal and unscheduled reviews (19.9%). This is an indication that some type of performance review is being done (see Figure 4.1). The study established that performance appraisal results are used for identifying the training needs (n=220;



79.7%), promotion of staff (n=222; 80.4%), rotation of staff (n=193; 69.9%), determine who to be rewarded (n=193; 69.9%) and in some case demotion of staff (n=55; 19.9%). There were some health workers (n=27; 9.8%) and their managers (slightly over one-third) who indicated that the results of performance appraisals are not used at all (see Table 4.26 and subsection 5.6.3.5.1). Some health service managers (n=11; 50%) indicated that the results of performance appraisals are used for identifying the support supervision needs, confirmation of staff in public service and for staff redistribution (see subsection 5.6.3.5.1).

The findings further showed that there are some attempts by the health service managers to set standards and indicators against which the performance of health workers is evaluated. The results showed that most of the health workers have job descriptions with clearly stated objectives, and lines of authority and accountability (see Table 4.27). It was, however, important to note the difference in the responses between the managers and the health workers regarding target setting. Whereas most health workers indicated that target setting takes place, on the contrary, most managers reported that rarely do pre-appraisal meetings take place for setting targets. Most managers mentioned that while performance appraisal guidelines are available, target setting is inadequately done, pre-appraisal planning meetings are not held and performance agreements are never signed. This affects the quality of the performance management process (see subsection 5.6.3.1.1).

It was established that some attempts have been made by health services managers to measure the performance of health workers, however, the findings demonstrated that not all health workers knew what performance measurement is all about and what indicators are applied (see Table 4.14 and Table 4.28). Many of the health service managers mentioned lack of clear tools for measuring performance since even the appraisal forms from the ministry of public service lack clear indicators for measuring and monitoring performance of health workers. The findings further indicate that for those districts where performance measurement is done, they know that it is supposed to be done regularly but in practice it is done on an adhoc basis. According to the ministry of public service,

in Uganda, performance appraisal is supposed to be done every six months for those health workers on probation and annually for those who are permanent. In practice this is hardly done (see subsection 5.6.3.2.2).

The findings revealed differences in the responses concerning reporting performance appraisal results. Most the health workers reported that somehow their managers report the results of their performance. About 30% of health workers (n=84; 30.4%) do not receive regular constructive feedback about their performance and another 30.1% (n=83) do not believe that managers report the health workers' performance results to the external stakeholders (see Table 4.29).

From the managers' perspective there were still differences in responses concerning reporting performance. For those managers who do not report they do so just because they do not measure performance. 'How can you report something you don't measure?' For the managers who attempted to report, they are faced with challenges of doing so and in most cases they report generalised group performance and not individual performance. In cases where individual performance reporting is done, it is usually verbal unless if there is indiscipline, when warning letters are written to the concerned staff. The frequency of reporting performance is generally quarterly but most times annually. The findings from the managers indicated that in case of individual performance, supervisors provide feedback every time the appraisal is done. The managers also believed that face-to-face discussion of performance appraisal results is the best way of showing the health workers their strength and weaknesses. Without a functional feedback mechanism the health workers are likely to be unmotivated to participate in performance management process since they do not see its benefits (see subsections 5.6.3.3.1 and 5.6.3.3.2).

The findings showed that there were deficiencies in the area of performance improvement. It was established that the analysis of the information from the performance management system is not used effectively to improve service delivery. Without proper analysis of the performance appraisal results there is no

way managers can implement corrective interventions. In order to ensure proper performance improvement health workers should be given a chance to suggest ways they want to see performance improved and the supervisors should always be available to guide health workers perform up to their organisations expectations (see Table 4.30).

The findings of this study clearly revealed insufficiency in the rewarding system within the districts (see Table 31). This hinders the performance of health workers in many ways. The health service managers recognise that monetary rewards are not the only means health workers' performance can be rewarded or recognised. Health service managers mentioned a number of ways they have been using to recognise performance of health workers including issuing certificates of achievement, gifts for outstanding performance, end of year parties and a word of praise. These indeed motivate health workers to perform better (see subsection 5.6.3.4.1).

The results indicated that although the health service managers attempted to address the short term training needs of the health workers the long-term training and development needs are not adequately addressed (see Table 4.32). Many health service managers blamed decentralisation as a hindrance to staff training and development. Most managers mentioned that the opportunities for further training are limited in the districts, and where they exist, nepotism clouds the selection of the candidates. In addition, on completion of their further training, most health workers are not promoted and sometimes they do not fit into the district staffing structures. This may hamper their performance and subsequently may lead attrition of staff (see section 5.6.1.1.7, 5.6.1.1.10 and 5.6.1.1.11).

The researcher believes that the current practices for managing the performance of health workers could be effective if the individual efforts of managers and their subordinates were supported by solid and functional organisational strategies (Figure 1.2). The health managers and the health workers may be self motivated

to improve performance but may fail to attain their goals in the absence of a conducive organisational environment.

#### **6.4.3 Determine the views of health workers and their managers on how to improve performance of health workers**

The findings in Table 4.35 showed that health workers would like to see an improvement in their motivation. This was the most recurring response among all the suggestions put forward by the health workers and their managers. The motivation attributes suggested by the health workers included improvement in remunerations, provision of drugs and equipment to enable them perform their duties, provision of uniforms and provision of accommodation nearer to the health facilities. The study revealed that most health workers do not have accommodation at their respective duty stations.

The study revealed that health workers would like to see improvements in the management and administration of further formal training opportunities so that they can upgrade their skills and advance their careers. Health workers also suggested regular refresher courses. Training can be a motivator for performance and may also act as a catalyst for improving the skills and competences of health workers.

The findings established that health workers would like to have regular meetings with their managers to discuss performance related issues. This is one way health workers can get feedback about their performance and be able to make timely corrective actions.

Some health workers suggested the need for regular staff rotation to various departments and health facilities. This would facilitate in the transfer of skills and competencies which could assist in enhancing performance of health workers.

The managers interviewed had similar suggestions to those of the health workers. In addition to recommending improvements in remuneration and training opportunities, the managers suggested that there should be more delegation of duties and responsibilities to the health workers to empower them

and increase their motivation to perform. In addition, the health workers should be given more powers and authority to make decisions on how to manage their health facilities.

The health service managers suggested that the local governments should look into the possibility of improving the infrastructure in the health facilities, provide accommodation for staff and transport facilities to enable health workers carry out support supervision. Furthermore, the findings of the research showed that the health workers were suggesting an improvement in the way support supervision is conducted. Support supervision should be continuous on-the-job training process and should not be used as a fault finding mission. In order for support supervision to be effective it should be planned properly and those plans should be communicated to all stakeholders. At the end of each support supervisory visit, proper feedback should be given immediately to the workers who have been supervised both verbally and in writing.

In terms of the institutional initiatives, some health service managers suggested that the position of DHO should be centralised in order to reduce the political pressures put on them to influence some decisions. If this is done, it means the appointment will not be politicised and that the DHOs can be transferred across the districts within Uganda by the central government. This is likely to improve performance in the long run.

The health services managers further suggested that the communities should be supportive of health workers. They should appreciate what the health workers are doing instead of harassing them. The health workers are frequently harassed by the communities they serve. This affects their morale and could eventually translate into poor performance (see subsection 5.6.2.3.1).

Furthermore, health service managers want to see an improvement in performance management. The managers suggested that the appraisal tools/forms should be shortened. This will motivate the health workers to complete the appraisal forms. It should be the responsibility of the line managers

to ensure that the performance appraisal forms are available and accessible to all the health workers to be assessed during the performance cycle. The performance appraisal tool should also include indicators that can be used to measure the performance of health workers.

The managers further suggested that performance appraisal should be continuous and interactive. The process should be open and feedback should be given as soon as the appraisal process is completed. The managers also suggested that the performance appraisal process should be linked to the rewarding system as one way of enhancing performance of health workers. Such rewards and recognitions should include recommending health workers for training, confirmation and promotions in civil service. Other means suggested were giving letters of recognition and where possible certificates of achievements.

Lastly, the health service managers suggested that all stakeholders involved in conducting performance appraisals should be trained about the process, the importance of performance appraisals and how to give effective feedback to the staff (see subsection 5.6.4.6.1).

The suggestions given by the health workers indicate that both the individual and organisational constraints to effective performance must be addressed. All the stakeholders including the politicians should contribute to the improvement of health workers' performance.

#### **6.4.4 Develop a performance management framework for health workers based on the research findings**

The findings of this study have facilitated the researcher to develop a performance management framework that might be used to monitor and enhance the performance of health workers in the decentralised services. The strategies and the recommendations proposed in the framework (see Table 6.1)

were developed with the assumption that some forms of performance management are currently implemented in the districts.

The eight key components of performance management where deficiencies or gaps have been identified and need improvement include; understanding the context for performance management in health sector, performance planning, coaching, staff training and development, performance reviews, performance feedback, rewards and recognition of performance and provision of continuous monitoring and evaluation of the performance management systems (see Table 6.1).

The researcher has proposed strategies for each key component in the framework to direct the implementation of corrective actions. The researcher has further proposed some recommendations for improving performance management practices in the health sector. These strategies and recommendations are aimed at addressing the inefficiencies in the execution of performance management in the decentralised health sector in Uganda. The performance management framework presented in Table 6.1 aims at assisting health workers and their managers in understanding what is expected of them to ensure effective performance.

**Table 6.1: The performance management framework for health workers in the decentralised services**

<b>Key performance management component: Understanding the context for performance management in health sector</b>		
<b>Key research findings to support the proposed strategies</b>	<b>Proposed strategies</b>	<b>Recommendations for practice in the health sector</b>
<ul style="list-style-type: none"> <li>• About a tenth of the health workers indicated that the way their work is related to the overall objectives of the organisation is not clear.</li> <li>• Slightly over a tenth of the health workers were not familiar with the organisation's mission towards clients.</li> <li>• Close to forty percent of the health workers were not clear about the way their performance is measured and slightly over a tenth were undecided.</li> <li>• About forty percent of the health workers were not clear about the way the performance results are used and over a fifth were undecided.</li> <li>• Close to three quarters of the health services managers indicated that many low cadre staff do not understand the mission of their organisation.</li> <li>• Most health service managers and some health workers blamed inadequate performance to poor working environment, lack of drugs and supplies, poor remuneration, poor living conditions, poor staffing levels, inadequate support supervision, and low funding for the PHC activities.</li> </ul>	<ul style="list-style-type: none"> <li>• Align the individual performance with the mission and objectives of the organisation.</li> <li>• Prepare and educate health workers on performance management.</li> <li>• Scan the environment for the factors that are likely to affect performance management.</li> </ul>	<ul style="list-style-type: none"> <li>• The health services managers in the health sector need to understand the link between performance management and the individual performance expectations.</li> <li>• Health workers and their managers should make use of available information and documentations such as the strategic plans, operational plans, job descriptions and previous performance appraisals of each worker to align individual performance with the organisation goals and objectives.</li> <li>• The health services managers should use any available opportunity to disseminate the mission and strategic objectives of MoH and ensure that all stake holders in health understand them.</li> <li>• The health service managers should identify and find solutions to external factors that are likely to affect the performance of the health workforce and search for solutions for effective service delivery.</li> <li>• The health services managers have to prepare and educate health workers about performance management, including but not limited to its relevance, how it is implemented and what is expected of each of the individuals involved in the process.</li> </ul>



<b>Key performance management component: Performance planning</b>		
<b>Key research findings to support the proposed strategies</b>	<b>Proposed strategies</b>	<b>Recommendations for practice in the health sector</b>
<ul style="list-style-type: none"> <li>• Close to a third of the health workers were not clear on how to divide their time among the tasks required for the job.</li> <li>• Nearly a third of health workers were not clear on how to determine the appropriate procedures for each work assignment.</li> <li>• A few health workers were not clear of the expected results of their work.</li> <li>• About a third of the health workers did not have clear job descriptions</li> <li>• Some health workers indicated that no targets are set for activities to be achieved in a given period and close to a fifth were undecided.</li> <li>• No appropriate performance indicators to measure their performance was indicated by nearly a third of health workers.</li> <li>• Almost a fifth of health workers indicated that performance standards, indicators, and targets are not communicated to all departments, and another fifth were undecided.</li> <li>• Almost a fifth of health workers indicated that the performance standards are not clear and some were undecided.</li> <li>• Most managers indicated that no pre-appraisal meetings take place between the appraisees and the appraisers to set targets.</li> </ul>	<ul style="list-style-type: none"> <li>• Establish and agree upon performance expectations.</li> <li>• Clarify what health workers will be evaluated upon.</li> <li>• Set a stage for ongoing feedback and coaching throughout the performance cycle.</li> <li>• Agree on performance plans.</li> </ul>	<ul style="list-style-type: none"> <li>• The health services managers together with the health workers should clearly identify the job tasks to be executed and ensure that the worker understands the link between his or her responsibilities and the overall goal.</li> <li>• The supervisors and the health workers should agree on the main job responsibilities, the individual goals to be achieved and the mechanisms for determining success or achievements.</li> <li>• The supervisors and health workers should be in position to know the type of help the senior manager of the organisation can provide any potential barriers to achieving the goals and the ways to overcome the barriers for performance.</li> <li>• The supervisors and health workers should always come up with a formal performance plan that summarises their discussions and agreements. This performance agreement should be documented and signed by the supervisors and the health workers.</li> <li>• Whenever necessary the job tasks should be modified to reflect changes in the job context.</li> </ul>

<b>Key performance management component: Coaching</b>		
<b>Key research findings to support the proposed strategies</b>	<b>Proposed strategies</b>	<b>Recommendations for practice in the health sector</b>
<ul style="list-style-type: none"> <li>• Slightly over a tenth of the health workers do not always have access to their supervisors.</li> <li>• A lack of support from their supervisors were reported by close to a fifth of health workers and a tenth were undecided.</li> <li>• Constructive feedback from their supervisors were not received by almost a fifth of health workers.</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage ongoing two way communication during the performance cycle.</li> <li>• Focus on improving current performance and building capabilities for the future.</li> </ul>	<ul style="list-style-type: none"> <li>• The supervisors should always be accessible to their subordinates for ongoing support. The health services managers should appreciate that it is dialogue that links performance planning and performance review.</li> <li>• The supervisors and health workers should be encouraged to constantly share information concerning work progress, potential barriers and possible solutions.</li> <li>• The supervisors should use techniques such as informal conversations or notes as well as formal coaching meetings and written documentations to provide ongoing support to the health workers.</li> </ul>

<b>Key performance management component: Staff training and development</b>		
<b>Key research findings to support the proposed strategies</b>	<b>Proposed strategies</b>	<b>Recommendations for practice in the health sector</b>
<ul style="list-style-type: none"> <li>• Slightly over a third of the health workers indicated that they did not know about the existence of a training and development policy in their organisations and about a fifth were undecided.</li> <li>• A lack of career advancement opportunities in their organisations were reported by forty percent of health workers.</li> <li>• A lack of specific refresher courses being provided on regular basis were indicated by nearly a half of health workers and a few were not decided.</li> <li>• Nearly a half of the health workers indicated that the in-service training provided to them is not adequate in addressing existing skills gaps.</li> <li>• Slightly over sixty percent of health workers indicated that in the past 6 months their supervisors have not discussed their career development prospects with them.</li> <li>• A third of the health workers disagreed that less competent health workers are provided with the necessary support to improve their knowledge and skills.</li> <li>• Slightly less than three quarters of the health managers reported lack of prospects for further studies in the districts, lack of promotion prospects was reported by all managers.</li> <li>• Majority of the health service managers complained of nepotism in the selection of who should go for further training opportunities or be promoted in service.</li> </ul>	<ul style="list-style-type: none"> <li>• Put in place a mechanism for keeping health workers abreast with up- to-date professional knowledge and skills for best performance.</li> <li>• Promote the concept of learning organisation.</li> <li>• Ensure fairness in the management and administration of the training opportunities.</li> </ul>	<ul style="list-style-type: none"> <li>• The HRH and the health training policies of the MoH should be disseminated to all the health workers for them to know the contents and the implications to their profession.</li> <li>• The district officials should strengthen in-service training as one of the performance enhancement schemes. This will boost the skills and confidence of the health workers.</li> <li>• The continuing medical education (CME) programmes that are implemented by the MoH should be strengthened so that even the health workers in the rural and remote areas can benefit from it.</li> <li>• The training programmes should be correlated to the performance norms and measurement and should be reinforced through supportive supervision and problem solving.</li> <li>• The districts managers should put in place clear criteria regarding when and how to provide in-service training.</li> <li>• The health services managers should ensure that nominations or recommendations for training are based on merit and not nepotism or any other unconventional means.</li> <li>• The districts officials should put in place bursary schemes to support health workers would wish to go for further studies and on completion they should work in the districts that sponsored them for an agreed period.</li> </ul>

<b>Key performance management component: Performance review</b>		
<b>Key research findings to support the proposed strategies</b>	<b>Proposed strategies</b>	<b>Recommendations for practice in the health sector</b>
<ul style="list-style-type: none"> <li>• Slightly less than a half of the health services managers indicated that performance measurement is not done in their health facilities.</li> <li>• Slightly over three quarters of the managers reported lack of clear indicators for measuring performance.</li> <li>• More than half of the managers indicated that they do not have clear tools for measuring performance.</li> <li>• Close to a half of the health service managers reported that where performance review is done it is not always frequent and regular.</li> <li>• Slightly over a third of the health workers indicated that performance standards expected from the staff are not clearly understood and are not understood by all.</li> <li>• Slightly over a fifth of the health workers are not fully aware of the processes used to measure their performance and about a fifth were not decided.</li> <li>• Close to a fifth of the health workers indicated that individual performance is not measured regularly and another fifth were undecided.</li> <li>• About a third of the health workers indicated that their organisations do not clearly define how to measure individual task or activity performance.</li> <li>• Just over a tenth of the health workers indicated that their performance is not evaluated based on their job descriptions and about a tenth disagreed.</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluate performance based on the performance planning discussions.</li> <li>• Determine the extent to which the set targets are achieved.</li> <li>• Identify the development needs of health workers with a view to develop their potential.</li> <li>• Provide regular performance reviews..</li> </ul>	<ul style="list-style-type: none"> <li>• The health services managers should ensure that performance appraisal of the health workers is done based on the agreed performance plan.</li> <li>• Job description should form the basis for the agreements on the time-bound activities in the performance plan.</li> <li>• Every supervisor should evaluate each health worker individually and should use the standard format developed by the Uganda's Ministry of Public Service (MoPS).</li> <li>• Clear quantitative or qualitative indicators should always form the basis for performance review.</li> <li>• The health services managers should use the various tools such as job descriptions, treatment schedules, guidelines and standards, daily task schedules that are in use in some health facilities to provide a framework for performance monitoring.</li> <li>• Regular performance appraisal or reviews should be conducted as specified in the Uganda MoPS guidelines of 2007 (Ministry of Public Service 2007).</li> <li>• Health service managers should recognise that individual health workers' performance is not entirely under the workers' control since external factors such as decisions of others, resources availability and work systems and processes can influence job performance.</li> <li>• The supervisors should afford the health workers the opportunity to share their self evaluation, discuss learning and development needs, set objectives for improvement, set learning and development targets and answer the workers' questions regarding performance review.</li> <li>• The supervisors and health workers should both sign the performance review reports.</li> </ul>

<b>Key performance management component: Performance feedback</b>		
<b>Key research findings to support the proposed strategies</b>	<b>Proposed strategies</b>	<b>Recommendations for practice in the health sector</b>
<ul style="list-style-type: none"> <li>• Slightly over a third of the health workers disagreed that constructive feedback on performance appraisal is given regularly and close to a tenth were undecided.</li> <li>• Just over a third of the health workers disagreed that their organisations report health workers performance information to external stakeholders and about a were undecided.</li> <li>• About a fifth of the health workers disagreed that their organisation has a specific system for regularly reporting the performance of health workers.</li> <li>• A half of the health services managers do not report performance of health workers.</li> <li>• About forty-three percent of the managers reported lack of one to one feedback about their subordinates' performance.</li> <li>• A half of managers indicated that performance feedback when given it is most of the time verbal and not written</li> <li>• Where performance feedback is given most of the time it is not frequently done unless if there is a problem</li> </ul>	<ul style="list-style-type: none"> <li>• Provide regular feedback to the health workers concerning their performance.</li> <li>• Provide health workers with additional sources of feedback other than the supervisors.</li> <li>• Report performance appraisal results to the all the stakeholders.</li> <li>• Document the performance feedback.</li> </ul>	<ul style="list-style-type: none"> <li>• The supervisors should provide individualised feedback concerning employee performance, including priority objectives identified during performance planning.</li> <li>• The supervisors should gather feedback information from other source than the supervisors, for example, from patients and peers.</li> <li>• The supervisor should schedule time to discuss feedback information with the health workers either prior to or during the performance review.</li> <li>• Health workers should take adequate time to do self evaluations in a meaningful and thoughtful manner and objectively rate their performance.</li> <li>• In addition to giving verbal feedback there should be written feedback concerning the worker's performance.</li> <li>• Where necessary, the performance results should be reported to stakeholders in order to implement actions such as salary increments, promotions, confirmation in public service and training.</li> </ul>

<b>Key performance management component: Rewards and recognition of good performance</b>		
<b>Key research findings to support the proposed strategies</b>	<b>Proposed strategies</b>	<b>Recommendations for practice in the health sector</b>
<ul style="list-style-type: none"> <li>• Nearly a half of the health workers agreed that rewards and sanctions should be based on performance results and about a fifth were undecided.</li> <li>• Almost a half of health workers agreed that health workers' performance information should be used to set priorities for personal development and about a third were undecided.</li> <li>• Slightly over a third of the health workers indicated that hard work is not acknowledged or rewarded and about forty percent were undecided.</li> <li>• A high percentage of health workers indicated that they did not know their fringe benefits and close to a tenth were undecided.</li> <li>• About a third of the health workers indicated that their salaries are not paid according to job responsibilities.</li> <li>• More than half of the health workers indicated that their organisations do not offer sufficient opportunities for promotions.</li> <li>• All health service managers were of the view that good performance should be recognised and rewarded even using non monetary means such promotions in service, giving letters and certificates of recognition among others.</li> <li>• Almost a half health managers were of the view that remuneration of health workers should be based on their performance results.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a link between performance appraisal outcomes and rewards/recognition.</li> <li>• Align spending to results and outcomes instead of inputs in order to reduce costs.</li> </ul>	<ul style="list-style-type: none"> <li>• The rewards and sanctions should be provided based on individual performance.</li> <li>• The district health managers should consider the possibility of introducing performance related payment (PRP) as a mechanism to augment the performance of health workers.</li> <li>• The rewards should be given to the health workers who strive to meet the needs of clients by providing quality health services.</li> </ul>

<b>Key performance management component: Monitoring and evaluation of the performance management system</b>		
<b>Key research findings to support the proposed strategies</b>	<b>Proposed strategies</b>	<b>Recommendations for practice in the health sector</b>
<ul style="list-style-type: none"> <li>• Close to a third of the health workers indicated that their organisations do not have a system for collecting and tracking staff performance data.</li> <li>• There were over a third of the health workers indicating that no timely action is taken when performance falls below acceptable levels and about a fifth were undecided.</li> <li>• It was indicated by slightly over a fifth of health workers that performance reports are not used effectively to make decisions and about forty percent were undecided.</li> <li>• Slightly over a tenth of the health workers disagreed that their organisations documents the progress related to performance standards and targets and close to a fifth were undecided.</li> <li>• There were about a fifth of the health workers who disagreed that their performance data is analysed and reviewed according to the set performance standards, indicators and targets</li> <li>• Most health services managers indicated that support supervision should be ongoing to enable health workers learn, identify problems and solve them accordingly.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop and implement a plan for monitoring performance of health workers on a continuous basis throughout the year to ensure that the activities are in line with the agreed performance plans.</li> </ul>	<ul style="list-style-type: none"> <li>• Use performance information as a management tool to continually improve health outcomes.</li> <li>• Decision for improvement of health services should be based on the performance results.</li> <li>• Document good practices for performance management.</li> <li>• In all organisations, the performance management system needs to monitored and evaluated regularly in order to guarantee its effective implementation.</li> <li>• Regular support supervision within the health sector should be used as one of the means to monitor and evaluate performance management.</li> <li>• The health services managers should organise quarterly reviews to discuss the work progress, competences, personal development needs and any other issues related to performance.</li> <li>• The health service managers should keep track of individual performance, quarterly review reports have been suggested in the MoPS guidelines.</li> </ul>

The performance management framework presented in Table 6.1 is meant to assist health workers and their managers in understanding what is expected of them in relation to performance.

#### **6.4.4.1 The key components of the performance management framework**

The components of the proposed performance management framework (see Table 6.1) include understanding the context for performance management, performance planning, coaching, staff training and development, performance review, performance feedback, rewards and recognition of good performance and continuous monitoring and evaluation of the performance management system.

##### **6.4.4.1.1 Understanding the context for performance management in the health sector**

Performance management is an important component in demonstrating that health sector stakeholders provide high quality services and achieve both the local and national objectives. The presence of a comprehensible performance management framework allows the health workers to recognise how their activities contribute to attainment of the priority health indicators outlined in the second and the subsequent Uganda national health sector strategic plans (HSSPs).

In the health sector, the performance management system is meant to:

- improve the health workers' performance in their quest to achieve the strategic goals and objectives;
- support health workers' development and continuous learning;
- align compensation with the desired health sector outcomes; and
- reinforce management responsibilities.

In order to ensure that these variables are achieved, the health workforce has to understand the goals and mission of the health sector and how they are linked to



performance. Where this link is not clear, the health services managers should ensure that the stakeholders are prepared and educated about the organisation's mission and objectives, the performance management procedures and how they relate to each other. Additionally, both the health workers and their managers must understand that performance can be affected by external factors, hence, conducting SWOT analysis would be a useful tool in identifying such factors and devise means to overcome them.

#### **6.4.4.1.2 Performance planning**

Performance planning is one of vital processes in performance management. The goal of performance planning is to examine the core competencies required and how they are related to the worker's job. During the planning phase, there should be a discussion between the supervisors and the health workers to establish clear and specific performance expectations. In efficient organisations, the tasks and processes are planned in advance. The workers' involvement during the planning phase allows them to understand better the objective of the organisation. Ideally, the outcome of the planning process should be the alignment of the job responsibilities and performance goals of the health workers to the goals and objectives of the organisation. It is during the planning phase that the workers should understand the link between their responsibilities and the overall organisational strategy.

The supervisors and the health workers need to agree on the main tasks and objectives the job. At the same time they have to comprehensibly agree on how achievement will be measured and prioritise the work assignments. Where there is need, the job responsibilities can be modified to reflect changes in the work context. During the planning process, the health workers and their supervisors should be able to identify any potential barriers to achieving the objectives and devise means of overcoming those obstacles. When the planning phase is executed well, the managers and their subordinates should come up with a formal performance plan

that summarises the discussions and agreements. It is imperative that the performance plan is signed by both the supervisors and the health workers since it forms the basis for performance review.

#### **6.4.4.1.3 Coaching**

Coaching involves continuous communication between the supervisors and health workers with the focus on improving performance and building capabilities through information sharing. Coaching may take various forms such as observing performance, providing instructions, providing encouragement, correcting poor performance, recognising good performance, listening to health workers' concerns and removing barriers leading to poor performance. Coaching should occur more frequently and whenever necessary throughout the year. The health worker or the supervisor can initiate the coaching sessions. It is, however, imperative that what is discussed by the health workers and the managers during the coaching sessions be documented for appropriate use in improving performance.

#### **6.4.4.1.4 Staff training and development**

Training plays a critical role in assisting health workers and organisations meet their goals and keep pace with advances in medicine and public health. Training health workers improves performance by enhancing skills, improving attitudes and increasing job satisfaction and motivation which might encourage good performance. Training capacitates health workers to gain knowledge and skills that allow them to adjust to the changes in their work.

As basis for improving workers' performance, the MoPS in Uganda instituted a training policy for public servants (Ministry of Public Service 2006:2-9). Guided by this policy the MoH also developed its training and HRH policy which was supposed to trickle down to the districts and health sub districts. Despite having these policies, some health workers are not aware of their existence. There is, therefore, a need for the MoH to disseminate these policies. Health workers should be kept abreast

with the new advances in medicine and public health. This can be achieved by reinforcing in-service training programmes and CME both in urban and rural areas. When health workers need long-term formal trainings the districts should put in place a mechanism of a financial support to assist health workers who would wish to upgrade their knowledge through further studies. Such funding opportunities should be accessible to all health workers who qualify without discrimination. This is one of the means the health sector can improve the skills and performance of its workforce. Where possible the health workers who go for further training using the public funding should be bonded for a given period to the districts where they accessed the training grants. This will enable communities to benefit from the new knowledge and skills acquired by these workers.

#### **6.4.4.1.5 Performance review**

Districts need to identify the performing and non performing health workers. The health service managers should constantly review the workers' performance. Performance review is a vital component of the entire performance management process. It is the culminating discussions between the supervisors and health workers regarding their performance training and development requirements, and the feedback from others. The health services managers need to appreciate that what is discussed and agreed upon during the performance planning should form a basis for measuring the performance. During performance review, the health service managers rate and evaluate the health worker's performance according to the standards and needs agreed upon in the performance plan. It is vital to set targets and have indicators that can be used as benchmarks for measuring performance.

Skinner and Green (2010:1) emphasise that nothing that is discussed during the appraisals should be new to the workers. Saving problems and issues until the end-of-the-year review wastes the opportunity to address and resolve these issues at their inception in a non confrontational manner. Any issues or compliments that are

raised during the performance cycle should be documented and should become part of the appraisal process. Holcomb (2006:572) mentions that managers who keep their workers informed about their performance help to eliminate the fear of the unknown. Offering constant feedback rather than once a year session draws attention to the performance relationships between health service managers and the health workers. Consistent feedback also provides health workers the opportunity for continuous professional development. Additionally, regular communication between the health workers and their managers contributes to a pleasant working environment.

Goulding and Harrison (1997:9) mention that the most obvious reason for appraising worker's performance is to secure improvement. Therefore, appraisal should be treated as a chance for the health workforce to review the annual performance and plans positively for the future. Performance review should not be treated as session for criticism. The managers should ask the health workers about the assessment of their own performance, the job and opportunities for career advancement. Therefore, performance review should utilised as a tool for career development of the workers.

#### **6.4.4.1.6 Performance feedback**

In institutions where performance management is taken seriously the managers allow for the workers to self assess their performance and that of the organisation. Health workers are not working in isolation. One of the criticisms regarding performance assessments is that it does not regularly take into consideration the external environmental factors that affect health workers' performance. The health services managers should practice the use of multiple sources (such as from patients, peers, self-evaluation) to offer constructive feedback. This helps the workers to know their strength and weakness and when they need to change.

#### **6.4.4.1.7 Rewards and recognition of good performance**

Performance management system in organisations should recognise the workers for their contributions towards achieving the mission and strategic objectives. When the workers perform well they should be rewarded. This can be done through the use of formal or informal awards. Informal awards may include a word of praise or even a 'thank you'. The health services managers have to understand that the awards policy need not only provide rewards to the best workers but should also be an encouragement to poor performers. The health services managers should strive to find out the reasons and consequences of poor personnel performance and agree on practical solutions. In addition, as part of the action plan it is important for the health services managers to follow up any actions agreed upon during the performance review whether for additional training, salary increments, promotions or disciplinary actions.

It is imperative that actions discussed during performance reviews, particularly rewards, should only be given as a consequence of improved performance and not as empty promises in an effort to motivate a worker for the future performance. The appraisal is not complete until both the managers and the workers have followed through on all of the aspects that were discussed during the review. Skinner and Green (2010:1) mention that managers who do not fulfil the promises made during performance review are perceived as not serious about the welfare of their staff. Furthermore, in this study some health services managers have recommended that the MoH should look into the possibility of introducing performance related payment and that all the future spending should be aligned to results and health outcomes.

#### **6.4.4.1.8 Monitoring and evaluation of performance management system**

Performance management is aimed at improving quality of management by supporting managers in making decisions and facilitate resources allocation (Diamond 2005:4). Therefore, monitoring and evaluation using quantified performance indicators facilitates taking timely remedial action (Diamond 2005: 4). Monitoring plays a crucial role in determining the follow up step in any performance management system. It is vital that organisations monitor their performance management systems to ensure quality of the assessment results and unearth any weaknesses that may require strengthening. It the responsibility of the health services managers to continuously monitor performance in order to ensure that the activities agreed in the performance plan are on track. The health workers should be encouraged to seek guidance from their managers if they are in doubt. All the critical events and outcomes that occur during the performance cycle should be documented by the respective line managers and health workers. Furthermore, the managers should organise quarterly review meeting to discuss the work progress, competences, personal training and development plans and any other issues related to performance.

### **6.5 LIMITATIONS OF THE STUDY**

The following limitations may affect the generalisation of the study results:

- This study was conducted among health workers in four districts of Eastern Uganda, therefore the results may not necessarily be generalised to the entire country.
- The study focused on three categories of health workers including doctors, clinical officers and professional nurses/midwives. The other categories of health

workers such as laboratory, pharmacy, dental, and nursing assistants might have had different views about performance which has not been captured by this study.

- The small number of doctors (n=19; 6.9%) and clinical officers (n=51; 18.5%) at the health facility level (level I) limits the research findings relevant to these categories of health workers.
- Data from the health workers at the health facility level was obtained using highly structured questionnaire based on 5-point Likert scale which was self administered, so, it was not possible to probe on the responses given by the participants.
- Data from the health services managers was obtained using semi-structured interviews conducted with 21 managers who agreed to participate. It cannot be assumed that their ideas about performance of health workers are essentially the same as those managers who were not interviewed.
- The participants at both health facility and district level expressed expectations that the study would result into the implementation of performance improvement programmes to help enhance the quality of health services in the districts. The researcher explained that no short-term benefits were likely but the research might attract long-term benefits in terms of policy change. These expectations might have influenced the way they responded to the questions.
- Lastly, performance management framework suggested in Table 6.1 has not been tested empirically and remains suggestions and proposals until tested.

Notwithstanding the limitations, the study findings are reliable, valid and trustworthy. The use of quantitative and qualitative data collection and analysis methods and the different levels of data collection increased the validity, reliability and trustworthiness of the study results.

## **6.6 RECOMMENDATIONS**

Based on the study findings, the researcher would like to make the recommendations for improving the performance of health workers in the decentralised services. The researcher also recommends areas for further research.

### **6.6.1 Recommendations for addressing the factors that hinder the performance of health workers**

- The district health service managers should ensure that all health workers including the low cadre staff are knowledgeable about the mission and objectives of the health sector towards which they are expected to contribute.
- Although the ministry of health has good health policies, the implementation of these policies should be done in a phased manner and if there are any policy changes they should be communicated clearly to the health workers and their managers at the district and health facility levels on a timely basis.
- The local political leadership should be partners in the delivery of health services instead of being antagonists. If there is good collaboration between the leaders and the health workers, there is a likelihood in the improvement of health service delivery at all levels since they will be planning and implementing activities in unison.
- There is a need for the ministry of health and the DHOs to ensure that the drug supply chain is consistently maintained. Proper quantification of drug requirements should be done in order to avoid health facilities running out of stocks of essential drugs. In addition, the ministry has to ensure that medical equipment are provided to all health facilities and the health workers are trained in preventive maintenance of these equipment.
- The ministry of health in collaboration with the ministry of public services should look into the possibility of improving the remuneration of health workers as one



way of improving their performance. This will ensure better attraction, retention and productivity of these workers. At the same time incentives should be put forward for health workers in hard-to-reach areas. Without these incentives or hardship allowances it will be very difficult to attract and retain health workers in some districts. For the health workers who work overtime, there should be a compensation mechanism developed to reward them for the extra time they devote to their work. This will improve their performance and that of the health sector.

- There is a need for the local governments to provide accommodation for health workers at the health facilities. This will reduce late coming, absenteeism and the general poor time management which is experienced in the health facilities.
- The DSCs should advertise and recruit health workers to improve on the staffing levels within the districts and particularly in the health facilities. This will help to reduce on the workload that is currently experienced by the few health workers currently on the ground.
- The district should ensure that short courses are organised for health workers in communication skills. This will ensure that health workers are competent in communicating to their clients, leaders and among themselves. With good communication skills health workers are likely to perform better. The ministries of health and education should also incorporate communication skills training into the health training curriculum for all cadres in the sector.
- The management of HRH should be centralised so that all the control including recruitment, distribution and transfers are handled by the central government instead of the district local governments. This will reduce on the levels of political influence and nepotism that are being experienced in the current dispensation.

### **6.6.2 Recommendations for addressing the current practices for managing performance of health workers**

In addition to the recommendations in Table 6.1, the researcher would like to recommend the following:

- The district health systems should use the formal appraisal system that has been put forward by the ministry of public service. The performance management guidelines should be adhered to and followed as stipulated. The quarterly performance reviews should also be enforced as one way to improve the performance of the health workers.
- The ministries of health and public services should include quantified indicators into the performance appraisal forms to enable the managers to measure performance of health workers objectively.
- There is a need for the health managers to understand the importance of the pre-appraisal meeting and the target setting exercise. Without understanding the importance of this it will be impossible for the stakeholders to improve performance of health workers.
- There is a need to orient health services managers and the workers to the process of performance management since its knowledge and application seems to be limited not only to the health workers to be assessed but also to the managers themselves.
- The health services managers should provide feedback to their supervisees whenever necessary, both verbally and in writing. The feedback must be constructive and preferably from more than one sources of information. This feedback should be given individually to each health workers supervised.
- The district health systems and local governments should put in place some mechanisms of rewarding and recognising good performance. This should be based on clear criteria agreed upon between the district managers and representatives of the health workers. In case one is rewarded or recognised by

- going for further training this should be done objectively and on merit rather than using nepotism as a basis for rewards and recognition.
- The results of performance management should be used for performance improvement rather than for punishment. The use of performance appraisal results should be towards improving health service delivery and health workers should be given opportunity to suggest ways to improve their performance.
  - The district and health sub-district managers should conduct regular support supervision at least once every quarter to ensure that their workers are performing based on the standards set by the ministry of health. Therefore, the district officials should provide transport facilities to enable this support supervision to be carried out effectively and in a more integrated manner.
  - The government of Uganda should explore the possibility of introducing performance based remuneration system as a way to enhance performance of its workforce.

### **6.6.3 Recommendations for further research**

Based on the results of this study, the researcher recommends the following potential areas for further research:

- Qualitative research should be carried out among health workers to obtain more in-depth information about the factors that enhance their performance in Uganda. This should be carried out in all the regions of the country and among all categories of health workers.
- Research should be carried out to investigate the effectiveness of the current performance appraisal forms from the ministry of public service in measuring performance of health workers.
- Investigative research should be conducted to find out why Uganda usually develops good policies for the health sector but usually fails to implement whereas when the same policies are adapted by the neighbouring countries they succeed.

- Exploration of the views of health workers on performance based remuneration systems as a vehicle for improving performance in the health sector.
- Research should be carried out to investigate the causes and consequences of the communication challenges experienced by health workers and what strategies should be put in place to address them effectively.
- Research should be conducted to establish the effects of feedback given to the health workers by their managers on changes in the behaviours for performance within the health sector.

## **6.7 CONTRIBUTION OF THE STUDY**

Theoretically this study falls into the present focus of the Kampala declaration of HRH. This declaration calls upon 'leaders of bilateral and multilateral development partners to provide coordinated and coherent support to formulate and implement comprehensive country health workforce strategies and plans' (Global Health Workforce Alliance 2008:1).

The findings of this study have provided more understanding and awareness about the factors that may facilitate or hinder the performance of health workers. The study has also produced some evidence on how performance management is implemented in the health sector in Uganda and the challenges that need to be addressed in order to have an efficient decentralised health system. It is, therefore, envisaged that this study has contributed to the existing body of knowledge on HRH by generating greater awareness among the stakeholders in the health sector on having proper strategies for performance and performance management. These would serve as means for organisational effectiveness in achieving the health related millennium development goals (MDGs) by 2015.

Lastly, as a result of the findings of this study the researcher has developed and proposed a performance management framework that can be applied to the health sector in Uganda. If this performance management framework is operationalised, it is hoped that it will greatly assist in the improvement of the performance of health workforce in the decentralised services not only in Uganda but also in other limited resource countries in Africa and elsewhere in the world.

### **6.7.1 Implications of the study**

The findings of this study have implications to all the stakeholders involved in the management of the HRH at national, district and health facility levels. The ministries of health, local governments and public service as well as the bilateral and multilateral partners need to discuss the issues and recommendations raised by this study. If this is done it is hoped that key issues that are brought forward by this study will be used as a basis for improving the performance of health workers in the decentralised services, which will in turn improve the outputs related to the third Uganda national health sector strategic plan (HSSP III).

## **6.8 CONCLUDING REMARKS**

The aim of this study was to investigate the performance of health workers in the decentralised services with a view of developing a management framework that may be used to improve performance in the health sector. Indeed the objectives of this study have been achieved. It has been established that the inadequate performance of health workers is generally due to organisational or health systems related factors rather than individual factors. The health workers are skilled, competent and most of them have a positive attitudes and behaviours towards the patients and clients.

Although there is a performance management system developed by ministry of public service the study uncovered a number of loop holes in its implementation. In many instances no target setting is done and no planning for performance management is done in the districts. At the same time, the indicators for measuring performance are not clearly defined to the individuals to be assessed and to the managers themselves. The schedule for performance appraisal is not always adhered to as stipulated by the ministry of public service. The career progression is limited and staff training and development seems to be lacking in most districts. The performance feedback mechanisms seem not to be functioning as well as expected at all levels of service delivery.

Despite the political interference and to some extent the nepotism that is practiced in recruitment, posting and nominations of candidates for further training and in the overall management of management of the health services at district level, the health workers are committed to their work and are willing to put in more effort to improve the health status of the people of Uganda.

The researcher is of the opinion that the performance management framework that has resulted from the findings of this study be implemented both as short term and long-term strategy for improving the performance of health workers and overall improvement of the results from the health sectors will be realised.

Scholars in organisational behaviour and human resource management (Zhang, Song, Hackett & Bycio 2006:280) have said that...

*“Performance improvement follows alignment of perceived and actual capabilities, matching authority with resources, and implementation of work strategies that strengthen connections between efforts, performance results, personal rewards, and overall organisational well being”.*

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## ANNEXURES

### ANNEXURE A: CERTIFICATE OF CLEARANCE FROM THE UNIVESRSITY OF SOUTH AFRICA HEALTH STUDIES RESEARCH AND ETHICS COMMITTEE

UNIVERSITY OF SOUTH AFRICA  
Health Studies Research & Ethics Committee  
(HSREC)  
College of Human Sciences

#### CLEARANCE CERTIFICATE

Date: 15 September 2009 Project No: 4502 562 2

Project Title: THE PERFORMANCE OF HEALTH WORKERS IN DECENTRALISED SERVICES IN UGANDA

Researcher: GW Lutwama

Supervisor/Promoter: Prof JH Roos

Joint Supervisor/Joint Promoter: Dr BL Dolamo

Department: Health Studies

Degree: D Litt et Phil

#### DECISION OF COMMITTEE

Approved

Conditionally Approved

Date: 15 September 2009

  
Prof VJ EHLERS

RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES

  
Prof JH ROOS: SUPERVISOR

  
DR BL DOLAMO: JOINT SUPERVISOR

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

## ANNEXURE B: LETTER OF ETHICAL CLEARANCE FROM THE UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY



Uganda National Council For Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

Your Ref:.....

Our Ref:.....SS.2306

Date:.....20/04/2010....

Dr. George William Lutwama  
C/o UNDP Head Office  
Kampala

Dear Dr. Lutwama,

### RE: RESEARCH PROJECT, "THE PERFORMANCE OF HEALTH WORKERS IN THE DECENTRALIZED SERVICES IN UGANDA"

This is to inform you that the Uganda National Council for Science and Technology (UNCST) approved the above research proposal on **February 08, 2010**. The approval will expire on **December 08, 2010**. If it is necessary to continue with the research beyond the expiry date, a request for continuation should be made in writing to the Executive Secretary, UNCST.

Any problems of a serious nature related to the execution of your research project should be brought to the attention of the UNCST, and any changes to the research protocol should not be implemented without UNCST's approval except when necessary to eliminate apparent immediate hazards to the research participant(s).

This letter also serves as proof of UNCST approval and as a reminder for you to submit to UNCST timely progress reports and a final report on completion of the research project.

Yours sincerely,

  
Leah Nawegulo  
for: Executive Secretary  
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

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#### LOCATION/CORRESPONDENCE

Plot 3/5/7, Nasser Road  
P.O. Box 6884  
KAMPALA, UGANDA.

#### COMMUNICATION

TEL: (256) 414-250499, (256) 414 705500  
FAX: (256) 414-234579  
EMAIL: [uncst@starcom.co.ug](mailto:uncst@starcom.co.ug)  
WEBSITE: <http://www.uncst.go.ug>



# ANNEXURE C: LETTER OF ETHICAL CLEARANCE FROM INSTITUTIONAL REVIEW BOARD OF MBALE REGIONAL HOSPITAL

Telephones: General Line: 045 44 433193  
Masaba Wing: 045 44 425021  
Fax: 045 44 435894  
E-mail: [MRHIRC@gmail.com](mailto:MRHIRC@gmail.com)



THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH  
MBALE REGIONAL HOSPITAL  
P.O. BOX 921  
Mbale -- Uganda

In any correspondence on this  
Subject, please quote: REIRC 110/2010

Date 6<sup>th</sup> May 2010

MRHIRC ACCREDITED BY THE FACST. REGISTRATION NUMBER 001/019

ATT: **Dr. George Lutwama**  
**The Principal Researcher,**  
**The performance of Health Workers in Decentralized Services in Uganda**

Dear Dr. George Lutwama


RE: **ETHICAL CLEARANCE OF STUDY**

At the sitting of the Mbale Regional Hospital Institutional Review Committee (MRHIRC) on 6<sup>th</sup> May 2010 to review your study, the committee was satisfied with the protocol and prior ethical clearance from the UNCST.

I am pleased to let you know that during the meeting, *minute 13.3* of the MRHIRC meeting on 6<sup>th</sup> May 2010 passed your study on 'The performance of Health Workers in Decentralized Services in Uganda'. The study may proceed. This clearance is valid for the period 6<sup>th</sup> May 2010 – 5<sup>th</sup> May 2011. If the study has not been completed by then, you will need to seek clearance for extension of the study from the MRHIRC. You are requested to avail the MRHIRC with progress Data Management Reports (DMR) on the study as scheduled.

Note further that the MRHIRC will schedule visits to the study site and carry out protocol and ethical adherence verification.

Yours sincerely,

  
MBALE REGIONAL HOSPITAL  
INSTITUTIONAL REVIEW COMMITTEE  
P.O. BOX 921 MBALE  
APPROVED 6/5/2010  
2010.....

Dr. Crispus Teguh  
Senior Consultant Paediatrician  
**CHAIRMAN MRHIRC**  
cc. MRHIRC file

## ANNEXURE D: LETTER OF PERMISSION FROM OFFICE OF PRESIDENT



THE REPUBLIC OF UGANDA

### OFFICE OF THE PRESIDENT

PARLIAMENT BUILDING P. O. BOX 7168 KAMPALA, TELEPHONES: 254881/6, 343934, 343926, 343943, 233717, 344026, 230048, FAX: 235459/256143

**ADM 154/212/01**

March 3, 2010

The Resident District Commissioner, Mbale District  
The Resident District Commissioner, Sironko District  
The Resident District Commissioner, Tororo District  
The Resident District Commissioner, Kumi District

This is to introduce to you **Dr. George William Lutwama** a Researcher who will be carrying out a research entitled "**The performance of health workers in the decentralized services in Uganda**" for a period of **04 (four) months** in your district.

He has undergone the necessary clearance to carry out the said project.

Please render him the necessary assistance.

By copy of this letter **Dr. George William Lutwama** is requested to report to the Resident District Commissioner of the above districts before proceeding with the Research.

A handwritten signature in cursive script, appearing to read 'Alenga Rose'.

Alenga Rose

**FOR: SECRETARY, OFFICE OF THE PRESIDENT**

Copy to: Dr. George William Lutwama

## ANNEXURE E: THE CONSENT FORM

### STUDY TITLE: THE PERFORMANCE OF HEALTH WORKERS IN THE DECENTRALISED SERVICES IN UGANDA.

#### PRINCIPAL INVESTIGATOR: DR. GEORGE WILLIAM LUTWAMA

Dr. George W. Lutwama, a medical doctor currently pursuing a Doctoral degree from the University of South Africa. Dr. Lutwama is currently conducting a study as titled above in the fulfilment of the requirements for the award of Doctor of Literature and Philosophy degree in Health Studies (DLitt et Phil). This study will be carried out in the districts of Kumi, Mbale, Sironko and Tororo.

The purpose of this study is to identify gaps in performance and performance management of health workers in wake of the health reforms. The researcher intends to use the findings from this research to develop performance management framework/guidelines that are specific to health worker.

The Uganda National Council for Science and Technology (UNCST) and the Research Secretariat Office of the President as well as the district authorities have been approached and have approved that the study can be conducted these districts. The health facility managers have been notified to this effect.

There will be no risk or harm to your participation in this study. You are expected to respond to the questions in the questionnaire in your free time. This questionnaire will take less than 30 minutes to complete. You are free to ask any questions if clarity is required. Your participation in this study is voluntary. You are under no obligation to participate. You have the right to withdraw at any time however your participation is highly appreciated. Your identity will not be revealed during the study, reporting or publishing the research findings. On completion of the questionnaire, kindly return it to Dr/Mr/Ms.....who has been trained in ethical data collection methods and will not share the information with any other person.

In case your need any clarification or any other questions kindly contact the following people. Dr. George W. Lutwama Tel:+256 787393413; +265 999 414748, e-mail: [george.lutwama@undp.org](mailto:george.lutwama@undp.org) or [wglutwama@yahoo.co.uk](mailto:wglutwama@yahoo.co.uk) or [45025622@mylife.unisa.ac.za](mailto:45025622@mylife.unisa.ac.za).

**I have read this form and voluntarily consent to participate in this study.**

**Participant's Signature:**..... **Date:** .....

I have explained this to the above participant and have sought his/her understanding for informed consent.

**Researcher/ Assistant's Signature:** ..... **Date:** .....

**ANNEXURE F: COVERING LETTER ACCOMPANYING THE SELF  
ADMINISTERED QUESTIONNAIRE**

**Date: 2<sup>nd</sup> May 2010**

Dear Sir/Madam,

**SUBJECT: THE PERFORMANCE OF HEALTH WORKERS IN THE  
DECENTRALISED SERVICES IN UGANDA**

This survey is conducted as a requirement for the completion of the degree of Doctor of Literature and Philosophy (DLitt et Phil) in Health Studies from the University of South Africa. The main purpose of this research is to investigate the performance of health workers in the decentralised services in Uganda, following the health reforms.

I would like to invite your participation in this survey by filling up the attached questionnaire. All information provided will be treated with the strictest confidentiality and only aggregate data will be analysed. As such individuals who respond to this questionnaire will not be identified.

This survey will take approximately 30 to 45 minutes and your participation is very much appreciated.

I would really appreciate if you could return the questionnaire to the undersigned.

Thank you for your valuable contribution in participating in this survey.

Kind regards

**Dr. George William Lutwama (MChB, MPH, DLitt et Phil (Candidate))**  
Tel: +256 787393413; 265 999 424748 e-mail: [george.lutwama@undp.org](mailto:george.lutwama@undp.org).

**ANNEXURE G: LETTER REQUESTING FOR PERMISSION FROM HEALTH SERVICE MANAGERS TO COLLECT DATA AND CONDUCT INTERVIEWS**

**Date: 2<sup>nd</sup> May 2010**

**To:** .....

Dear Sir/Madam,

**RE: REQUEST FOR PERMISSION TO COLLECT DATA FROM HEALTH WORKERS IN HEALTH FACILITES AND THEIR MANAGERS.**

I am a Doctoral student (DLitt et Phil in Health Studies) at the University of South Africa. I write to request permission to collected data for my thesis from health workers in selected health facilities in Eastern Uganda. The approved title for my thesis is ***'The Performance of health workers in the decentralised services in Uganda'***. I intend to carry out this research in 4 districts located in Eastern Uganda namely: Kumi, Mbale, Sironko and Tororo. The study will involve interviews with health workers and their managers. I intend to use findings from this study to develop a performance management framework that is specific to health workers in Uganda and Africa as a whole.

I am requesting to undertake the following activities in the health facilities.

1. Distribute self-administered to doctors, clinical officers, and Nurses.
2. Conduct interviews with health service managers at district, hospital and health sub districts.
3. Review some records on patients' attendance and health performance indicators.

I have attached copies of the ethical clearance by the University of South Africa and the Uganda National Council for Science and Technology. I addition the copies of the questionnaires and interview schedules are attached.

Thank you for your consideration

**Dr. George William Lutwama (MBChB, MPH, DLitt et Phil (Candidate)**

Tel: +265 999 424747; e-mail: [george.lutwama@undp.org](mailto:george.lutwama@undp.org) .

## ANNEXURE H: SELF-ADMINISTERED QUESTIONNAIRE FOR HEALTH WORKERS

Serial No: 

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### SECTION A: PERSONAL AND HEALTH FACILITY INFORMATION

Please give your answer to each of the following questions. Read all the options first and **circle only one answer** for each statement. You are requested to answer all questions as **truthfully** as possible.

**1. My gender is....**

Female	1
Male	2

**2. I am in the age category of ....**

less than 20 years	1
20-29 years	2
30-39 years	3
40-49 years	4
50 -59years .	5
60 years and above	6

**3. My marital status is....**

Single	1
Married	2
Divorced	3
Widowed	4
Separated	5

**4. My current profession is ...**

Medical Doctor	1
Clinical Officer	2
Registered Nurse/Midwife	3
Enrolled Nurse/midwife	4

**5. The highest professional qualification I have attained is ....**

Doctoral degree (e.g. PhD, D Litt et Phil)	1
Master degree (e.g. MMed, MPH, MScN, MA).	2
Postgraduate diploma (e.g. Administration, Public Health, Mental health)	3
Postgraduate certificate (e.g. Cerf. In Public Health, Cert. Mental health etc)	4
Bachelors degree (e.g. MBChB, Bsc Nursing, Bsc Clinical Medicine etc)	5
Diploma (e.g. Clinical Medicine, Diploma in Nursing & Midwifery, Dip Public Health etc)	6
Certificate (e.g. Nursing and Midwifery, Clinical Medicine etc)	7

**6. I have ..... of experience in the health profession**

0 – 5 years	1
6 - 10 years	2
11-15 years	3
16-20 years	4
21 years and above	5

**7. The type of health facility where I work is ....**

Hospital	1
Health Centre IV	2
Health Centre III	3
Health Centre II	4

**8. I have been working in this health facility for .....**

0 – 11 months	1
1 – 5 years	2
6 – 10 years	3
11 -15 years	4
16-20 years	5
21 years and more	6

**9. I work in the district of .....**

Kumi	1
Mbale	2
Sironko	3
Tororo	4

**10. My health facility is located in .....area.**

Urban	1
Rural	2

**SECTION B: INDIVIDUAL ATTRIBUTES**

**11. Please indicate how you perceive your job related skills and abilities by circling only one answer to each of the statements below as follows:**

**1= Very poor (VP); 2= Poor (P); 3= Average (Av); 4= Good (G); 5= Very good (VG)**

	Skills and abilities	VP	P	Av	G	VG
11.1	My skills in assessing clients are....	1	2	3	4	5
11.2	My abilities in delivering health education are....	1	2	3	4	5
11.3	My clinical competencies are....	1	2	3	4	5
11.4	My skills in counselling clients are....	1	2	3	4	5
11.5	My interpersonal relations are....	1	2	3	4	5
11.6	My abilities in providing in-service training are....	1	2	3	4	5
11.7	My time management abilities are....	1	2	3	4	5
11.8	My skills in supervising other health workers are....	1	2	3	4	5
11.9	My skills in maintaining health facility equipment are....	1	2	3	4	5
11.10	My abilities to Implement the Uganda National Minimum Health Care Package (UNMHCP) are....	1	2	3	4	5

**12. To what extent do you agree with the statements below regarding your self-monitoring ability? Please circle only one answer for each as follows:**

**1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)**

	Statement	SD	D	U	A	SA
12.1	I find it easy to copy the behaviour of others.	1	2	3	4	5
12.2	I always defend the ideas that I already believe in.	1	2	3	4	5
12.3	I am able to adapt myself to different situations and with different people.	1	2	3	4	5
12.4	I can be friendly towards others even though I really I dislike them.	1	2	3	4	5

**13. To what extent do you agree with the statements below concerning your self-motivation (Intrinsic motivation)? Please circle only one answer for each as follows:**

**1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)**

	Statement	SD	D	U	A	SA
13.1	I feel satisfied when I do my job well.	1	2	3	4	5
13.2	When I perform my job well, it contributes to my personal growth and development.	1	2	3	4	5
13.3	I get a sense of accomplishment when I perform my work well.	1	2	3	4	5
13.4	My job increases my feeling of self-esteem.	1	2	3	4	5

13.5	I have considerable freedom on how to do my work.	1	2	3	4	5
13.6	I feel satisfied when I help others to achieve their goals.	1	2	3	4	5
13.7	I feel satisfied when others recognise my achievements.	1	2	3	4	5
13.8	I achieve my goals by satisfying my clients' needs.	1	2	3	4	5
13.9	In general, I am satisfied with my job.	1	2	3	4	5

**14. Please indicate the extent to which you agree with the following statements regarding your commitment to the organisation by circling only one answer for each as follows:**

**1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)**

	Statement	SD	D	U	A	SA
14.1	I am willing to put more effort than what is normally expected to help my organisation become successful.	1	2	3	4	5
14.2	I am willing to accept almost any type of work in order to continue working in this organisation.	1	2	3	4	5
14.3	My organisation inspires me to perform to the best of my ability.	1	2	3	4	5
14.4	I talk highly about this organisation to my friends as a great place to work for.	1	2	3	4	5
14.5	I would encourage my friends and family to seek health care from this facility.	1	2	3	4	5
14.6	My supervisor takes personal interest in my career.	1	2	3	4	5
14.7	My organisation strongly acknowledges my goals and values.	1	2	3	4	5
14.8	I would be very happy to spend the rest of my career with this organisation.	1	2	3	4	5
14.9	It would be very hard for me to leave this organisation right now even if I wanted.	1	2	3	4	5
14.10	I think that moving from one organisation to another would interfere with my career development.	1	2	3	4	5
14.11	Overall, I am committed to this health facility.	1	2	3	4	5

**15. To what extent do you agree with the following statements concerning your values and beliefs in the organisation? Please circle only one answer for each as follows:**

**1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)**

	Statement	SD	D	U	A	SA
15.1	I communicate openly with everyone in this organisation.	1	2	3	4	5
15.2	When I make a mistake, I honestly admit and try to rectify it.	1	2	3	4	5
15.3	I think it is better to work as a team in order to realise my potential and get work done.	1	2	3	4	5
15.4	Safety of patients is very important to me.	1	2	3	4	5
15.5	I am in support of continuous improvement in patients' care.	1	2	3	4	5
15.6	I put in a lot of effort to achieve positive health outcomes for my patients.	1	2	3	4	5
15.7	I believe in provision of client-driven services.	1	2	3	4	5
15.8	I believe in respect for the clients.	1	2	3	4	5
15.9	I believe organisational loyalty should be encouraged and rewarded.	1	2	3	4	5
15.10	I believe promotions should be based on individual performance.	1	2	3	4	5
15.11	I believe teamwork is valuable and should be rewarded.	1	2	3	4	5

### SECTION C: INDIVIDUAL BEHAVIOURS FOR PERFORMANCE

**16. Please indicate the extent to which you agree with the statements below concerning your proficiency behaviour by circling only one answer for each as follows:**

**1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)**

	Statement	SD	D	U	A	SA
16.1	I always use standard procedures to ensure that my core tasks are completed properly.	1	2	3	4	5
16.2	I coordinate my work with co-workers.	1	2	3	4	5



16.3	I communicate openly with my co-workers.	1	2	3	4	5
16.4	I provide help to my co-workers when asked.	1	2	3	4	5
16.5	I portray a positive image of my organisation to other people (such as patients).	1	2	3	4	5

**17. To what extent do you agree with the statements below concerning your adaptive behaviour? Please circle only one answer for each as follows:**

**1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)**

	Statement	SD	D	U	A	SA
17.1	I always adjust well to changes in my core tasks.	1	2	3	4	5
17.2	I have learned new skills to help me adjust to changes in my core tasks.	1	2	3	4	5
17.3	I respond constructively to changes in the way my team works.	1	2	3	4	5
17.4	I am flexible with regard to the overall changes in my organisation (e.g. changes in management).	1	2	3	4	5

**18. To what extent do you agree with the statements below concerning your proactive behaviour? Please circle only one answer for each as follows:**

**1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)**

	Statement	SD	D	U	A	SA
18.1	I have initiated better ways of performing my core tasks.	1	2	3	4	5
18.2	I have developed new and improved methods to help my work unit perform better.	1	2	3	4	5
18.3	I have made suggestions to improve the overall performance of the organisation (e.g. suggesting changes to administrative procedures).	1	2	3	4	5

**19. Please indicate the extent to which you agree with the statements below concerning your client-orientation behaviour by circling only one answer for each as follows:**

**1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)**

	Statement	SD	D	U	A	SA
19.1	I try to assess what the needs of clients are.	1	2	3	4	5
19.2	I have the clients' best interest in mind.	1	2	3	4	5
19.3	I try to address the clients' needs with the appropriate treatment available.	1	2	3	4	5
19.4	I am aware that my task is to serve my clients to the best of my ability.	1	2	3	4	5
19.5	I respect what the patients have to say.	1	2	3	4	5
19.6	I have respect for my clients.	1	2	3	4	5
19.7	I give clients the opportunity to express their needs with me.	1	2	3	4	5
19.8	I take a problem-solving approach to care for my clients.	1	2	3	4	5
19.9	I always take time to perform my clinical work.	1	2	3	4	5
19.10	I always behave in a professional manner.	1	2	3	4	5

#### **SECTION D: ORGANISATION FACTORS**

**20. Please indicate how clear your organisation strategy is to you by circling only one answer to each of the statements below as follows:**

**1= Very unclear (VU); 2= Unclear (U); 3= Neutral (N); 4= Clear (C); 5= Very Clear (VC)**

	Statement	VU	U	N	C	VC
20.1	My organisation's mission is .....	1	2	3	4	5
20.2	My duties and responsibilities are.....	1	2	3	4	5
20.3	The goals and objectives of my job are.....	1	2	3	4	5
20.4	The way my work is related to the overall objective of the organisation is.....	1	2	3	4	5
20.5	The expected results of my work are.....	1	2	3	4	5
20.6	The way I divide my time among tasks required for my job is .....	1	2	3	4	5
20.7	The way to determine the appropriate procedures for each work assignment is.....	1	2	3	4	5
20.8	The way performance is measured is.....	1	2	3	4	5

20.9	The way performance appraisal results are utilised is....	1	2	3	4	5
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21. Please indicate the extent to which you agree with the statements below regarding your working environment by circling only one answer for each as follows:

1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)

	Statement	SD	D	U	A	SA
21.1	My working environment is considerably safe.	1	2	3	4	5
21.2	My health facility has a good working space arrangement.	1	2	3	4	5
21.3	All the necessary equipment are available.	1	2	3	4	5
21.4	The health facility equipment are in good working condition.	1	2	3	4	5
21.5	Drugs and supplies are sufficient.	1	2	3	4	5
21.6	There are clear infection control guidelines.	1	2	3	4	5
21.7	I participate in decision making concerning patients' care.	1	2	3	4	5
21.8	I am satisfied with my opportunity to participate in decision making.	1	2	3	4	5
21.9	I receive constructive comments from my supervisors.	1	2	3	4	5
21.10	I receive constructive comments from my co-workers.	1	2	3	4	5
21.11	I receive constructive comments from the patients/their relatives.	1	2	3	4	5
21.12	My opinion is respected at work.	1	2	3	4	5
21.13	I feel my job is secure.	1	2	3	4	5

22. Please indicate the extent to which you agree with the statements below concerning staffing in your organisation by circling only one answer for each as follows:

1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)

	Statement	SD	D	U	A	SA
22.1	The allocated staff in this facility are sufficient to cover the current workload.	1	2	3	4	5
22.2	Support of staff in form of counselling at workplace is available.	1	2	3	4	5
22.3	I have opportunity to make inputs into staffing policies and procedures.	1	2	3	4	5
22.4	There is a good balance between health workers and their supervisors.	1	2	3	4	5

23. Please indicate the extent to which you agree with the statements below concerning your work schedule by circling only one answer for each as follows:

1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)

	Statement	SD	D	U	A	SA
23.1	I have opportunities for a flexible work schedule.	1	2	3	4	5
23.2	Overall, I perceive my work schedule to be fair.	1	2	3	4	5
23.3	I am always compensated when I work overtime.	1	2	3	4	5
23.4	My workload is manageable.	1	2	3	4	5
23.5	I am able to balance the demands of my work with my personal life.	1	2	3	4	5

24. Please indicate the extent to which you agree with the statements below concerning the organisational culture in your facility by circling only one answer for each as follows:

1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)

	Statement	SD	D	U	A	SA
24.1	Members of this organisation share a common purpose.	1	2	3	4	5
24.2	My performance is assessed according to how best I execute my duties.	1	2	3	4	5
24.3	Employees of this organisation try hard to identify problems and solve them accordingly.	1	2	3	4	5
24.4	The policies of this organisation are consistent with the cultural beliefs of the community.	1	2	3	4	5
24.5	Recruitment of new health workers is done based on qualifications.	1	2	3	4	5
24.6	Promotion of health workers is based on merit.	1	2	3	4	5
24.7	The local political leadership is supportive of health workers.	1	2	3	4	5
24.8	Decentralisation has led to improvement in performance of health	1	2	3	4	5

	workers.					
24.9	Decentralisation has improved my chances for career progression.	1	2	3	4	5
24.10	My co-workers have adequate skills for their jobs.	1	2	3	4	5
24.11	My health facility manager is competent in his/her duties.	1	2	3	4	5

## SECTION E: PERFORMANCE DIMENSIONS

25. Please indicate the extent to which you agree with the statements below regarding the responsiveness of the services you provide at this facility by circling only one answer for each as follows:

1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)

	Statement	SD	D	U	A	SA
25.1	Clients are always happy with the friendly services offered by health workers.	1	2	3	4	5
25.2	Clients are satisfied with the quality of services we provide.	1	2	3	4	5
25.3	Clients are satisfied with the timeliness of the services.	1	2	3	4	5
25.4	The complaints from stakeholders towards individual health workers are rare.	1	2	3	4	5
25.5	The stakeholders are satisfied with the health workers' cooperation.	1	2	3	4	5
25.6	The health workers clearly know who they serve.	1	2	3	4	5
25.7	Health workers are always willing to address the clinical & emotional demands of the patients.	1	2	3	4	5
25.8	Health workers get professional support to improve their performance.	1	2	3	4	5
25.9	When at work, I know what is expected of me.	1	2	3	4	5

26. Please indicate the extent to which you agree with the statements below regarding the availability of health workers in your facility by circling only one answer for each as follows:

1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)

	Statement	SD	D	U	A	SA
26.1	This organisation has a retention policy with clear strategies.	1	2	3	4	5
26.2	I am always available when my services are required.	1	2	3	4	5
26.3	This facility has adequate numbers of health workers to deliver the services.	1	2	3	4	5
26.4	The rural facilities are as well staffed as the urban ones.	1	2	3	4	5
26.5	This facility has an attendance register which is filled by every staff member.	1	2	3	4	5
26.6	I am always present during the official working hours.	1	2	3	4	5
26.7	I put in much effort when I am on duty.	1	2	3	4	5
26.8	Staff attendance in this organisation is good.	1	2	3	4	5
26.9	The workload in this facility is manageable.	1	2	3	4	5
26.10	In this facility the patient waiting time is short.	1	2	3	4	5

27. Please indicate the extent to which you agree with the statements below regarding the productivity of health workers in your facility and district by circling only one answer for each as follows:

1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)

	Statement	SD	D	U	A	SA
27.1	My productivity is measured according to the number of patients I attend to.	1	2	3	4	5
27.2	This organisation has indicators for measuring staff productivity.	1	2	3	4	5
27.3	I spend most of my time at work attending to the patients.	1	2	3	4	5
27.4	My skills are suited for the type of work I do.	1	2	3	4	5
27.5	My productivity is increased by the availability of drugs & equipment.	1	2	3	4	5
27.6	The management structures in this facility encourage the performance of health workers.	1	2	3	4	5

28. Please indicate the extent to which you agree with the statements below regarding your competence by circling only one answer for each as follows:

1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)

	Statement	SD	D	U	A	SA
28.1	I am confident about my ability to do my job.	1	2	3	4	5
28.2	I have mastered the skills necessary for my job.	1	2	3	4	5
28.3	I am confident about my prescribing practices.	1	2	3	4	5
28.4	I always improve my knowledge and skills through continuous professional education.	1	2	3	4	5
28.5	My attitude towards the care of patients is good.	1	2	3	4	5
28.6	I use my knowledge & skills to improve safety of patients.	1	2	3	4	5
28.7	I always make timely referral of patients that are in need of specialised treatment.	1	2	3	4	5
28.8	I have good communication skills.	1	2	3	4	5
28.9	I am able to use the available communication technology to support patient care.	1	2	3	4	5

#### SECTION F: PERFORMANCE MANAGEMENT

29. How, if at all is the performance of health workers reviewed in your organisation? Circle only one.

A formal system of regular appraisals with the review of the past performance objectives.	1
Informal, but regular reviews involving discussions about past performance and agreed actions for the future.	2
Informal unscheduled reviews are undertaken especially when there is a performance problem.	3
Not reviewed.	4

30. If you have performance management system in place, how are the results of the performance review utilised? Circle the correct answer to each of the statements below as follows: No =1 Yes = 2

	Statement	NO	YES
30.1	Training	1	2
30.2	Promotion	1	2
30.3	Demotion	1	2
30.4	Rotation	1	2
30.5	Reward	1	2
30.6	Not used	1	2

31. Please indicate the extent to which you agree with the statements below concerning the setting of performance standards in your district by circling only one answer for each as follows:

1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)

	Statement	SD	D	U	A	SA
31.1	All health workers are familiar with the organisation's mission towards the clients.	1	2	3	4	5
31.2	I have a clear job description.	1	2	3	4	5
31.3	The performance standards are clear.	1	2	3	4	5
31.4	There are appropriate performance indicators to assess the health worker's performance.	1	2	3	4	5
31.5	Targets are set for activities to be achieved in a given period.	1	2	3	4	5
31.6	The performance standards, indicators, and targets are communicated to all departments to ensure that health workers understand them.	1	2	3	4	5
31.7	This organisation regularly reports the performance standards, indicators, and targets to the external stakeholders (e.g. consumers, councillors, superior authority, suppliers etc).	1	2	3	4	5
31.8	All the stakeholders in this organisation (e.g. health workers, clients, councillors and suppliers) participate in setting the performance standards.	1	2	3	4	5

**32. Please indicate the extent to which you agree with the statements below concerning performance measurement in your district by circling only one answer for each as follows:**

**1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)**

	Statement	SD	D	U	A	SA
32.1	Objectives to be achieved are known by individuals to be assessed.	1	2	3	4	5
32.2	The performance standards expected from the staff are clear and understood by all.	1	2	3	4	5
32.3	The district clearly defines the ways of how to measure individual activity performance.	1	2	3	4	5
32.4	This organisation has a system for collecting and tracking staff performance data.	1	2	3	4	5
32.5	This organisation measures most of the established individual performance standards and targets.	1	2	3	4	5
32.6	Individual health worker's performance is measured regularly.	1	2	3	4	5
32.7	I am fully aware of the processes used to measure my performance.	1	2	3	4	5
32.8	My performance is evaluated based on my job description.	1	2	3	4	5
32.9	My performance is fairly evaluated.	1	2	3	4	5

**33. Please indicate the extent to which you agree with the statements below regarding performance reporting in your district by circling only one answer for each as follows: .**

**1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)**

	Statement	SD	D	U	A	SA
33.1	This organisation documents the progress related to performance standards and targets.	1	2	3	4	5
33.2	This organisation has a specific system that regularly reports the performance of health workers.	1	2	3	4	5
33.3	Constructive feedback on performance appraisal results is provided on a regular basis.	1	2	3	4	5
33.4	This organisation always reports the health workers' performance information to the external stakeholders (such as superiors, clients, councillors etc).	1	2	3	4	5
33.5	The health workers' performance data is analysed and reviewed according to the set performance standards, indicators, and targets.	1	2	3	4	5
33.6	The health workers are given opportunity to make comments on the results of their performance.	1	2	3	4	5

**34. Please indicate the extent to which you agree with the following statements about performance improvement in your district by circling only one answer for each as follows: .**

**1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)**

	Statement	SD	D	U	A	SA
34.1	Timely action is taken when performance falls below the acceptable levels.	1	2	3	4	5
34.2	The performance reports are effectively used for decision-making.	1	2	3	4	5
34.3	The health worker's performance information is used to set priorities for personal improvement.	1	2	3	4	5
34.4	The staff are involved in decision about performance improvement.	1	2	3	4	5
34.5	This organisation has specific processes to manage changes in policies, programmes, or infrastructure.	1	2	3	4	5
34.6	My supervisors encourage me to use different ways to improve my performance.	1	2	3	4	5
34.7	Rewards and sanctions are based on performance results.	1	2	3	4	5
34.8	The analysis of employee's training needs is based on the performance appraisal reports.	1	2	3	4	5
34.9	There are procedures to collect suggestions for performance improvement from the employees.	1	2	3	4	5
34.10	I always have access to my supervisor when I need support.	1	2	3	4	5

35. Please indicate the extent to which you agree with the following statements regarding the rewarding system in your district by circling only one answer for each as follows:

1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)

	Statement	SD	D	U	A	SA
35.1	I am paid in accordance with my experience.	1	2	3	4	5
35.2	My salary is according to my job responsibilities.	1	2	3	4	5
35.3	Hard work is acknowledged and rewarded accordingly.	1	2	3	4	5
35.4	All health workers know their fringe benefits.	1	2	3	4	5
35.5	I am satisfied with the fringe benefits I get from my organisation.	1	2	3	4	5
35.6	I feel my organisation offers sufficient opportunities for promotion	1	2	3	4	5

36. Please indicate the extent to which you agree with the following statements concerning staff training and development system in your district by circling only one answer for each as follows:

1= Strongly disagree (SD); 2= Disagree (D); 3= Undecided (U); 4= Agree (A); 5= Strongly agree (SA)

	Statement	SD	D	U	A	SA
36.1	This organisation has a staff training and development policy.	1	2	3	4	5
36.2	Opportunities exist for career advancement in this organisation.	1	2	3	4	5
36.3	Appropriate training is conducted to ensure that health workers carry out their duties well.	1	2	3	4	5
36.4	Job-specific refresher courses are provided on regular basis.	1	2	3	4	5
36.5	The in-service training provided is adequate in addressing the existing skills gaps.	1	2	3	4	5
36.6	Health workers who are less competent are provided with the necessary support to improve their knowledge and skills.	1	2	3	4	5
36.7	Health workers participate in identifying their career development needs.	1	2	3	4	5
36.8	In the last 6 months my supervisors discussed with me my career development prospects.	1	2	3	4	5
36.9	I have received the training required to succeed in my position.	1	2	3	4	5

37. Overall how do you rate yourself on based on the following statements? Please indicate your responses by circling only one answer for each statement as follows:

1= Very poor (VP); 2= Poor (P); 3= Average (Av); 4= Good (G); 5= Very good (VG)

	Statement	VP	P	Av	G	VG
37.1	My overall performance is...	1	2	3	4	5
37.2	My competence to deliver services is...	1	2	3	4	5
37.3	The quality of service I provide in this facility is...	1	2	3	4	5
37.4	My overall daily attendance is...	1	2	3	4	5
37.5	My overall productivity is...	1	2	3	4	5
37.6	The overall responsiveness of the services I provide is...	1	2	3	4	5

38. In your opinion what suggestions can you make on how your performance can be improved? List at least 4 options in the space provided below.

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

**THANK YOU FOR PARTICIPATING IN THE SURVEY**

## ANNEXURE I: INTERVIEW SCHEDULE FOR THE HEALTH SERVICE MANAGERS

Serial No:

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### SECTION A: BIOGRAPHIC DATA

1. What is your district of work?

Kumi	1
Mbale	2
Sironko	3
Tororo	4

2. For how long have you worked in this district? .....

3. What is your gender?

Female	1
Male	2

4. What is your age category?

less than 20 years	1
20-29 years	2
30-39 years	3
40-49 years	4
50 -59 years	5
60 years and above	6

5. Do you have any human resource/management qualification/training? **Circle only one answer.**

Yes	1
No	2

*If yes, what type of training/programme?*

.....

6. Are there any forums/opportunities where performance of health workers is discussed? **Circle the appropriate answer.**

Yes	1
No	2

7. If you answer 'Yes' to 6 above, at which of the levels indicated here below are they held? **Circle whatever is applicable.**

Levels	Yes	No
Ministry of Health	1	2
District	1	2
Health Sub-district	1	2
Health facility	1	2
One-to-one	1	2

## **SECTION B: OPEN-ENDED QUESTIONS**

8. Performance of health workers seems to be a major challenge facing health care organisations in Uganda. In your view
  - 8.1 What are the most important aspects or factors that enhance the performance of health workers in your district?
  - 8.2 What are the most important aspects or factors that hinder the performance of health worker in your district?
9. Decentralisation of health services was meant 'to improve the accountability, efficiency and effectiveness in the delivery of services. Some commentators are blaming the sub-optimal performance of health workers to decentralisation in Uganda.'
  - 9.1 In your organisation, how has decentralisation affected the performance of health workers?
10. Health workers' behaviour has an important contribution towards delivery of services in their respective health facilities. How do you describe the behaviour of health workers under the following areas:
  - 10.1 Behaviours towards the patients/clients?
  - 10.2 Adaptive behaviour to changes in the health sector?
  - 10.3 Proactive behaviour with regards to innovativeness towards service delivery?
  - 10.4 Proficiency behaviour for performance?
11. In your district, how do you describe the following as regards to health workers:
  - 11.1 Availability?
  - 11.2 Competence?
  - 11.3 Responsiveness?
  - 11.4 Productivity?
12. In your opinion, what could be done to improve the performance of health workers in this organisation or district?
13. Noe et al (2008:344), describe performance management as "a means through which managers ensure that employees' activities and outputs are in line with the organisation's goals". In your organisation or district, how do you implement the following activities geared towards managing health worker performance?
  - 13.1 Plan for performance appraisal of health workers?
  - 13.2 Measure performance of health workers?
  - 13.3 Reporting performance of health workers?
  - 13.4 Recognise performance of health workers?
14. In your organisation, how do you use the information obtained during health workers' performance evaluation?
15. Do you have any suggestion on how the process of performance appraisal of health workers in your organisation or district can be improved?

***THANK YOU FOR PARTICIPATING IN THE SURVEY***



**ANNEXURE J: TESTS FOR NORMALITY OF DATA FROM HEALTH WORKERS' QUESTIONNAIRE**

	Kolmogorov-Smirnov <sup>a</sup>			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Q12. Self monitoring ability	.122	276	.000	.936	276	.000
Q13. Self motivation (Intrinsic Motivation)	.263	276	.000	.755	276	.000
Q14. Commitment to the organisation	.261	276	.000	.805	276	.000
Q15. Individual values and beliefs	.210	276	.000	.840	276	.000
Q16. Individual proficiency behaviours	.193	276	.000	.888	276	.000
Q17. Individual adaptive behaviours	.271	276	.000	.846	276	.000
Q18. Individual proactive behaviours	.299	276	.000	.796	276	.000
Q19. Individual client oriented behaviours	.180	276	.000	.856	276	.000
Q20. Clarity of the organisation strategy	.125	276	.000	.918	276	.000
Q21. Working environment	.160	276	.000	.923	276	.000
Q22. Staffing of your organisation	.196	276	.000	.918	276	.000
Q23. Your work schedule	.169	276	.000	.924	276	.000
Q24. Your organisation culture	.193	276	.000	.918	276	.000
Q25. Responsiveness of the services you provide	.242	276	.000	.896	276	.000
Q26. Availability of health workers	.262	276	.000	.828	276	.000
Q27. Productivity of health workers	.193	276	.000	.913	276	.000
Q28. Competence of health workers	.131	276	.000	.927	276	.000
Q31. Setting of performance standards	.257	276	.000	.857	276	.000
Q32. Performance measurement in your district	.257	276	.000	.817	276	.000
Q33. Performance reporting in your district	.134	276	.000	.908	276	.000
Q35. Rewarding system in your district	.140	276	.000	.931	276	.000
Q36. Staff training and development in your district	.257	276	.000	.889	276	.000
Q37. Your overall performance	.238	276	.000	.804	276	.000
Q34. Performance improvement in your district	.187	276	.000	.891	276	.000
Q11. Skills and abilities	.127	276	.000	.931	276	.000

a. Lilliefors Significance Correction

**ANNEXURE K: CORRELATION MATRICES BETWEEN INDIVIDUAL ATTRIBUTES AND PERFORMANCE DIMENSIONS**

**Correlations**

Spearman's rho rank order Non parametric correlations			Q11. Skills and abilities	Q12. Self monitorin g ability	Q13. Self motivation (Intrinsic Motivation )	Q14. Commitm ent to the organisati on	Q15. Individual values and beliefs	Q25. Responsi veness of the services your provide	Q26. Availabilit y of health workers	Q27. Productivi ty of health workers	Q28. Compete nce of health workers
Spearman's rho	Q11. Skills and abilities	Correlation Coefficient	1.000	.353**	.161**	.130	-.098	.180**	.018	.453**	.998**
		Sig. (2-tailed)	.	.000	.007	.030	.105	.003	.770	.000	.000
		N	276	276	276	276	276	276	276	276	276
	Q12. Self monitoring ability	Correlation Coefficient	.353**	1.000	.766**	.533**	.536**	.391**	.642**	.067	.316**
		Sig. (2-tailed)	.000	.	.000	.000	.000	.000	.000	.269	.000
		N	276	276	276	276	276	276	276	276	276
	Q13. Self motivation (Intrinsic Motivation)	Correlation Coefficient	.161**	.766**	1.000	.877**	.858**	.687**	.798**	.371**	.586**
		Sig. (2-tailed)	.007	.000	.	.000	.000	.000	.000	.000	.000
	N	276	276	276	276	276	276	276	276	276	
Q14. Commitment to the organisation	Correlation Coefficient	.130	.533**	.877**	1.000	.671**	.794**	.820**	.439**	.452**	
	Sig. (2-tailed)	.030	.000	.000	.	.000	.000	.000	.000	.000	
	N	276	276	276	276	276	276	276	276	276	
Q15. Individual values and beliefs	Correlation Coefficient	-.098	.536**	.858**	.671**	1.000	.617**	.570**	.346**	.577**	
	Sig. (2-tailed)	.105	.000	.000	.000	.	.000	.000	.000	.000	
	N	276	276	276	276	276	276	276	276	276	
Q25. Responsiveness of the services your provide	Correlation Coefficient	.180**	.391**	.687**	.794**	.617**	1.000	.908**	.515**	.437**	
	Sig. (2-tailed)	.003	.000	.000	.000	.000	.	.000	.000	.000	
	N	276	276	276	276	276	276	276	276	276	
Q26. Availability of health workers	Correlation Coefficient	.018	.642**	.798**	.820**	.570**	.908**	1.000	.484**	.416**	
	Sig. (2-tailed)	.770	.000	.000	.000	.000	.000	.	.000	.000	

	N	276	276	276	276	276	276	276	276	276
Q27. Productivity of health workers	Correlation Coefficient	.453**	.067	.371**	.439**	.346**	.515**	.484**	1.000	.031
	Sig. (2-tailed)	.000	.269	.000	.000	.000	.000	.000	.	.603
	N	276	276	276	276	276	276	276	276	276
Q28. Competence of health workers	Correlation Coefficient	.998**	.316**	.586**	.452**	.577**	.437**	.416**	.031	1.000
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.603	.
	N	276	276	276	276	276	276	276	276	276

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

**ANNEXURE L: CORRELATION MATRICES BETWEEN INDIVIDUAL BEHAVIOURS AND PERFORMANCE DIMENSIONS**

**Correlations**

Spearman's <i>rho</i> rank order Non parametric correlations			Q16. Individual proficiency behaviours	Q17. Individual adaptive behaviours	Q18. Individual proactive behaviours	Q19. Individual client oriented behaviours	Q25. Responsiv eness of the services your provide	Q26. Availability of health workers	Q27. Productivit y of health workers	Q28. Competen ce of health workers
Spearman's rho	Q16. Individual proficiency behaviours	Correlation Coefficient	1.000	.593**	.597**	.823**	.856**	.724**	.235**	.562**
		Sig. (2-tailed)	.	.000	.000	.000	.000	.000	.000	.000
		N	276	276	276	276	276	276	276	276
	Q17. Individual adaptive behaviours	Correlation Coefficient	.593**	1.000	.455**	.396**	.623**	.659**	.343**	.643**
		Sig. (2-tailed)	.000	.	.000	.000	.000	.000	.000	.000
		N	276	276	276	276	276	276	276	276
	Q18. Individual proactive behaviours	Correlation Coefficient	.597**	.455**	1.000	.409**	.598**	.759**	.262**	.359**
		Sig. (2-tailed)	.000	.000	.	.000	.000	.000	.000	.000
		N	276	276	276	276	276	276	276	276
	Q19. Individual client oriented behaviours	Correlation Coefficient	.823**	.396**	.409**	1.000	.669**	.537**	.396**	.449**
		Sig. (2-tailed)	.000	.000	.000	.	.000	.000	.000	.000
		N	276	276	276	276	276	276	276	276
	Q25. Responsiveness of the services your provide	Correlation Coefficient	.856**	.623**	.598**	.669**	1.000	.908**	.515**	.437**
		Sig. (2-tailed)	.000	.000	.000	.000	.	.000	.000	.000
		N	276	276	276	276	276	276	276	276
	Q26. Availability of health workers	Correlation Coefficient	.724**	.659**	.759**	.537**	.908**	1.000	.484**	.416**
		Sig. (2-tailed)	.000	.000	.000	.000	.000	.	.000	.000
		N	276	276	276	276	276	276	276	276
	Q27. Productivity of health workers	Correlation Coefficient	.235**	.343**	.262**	.396**	.515**	.484**	1.000	.031
		Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.	.603

	N	276	276	276	276	276	276	276	276
Q28. Competence of health workers	Correlation Coefficient	.562**	.643**	.359**	.449**	.437**	.416**	.031	1.000
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.603	.
	N	276	276	276	276	276	276	276	276

\*\* . Correlation is significant at the 0.01 level (2-tailed).

## ANNEXURE M: CORRELATION MATRICES BETWEEN ORGANISATIONAL FACTORS AND PERFORMANCE DIMENSIONS

### Correlations

Spearman's <i>rho</i> rank order Non parametric correlations			Q20. Clarity of the organisati on strategy	Q21. Working environm ent	Q22. Staffing of your organisati on	Q23. Your work schedule	Q24. Your organisati on culture	Q25. Responsi veness of the services your provide	Q26. Availabilit y of health workers	Q27. Productivi ty of health workers	Q28. Compete nce of health workers
Spearman' s rho	Q20. Clarity of the organisation strategy	Correlation Coefficient Sig. (2-tailed) N	1.000  276	.807**  276	.700**  276	.519**  276	.841**  276	.747**  276	.756**  276	.600**  276	.473**  276
	Q21. Working environment	Correlation Coefficient Sig. (2-tailed) N	.807**  276	1.000  276	.920**  276	.873**  276	.965**  276	.889**  276	.963**  276	.451**  276	.332**  276
	Q22. Staffing of your organisation	Correlation Coefficient Sig. (2-tailed) N	.700**  276	.920**  276	1.000  276	.824**  276	.916**  276	.814**  276	.908**  276	.592**  276	.176**  276
	Q23. Your work schedule	Correlation Coefficient Sig. (2-tailed) N	.519**  276	.873**  276	.824**  276	1.000  276	.811**  276	.742**  276	.869**  276	.268**  276	.206**  276
	Q24. Your organisation culture	Correlation Coefficient Sig. (2-tailed) N	.841**  276	.965**  276	.916**  276	.811**  276	1.000  276	.890**  276	.934**  276	.538**  276	.386**  276
	Q25. Responsiveness of the services your provide	Correlation Coefficient Sig. (2-tailed) N	.747**  276	.889**  276	.814**  276	.742**  276	.890**  276	1.000  276	.908**  276	.515**  276	.437**  276
	Q26. Availability of health workers	Correlation Coefficient	.756**	.963**	.908**	.869**	.934**	.908**	1.000	.484**	.416**

	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.	.000	.000
	N	276	276	276	276	276	276	276	276	276
Q27. Productivity of health workers	Correlation Coefficient	.600**	.451**	.592**	.268**	.538**	.515**	.484**	1.000	.031
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.	.603
	N	276	276	276	276	276	276	276	276	276
Q28. Competence of health workers	Correlation Coefficient	.473	.332	.176	.206	.386	.437	.416	.031	1.000
	Sig. (2-tailed)	.000	.000	.003	.001	.000	.000	.000	.603	.
	N	276	276	276	276	276	276	276	276	276

\*\* . Correlation is significant at the 0.01 level (2-tailed).

**ANNEXURE N: CORRELATION MATRIX BETWEEN PERFORMANCE MANAGEMENT AND PERFORMANCE DIMENSIONS**

Spearman's <i>rho</i> rank order Non parametric correlations			Q31. Setting of perform ance standar ds	Q32. Perform ance measur ement in your district	Q33. Perform ance reportin g in your district	Q34. Perform ance improve ment in your district	Q35. Rewardi ng system in your district	Q36. Staff training and develop ment in your district	Q25. Respon siveness of the services your provide	Q26. Availabi lity of health workers	Q27. Producti vity of health workers	Q28. Compet ence of health workers
Spearman's rho	Q31. Setting of performance standards	Correlation Coefficient Sig. (2-tailed) N	1.000 .276	.893** .000 276	.875** .000 276	.803** .000 276	.717** .000 276	.738** .000 276	.842** .000 276	.885** .000 276	.569** .000 276	.365** .000 276
	Q32. Performance measurement in your district	Correlation Coefficient Sig. (2-tailed) N	.893** .000 276	1.000 .000 276	.860** .000 276	.629** .000 276	.496** .000 276	.614** .000 276	.676** .000 276	.644** .000 276	.469** .000 276	.349** .000 276
	Q33. Performance reporting in your district	Correlation Coefficient Sig. (2-tailed) N	.875** .000 276	.860** .000 276	1.000 .000 276	.787** .000 276	.710** .000 276	.714** .000 276	.728** .000 276	.712** .000 276	.680** .000 276	.094 .120 276
	Q34. Performance improvement in your district	Correlation Coefficient Sig. (2-tailed) N	.803** .000 276	.629** .000 276	.787** .000 276	1.000 .000 276	.860** .000 276	.892** .000 276	.874** .000 276	.861** .000 276	.349** .000 276	.195** .001 276
	Q35. Rewarding system in your district	Correlation Coefficient Sig. (2-tailed) N	.717** .000 276	.496** .000 276	.710** .000 276	.860** .000 276	1.000 .000 276	.737** .000 276	.735** .000 276	.871** .000 276	.435** .000 276	.319** .000 276
	Q36. Staff training and development in your district	Correlation Coefficient Sig. (2-tailed) N	.738** .000 276	.614** .000 276	.714** .000 276	.892** .000 276	.737** .000 276	1.000 .000 276	.799** .000 276	.801** .000 276	.387** .000 276	.842** .000 276
	Q25. Responsiveness	Correlation Coefficient	.842**	.676**	.728**	.874**	.735**	.799**	1.000	.908**	.515**	.437**



s of the services your provide	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000
	N	276	276	276	276	276	276	276	276	276	276
Q26. Availability of health workers	Correlation Coefficient	.885**	.644**	.712**	.861**	.871**	.801**	.908**	1.000	.484**	.416**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.	.000	.000
	N	276	276	276	276	276	276	276	276	276	276
Q27. Productivity of health workers	Correlation Coefficient	.569**	.469**	.680**	.349**	.435**	.387**	.515**	.484**	1.000	.031
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	.	.603
	N	276	276	276	276	276	276	276	276	276	276
Q28. Competence of health workers	Correlation Coefficient	.365**	.349**	.094	.195**	.319**	.842**	.437**	.416**	.031	1.000
	Sig. (2-tailed)	.000	.000	.120	.001	.000	.000	.000	.000	.603	.
	N	276	276	276	276	276	276	276	276	276	276

\*\* . Correlation is significant at the 0.01 level (2-tails)

