

UNIVERSITY OF KWAZULU-NATAL

**ACTION STRATEGIES FOR ENHANCING THE
IMPLEMENTATION OF PERFORMANCE IMPROVEMENT
INITIATIVES WITHIN THE HEALTH SECTOR IN BOTSWANA**

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Graduate School of Business and Leadership

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(i)

DECLARATION

I, Lasting Ketsile Kachingwe, declare that

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(ii)

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ABSTRACT

This study investigates the extent to which performance improvement initiatives are efficiently and effectively implemented in the Botswana health sector. The study is prompted by numerous public complaints through various media, the results of customer satisfaction surveys that lowly rated the delivery of health services, and the acknowledgement by public officials that the provision of services, particularly health services, left a lot to be desired. The perceived under-performance in the delivery of health services to the public was in spite of the significant health sector expenditure that is in line with the Governments' efforts to prioritise the improvement of the health status of the nation and the introduction of performance improvement initiatives.

The study assesses the evidential base for sustaining a three-fold hypothesis, that is: performance improvement initiatives were imposed in a top-down manner in the Botswana health sector with the noble belief that they were valuable in contributing towards the achievement of the goals of Vision 2016; there is limited knowledge on the part of the health workers at the operational level regarding the usefulness of the performance improvement initiatives and this contributes to their low uptake of the initiatives in Botswana health sector; and the frequency of complaints by health services consumers is a reflection of the poor quality of health services provided in the health sector in Botswana.

The perceptions of staff and patients regarding the quality indicators of efficiency, effectiveness, empowerment and equity were examined. Data collection was triangulated through the use of different data collection methods and the collection of data from different sources such as self-administered questionnaires for senior management in the Ministry of Health, in-depth interviews of health workers and consumers of health services in the form of patients and Focus Group Discussions for community members. The health facilities under study in the public sector were stratified according to the level of operation with systematic sampling used to select hospitals from each level.

The conclusions of the study, based on the empirical work, is that although the staff proved to be knowledgeable of the existence of the performance improvement initiatives, there was a moderate effectiveness of the initiatives in the public health sector with a higher success rate in the private health sector. The efficiency with which the initiatives were implemented was compromised by the perceived internal inequities and poor conditions of service as well as low remuneration packages for health sector staff. The consumers of health services indicated their satisfaction with the equitable distribution of

services. There were weaknesses in the empowerment mechanisms for both health workers and consumers of health services. The findings revealed inadequacies in the implementation of the initiatives. Positive results were noted for the empowerment of employees through their participation in the planning for health services delivery.

Recommendations include: the need to strengthen the community interface with health service providers; the inculcation into health workers of values that prioritise the interests of clients; the involvement of all stakeholders in planning; and the contextualisation of the performance improvement initiatives.

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CHAPTER ONE

1. PUBLIC SECTOR HEALTH POLICY IN BOTSWANA: OVERVIEW

1.1 Introduction

This chapter sets the scene for the research by outlining the major milestones in the Government of Botswana's approach to the public sector policy since the attainment of political independence from British rule. The chapter provides a description of the national health system and its development since independence. Some pertinent Acts with a bearing on the delivery of health care have been quoted together with the roles of the main actors in the provision of health services.

1.2 Background to provision of national health services

Botswana is a landlocked Southern African country which is bordered by Zimbabwe in the north-east, South Africa in the south and south-east as well as Namibia to the west. National independence from British rule was attained on 30th September 1966. According to the Web Population Projection, the population of Botswana is expected to be 1 826 022 by the year 2011.

Since the attainment of national independence, a network of clinics, mobile health services, primary, district and referral hospitals has been developed for the delivery of health services to the nation. The Botswana government health policy, since 1973, has been based on the provision of basic health services through health posts in every village with a population of over four hundred people as well as clinics within a fifteen kilometre radius in each village of more than four thousand people (Parsons 1999). The health facilities in the country consist of referral, district, and primary hospitals, as well as clinics and private practitioner centres. Since the 1980s, investments have been made in three national referral hospitals, that is, the Princess Marina Hospital in Gaborone, the Nyangabgwe Hospital in Francistown and the Lobatse Mental Hospital. The health facilities include three private or mine hospitals in Botswana, two belonging to Debswana and one run by BCL Mine as well as the Gaborone Private Hospital.

1.2.1 Botswana Ministry of Health Departments: Headquarters

a) Department of Clinical Services

The Department of Clinical Services exists for the purpose of providing quality preventative, curative and rehabilitative care to patients in public hospitals. Its specific objectives are to: provide patient care services in public hospitals; develop and ensure implementation of policies and professional standards of practice for patient care; develop and provide quality assurance systems in patient care; monitor and evaluate patient care services; and provide hospital-based rehabilitation services.

b) Department of Public Health

The Department of Public Health has the purpose of developing and implementing public health policy as well as ensuring that public health goals are met. The accomplishment of this broad aim involves the undertaking of operations that include planning, coordination, setting standards, monitoring and evaluation of public health services as well as providing technical support and guidance to stakeholders. The more specific objectives of the department range from: provision of leadership in matters pertaining to public health services; facilitation of the availability, interpretation and elaboration of relevant public health policies, including legislation, standards and regulations; development and implementation of a system for planning, resource mobilization and coordination of public health services; development and execution of appropriate in-service training programmes and curricula, as well as undertaking relevant research to strengthen public health programmes and operations; development, promotion and strengthening collaboration with communities; and provision, coordination and support for public health services.

c) Department of AIDS Prevention and Care

The Department of HIV/AIDS Prevention and Care serves the purpose of providing leadership in the provision of comprehensive HIV/AIDS services in the health sector. The means by which the leadership activities are achieved are through the facilitation of policy and programme development to enable the health system to adequately respond to the provision of preventive and curative care as well as support services of HIV/AIDS. The specific objectives of the Department are: development and implementation of strategies, interventions and programmes for the prevention of HIV and other Sexually Transmitted Infections (STIs); provision of leadership and guidance in the coordination and implementation of treatment, care and support services at all levels for people infected and affected by HIV and AIDS;

provision of technical and institutional support to projects, programmes, institutions, organizations, NGOs and CBOs including the Traditional Healers and the People Living With HIV and AIDS (PLWHA) in health related interventions; coordination and implementation of the HIV/AIDS/STI information management system and ensure its integration into the health sector programmes; and the development of the capacity for HIV/AIDS/STI programme implementation and management in the health sector through coordination and facilitation of HIV/AIDS training.

d) Department of Health Policy Development, Monitoring and Evaluation

The Department of Health Policy Development, Monitoring and Evaluation (HPDME) was established in 2010 as a result of the restructuring exercise. The purpose of the department is to provide strategic direction and support on issues pertaining to health policy, planning, research and information management. Its specific objectives are to: coordinate national health sector planning at inter-departmental, inter-ministerial and national level; provide health policy, planning and research expertise to the Ministry; coordinate the provision of health management information systems; develop and review health financing policies and strategies; and develop health service monitoring and evaluation mechanisms.

e) Department of Health Inspectorate

The Department of Health Inspectorate has the purpose of coordinating health inspectorate functions which used to be widely dispersed in different government organisations. The department ensures that health facilities maintain high operational standards to promote and protect the rights of the customers and that health inspections are carried out efficiently.

f) Department of Corporate Services

The Department of Corporate Services has functions that are, in the main, generic to government departments in Botswana. It provides leadership in the coordination and management of the Ministerial human, financial and material resources as well as implementation of public service policy. It provides expertise in carrying out general human resource management and financial or accounting activities such as: recruitment; staff development; promotions; terminations; budgeting; and procurement. The specific divisions of the Department of Corporate Services are the: Development, Finance and Procurement which

is responsible for the financial management of the Ministry; Human Resource Management which is responsible for recruitment, training, staff wellness, industrial relations and human resource planning; coordination of the Institutes of Health Sciences; Office Operations, which coordinates the management of records, transport, secretarial, messengerial and security services; and Performance Improvement, which coordinates and monitors the implementation of government reforms and produces performance reports.

1.3 Vision 2016

Strategies have been developed to activate the government policies, including in the health sector. The Vision 2016 is an initiative whose strategies are geared towards attaining the nation's aspirations of an educated, informed, prosperous, productive and innovative; compassionate, just and caring; safe and secure; open, democratic and accountable; moral and tolerant; and a united and proud nation. An eighth area that addresses the needs of the youths was introduced in 2010. The Vision contains ideals for distributing income equitably, and eradicating poverty by the year 2016. It is anticipated that all Botswana will have access to good quality health services, sanitation and nutrition. Linkages existed between the Vision 2016 and the ninth National Development Plan (NDP9) since the latter is designed to put the Vision into practice.

The NDP 8 (1997/1998 – 2002/2003) specifically aimed at improving the efficiency and cost-effectiveness of health care delivery; ensuring equitable distribution of services; improving the quality of health care; training appropriate skilled personnel; and strengthening primary health care programmes. The NDP9 (2003/2004 – 2008/2009) prioritises human resources development; health sector reform; strengthening of primary, secondary and tertiary health services; and HIV/AIDS.

The Ministry of Health Corporate Plan targets the provision of quality health services to Botswana in order to;

1. Improve their health status.
2. Improve life expectancy through the implementation of the Primary Health Care (PHC) strategy.
3. Provide customer focused health services for the attainment of customer satisfaction
4. Improve quality service delivery through the development and implementation of comprehensive health policies and standards by the end of NDP9.

5. Enhance the Ministry of Health's efficiency and effectiveness through the implementation of innovative performance improvement initiatives.
6. Review existing human resources for health plans in order to produce a comprehensive plan consistent with the health needs of the country.

According to the final report of the Organisational Review of the Botswana Ministry of Health (2002), the Ministry's Corporate Plan needs to establish closer linkages between objectives, strategies, resources, targets, implementation machinery and its capacity. This was taking into cognisance the fact that when an organisation has a neat package of objectives it does not automatically lead to the conclusion that implementation success is guaranteed.

A worrisome point reflected in the Organisational Review is the observation that channels for communication between the various health sector components are not always utilised optimally. The Review further notes that communications with other service providers in the health sector, like Mission Hospitals and NGOs, seem to be mostly on an ad-hoc basis. Identified as a key issue is how the dual functions of policy formulation and policy implementation are handled by the Ministry of Health, and how they can be best organised in the future. This issue needs to be examined with a view to streamlining these functions. The Review document aptly states that the impact of the Corporate Performance Plan will only be realised by its effective implementation.

1.4 Challenge posed by HIV/AIDS Scourge

According to Kandala, *et al* (2012:96) "Botswana has the second-highest HIV infection rate in the world after Swaziland, with one in three adults infected." In Botswana, national development planning efforts target HIV/AIDS with a view to reducing the HIV incidence and prevalence rates. Key health indicators such as life expectancy and child mortality have deteriorated due to the HIV/AIDS impact. Lule and Haacker (2012) note that the epidemic affects public servants as well as the general population with the consequent depletion of fiscal revenues. HIV/AIDS has, therefore, the potential to not only deplete financial resources but the human resources as well, that are critical for the implementation of performance improvement initiatives in the health sector and the public service in general. Overall, the impact of HIV/AIDS has had negative socio-economic consequences.

Botswana introduced the first programme of providing free antiretroviral therapy to its citizens in Sub-Saharan Africa in 2002. According to the World Health Organisation (2011) the country has since

achieved universal treatment access, with at least 80% of citizens in need of HIV/AIDS therapy receiving it. The government prioritisation of the measures to control the spread of HIV are noted in the fact that a huge amount of national resources have been spent on campaigns to reduce the infection rates compared to other sub-Saharan African countries that depend mainly on foreign aid.

Recent surveys have indicated a decline in HIV incidence but new infections and the large number of people who are already infected are still a cause for concern. In line with the aims of Vision 2016, the country has a long-term vision of having no new HIV infections by 2016. In order to achieve this goal, there is need for a sustained HIV prevention campaign and this was aptly stated by the former President of Botswana, Festus Mogae, as reported in the local Mmegi/The Reporter newspaper (2008) when he said that the prevention of new infections should be the first, second and third priority. The threat posed by HIV/AIDS to the country's development efforts has to be taken seriously because even the national ambitions stated in Vision 2016 may not be realised if the rate of HIV infections is not halted significantly.

1.5 Government approach to public sector policy

Although the study is on the health sector, which includes the private health providers of services, more emphasis is given to the public sector since, as Sebusang and Moeti (2005:93) note, Botswana 'depends largely on the public sector for the delivery of goods and services.' Lane (1995) writes that the public sector comprises a variety of institutions for the making and implementation of decisions with regard to various interests of the public. Through public institutions, various interests are coordinated by the making and implementation of policy, while in the private sector, there are market institutions that offer mechanisms for the coordination of different interests (Lane, 1995:13). Mackintosh, (cited in Hope, Sr. and Somolekae 1998:3) defines public policy as 'purposive action undertaken or defended by public institutions to promote the welfare of society'. Hope, Sr. and Somolekae state that since Independence, the Government approach to policy formulation and implementation has often been technocratic without much input from or participation by ordinary citizens in the public policy-making process.

The public policy formulation process has largely been centralised, especially in the Ministry of Finance and Development, followed by Cabinet consideration of policies before devolution to Ministries for implementation. Tsie, (cited in Hope, Sr. and Somolekae 1998) argues that top civil servants have been the main actors in the formulation of public policies in Botswana. Civil society, on the other hand, has

had little influence in public policy-making due to the weakness of civil society institutions. The weakness of civil society has been attributed to its tendency of promoting the interest of members without addressing relationships with the state. In agreement with this view regarding civil society, Molutsi (1995) concluded that the state has had the tendency to label and isolate some civil society organizations as political while some sections of civil society have been labelled as agents of foreign interests.

The main thrust of the public policy-making process after independence was to address the imbalances that had resulted from the colonial policies whereby there was not much meaningful development in the country. Government policies were geared towards achieving economic growth for the sustained increase in the production of goods and services and the reduction of poverty, unemployment, gender inequalities and the provision of social services such as education, health, housing and clean water to the nation. Harvey and Lewis, Jr. (1994:1) write that from 1965 to 1985, Botswana had the most rapid rate of growth of Gross National Product (GNP) per capita (8.3%) in the world. This remarkable performance is attributable to a visionary political leadership. Harvey and Lewis, Jr. (1994:10) note, though, that some critics have raised concern that although there was a fast rate of economic development after the attainment of National Independence, such development tended to benefit the urban elite at the expense of the rural population resulting in an increasingly unequal distribution of wealth. Another weakness noted in the post-independence era has been the dependence of the country on foreign skilled labour leading to suspicions that the benefits of economic development have accrued to foreigners rather than to citizens of Botswana.

Harvey and Lewis, Jr. (1994:283) observe that as from 1973-1978, one of the main priorities of the Botswana government was the provision of basic health facilities throughout the country. Health related efforts were directed at making improvements in the provision of water and sanitation as well as supplementary feeding for children. The 1970s decentralisation of services in the public sector was, according to Lauglo (1996) a way of realising broader policy goals such as furthering development, enhancing democracy, implementing the Primary Health Care strategy and increasing operational efficiency.

Somolekae (1992:24) notes that since the early 1980s, there has been less emphasis on the expansion of public institutions, which was a feature of the Government policy up to then with more attention paid to public service efficiency and effectiveness. Kaunda (2004) observes that public service reforms, at the micro-level, included initiatives such as Organisation and Methods (O & M) reviews, Job Evaluation, Work Improvement Teams (WITS) and the Performance Management System (PMS). There was a

paradigm shift from the traditional or bureaucratic model of public administration to a results-oriented new public management (NPM), a world-wide trend. A feature of the public service reforms was the aim of reducing state intervention in economic affairs by streamlining the size and functions of public sector institutions. Kaunda (2004:2) observes that although Botswana has been successful in terms of economic growth, there has been concern at the poor performance of the public sector.

Concern over poor public sector performance has been expressed in the National Development Plans (NDPS), annual budget speeches and the Vision 2016 document which have identified low productivity and weak implementation capacity as some of the major reasons hampering the realisation of public policies. Kaunda (2004:3) states that a 2003 study conducted by the Botswana Institute of Development Policy Analysis (BIDPA) in the public sector revealed ‘lack of clarity of functions, roles and responsibilities ... ignorance of policy objectives, strategies and expected outcomes by line officers, and a general lack of human capacity and skills.’ The BIDPA study also revealed that although decentralisation was considered as one of the measures of reforming the public service, there was no comprehensive decentralisation policy and this tended to compound the organisational and implementation problems in the public service. These findings were congruent with the observation by Sebusang and Moeti (2005:94) that despite the stated aim of decentralising the public service, ‘the government seems bent on centralising authority ...’. The study by Sebusang and Moeti (2005), which assessed the extent to which the Botswana public service adopted customer-centric work models concluded that the public service is still not delivering to customer expectations.

Kaunda (2004:3) refers to a 2003 study on decentralisation which had results that indicated that recipients of public services had perceptions of low efficiency and effectiveness as well as poor responsiveness of the service to public demands. The implications of these observations were that the initiatives such as O & M, WITS and PMS have not necessarily produced the desired results in service provision. Following this 2003 study, one of the means identified for improving public access to services was the strengthening of public participation in the development process. This tallies with the argument presented by Tsie (cited in Hope, Sr. and Somolekae 1998) that after the attainment of independence the public service exhibited a top-down supply-driven approach with only a token involvement of users in the planning decisions. Tsie (cited in Hope, Sr. and Somolekae 1998) supports the involvement of recipients of services in decision-making because they are well-placed to identify and help resolve service delivery failures. He advocates a bottom-up, demand-driven approach as one way of remedying policy implementation problems. Lekorwe (cited in Hope, Sr. and Somolekae 1998:91) cautions against the type of policy consultations that occurs in the *kgotla* ‘as they tend to be superficial and to some extent give

only a semblance of consultation.’ The importance of enabling the public to have access to services is that it would avoid denying the intended beneficiaries the enjoyment of services that they are entitled to.

1.6 Botswana position on public-private partnership (PPP) with specific reference to health service provision

Professor Bonu, (2002) in a case study article on the public private partnership in Botswana defined a Public Private Partnership (PPP) as a collaborative joint venture ‘between public bodies such as central government or local authorities, and private Companies’ for the purpose of developing an economic activity. An important characteristic of a PPP arrangement is that the public and the private entities have stakes in the project. In their case study of the Pelonomi and Universitas Hospital Co-Location Project, Shuping and Kabane (2009) have their working definition of PPP as ‘a contractual arrangement between a public sector institution and a private party in which the private party performs an institutional function or uses state assets and assumes substantial financial, technical and operational risk in the design, financing, building and or operation of the project, in return for a benefit.’

In a PPP scheme, Government stands to benefit from the resource contribution of the private sector, for example, in the form of management skills and finances while the private sector tends to benefit from financial profits facilitated by the partnership. Bonu (2002) notes that with the attainment of independence in 1966, the Government of Botswana made a policy decision to have partnerships with the private sector in service and business ventures. To date, the government values and encourages public-private partnership and private investment. The Government’s economic diversification programme targets sectors with the potential to contribute to economic activity in areas like tourism, Information, Communication and Technology (ICT) mining financial services and the health sector.

The commitment of the Botswana Government to supporting the private sector in efforts towards national development is attested to by its formulation of the Privatisation Policy for Botswana (2000) which has, among other objectives, the improvement of efficiency and productivity of enterprises as well as relieving the financial and administrative burden of government in undertaking and maintaining a constantly expanding network of services and investments in infrastructure.

In the health sector, the Health Hub was established in the Ministry of Health in 2008 to identify projects and programmes for the purpose of making Botswana a centre of excellence in health service delivery.

The Health Hub made plans to utilise existing and future infrastructure to achieve objectives that include the following: outsource selected health services so as to improve the efficiency of service provision, outsource the freight logistics and pharmaceutical/medical distribution functions of the Central Medical Stores, and benefit from private sector capacity by leasing out entire hospitals or sections of them where necessary. Plans for outsourcing hospitals included the refurbishment of old hospitals for use by the private sector. Besides outsourcing of facilities, a model was being considered as at 2009 to outsource the maintenance of rural, district and central health facilities to the private sector. The challenge of maintenance and the management of non-clinical services were increasingly being viewed as non-core services of the Ministry of Health. Some of the hospitals ear-marked for outsourcing of the management of their facilities were Scottish Livingstone, Sekgoma Memorial, Mahalapye and Letsholathebe II District Hospitals and the Princess Marina and the Nyangabgwe Referral Hospitals. In addition to maintenance services, other areas to be outsourced were the catering, cleaning, and landscaping functions. Managers for the outsourced functions were to be employed on fixed term contracts based on service level performance.

1.7 Context of efficiency and effectiveness with regard to models of public/private mixes

It is generally accepted that efforts to implement public-private mix activities are influenced by the need to maximise benefits for citizens from the resources within these different sectors. The choice of a public-private partnership can be influenced by the political ideology of a country with capitalism being more oriented towards a free market and governments with a socialist leaning more inclined to implement managed markets in the public interest. In capitalist societies, the market is left to regulate the supply and demand of services while societies that pursue more egalitarian policies place the responsibility for ensuring that the public obtains quality health care on the government, although not necessarily by providing health care directly.

A fundamental reality is that optimum use should be made of the existing resources since they are limited. In the case of health services provision, the aim of the different models of public-private mix is to harness the strengths of the two sectors so that they work effectively and efficiently to afford communities appropriate health care.

A European Parliament publication entitled 'PUBLIC - PRIVATE PARTNERSHIPS Models and Trends in the European Union' (2006:2) identified the main variants of public-private partnerships as:

- a) Service contracts, whereby the private party procures, operates and maintains an asset for a short period with the public sector bearing the financial and management risks.
- b) Operation and management contracts, in which an asset that is owned by the public sector is operated and managed by the private sector, while the former bears the financial and investment risks. The financial benefits enjoyed by the private party are linked to performance targets. A typical example of this kind of public-private partnership in Botswana is the outsourcing of the management of sections of some hospitals to the private sector.
- c) Leasing-type contracts which are of three kinds, that is, Buy-Build-Operate (BBO), Lease-Develop-Operate (LDO), and the Wrap-Around Addition (WAA). In the lease-type contracts, the private sector buys or leases an existing asset from the government and then renovates it before operating it without any obligation to transfer ownership back to the government.
- d) Build-operate-transfer (BOT) arrangement which has different schemes such as Build-Own-Operate-Transfer (BOOT), Build-Rent-Own-Transfer (BROT), Build-Lease-Operate-Transfer (BLOT) and Build-Transfer-Operate (BTO).

In the BOT partnership, the private sector designs and builds an asset which it then operates before transferring ownership to the government at the end of the contract period.

- e) Design-Build-Finance-Operate (DBFO) partnership which has variants such as Build-Own-Operate (BOO), Build-Develop-Operate (BDO) and Design-Construct-Manage-Finance (DCMF).

In this kind of partnership, the private sector designs, builds, owns, develops, operates and manages an asset without having to transfer ownership to the government.

It was argued in the European Union publication that indications are that PPPs can largely be successful only in the sectors where service quality can be articulated and measured and hence difficulties are bound to be encountered in areas such as healthcare and education for the reason that their public-interest

objectives often conflict with the motivation for profit typical of the private sector. This observation could partly be responsible for developments in the mid 1980s whereby there was much widespread international mobilisation, including within the World Bank, for a smaller role to be played by the public sector in the provision of health services with promotion of the private sector as an option. This public sector management thinking was termed 'the new public management' and it had the goal of enhancing the efficiency of service provision through market mechanisms even though the extent to which evidence of private sector efficiency could be relied on was debatable.

It is generally accepted that the health care is characterised by market failure and information asymmetry and that the public sector has a tendency to inefficiently and ineffectively produce goods and services hence the provision of services should not be governed by market conditions. Regardless of the controversy over the supremacy of the private sector in relation to the public sector in matters of efficiency and effectiveness, many developing countries have embraced PPP initiatives with varying levels of success and they include Zambia, Tanzania, Mozambique, Malawi, Malaysia, South Africa, and Botswana. The debate, therefore, seems to have shifted from arguing about which is more efficient and effective, the public or the private sector, to the task of how to ensure that the positives of both these sectors are harnessed for the equitable distribution of efficient and effective health care.

1.8 General public sector management challenges

Thornhill (n.d.) wrote that the state has particular responsibilities concerning the well being of its citizens that it is expected to meet efficiently and effectively through the provision of public services. The author notes that in contemporary states, there is a thin line between the public and the private sectors, partly due to the complexity of society and the wide range of services that citizens demand in both developing and developed countries. Governments, in order to better handle the complex societal demands often resort to public-private partnerships or contracting of the private sector to undertake some activities.

Management of the public sector has peculiar challenges in that this sector is not primarily concerned with managing for profit but has activities that are guided by political structures. Thornhill (n.d.:1) observed that due to the complex nature of the societal demands, there is need to reconsider the prerequisites for effective and efficient service delivery since traditional approaches are outdated. New approaches are required even though there is still need for public accountability for actions undertaken, upholding transparency requirements and assessing the capacity of the state to deliver services.

Transparency, in particular, would facilitate the equitable allocation of resources and strengthen democratic governance. Thornhill (n.d.:6) stated that ‘It seems as though governments profess to promote transparency and take active steps to promote this principle. However, lack of commitment by public servants to adhere to the prescribed guidelines is a serious challenge that should be addressed to give practical effect to the principle.’

Ketelaar (2007) stated that in most societies, citizens’ daily activities revolve around the delivery of public services hence the quality of the services is an important determinant of their perceptions of government performance. Ketelaar (2007:1) observed that in many of the developing countries, public sector performance is not, ‘... on the whole, winning high marks for effectiveness among their constituents.’ The main challenges noted in the public sector of most developing countries include lack of discernible improvements in responsiveness and accountability to the public. Typical problems of public sector management relate to factors that encompass failure to retain qualified staff due to demotivating work environment such as unclear career paths and inadequate opportunities for professional development. High staff turnover contributes to difficulties in retaining institutional management knowledge. Even in instances where public sector management systems value performance-based measures for enhancing accountability, personnel issues such as promotions, pay increases and non-monetary rewards tend to be ignored and this hinders the effectiveness of public sector organisations. Ayee (2005) summarised the public sector challenges in Africa as being its propensity to accumulate excessive power, lack of accountability, indifference towards the needs of the public and inaccessibility.

A publication by the Economic Commission for Africa (2003) concluded that there is consensus that public sector performance in the area of service delivery needs to be revamped. The publication identified a number of challenges that have curtailed the quality of services provided to the public and these included lack of institutional capacity, lack of clarity of accountability relationships, declining public service ethics, declining civil service morale due to low salaries, poor working conditions and appointment based on patronage, corruption, inadequate physical infrastructure as well as office equipment and other facilities required for effective work performance. Systems for reinforcing the values of integrity, courteousness and fairness were considered to be weak. It is notable that a number of African countries, such as Ghana, Ethiopia, Nigeria, Namibia, Tanzania, Sudan, Zambia, Zimbabwe and Botswana have taken measures to curb corrupt practices through a variety of institutional mechanisms such as setting up offices of the Ombudsman. Due to a number of drawbacks that include the lack of resources, the measures put in place to deal with corrupt practices have not always achieved the expected results.

The majority of public sector employees were said to be lacking in skills for formulating, implementing, and monitoring policies, programmes and strategies for sustainable development and improvement of service delivery. The environment of public sector organisations was not positive for effective service delivery because many of the countries had negative economic growth rates during the 1980s and 1990s and this problem was partly attributed to public sector organisations which were characterised by corruption, nepotism, inefficiency, poor coordination, mismanagement and political interference. The problems of public sector performance were seen to have roots in factors that were both within and external to the public sector organisations.

An additional challenge for the public sector to address is the requirement for prioritising the most crucial needs that have to be satisfied in an environment where those needs exceed the human, financial and other resources at the disposal of the public sector. The public sector also faces challenges of ensuring the existence of political commitment to enforce formulated public sector policies, especially where governments do not have political legitimacy and thus cannot be relied upon to act impartially and deliver services identified as priorities. Constraints faced by the public sectors of many developing countries include the lack of sound managerial systems and adequately trained staff to spearhead development initiatives. There is often a dearth of valid information to enable employees and populations to access information from public sector institutions to determine the success or failure of policies through participation in policy making and monitoring of performance. The public sector in developing countries tends to be negatively affected by unethical conduct on the part of public servants which is manifested through the abuse of office or corrupt practices most notably in the procurement of public goods. Corruption adversely affects the efficiency and effectiveness with which public services are provided and drains public funds to the detriment of society as a whole.

McInerney and Barrows (2000), in agreement with the ideas of Thornhill mentioned above, argue that as we entered the new millennium, it was imperative that we have new approaches to management in the public sector. This calls for systematic ways of sustaining public sector performance improvement to keep abreast of changes in the environment. These authors observed that public sector management challenges emanate from market dynamics through the emergence of the global economy, technological advances and the need to meet ever-increasing social needs through limited resources. Further challenges to management processes in the public sector arise from more accessible globalised information systems that contribute to organisational scrutiny and increased media attention that exposes public sector inefficiencies in the provision of services. Addressing the management challenges in the public sector requires that government be responsive to the interests of stakeholders that government interacts with in

the process of service provision. It is noted that the bureaucratic process that is normally symptomatic of government operations has made the public sector to lag behind the private sector in responding to management challenges.

Pedraja-Chaparro *et al* (2010:1) wrote that ‘a more efficient public sector has become a universal target of central importance in economic policy.’ The efforts to improve public sector efficiency worldwide is largely due to the recognition of the importance of the role of the public sector in the overall development of countries. The success of different initiatives in improving public sector efficiency and effectiveness has depended much on the extent to which the performance of public services is measurable. Pedraja-Chaparro *et al* noted that one of the main challenges in measuring the performance of the public sector is that the public sector lacks a market in the conventional sense. The authors state that in addition to efficiency, public sector activities often have the aim of also achieving equity goals and as such, there tends to be a trade-off among these aims, as discussed in section 2.4.4 of this study.

The public sector, more than the private sector, has a diversity of stakeholders in the form of politicians, users, and the general public whose interests all need to be satisfied thus making the management of the public a complex one due to the difficulty of measuring public output under such circumstances. Aspects such as the quality of services are difficult to calculate and the lack of a market makes it difficult for consumers to make a precise valuation of the services that they receive thus contributing to an evaluation of public output through inferences based on public service activities. Yet another complexity of the public sector is that it is not uniform since it often has different service organisations. Attribution problems are also a feature of public services since outcomes may be indirectly related to the activities conducted in the public service. The measurement and attribution complications contribute to monitoring and control problems in the public sector with the likelihood of difficulties in the attainment of productivity goals.

According to a White Paper by the ‘Economist’, entitled ‘Business 2010: The public sector - Embracing the challenge of change’ (2005), public sector management is in flux due to the rapid socio-political and technical changes characterised by economic crises, privatisation, budget reductions, e-governance, the need for adaptability to changing environments, and public awareness of the right to demand more efficient services and transparency of operations. The Economist’s White Paper (2005) noted that a survey of hundreds of executives world-wide into the public-sector landscape of 2010 revealed that the majority of respondents (57%) said that the quality of public services will be most important to citizens in 2010. Public sector achievements will depend much on visionary leadership for them to be sustainable

and this may entail borrowing some management practices from the private sector which tends to have less bureaucratic organisational structures. Public sector management, with regard to people-centred processes, covers issues such as leadership, staff training and development as well as the motivation of the workforce. The challenge for the public sector is to institute participative management processes which contribute to staff being partners of the leadership in the decision making processes rather than passive recipients of directives from the top. (see section 2.2.2 on employee empowerment).

Other challenges for public sector management stem from the political pressure to provide employment for citizens who will have graduated from institutions of learning such as schools, colleges and universities thus contributing to the over-staffing of public organisations and a waste of public funds through overall huge salary bills with, on the other hand, low salaries for individual employees. In some cases the compression of pay scales has meant that there are insufficient incentives to staff resulting in employees failing to meet basic life requirements and hence being dissatisfied in their jobs. Low remuneration often leads to a demotivated workforce resulting in a high staff attrition rate and consequently, a loss of process knowledge and strategic focus.

Unsystematic personnel management procedures have, in many instances, resulted in inexperienced personnel being elevated to senior positions that they will not have been adequately prepared to perform well in. Such a scenario is characterised by a myriad of problems, least of which are the management of employee performance and the difficulty of putting in place measures for institution building due to weaknesses in systems for enhancing the skills and knowledge of staff to improve work performance. According to de Merode (1991:pii) ‘anecdotal evidence in Ghana... suggests that public sector workers respond with much improved performance to a combination of strong leadership, better pay, better working conditions, and satisfying work.’ The creation of conditions that satisfy these requirements poses serious challenges for many public sector organisations.

A Strategic Consulting Services publication (2010:1) entitled ‘Public Sector Challenges’ noted that the public sector is unique in its need for transparency to its constituents and customers but attempts at achieving such transparency, which is necessary for improved efficiencies and enhanced accountability, is often hampered by ‘its cultures, structures and processes.’ The publication noted that although calls for governments to improve accountability have increased in the last few decades, many public sector organisations struggle to instil systemic accountability, with the result that the media is left to ensure the existence of such accountability to citizens but this hardly achieves the goal of improved management practices that facilitate the success of performance improvement initiatives.

Karim (1995) in a case study on improving the efficiency of the public sector in Malaysia stated that public sector reform has been a priority of government since its independence in 1957. To enhance the provision of quality services, the government identified measures that included the inculcation of values and ethics such as honesty, discipline, integrity, dedication, accountability, trustworthiness and efficiency among public servants. These efforts were complemented by structural changes, total quality management and the introduction of measures of efficiency and effectiveness in the public sector. The government earmarked the civil service as the vehicle for socio-economic development and the efficient and effective delivery of the new expanded services through the Development Administration Unit which introduced administrative changes in the public service, including the review of personnel management practices with regards to areas such as recruitment, promotion, training and performance reviews. Challenges for the public sector arose from the rapid transformation of the country through advances in citizen education which contributed to more increased demands on the public sector to perform to societal expectations. Criticisms were levelled at the bureaucratized public sector which was said to be too large and suffered from red tape and austerity measures had to be balanced with the need for implementing equity policies which depended on economic development to succeed. A reduction of the size of the civil service was done in conjunction with streamlining of operational processes to improve public sector efficiency and effectiveness and institutionalise a quality culture. There was also the promotion of privatisation so that the private sector assumed responsibility for some functions that were originally performed by the public sector thus realising financial savings for Government.

Therkildsen (2001) explored the process of public sector reform in East and Southern Africa zeroing in on aspects such as whether, since the 1980s, the size of the public sector in terms of employment has changed, the level of accountability since then, and whether government operations have become more focused on core activities. The study included Kenya, Tanzania, Uganda, Malawi, Mozambique, South Africa, Zambia and Zimbabwe. A major influence of the reforms was quoted as being the principles of the New Public Management (NPM) with its emphasis on the adoption of private sector-style management practices, decentralisation in the public sector to make units more manageable, results-based rather than input-based operations, the identification of performance measures and clear standards, and a concern with value for money as well as efficiency and effectiveness in public sector functions.

A general observation by Therkildsen (2001:1) was that ‘fiscally driven reductions of state employment and functions have not led to general and significant efficiency and accountability improvements.’ There were accountability problems with regards to the political justification of decisions and actions and weaknesses in managerial implementation of activities in accordance with agreed performance criteria.

The evidential base for decision making was, thus, lacking. In some instances, reform efforts had negative results with short-comings noted at times in the involvement of some donors who did not have privileged knowledge about how to address public sector performance problems in the countries studied. A common feature in the region was that efforts were being made to reform the public sectors with the aim being to reduce costs and promote the role of the private sector to achieve efficient service provision and economic development. The reforms were largely due to the need to address economic crises, donor imposition and duplication of reforms in other countries. There was also little understanding of the dynamics of reform with well-designed reform measures often undermined by political resistance. The performance of the public sectors was characterised by a gap between objectives and reality and political conflicts in the management of reform processes which, according to Therkildsen (2001) led to intended and unintended consequences.

The public sectors of the countries in question were reported, to varying degrees, as being plagued by inefficiencies, centralisation, poor leadership, lack of capacity, poor accountability and the rewarding of political and personal loyalty instead of merit. In many instances, the start-up costs of reform were noted to be often high with a long gestation period before significant improvements occurred. These problems were linked to the global economy which was said to contribute to the resource scarcity of public sector operations in developing countries.

Maphunye (2010) reflecting on the challenges facing African public sectors commented that the period immediately after colonial rule saw the uncritical application of Western derived ideas which ignored the uniqueness of the socio-economic, political and other realities of the African countries. Policies and programmes were often crafted in the West by Western policy makers and planners and as a result, they were incongruent with the needs of the targeted nations. The author argues that it has taken many years for African governments to realise that what they need are home-grown solutions to tackle contemporary challenges.

According to Maphunye (2010), the public sector challenges are complex with evidence of inappropriate appointments, migration of qualified staff to Europe for better remuneration, bad governance, poor administration and mismanagement. Suggestions for remedying the situation include the examination of supply and demand issues concerning the availability of human resources with the required skills, a process that calls for the public sector to liaise with relevant stakeholders in civil society and the private sector. Also advocated as a way of improving public sector service delivery is the use of research that informs the public policy making process in the African countries. There is a need for specific policies

and long-term visions in relation to training. Evidence-based policy and practice should be as a result of research conducted by Africans to make the policy making and implementation more relevant. Yet another solution recommended is the need to achieve equity in the public sector by being sensitive to the diverse ethnic, religious, racial and other socio-cultural features of the African societies.

A workshop on public sector management reforms held in Ethiopia as from 28-29 May 2003 reviewed the status of public service policy reforms in African countries with the aim of promoting better public service delivery. The workshop participants noted that the public sector in Africa was taking the centre stage in the development of the individual countries. It was revealed at the workshop that despite comprehensive public sector reforms, there were only a few success stories while for the majority of the countries progress remained elusive. Factors identified as contributing to lack of progress in the reform process were inefficient and ineffective management practices, low civil service morale, wastage of scarce resources and corruption. Most of the countries failed to make progress in areas such as public accountability, community responsiveness, provision of quality service, the coordination and integration of services and strategic management. Management weaknesses negatively affected the scope, speed and quality of services provided.

The major recommendations made at the Ethiopia workshop to enhance efficiency in the management of the public service reforms included: the need for African countries to take into consideration the assumptions underlying public sector management; for example, the rights of citizens; the setting of priorities; the requirement for governments and public administration to be accountable and responsive to citizens; the need to involve civil society organisations in public sector management; introduction of measures such as decentralisation to enhance public service effectiveness; the setting up of performance contract systems for the management of public enterprises, which was advocated by the World Bank as a principal measure of public enterprise reforms; the enhancement of partnerships in public service delivery in order to promote equity and effectiveness at the level of the community; promotion of use of information and communication technologies (ICT) including the internet in government (e-governance) and institutions of the public service; establishment of the Citizen's Charter by African countries with specifications of what citizens can expect from their governments; the adaption of New Public Management (NPM) techniques that include a performance oriented civil service, Total Quality Management (TQM), Performance Management System, Results-Oriented Management and a customer-driven government; and ensuring the creation of an enabling environment for the development of the private sector.

In order to strengthen the role of the private sector in socio-economic development, the workshop participants reached the consensus that African governments needed to tackle some challenges such as improving the capacity of indigenous people to manage enterprises, establishing internal accountability systems and agreeing on areas to remain under the control of governments. It was acknowledged that deficiencies in human capacity and financial resources made it difficult for African countries to cope with the emerging challenges of information and communication technology; hence there was need for the formulation of policies and strategies with the purpose of building capacities in this area. Other challenges related to leadership commitment to quality management which was to be addressed as an important theme for sound public administration and management.

The Ethiopia workshop identified the need for the commitment of Ministers and senior officials to facilitate the implementation of successful public service reforms. Public services were requested to establish clear visions and missions to guide employees in the execution of their duties. Performance information was to be used as a basis for decision-making at different organisational levels. The meeting acknowledged that although many African public services had well written codes of conduct there was still a need for the governments to strengthen the culture of ethical behaviour and address the challenge of attitudinal and mind set changes for the effective implementation of public sector management reforms. The public sectors were encouraged to invest in the development of human capital for effective policy formulation, analysis, implementation and evaluation. It was pointed out that trained personnel coupled with political will and commitments were important for the success of public sector reforms in Africa.

An example of a country that introduced public service reforms was Ethiopia which introduced the Civil Service Reform Programme (CSRP) in 1997. The CSRP emphasised the need for an in-depth analysis of the problems encountered in the civil service and how they impacted on performance as well as the development of recommendations on how the problems could be resolved. The country utilised local skills and only resorted to the hiring of external consultants when the required skilled human resources were not available in Ethiopia. Reports indicate that although there were some notable improvements in efficiency and effectiveness there were only limited successes in introducing tangible changes in performance and service delivery, effective policy formulation, programme and project implementation and addressing general public sector problems. The snags in the reform process were attributed to delays in the transition from the phase of problem identification to implementation, weaknesses in the integration and coordination of activities and lack of resources to ensure success.

Kabumba (2005) added to the chorus of voices that pointed out challenges faced by the public sector in African countries in their bid to achieve accepted levels of productivity by focusing on employee productivity and socio-cultural factors. He suggested the adoption of factors that promote productivity, such as rigorous job analysis, equitable and adequate remuneration, management styles that are participative, effective staff appraisals and improved education and training practices. On the other hand, the author pointed out the need to avoid the factors that inhibit productivity such as negative staff attitudes, poor management practices, lack of or low levels of knowledge on how to strategise for organisational success, placing of more importance on paper qualifications than ability of employees to perform duties effectively, cultural practices that admire dishonest means of achieving success both at work and outside the workplace, nepotism, poor resource management, and spending an unnecessarily long time fulfilling cultural obligations such as attending marriage ceremonies and mourning the dead.

In the Botswana setting, Washington and Hacker (2009) observed that reforms date back to the attainment of independence in 1966 when efforts were made to develop a local base of skilled labour and increase productivity in the public and private sector. The authors state that there has been some debate as to the effectiveness of government reforms especially in relation to the adoption of the New Public Management ideas. A milestone development in the reform process was the creation of the Botswana National Productivity Centre in 1993 with the main purpose of enhancing productivity at the individual and organisational level. Other major reform components, in addition to the WITS strategies of 1993 were the 1998 introduction of PMS, Decentralisation, Computerisation of the Personnel Management System (CPMS), and the Human Resource Development (HRD).

The 1998 Botswana Presidential Commission on Public Service Salaries and Conditions of Service led to the establishment of a unit in the Office of the President that was to be responsible for the coordination of public service reforms. Washington and Hacker (2009) reported that there were some set-backs in the reform process because the performance improvement initiatives, while they were of value by themselves, were introduced one after the other at a rapid pace which tended to cause confusion through a lack of integration hence they missed the targeted breakthrough results. Progress was thus retarded by overloading the public service system with initiative training which tended to overwhelm the staff. Washington and Hacker (2009:3) quote a Performance Improvement Coordinator who stated that 'We don't even complete the last mandated change before the next one is launched. We are moving backwards!' The authors indicated that organisational change would have been more successful had there been a holistic approach aimed at changing the individuals in the organization coupled with a strong results measurement system. They noted that piecemeal initiatives are often both ineffective and

counterproductive and that the organizational culture becomes skeptical of any future change when initiatives are not well designed.

Public service managers had to contend with the challenge of changing from normal management and maintenance of systems to the kind of transformational leadership required of performance management initiatives in organisations. Washington and Hacker (2009:4) contend that although management was and continues to be important for running ministries, 'it was however, proved inadequate to facilitate transformation.' The authors further state that quite a few of the leaders had the necessary leadership skills to guide the transformation process at the required level and the critical working relationship between Permanent Secretaries and Cabinet Ministers was put to the test in most cases. Leadership weaknesses made it difficult for organisational strategic plans to be implemented especially in the area of developing appropriate measures and cascading the strategies as well as effectively linking budgets to the planning process. The country made efforts to overcome leadership problems by investing in leadership training.

The Botswana NDP9 (2004-2009) noted that public sector management covers management aspects such as productivity, human, financial and other resources and also involves a wide range of activities that include the planning, formulation and implementation of policies and initiatives for delivering goods and services to the nation. The challenge for the country, particularly the Directorate of Public Service Management which guides policy formulation regarding human resource and productivity practices, is to ensure that the public sector structures, policies and operations respond adequately to national socio-economic needs. The NDP9 (2004-2009:367) stated that a major challenge faced during the implementation of the Performance Management System 'was the entrenched paradigms among some leaders, which tended not to support the introduction of PMS' because it was viewed as just another programme that was destined to end in failure.

Management of the public sector has posed further challenges in the area of grading of positions for remuneration purposes as was evidenced by the introduction of the scarce skills grades in 1998, the purpose of which was to attract and retain local personnel with skills that were in critical shortage. The scarce skills scheme was, however, flawed in that errors in its application resulted in inconsistencies such as excluding deserving cadres while others who were not expected to benefit were included, thus distorting the salary structure in the public service. The government response was to abolish the scarce skills grades following some litigation cases initiated by concerned employees and replace it with a scarcity allowance which was implemented during NDP9. Section 19.63 of the NDP9 explains yet another challenge for the Botswana public sector management in that the government manpower

establishment expanded in 2002/2003 in such a way that it represented an average annual rate of growth of 1.3 percent which was 0.2 percent higher than the target rate of growth of 1.1 percent set for NDP8. It is noted that while this expansion could be attributed to the establishment of new projects, in some cases the cause was attributable to the mismanagement of existing projects leading to delays in their completion. Yet another contributory factor to the expansion in the establishment was the manpower planning weakness arising from an under-estimation of manpower requirements.

In Botswana, the majority of the employees in the public service leave employment through resignations. While this may be expected considering that most of them tend to be in the 25-39 age group and can thus be regarded as youthful and hence with a tendency to be more mobile, there is still need to consider other contributory factors influencing attrition, such as the extent to which conditions of service may impact on the employee decisions of whether to remain in public sector employment or move elsewhere. The delivery of health services in Botswana has always been negatively affected by the shortage of human resources for health. This shortage has been felt despite efforts made by the Government to increase the capacity of training institutions mainly because of working conditions that are perceived by employees as being unattractive. The demands of taking care of patients who suffer from HIV/AIDS have also overstretched the existing skilled staff.

A 2007 statement by the Permanent Secretary to the President and Cabinet indicated that the Botswana public sector had enjoyed a high level political support in the implementation of reforms which resulted in a shift of focus from merely concentrating on socio-economic development to the development of strategies that are intended to improve productivity and accountability for results in the sector. The aim of the strategies was to adopt best practices in the management of the public sector that incorporated visionary leadership, implementation and coordination skills, human resource and financial management, information management and communication skills.

The realisation of the strategic foundations of the public service, which comprised of the developed Vision, the Mission and Values, depended on the effective implementation of the performance improvement initiatives through which commitment was being made to serve the public. The connection of the performance improvement initiatives to the Vision was, therefore, to make the public service more relevant to its customers. An additional development, derived from the Vision 2016, was the creation of the Botswana Public Service Vision which was meant to focus and guide the activities of public servants. Ministries' vision statements were, in turn, to be aligned to the Public Service Vision to facilitate a more efficient and effective implementation of programmes with a focus on customer satisfaction. The

Botswana Public Service vision was stated as ‘We, the Botswana Public Service, will provide a world class service that is efficient, effective, caring and responsive to local and global challenges’. The Public Service Vision statement was a commitment to compare service provision to the worldwide best in terms of meeting customer expectations and achieving objectives with optimal resources within the least possible time.

In spite of the existence of the national vision, Botswana has faced challenges arising from the paucity of relevant health information for planning and making timely interventions as well as monitoring and evaluating service delivery in the health sector. While progress has been made in some programmes, such as those related to HIV/AIDS, there is generally inadequate evidence-based planning, monitoring and evaluation of activities. According to the WHO Country Cooperation Strategy, Botswana (2008-2013), inconsistencies are often noted in the health information with regards to indicators presented by different programmes and partners, including agencies of the United Nations. Expectations are that the scaling up of interventions towards achieving the targets of the health related MDGs will provide an opportunity for enhancing the health management information systems.

Marobela (2008) observed that domestic and international economic challenges have made it mandatory that the Botswana public sector be reformed in order to make it more efficient so that it can be competitive and satisfy its customers through quality service provision. He notes that reforming the public sector requires addressing challenges that include the maintenance of sizeable but efficient institutions, rationalising responsibilities and strengthening the monitoring and evaluation of the public service employees. Marobela (2008) wrote that initiatives for public sector reforms world-wide have occurred mainly due to what proponents identified as low productivity that has been attributed to poor civil service performance. He notes that there seems to be a paradox because those who spearhead public sector reforms give a negative picture of the public sector performance. Bach (cited in Marobela 2008) challenged the unquestioned belief of poor public service productivity that is based on a unilateralist model with its view of the private sector as having more efficient workplace operations. In the same publication, Marobela argues that the performance of Botswana’s state-owned enterprises attests to their efficiency as they have been financially viable over the years. His main argument was that the public sector, unlike the private sector, is not largely driven by profit-making but by service provision, and as such, the private sector should not be used as a benchmark for the public sector efficiency. Marobela concludes by noting that the problems associated with public sector reforms in Botswana are not peculiar to the country but form part of a global strategy copied from the private sector management to enhance performance.

Hope, Sr. (2004) reports on findings of a 1999 study conducted in two Botswana central government institutions with the selection criteria of the institutions being that one had a reputation for the efficiency of its operations while the other was widely believed to be under-performing. The findings showed that there were clear strategic plans which incorporated a vision statement and organisational objectives while the other institution had a leadership that was considered to be weak with a haphazard strategic plan and no concrete operational policies, hence contributing to a lack of common understanding by the staff of the organisational objectives. Other differences between the two institutions stemmed from the fact that employees in the efficient institution reported that their superiors consulted them frequently to solicit their input in decision making while 87% of the employees in the under-performing institution stated that management did not give them the opportunity to participate in decision making. It is notable, however, that 49% of the respondents from the better run organisation said that they were dissatisfied with their jobs due to staff shortages resulting in work overload, lack of challenging tasks and lack of opportunities for promotion. In the poorly managed institute, 56% of the respondents were dissatisfied with their jobs due to reasons such as inadequate rewards for their work, heavy workloads and job descriptions that were not followed and lack of transparency in the handling of staff promotions.

Public sector reforms at the macro-level in Botswana have been in the form of initiatives introduced by government such as decentralisation and the establishment of institutions, for example, the Ombudsman, the Directorate on Corruption and Economic Crime (DCEC), and the Public Enterprises Evaluation and Privatisation Agency (PEEPA). The literature indicates that low public sector productivity and lack of managerial capacity are the major factors that constrain the successful implementation of public policies that are otherwise well drafted and clear. With the attainment of political independence, administrative and political reforms were introduced. Administratively, new institutions were established, such as departments for development planning and institutions for capacity building.

The public sector reforms had the general aim of improving the capacity of the sector in its endeavours to provide efficient and effective services. Just like in many other developing countries, the challenge for the public sector lay in streamlining the functions and size of the public sector agencies with efforts being made to move away from the bureaucratic model of public administration to a results-oriented style of management. The main thrust of reforms in Botswana have been in the area of public administration, decentralisation and privatisation with the reform process characterised by the introduction of productivity improvement programmes, accountability, organisational restructuring and strengthening practices for achieving customer satisfaction.

According to a 2009 BIDPA publication, it was noted at the turn of the century that the government's venture into the provision of goods and services was unsustainable in that it had overstretched the public sector's implementation capacity and negatively affected the quality in the provision of basic public services such as in the education and health sectors. Evidence, however, shows that there has not been any significant reduction of the public sector. Customer satisfaction surveys, some on behalf of the Directorate of Public Service Management (DPSM) have revealed the public perception that the public sector in Botswana lacks efficiency, effectiveness and responsiveness to the demands of its clients. The seriousness of this problem lies in the fact that poor service delivery by the public sector negates good governance by denying beneficiaries the enjoyment of services that they are entitled to.

Various studies in Botswana have shown that there are significant constraints that hamper the effective popular participation in the implementation of initiatives meant to improve the delivery of services in the public sector and that policy formulation and implementation are bureaucratically-determined and assumes a top-down approach. The BIDPA publication (2009:2) states that the poor perceptions held by the public regarding the public sector performance indicate that 'the process interventions, such as Organisation and Methods, Work Improvement Teams and the ...Performance Management Systems have not necessarily produced desired results in terms of improvement of public sector staff effectiveness, efficiency, responsiveness and perhaps morale too.' The implication of this statement is that the effects of reforms aimed at improving the effectiveness and efficiency of services to the public are yet to be realised.

Hope, Sr. (2004:5) stated that study findings revealed that the promotion system frustrated staff because it did not reward high performers and he observed that 'what seems to be coming through very loud and clear is that there is no direct link between promotion and performance.' His observation was that there are elements of the country's public service that are typified by weak administrative leadership, inept strategic planning, unmotivated staff, poor communication channels and archaic management practices. Nevertheless, in spite of the problems associated with public service reforms in Botswana, the country has, generally, been commended for being one of the few that has voluntarily introduced reforms to improve the performance of its public service whereas many other countries had reforms that were donor-driven.

From the foregoing, it is apparent that the public sector plays an important role in national development. Public sector efficiency and effectiveness depends on the extent to which the sector develops strategies

for enhancing improved productivity and the quality of services. Generally, while the management of the public sector in the countries noted above has had some positive impact, the main weaknesses related to the lack of a shared vision for public sector employees which made it difficult for any proposed changes to be implemented. The change process could have yielded better results had the need for change been more clearly communicated to all stakeholders with the necessary support structures provided to minimise resistance to the change process. Some countries performed better than others in allaying the anxieties of stakeholders which are a normal feature of any change process.

1.9 Current Botswana health policy

The Ministry of Health carries the portfolio responsibility to provide leadership on health matters. The Ministry executes this responsibility through the formulation of Health policies and ensuring their correct interpretation and implementation throughout the health care delivery system. Schmidt (2006) writes that health policy is one of the most important fields of policy. This is because in no other policy field does the hopes, aspirations, concerns and fears of people play such an important role. Health, defined by the World Health Organisation as ‘a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity’ (MedicineNet.com 2008:1) is such that it forms an indispensable foundation for the welfare of nations.

During NDP 9, the Ministry of Health reviewed a number of health policies for the purpose of enhancing the efficiency and effectiveness of health service delivery. The need for the review was mainly due to changing demographics and epidemiological trends. The policies that were revised were the Botswana National Health Policy, the Human Health Research Bill, the Drugs and Related Substances Act, the National Policy on Care for People with Disabilities, the National Policy on Mental Health, the National Policy on Blood Transfusion and the National Medical Laboratory Policy amongst others. The target was to have the policies in place by the 2010-2011 financial year.

The first National Health Policy, which came into effect in June 1995, outlined, amongst other issues, the philosophy of the health policy based on Primary Health Care, the rights and obligations of health users and the responsibilities of the Ministry of Health. The health policy document acknowledged that determinants of health care extend beyond health care to include factors such as individuals’ social and physical environments. Through this health policy, the Ministry of Health took the primary responsibility of organising the provision of health care to the nation while at the same time recognising the roles of

other health services providers such as the private sector, local authorities, and non-governmental organisations including Mission Hospitals. In attempting to address the determinants of the disease pattern, for example, poverty, inadequate education levels, and both poor nutrition and sanitation, the government was cognisant of the importance of inter-sectoral collaboration, equitable distribution of resources and community involvement in the provision of health services.

The first National Health Policy was introduced basically because the Ministry of Health was constrained in carrying out the functions of policy making and supervising health care providers in general. The health policy was meant to address this problem by spelling out the roles of the Government and other agencies in the provision of health services. The National Health Policy, therefore, went beyond strategies on rural development and the Local Government Act (1965) which, although acknowledging the importance of health services, did not elaborate on the roles of the District and Urban Councils as service providers. Lauglo (1996) stated that, at the time, besides the Local Government Act of 1965, there had been no legislation regarding PHC even though District Councils were generally known to have responsibility for implementation of PHC. The private sector was encouraged to cooperate with the public sector in the provision of health services (National Health Policy, 1995).

With effect from 2010, the primary health care services were transferred from the Ministry of Local Government to the Ministry of Health. This means that all health practitioners and public medical facilities, including the health posts that have been under the Ministry of Local Government are now under the control of the Ministry of Health and will be monitored by the District Health Management Teams. Kgosisejo (2010:4), quoting the Assistant Minister of Health, Mr Gaotlhaetse Matlhabaphiri, wrote that ‘persistent challenges in the provision of health care have prompted government to bring all health facilities under one Ministry to ensure proper coordination, ...’ The health services merger was also necessitated by the realisation by Government that the decentralisation of health services to the Ministries of Health and Local Government had not helped much to bring the health services to the public. The main problem identified for the failure of the decentralisation was that despite clinics or health posts offering general services, members of the public preferred to go the hospitals for the same treatment leading to overcrowding at hospitals.

The development of the second National Health Policy, which started in 2007, was necessitated by changes in the national health status as well as the re-organisation of the health sector in the country. Briefly, such changes included the disease burden, demographics and the socio-economic determinants of health. The Ministry of Health was re-organised through a process that started in 2002 while major

developments were undertaken in the management of Primary Health Care within Ministry of Local Government. The newly updated National Health Policy is expected to guide health development in the country for ten years starting in 2009. The major areas of focus will include: leadership and governance, health services delivery, lifestyle or behavioural determinants of health and the development of human resources for health, management of drugs and medical equipment, health infrastructure, and health financing.

1.10 Performance Improvement Initiatives in Botswana

Zulfiqar (n.d.:1) described a performance improvement initiative as ‘an enterprise learning program, project or activity which results in a recognizable business impact. It improves the performance management of the organization.’ In order to improve the quality of public services provided to the nation, the Government of Botswana introduced performance improvement initiatives such as Total Quality Management (TQM), Work Improvement Teams, the Performance Management System (PMS) and the Performance Based Management System (PBRS). The Ministry of Health, in particular, viewed the initiatives as pertinent since it is operating in an environment that is characterised by increasing demands for quality health services. The initiatives were regarded as necessary to enhance the management of health services. This study will include an examination of the process through which some performance improvement initiatives were initiated, communicated, implemented and evaluated.

1.10.1 Total Quality Management

Schlenker (1988:2) defines Total Quality Management (TQM) as ‘the control of all transformation processes of an organisation to better satisfy customer needs in the most economical way.’ Customers, it is noted, are clients both within and external to the organisation. Zablocki (1993) noted that no American industry could benefit more from the utilisation of Total Quality Management (TQM) techniques than health care considering that a huge amount of the country’s annual expenditure on health care goes to waste through inefficiency. The value of TQM, she noted, was that it would help in the delivery of quality service as well as the cutting of costs. The challenge for the public health sector was that in spite of the reported benefits of TQM, only a few hospitals in this sector practised TQM, most probably due to resistance to change amongst the leadership. TQM was seen to function well in institutions where there was effective communication that allowed the views of employees, patients and visitors to be accommodated. According to Zablocki (1993), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) revised its standards, due to the success of TQM practices in hospitals, to include

quality-improvement methods with the shift being towards addressing issues of systems and processes rather than merely apportioning blame to individuals identified as being responsible for problems.

Banham (1993) wrote that during the 1980s, the Harvard Community Health Plan, a Health Maintenance Organisation (HMO) in Brooklyn, Massachusetts, introduced TQM principles and successfully managed health delivery costs and improved health care processes. The HMO benefited from courses offered by W. Edwards Deming, an expert in the field of quality management. Specifically, improvements in health services delivery were recorded through projects that ranged from improving billing procedures to communication networks that facilitated the handling of referrals of patients from one hospital to another. The organisational efforts at performance improvement yielded positive results due to the adoption of innovative ways to analyse and change processes to improve quality.

Participants at an NFKL auditor quality workshop for candidates from the Botswana Ministry of Health and the Norwegian Board of Health held in Botswana in 1998 defined Total Quality Management as a 'management approach of an organisation, centred on quality, based on the participation of all its members and aiming at long term success through customer satisfaction ...' The workshop was part of the Health Sector Agreement of 1996 between the Botswana Ministry of Health and the Norwegian Board of Health in which the former was to be assisted to implement quality management systems. The introduction of TQM in Botswana required that health institutions put in place measures to determine whether quality activities complied with planned arrangements for effective implementation. The management of quality involves all members in an organisation engaging in activities to continuously improve the quality of its goods and services. TQM is meant to facilitate the process of preventing errors and attaining continued improvement in performance and quality. Teamwork and collaboration amongst the employees is paramount for success in improving the quality of services. Key problem areas in the quality management process have to be identified and remedial action taken.

Bashe (2007) defined quality as the degree of excellence of a commodity, whether a product or a service. A service or product is said to meet the appropriate quality criteria if it meets the set standards and customer expectations. An excellent service or product does not only meet customer expectations but exceeds them. Processes to ensure quality products need to be planned for with the appropriate tools and techniques provide for the implementation of processes. Planning necessarily requires the involvement of all staff whose efforts are essential for the maintenance of quality systems. Such a systemic approach to planning and implementation is important since quality is an aspect that has to be prioritised throughout the organisation and not restricted to some of its parts. Continual quality improvement requires that

monitoring systems be put in place to detect deviations from planned activities so that corrective measures can be taken timeously. Monitoring of activities helps to identify flawed processes and contributes to the efficiency of organizational processes. The attainment of continual improvement is dependent on strategies that include keeping employees motivated to perform their duties through provision of conducive conditions of work. An organisation that motivates its workforce is likely to achieve high productivity levels and be successful at retaining its staff. Empowerment of employees is an integral part of motivation efforts as employees have to be allowed to participate in decisions that affect their well-being.

Rampey and Roberts (1992) described Total Quality Management as not being a separate programme but a total system approach that is an integral part of the organisational strategy, extending horizontally and vertically across departments. The major goal of quality interventions is customer satisfaction which is achievable through a minimisation of errors in the process of producing goods and services and ensuring the competency of organisational members through measures that include training. The external customers are the main focus for Total Quality Management processes because they have to get value for money for the products or services that they purchase. Kurtus (2001) observed that in a company there could be a chain of employees who can be referred to as internal customers since each plays a role in improving a product and then passes it along until it finally reaches the external customer. Each worker seeks not only to satisfy the internal customers but the external ones as well. Practitioners in organisations that aim to apply Total Quality Management processes also have to satisfy the agencies from which they themselves purchase goods and services if they are to continue in business. Such suppliers have to be paid timeously for their contribution to the business.

Repenning and Sterman (2001:65) wrote that there is little doubt that when applied appropriately, 'TQM produces significant value to both organisations and their customers.' They also observed that a number of studies have demonstrated that companies that strictly adhere to the principles of TQM have often performed better than their competitors. A paradox that they noted, however, is that TQM is rarely ever used by companies, with TQM falling from the top three mostly used business tools in 1993 to 14th in 1999. A significant point made by Repenning and Sterman (2001) is that the number of performance improvement initiatives available for managers to use is ever increasing yet there has been little improvement in the capacity of organisations to incorporate the initiatives in their day to day activities.

Total Quality Management aims to improve organisational performance by pooling the efforts of organisational members for the achievement of a common goal. Through teamwork, the different organisational elements are expected to be productive by working smarter rather than harder since the

work that they do is complementary. The biggest challenge, it is noted, is having to implement the innovations successfully largely because they cannot simply be transplanted from elsewhere but have to be developed from within the implementing organizations, taking local conditions into consideration.

1.10.2 Work Improvement Teams

The WITS initiative was introduced in Botswana in 1993. Historically, the concept of WITS was adapted from the Japanese Quality Circles (Hope, Sr. 2001: 129). According to section 4.1 of ‘The Strategy for Productivity Improvement in the Botswana Public Service,’ (1994:4), a Work Improvement Team (WIT) is ‘a group of Civil Servants or other public officers from the same unit, ... who meet regularly’ to improve their work activities. ‘Work Improvement’ basically means quality improvement.

The Strategy for Productivity Improvement in the Botswana Public Service (1994:5) outlines the WITS structure as consisting of the following;

1. Productivity Improvement Committee for the Civil Service (PIC FORCE)
2. Ministerial Performance Improvement Committee for the Civil Service (MINI PIC-FORCE)
3. Departmental Productivity Committee (DPC).
4. Facilitators, chosen from the rank of supervisor. Their task is to oversee the formation and operation of WITS and form the linkage between management and employees. They register WITS and maintain records on WITS activities.
5. Leaders, also chosen from the supervisory level. They arrange for WITS meetings and train members in problem-solving.
6. Members, who are civil servants of any rank.

The WITS are meant to perform functions such as identifying, examining, analysing and solving work-related problems in a department or unit. The Team also strives to adapt the work unit and the department to changing circumstances. Recommendations made to management include measures for undertaking work operations efficiently and effectively. The WITS objectives include the professional development of human resources, participative leadership and teamwork, the introduction of an organisational culture in which staff learn from their experiences in order to improve performance and a strong client orientation in which the values of providing an efficient and effective service to the nation are upheld. The interaction between management and employees was to facilitate the flow of organisational communication. Through the introduction of WITS, it was anticipated that staff would be motivated to

perform duties effectively with satisfaction gained from identification with organisational strategies and activities.

In order to emphasise the importance of WITS as an initiative for improving productivity, the Head of the Civil Service, that is, the Permanent Secretary to the President, chairs the PIC-Force which has members that include Permanent Secretaries for Ministries, the Attorney General, the Auditor General and the Commissioner for Police. The Permanent Secretaries, in turn, chair the MINI-PIC FORCE which is expected to meet on a monthly basis. The WITS concept is cascaded further down the Ministries with Heads of Departments chairing the DPC.

The WITS initiative requires that all public officers be part of an improvement team which is expected to complete two projects in a year. The team members were to be trained in-house while the WITS Facilitators and Leaders are currently trained at the Botswana Institute of Administration and Commerce or the Botswana National Productivity Centre.

The WITS process is illustrated in the diagramme below;

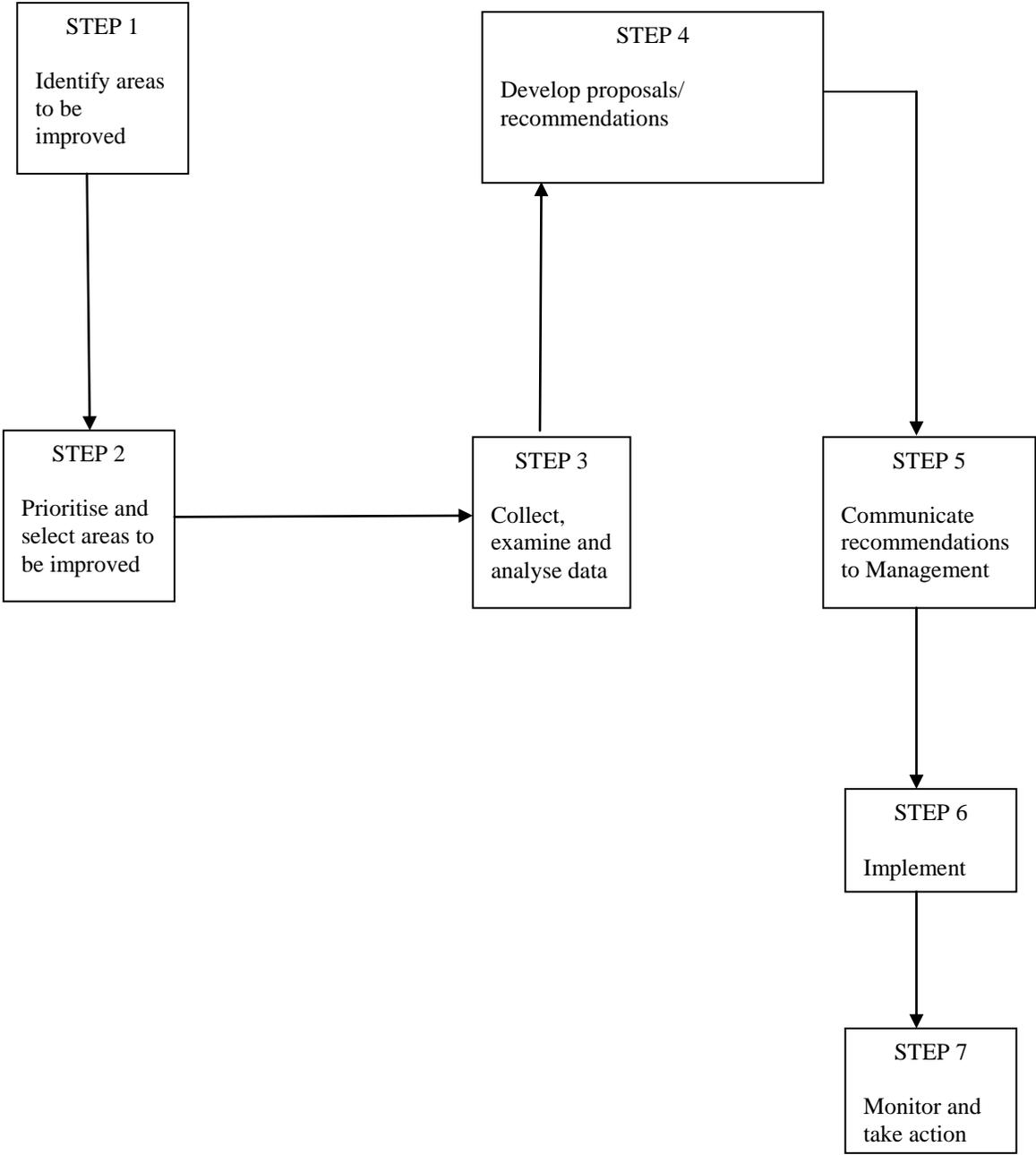


Figure 1.1: The WITS Process

(Source: Strategy for Productivity Improvement in the Public Service, 1994, p4)

1.10.3 Performance Management System (PMS)

Selepeng (2001), the then Permanent Secretary to the President, in his presentation of the Performance Management System (PMS) Philosophy Document, noted that PMS was meant to improve the management of performance at all organisational levels in the public sector. The major objectives of PMS were outlined as: to improve individual and organisational performance in a systematic and sustainable way; to provide a planning and change management framework that would be linked to the budgeting and funding process; to enhance Government capacity; and to inculcate the culture of performance and accountability to manage at higher levels of productivity so as to provide efficient service delivery. Through PMS, health managers were to develop performance indicators through the consideration of dimensions of cost effectiveness, efficiency and effectiveness. The progress of implementing PMS activities was to be reviewed periodically with appraisal of individual employee performance being done on a quarterly basis. Ministries were required to produce annual reports of the year's performance with highlights of areas needing improvement.

In his speech detailing the provisions of the newly introduced PMS, the Permanent Secretary to the President described the general public service performance environment as having earned Government a bad reputation characterised by insensitivity to public demands, non performance and the absence of accountability and discipline. Some of the areas specifically pointed out as undesirable, and needing to be attended to through PMS, were the inefficient management of financial and human resources. The situation whereby there was little information on performance was decried as this contributed to a general lack of confidence in the public service by the nation which increasingly viewed the Government as an ineffective and inefficient provider of services. The Government considered PMS to be a holistic approach that would contribute to sustainable productivity in the public service and not a one off productivity improvement initiative. It was expected that PMS would integrate other initiatives such as the Work Improvement Teams (WITS). The WITS initiative, in particular, was seen as being more of a necessity than an option. Through PMS, officers could be empowered through participation in the decision making process to the extent of developing a sense of belonging to their departments.

The essentials of PMS were stated in the PMS Philosophy Document as being the development of the vision, mission and value statements to guide the public service in its delivery of services. Departmental strategic plans were to be aligned to the vision and mission statements followed by the development of annual plans that were to be implemented within the framework of the chosen strategic direction. The implementation of PMS was to involve the setting of targets agreed between supervisors and their

subordinates with regular performance reviews all contributing to enhanced productivity. The performance reviews, to be conducted quarterly, were meant to serve as an objective appraisal for employees and the process was to be coupled with a performance based pay system in which individual achievements were to be rewarded. The PMS was seen as facilitating the ability to improve individual and organisational performance systematically. Through PMS, Government capacity was to be enhanced at the different organisational levels in the public service.

The Performance Management System Manual for the Botswana Public Service (2001:2) described the Performance Management System as ‘the approach chosen by the Botswana Public Service to achieve the goals of National Development Plans (NDP) and Vision 2016.’ The PMS approach was explained in the manual as being consistent with the ‘Plan-Do-Study-Act (PDSA)’ performance improvement methodology with the outputs of PMS matching the PDSA. The outputs are illustrated in Figure 2.2 below.

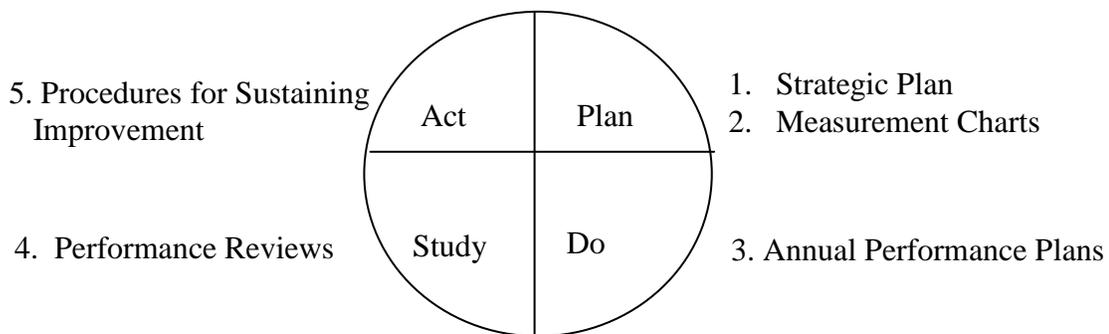


Figure 1.2: Linkage between the Performance Management System and the Plan-Do-Study-Act Methodology

(Source: The Performance Management System Manual for the Botswana Public Service, 2001:2)

The Mid-term Review of NDP 8 (2000:47) describes the Performance Management System (PMS) in Botswana as ‘one of the major reforms introduced in the public service.’ PMS involved developing a Vision, Mission, and Value Statements to guide the public service. The management system was introduced in the Botswana public service by the government in 1999. The process required the supervisor and the supervisee to set agreed targets to be achieved within a specific period. The setting or clarifying of the vision, mission and values of the organisation is the responsibility of the strategic apex in an organisation. The visions and missions at each departmental level are meant to be congruent with the

mission and objectives at the corporate level. On a regular basis, the supervisor appraises the performance of the subordinate so that problems of work performance can be identified and corrective action taken. PMS is meant to enhance productivity by having employees focus on priority areas of work to improve performance.

At the time that PMS was introduced, the Botswana Government acknowledged that the system had been used in other countries such as in the United States Federal Government, the US Postal Services and the New Zealand public service. In Botswana, PMS had already been introduced in two parastatals with reports of success at the Botswana Telecommunications Corporation and the Botswana Housing Corporation.

1.10.4 Performance Based Reward System (PBRS)

The Directorate of Public Service Management (DPSM) (2004:3) in Botswana defines the Performance Based Management System (PBRS) as a process “that allows linkage between the Performance Management System (PMS) and individual accountability through the development of performance objectives and employee reviews in a manner that will encourage continuous improvement”. PBRS was introduced in the public service of Botswana in the year 2000 to provide a linkage between the Performance Management System (PMS) and individual endeavours of performance based on objectives that are set annually.

The implementation of the PBRS process involves crafting work and development objectives which are then reviewed periodically against the actual performance achieved. Adjustments to the work plans are then made as necessary to take into account the realities on the ground. At the end of the reporting period, that is, at the end of the year, a decision can be made by the supervisor to award incentives which can be in the form of career advancement or some non-monetary incentive.

1.11 Relationship of the performance improvement initiatives

The relationship of the performance improvement initiatives is complementary since they have the aim of improving the efficiency and effectiveness of health service delivery. The performance improvement initiatives can be examined as sub-systems of a broader system. They take a systems view of improvement as they are interrelated and complement each other to achieve a common goal of improving

performance in the provision of health services in Botswana. From the viewpoint of the initiatives, poor performance is a manifestation of the problems embedded in the overall processes or systems designed to provide health services and not necessarily a reflection of the weaknesses of individuals' performance.

As outlined in 'The Performance Management System Manual for the Botswana Public Service' (2001:2) Botswana adopted the ABCD approach to achieving National Development Plan targets which ultimately should contribute to the achievement of the Vision 2016 goals. In this approach, the A corresponds to the administration of day to day organisational activities, the D is a recognition of the inevitability of 'dumb' or non-value adding activities and the C is for the management of crises or unscheduled tasks. The B, which is where the performance improvement initiatives like TQM, WITS, PMS and PBRs fall under, is for activities that are meant specifically for building organisations in terms of performance improvement. Attesting to the close relationship among the initiatives is the awareness that quality service provision can be achieved through the use of WITS to develop key performance indicators for achieving PMS targets.

Section 19.15 of the NDP9 document states that the various performance improvement initiatives are different but complementary strategies which have the purpose of improving productivity in the public service. Section 19.26 of the same publication, however, acknowledges that due to a misunderstanding of the functional relationship between WITS and PMS, the introduction of the latter 'posed a conceptual challenge to WITS because it was generally believed that PMS would replace WITS.' These initiatives are further described as being 'two sides of the same coin' with efforts being made by the Government to integrate them. The complementarities of the TQM, WITS, PMS and PBRs initiatives is depicted in Figure 2.3 below.

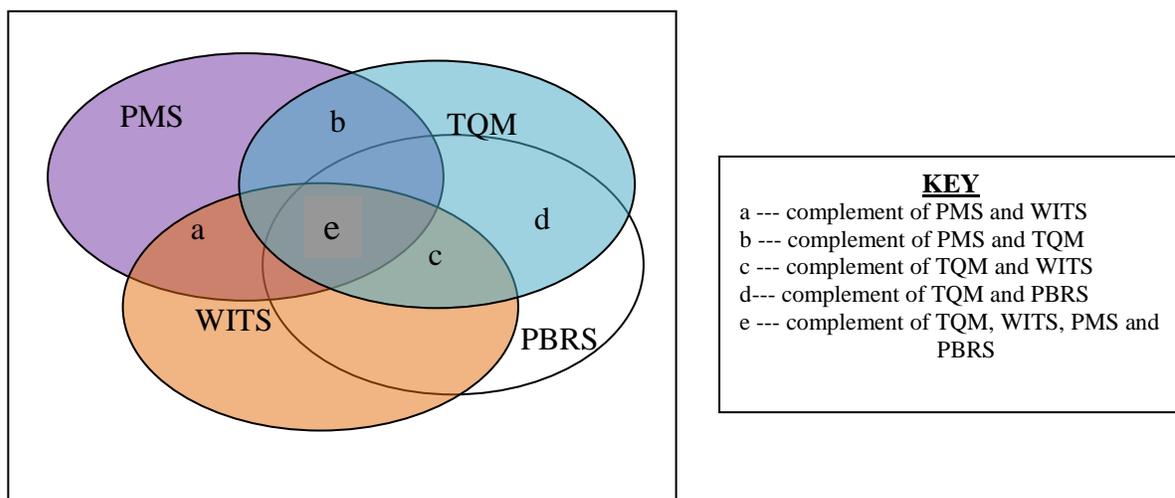


Figure 1.3 Linkage of TQM, PMS and WITS

1.12 Linkage of performance improvement initiatives to the Vision 2016

Performance management initiatives in the Botswana health sector are part of the reforms that have been introduced in order to facilitate, in the long term, the attainment of the national vision goals as they are encapsulated in the Vision 2016. With specific reference to the Performance Management System, Nkhwa (2009) observed that the initiative is driven by a strategy which has the objectives of: providing a planning and change management framework that is linked to the national development plan and budgetary process; enhancing the capacity of the government to achieve socio-economic governance; improving the performance capacity of public officers; and focusing efforts towards achieving national vision goals. Performance improvement initiative in each Ministry or Department were meant to support the realisation of the national vision goals by having each of them developing visions which were a subset of the national one. The strategic plans of each Ministry are aligned to strategies outlined in the National Development Plans which are the vehicle for the accomplishment of tasks that will lead to the attainment of the ideals stated in Vision 2016. Institutionalisation of Vision 2016 is, therefore, through the national development plans and the performance improvement initiatives.

The public service is acknowledged as the principal actor in macro socio-economic development and the realisation of the aspirations of a nation are normally depended on the efficiency and effectiveness with which the public sector is managed. In Botswana, the national aspirations are encapsulated in the Vision 2016 and the performance improvement initiatives are expected to facilitate the implementation of policies and operations that will guide the nation in the direction of attaining the Vision. The performance improvement initiatives were introduced in the public sector as part of measures to address a government concern, which has existed since the attainment of political independence, regarding the quality of service delivery to the public. Some of the concerns to be specifically addressed through improved service related to: the failure to complete national projects due to lack of effective planning and management, often leading to cost overruns; inefficiency in resource management; inadequate responsiveness of the public service to public needs; and poorly crafted Ministerial strategic plans which were not geared towards facilitating the achievement of goals contained in national development plans.

By the year 2016, the country anticipates a celebration of fifty years of independence and a failure in the implementation of performance improvement initiatives may result in low-key celebrations. Of the eight achievement areas identified in the Vision 2016, the health sector activities fall particularly under the ‘compassionate, just and caring nation’ pillar. The introduction of the initiatives to improve performance

was anchored on the national vision and as Nkhwa (2009:5) states, ‘from that point of reference appropriate strategies were designed to facilitate realignment and refocusing of Public Service plans and operations towards the achievement of the Vision 2016 goals.’ The performance improvement initiatives have linkages to the national vision in that they were meant to facilitate the realisation of the vision through the attainment of the short-term goals contained in the six-yearly national development plans which are designed to lead to Vision 2016. The initiatives were to facilitate an integrated and holistic approach to Public Service reforms and assist Ministries to deliver on their mandate.

The importance of the linkage between the performance improvement initiatives and the Vision 2016 is evidenced by the fact that ministers have to bi-annually inform the country’s President of the progress that they make on the implementation of reforms at a forum known as the Economic Committee of Cabinet (ECC) which is also a forum where ministers share their experiences on the implementation of the improvement initiatives. The accounting officers of different Ministries also attend the meetings to facilitate feedback to the President. Sectoral performance in the implementation of goals outlined in each Vision 2016 pillar is also discussed in the Vision Council where the public service, the private sector and civil society groups meet to share ideas on the progress made in their various areas. Information sharing on the reforms, which are driven by the national vision, necessarily includes discussions of the performance improvement initiatives. Through the performance improvement initiatives, the expectation was that performance standards in both the public and private sectors would be raised for the benefit of the service recipients through a shortening of turnaround times, productivity improvement, quicker problem solving regarding service delivery, and facilitating more focused activities to satisfy customer needs.

The Botswana government arranged for meetings to be held with individuals ranging from the Permanent Secretaries of the various ministries, the secondary school heads, the leaders of both the police and the military, and various other ministries in order to cascade information on the Vision 2016. The emphasis in the meetings was on what the Vision 2016 meant for each Ministry or department, and ultimately each individual in the various public sector organisations.

According to the “Tautona Times” of September 29, 2008, while presiding over a 2008 function to assess progress made in achieving Vision 2016 targets, the then Minister of Foreign Affairs and International Cooperation, Mr Mompoti Merafe, alluded to the important linkage between the performance improvement initiatives and the Vision 2016. He noted that the country could not progress unless there was productivity at the workplace. He stated that in order to address the low levels of productivity and

poor customer service, Government had invested heavily in performance improvement initiatives. He applauded the efforts made in Government agencies, Parastatals, and Non-Governmental Organisations which aimed to improve productivity through commitment and compliance to Vision 2016.

It is noted that the ideal situation was for public sector organisations to align their goals with the aims of Vision 2016. Washington and Hacker (2009) stated that one of the challenges of implementing the plans was that Botswana had an extremely robust planning system because planning was not only to be based on Vision 2016 but also on the national development plans and the annual performance plans, a process that required that all the plans be coordinated so that each person in government understood their roles and how they fitted into Vision 2016.

1.13 Health service delivery challenges in Botswana

The Botswana health sector faces challenges that range from policy issues to service delivery constraints. One of the challenges faced by the health sector in Botswana is the need to strengthen the health care system and ensure that the country attains a state of health that will enable the citizens to contribute meaningfully to national development. To achieve this ideal requires the provision of high quality health services throughout the health sector. The provision of quality health services falls within the broader framework of developing Botswana's socio-politico-economic aspects and it is a high priority for the Government. National development is guided by a number of policy documents, notably the Vision 2016, which outlines the ideals that Botswana should have achieved by the year 2016. This is reflected in the National Development Plan 9 (NDP) document, which prioritises the development projects that the country needs to undertake, and the sectoral development plans. The sectoral plans include the Ministry of Health Policy and Strategy Framework (2000) and the Ministry of Health's Corporate Performance Plan (2005).

Lauglo (1996) notes that the Public Health Act (1981) requires notification of infectious diseases and although it regulates some environmental health aspects like housing, food and water, it is not detailed with regard to environmental health. This Act is, as at 2011, being updated with the draft for the reviewed Act having received input from the Attorney General's Chambers. As per procedure, the Ministry of Health has to incorporate the Cabinet input into the draft bill before resubmission to Cabinet for final approval. Nurses are regulated through the Botswana Nurses and Midwifery Council while other health professionals are regulated through the Health Professions Council. In 1989, the Private Hospitals and Nursing Homes Act was introduced to regulate the for-profit hospital sector, including mine and mission

hospitals. In spite of these Acts, Lauglo (1996:24) observed that the health system is characterised by ‘remarkably little legislation or regulation in the form of certification, registration or licencing of health facilities to ensure that they comply with specified standards.’

The health workforce is categorised into Industrial Class employees who are mainly remunerated on a daily rate and the Permanent and Pensionable employees, who are professionals, on a monthly salary. The third main category is that of contract employees which largely consists of expatriates on fixed tours of duty. In order to achieve positive outcomes in the health sector, there is need for a dedicated and motivated health workforce whose responsibility is to plan and implement health programmes that benefit the nation. The experience in Botswana, however, is that the country has been losing professional health staff to the developed countries which tend to offer more attractive incentives to employees. This has, in some instances, contributed to the inability of the country to retain staff and maintain a continuity of services. The failure to retain staff also has adverse economic implications in that national funds are continuously spent on training health workers who leave after qualifying in their professions to work elsewhere. The country has also had problems in attracting back its pre-service health trainees, mainly medical doctors, who will have been trained in other countries.

Generally, there is dissatisfaction with the conditions of service throughout the public service. At the middle management levels and below (that is, below C1 salary scales) there have been major complaints about poor conditions of service mainly with reference to low salaries at the entry levels, long hours of work and inadequate opportunities for further training and staff development. At the senior management levels, efforts at staff retention are made difficult by the disparity in salaries between the public and private sectors. As a result, the public health sector continues to lose staff to the private sector or to the more developed countries.

In 2006, in an exercise that the investigator participated in, the Ministry of Health made recommendations which were approved by the Directorate of Public Service Management (DPSM) and improvements were made in enhancing the scheme of service for Medical Doctors and Dentists. The revised entry levels were such that the interns would start at the fifth notch of the C1 salary scale and progress to the 1st notch of the D4 scale as medical officers on completion of their internship. This exercise went a long way towards addressing the remuneration concerns through the separation of the internship and officer grades. Other recommendations to improve the working conditions for the health staff which were tabled for consideration by DPSM related to the facilitation of locums, private practice opportunities and post graduate training, as well as increasing overtime pay.

1.14 Significance of evidence-based health policy and practice in Botswana

Quoting the Oxford English Dictionary, Solesbury (2001:7) defined evidence as ‘the available body of facts or information indicating whether a belief or proposition is true or valid.’

Nutley (2003:4) quotes the UK Government Cabinet Office which defined evidence as ‘Expert knowledge; published research; existing statistics; stakeholder consultations; previous policy evaluations; the Internet; outcomes from consultations; costings of policy options; and output from economic and statistical modelling.’

Bowen and Zwi (2005:2) observed that the term ‘evidence-based policy’, when used in the literature largely refers to a single type of evidence, that is, research-based evidence. From the UK Government Cabinet Office definition, however, it is apparent that evidence is not only limited to the type of information contained in research documents since this is just one source of evidence. Dealing with everyday issues, therefore, calls for the use of the best available evidence which will be context specific. Besides research-based evidence, knowledge necessary for decision making can be obtained through sources like ‘histories and experience, beliefs, values, competency/skills, legislation, politics and politicians, protocols, ...’ (Bowen and Zwi 2005:601).

In Botswana, with its chosen democratic system of governance and a quest, after independence, for a growth of the economy, poverty alleviation, human resources development, gender equality and empowerment, environmental conservation and sustainable development, as well as a sustainable health sector, the need for evidence or factual information in policy making is of utmost importance. The observation by Allen (2007:6) that ‘Social science is bad at the accumulation and re-use of past data/findings’ need not be true for Botswana.

In a political system as exists in Botswana, the need for evidence, from whatever source, to inform health policy is necessary to increase transparency so citizens can be informed of how decisions that affect their health status have been arrived at. Accountability is one of the corner-stones of a democratic government; hence, evidence influenced health policy will increase such accountability. It is noted that there are other influences like political expediency, stakeholders, the public and the media that may determine the nature of policy decisions. (Campbell *et al* 2007:13).

There is congruency between the political, ideological and economic factors that influence policy development and decision-making and the use of evidence in support of those decisions. In stating this, it is recognised that more conflicts would be expected in a country with systems based on undemocratic ways of governance. Botswana should, therefore, take advantage of the enabling environment that already exists. There is already a fertile ground for the use of evidence in the health sector and the country should take advantage of it.

The observation by Pang (2003:2) that ‘in the face of continuing global health challenges, times of scarce resources and competing priorities, the use of evidence to inform policy-making should be the key driver for improving health system performance’ is pertinent for Botswana. The much acclaimed democratic political system of Botswana appears to be conducive for the use of evidence in policy formulation, implementation and evaluation. Dictatorships, in contrast, tend to be more restrictive and are not open to free discussion of ideas.

Solesbury (2001:9) argues that the commitment to evidence-based policy and practice is more demand than supply-driven. This is in contrast to the ‘top-down supply-driven approach’ that Tsie (cited in Hope, Sr. and Somolekae 1998) describes as having been a feature of the Botswana public service after the attainment of independence. Since evidence is crucial at all the stages of policy formulation, implementation and evaluation, upholding the value of evidence will improve health policy making through well informed government decisions and enhanced effectiveness of health policy implementation. Oxman *et al* (2006:2) wrote that health decisions in many countries have tended to ‘rely heavily on the opinions of experts.’ It is necessary in the Botswana setting to determine the extent to which there is consistency between the available evidence and the recommendations of experts at the level of policy formulation, implementation and evaluation. Well documented evidence will also facilitate effective feedback to influence future Botswana health policies and programmes.

The number of complaints in the Botswana media attests to the fact that the public has a poor perception of the quality of service delivery. With the purposeful use of evidence, however, authorities in government and the health sector would be in a better position to provide the rationale for health policy initiatives. Evidence-based information would also enhance the way in which the relevant authorities understand the nature and extent of health sector problems and assist in proposing more workable solutions. Armed with appropriate evidence, Government Ministers, policy makers and health sector authorities would be well placed to communicate their policy decisions to the public as well as defend such decisions. Evidence-Based Policy and Practice, which stresses ‘the primacy of client and user needs

and helpfulness' (Allen 2007:5) is significant for Botswana, where advocacy for customer care is on the increase.

It is noted that world-wide, there is general consensus among health service planners that evidence-based policies and practices should be the guiding principle wherever possible. Studies abound attesting to the advantages of having policies that are grounded in proven results and measurable outcomes. There are, however, various notable challenges to the effective implementation of evidence-based policies and practices. Davoudi (2006) writes that some of the challenges arise because of practical and institutional short-comings in decision-making processes which differ from the perfect rational planning model as is presented by the rhetoric of evidence-based planning. Various studies have indicated that much research-based evidence tends to be shelved by policy-makers because planning in the real world is also influenced by 'political and social ideologies and laden with value judgements' (Davaoudi 2006:5). Davoudi also refers to a UK Cabinet Office report which pointed out that not much of the research commissioned by government departments or other academic research was put to use by policy-makers.

The use of evidence in policy-making has to contend with factors such as ideological values and institutional beliefs which can determine the outcome of the policy-making process. In some instances, evidence may be used to justify pre-conceived policy directions, in which case policy becomes the outcome of a political process whereby evidence that is contrary to the chosen direction is disregarded. The institutional pressures for quick decisions make it difficult for policy-makers to review evidential documents which may be voluminous or too technical for them to make sense of. The challenge to the use of evidence in policy-making may be compounded by occasions where the available evidence is of poor quality as when it is incomplete or contradictory.

There are challenges, however, with the requirement that decisions be evidence-based, for example, the issue of *what* counts as evidence and *who* counts it as evidence. Nutley *et al* (2003) noted that there is no agreement as to what counts as evidence with research-based evidence being just one source amongst many. This has the attendant problems of selection as well as assessment and prioritisation of evidence in social sectors such as the health sector where the outcomes of interventions tend to be multiple and of a contested nature. It is noted that even in the medical field where evidence is said to be scientifically based, there is still some controversy as to whether this is not more of assumption than fact (Borgerson, 2003). Definitions of evidence in the social sector, therefore, tends to be context specific. Nutley *et al* (2003) aptly observed that there are gaps and ambiguities in research-based knowledge which makes it insufficient to inform policy and practice in the public sector. The fact that what counts as evidence is

decided on by experts or those that produce research documents, which are in themselves of dubious methodological quality, rather than the needs of the users of the research compounds the problem.

Chapman (2004), commenting on the public sector policy making process, argued that some approaches, such as the evidence-based approach, had presumptions that are not universally true. He contended that, firstly, evidence-based methods of policy making presume that the evidence that one collects in one context will necessarily apply in another yet contexts of policy making differ. Secondly, the evidence-based approach, he also argued, presumes a linear relationship between cause and effect whereas complex systems involve a number of feedback loops which contribute to non-linear behaviour. Thirdly, he stated, the evidence on which policy is based is quantitative and the unintended consequences of public policy are systematically ignored because the evaluation only measures outcomes which are intended.

Although much of the literature on evidence-based policy and practice acknowledges that there may be other factors like political and economic expediency that shape the formulation and implementation of policy, it is generally agreed that the use of evidence has potential advantages. Davies and Nutley (2002:3) suggest, as one way of improving evidence use in policy and practice, ‘a strategic approach to the creation of evidence, together with the development of a cumulative knowledge base.’ Notwithstanding the challenges faced by policy-makers in utilising evidence for policy-making, it is necessary for policies elsewhere and in Botswana to be based on transparent approaches so that they can be defensible. The outcome of policies has to be effective and this can be facilitated by policies based on realistic assumptions.

1.15 Need for realistic assumptions about conditions necessary for the implementation of performance improvement initiatives

This study assessed the extent to which the process of implementing performance improvement initiatives in Botswana avoided pitfalls of copying wholesale international cases that were reported as having worked exceptionally well elsewhere, for example, in Singapore. The objective of introducing performance improvement initiatives in an organisation is not to mimic international success stories, since conditions for implementation are not identical, but to adapt reforms so that they are implemented in the most efficient way. Merely adopting or transplanting initiatives tends to have implementation problems since conditions in the new setting may not be identical to those where the initiatives originated from.

Assumptions about conditions necessary for successful implementation of performance improvement initiatives need to be realistic. The new initiatives needed to be matched with the specific conditions of the health institutions in Botswana in order to attune the initiatives to the environmental reality or culture of the institutions so as to enhance the chances of success. The introduction of the initiatives was not an end in itself but a means to an end which was to improve customer satisfaction, a mission achievable through the generation of creative ideas, not mere replication of best practices. It was borne in mind in this study that the creation of much activity, such as the establishment of various teams in institutional departments or units, with respect to the new initiatives, was not necessarily an indicator of successful implementation. The value added by the initiatives to the work output counted more than the mere process of introducing the initiatives.

The study assessed evidence that suggested the failure by health service managements in the health sector to think critically about the requisite conditions for effective implementation of performance improvement initiatives. Such assessment of unrealistic expectations regarding the initiatives shed light on institutional decisions taken to either continue with initiatives or lose interest in them, after some period of intense introductory activity. The literature indicates that in instances where particular initiatives are deemed to have fallen short of meeting expectations the problem does not always lie in faults inherent to the initiatives themselves but in the institutions embracing initiatives without a rigorous interrogation of the environment in which they were to be applied. In such cases, a cycle of implementing different initiatives would begin anew, making the attempts at introducing subsequent improvements more difficult. The results of such short-comings are cynicism in the employees, a loss of management credibility and, overall, a wasted effort and resources.

1.16 Introduction to the statement of the problem

1.16.1 Identified problem that militates against the successful implementation of performance improvement initiatives

This section outlines the statement of the problem which provided the rationale for the study, as well as the aims of the study. Concerns expressed by the national leadership regarding the inadequacy of strategic management in the public service have been referred to in presenting the statement of the problem. The chapter also elaborates on the value of the study and why it has been worth doing. The theoretical framework, defined by Borgatti (1999:1) as ‘a collection of interrelated concepts’ served the purpose of guiding the research and identifying pertinent aspects for measurement in the study.

In identifying the main problem hindering the successful implementation of performance improvement initiatives in the Botswana health service, the investigator has benefited from having worked in the country's public health sector in a managerial capacity over a ten year period since 1999. The investigator's role in the Ministry of Health Headquarters was to coordinate administrative and personnel management functions as well as liaising with health partners of the Ministry, such as donor organisations. Besides information gleaned informally, the investigator is aware of documentation that abounds on customer satisfaction surveys to indicate that there is a culture of indifference amongst health sector employees, more notably in the public health sector. The Botswana President, Festus Mogae, (cited in Hope, Sr., 2000) stated in a 1993 introductory speech to the Performance Management System (PMS) initiative, that there was inadequate strategic management by managers in Government Ministries and Departments. The political leadership through the Office of the President was instrumental in the 1990s in introducing management initiatives or strategies that were meant to improve productivity at the work-place. In the public sector, such initiatives included Total Quality Management (TQM), Work Improvement Teams (WITS) and PMS. In spite of these initiatives, there has not been much evidence to suggest an improvement in productivity compared to the period before their introduction. Hope, Sr. (2000) observed that despite the reforms, some public service institutions still perform poorly.

1.16.2 Statement of the problem

This research will assess the perceptions that selected respondents in the health sector have about the extent to which performance improvement initiatives are effectively and efficiently implemented in the provision of health services in Botswana. A significant amount of resources are expended in the Botswana health sector to address national health needs with the aim of improving the health status of the nation. Part of this expenditure includes the implementation of performance improvement initiatives. During NDP 8 (1997-2003), for example, expenditure on the health sector represented 10.3% of the government's total expenditure on development (WHO Country Cooperation Strategy: Botswana - 2003-2007). It is, however, not clear the extent to which more resource allocation translates into quality health care. A Government of Botswana Customer Satisfaction Survey for the Public Service (2005) revealed that the Ministry of Health recorded the second lowest overall satisfaction rating in the public service. The impact on health indicators depends on numerous factors such as the efficiency and effectiveness with which health programmes are implemented. It is, therefore, necessary to ascertain within the Botswana context the major hindrances to the effective implementation of performance improvement initiatives in the health sector.

There is concern in various quarters about the low level of productivity in the Botswana public service in general and the health sector in particular. This has negative implications for the efficiency and effectiveness with which services and goods are produced in the health sector. Molale (2006), at a seminar at which the performance of the public service was discussed, noted in his capacity as the Permanent Secretary to the President, that some of the challenges that the political leadership was facing included poor delivery of public services, poor implementation of projects and programmes, low productivity and poor work performance in general. He also stated that Government was having to deal with public accusations of its perceived insensitivity to public demands, needs and aspirations coupled with lack of accountability and discipline in the provision of services.

Chirairo (2008), following a survey conducted by EOH Consulting and Credmark EDC, observes that the public, private and parastatal sectors in Botswana were facing challenges of implementing change for the improvement of performance and service delivery. He noted that performance reforms introduced by the Government followed a realisation that unless there was an improvement in service delivery, Government departments and the private sector would continually face challenges in fulfilling their mandates. Specifically, service delivery challenges in the public service were said to be characterised by a slow responsiveness to customer needs, low productivity levels, poor work ethic, inadequate and irregular performance reviews, and rewarding inappropriate behaviours. The Consultants concluded that it was necessary that a culture change programme be defined and implemented in order to entrench high performance and service.

Marobela (2008) states that reforms to improve productivity were justified on the premise of poor performance by public sector workers with managers ever engaged in efforts to change workers attitudes and perceptions about the quality of their work. There was still much room for the improvement of productivity then, long after the 2002 productivity week in Francistown, the second city of Botswana, whose theme was 'efficiency and effectiveness: the smart choice to customer satisfaction.' The NDP9 (2004-2009) stated that one of the challenges faced by the government was the as yet unmet public expectation for more improved services since the introduction of PMS.

Official statements made at various national work-related awards have indicated that productivity improvement, which is critical to the realisation of the Vision 2016 ideals, has continued to be elusive over the years. There has been general acknowledgement that much remains to be done in productivity improvement, hence, customer service has been compromised. It is notable that although a number of performance improvement initiatives have been introduced in the Botswana public sector, the health

service organisations included, what is not clear is the extent to which there is an uptake of the initiatives by the health staff and the way in which they contribute to productivity in the public health sector.

The study process involved an assessment of the evidential base for sustaining the three-fold hypothesis which emerges from the assumptions based on the implications of the statement of the problem in section 1.16.2 that is;

- i) performance improvement initiatives were imposed in a top-down manner in the Botswana health sector with the noble belief that they were valuable in contributing towards the achievement of the goals of Vision 2016;
- ii) there is limited knowledge on the part of the health workers at the operational level regarding the usefulness of the performance improvement initiatives and this contributes to their low uptake of the initiatives in the Botswana health sector
- iii) the frequency of complaints by health services consumers is a reflection of the poor quality of health services provided in the health sector in Botswana.

The assumptions, defined by Abdellah and Levine (1986:122) as ‘statements whose correctness or validity is taken for granted’ were instrumental in shaping the course of this study.

The study assessed the quality of evidence at the two levels of health sector policy formulation, implementation and evaluation, cross-cutting four key quality indicators of efficiency, effectiveness, empowerment and equity. The empirical study assessed the perception of these concepts or indicators held by staff and by patients in the health sector. This constituted the model for the research. The main focus of the study was on understanding the experiences of respondents in the study in their context or natural setting. It was necessary to define three closely related terms, that is, productivity, efficiency, and effectiveness as well as the context of the terms ‘empowerment’ and ‘equity’ in this study. The main interest of the study centred on the process of introducing and implementing performance improvement initiatives in the Botswana health sector.

1.16.3 Three-fold hypothesis: To what extent is it unique to Botswana?

Socio-economic development in African countries, which attained their national independence in the late 1950s and 1960s, had depended on the effectiveness of the public sector in the different countries to succeed. Writers such as Garnham and Haque, (cited in Ayee, 2005) state, however, that generally the public sector was not able to perform its function effectively due, amongst other reasons, to its indifference towards public needs and demands.

The literature indicates that most of the strategies undertaken by African states to improve the performance of their public services have not been able to achieve desired results due to constraints of a political, historical, economic, institutional and cultural nature. Following studies in Sub-Saharan Africa, Kuada (2003) notes that scholars have emphasised the importance of context, especially the cultural context, to the behaviour of managers and administrators in the public sector. He noted that indications are that development is constrained rather than supported by the social structures and relationships within the traditional societies. From a cultural perspective, studies of the behaviour of African managers showed a lack of the generally accepted principles of good management with evidence of wanton indifference to organisational performance, poor strategic management and unsatisfactory productivity levels. The economic success of Botswana, which has been singled out as one of the most remarkable in Africa, has been criticised in some circles as having been beneficial to a few elites at the expense of the majority.

Unfavourable government policies, poor management practices and negative employee attitudes all combine to support the view of an African continent with a public sector that has a culture of poor implementation of performance improvement initiatives. The framework for the hypotheses in this study is, therefore, not unique to Botswana even though it is nuanced by the specific cultural features of the Botswana.

1.17 Broad objective

To make an assessment of the performance improvement initiatives introduced for the purpose of improving the quality of health services delivery in the Botswana health sector.

1.17.1 Specific objectives

The specific objectives of this study are to:

1. assess the performance of the improvement initiatives from the point of view of the policy makers
2. assess the health sector staff knowledge and their perception of the effectiveness and efficiency of the performance improvement initiatives.
3. examine the perceptions of the health sector staff regarding internal equity and their empowerment to implement the performance improvement initiatives.
4. examine the perceptions of health service consumers on the quality of health care received.
5. To explore the various mechanisms of empowerment and equity in health services provision among the consumers of health services.
6. make recommendations to the Botswana Ministry of Health based on the study findings.

1.17.2 Research questions

- i) What are the expectations of the policy makers on the outcomes of the PIIs implementation?
- ii) To what extent are the health sector staff aware of the existence of the performance improvement initiatives and what are their perceptions on the effectiveness and efficiency of the initiatives?
- iii) What are the opinions of health staff regarding internal equity and their empowerment to implement performance improvement initiatives?
- iv) What are the perceptions of the health service consumers regarding the quality of services in the wake of the introduction of performance improvement initiatives?
- v) What are the opinions of health service consumers on the fairness of access to health care and what empowerment mechanisms are in place to facilitate such access?

1.17.3 Relationship of broad objective to the hypotheses

The rationale for the three hypotheses in this study came from concerns raised in official Government circles about perceived poor work performance in the public sector. The hypotheses, as indicated in section 1.16.2 are: performance improvement initiatives were imposed in a top-down manner in the Botswana health sector with the noble belief that they were valuable in contributing towards the achievement of the goals of Vision 2016; there is limited knowledge on the part of the health workers at the operational level regarding the usefulness of the performance improvement initiatives and this contributes to their low uptake of the initiatives in the Botswana health sector; the frequency of

complaints by health services consumers is a reflection of the poor quality of health services provided in the health sector in Botswana.

The hypotheses led to the broad objective. The extent to which performance problems in the Botswana health sector could be associated with limited knowledge on the performance improvement initiatives and the factors that may contribute to the perceived low quality health services in the Botswana public health sector were explored. The study involved an examination of the opinions of the senior management in the Ministry of Health regarding the effectiveness and efficiency of the initiatives and the manner in which the initiatives were introduced to the staff. The investigator sought to find out why the initiatives do not seem to achieve the desired results, in view of the points stated in the hypotheses. The study explored the manner in which strategic preparations are undertaken regarding the planning mechanisms for introducing the initiatives and the extent to which the management process ensured the requisite participation of stakeholders during the implementation of the initiatives. The information obtained served as the basis for achieving the objective of making recommendations to key personnel in the health sector on how to enhance the quality of evidence at the levels of policy formulation, implementation and evaluation.

A literature search indicated that major type changes tend to fail more often compared to smaller changes since they require more participant commitment, knowledge and adaptation to organisational culture. Improvements that require a cultural change of the participants, for example, take longer as they necessarily have to overcome greater resistance to change. Where the cultural characteristics required major transformational changes, it was important to find out how the process of instilling values such as commitment and the ability to adapt to a new way of operating in health sector organisations is handled in Botswana.

The objectives of the study, in relation to the hypotheses, are to examine the importance of the human factor in the selection of organisational improvement initiatives. The exploration of the means by which organisations carried out their strategic functions in the planning for and implementation of initiatives is meant to assess the view that there is limited knowledge on the performance improvement initiatives as outlined in the hypotheses and this took cognisance of the fact that it takes time to have stakeholder acceptance and implementation of initiatives.

The study objectives facilitated the exploration of the hypotheses to gain an understanding of how the health sector performance improvement initiatives were implemented with particular reference to whether the initiatives were implemented *continually* or *continuously*. The continual introduction of initiatives

would imply that the implementation process would have allowed pauses between implementing new changes to allow for reflection and stabilisation of the change before the next improvement was made while the continuous application of new initiatives would indicate a less systematic way of managing the improvement process. The relationship of the objectives of the study to the hypotheses is as indicated in Figure 1.4 below;

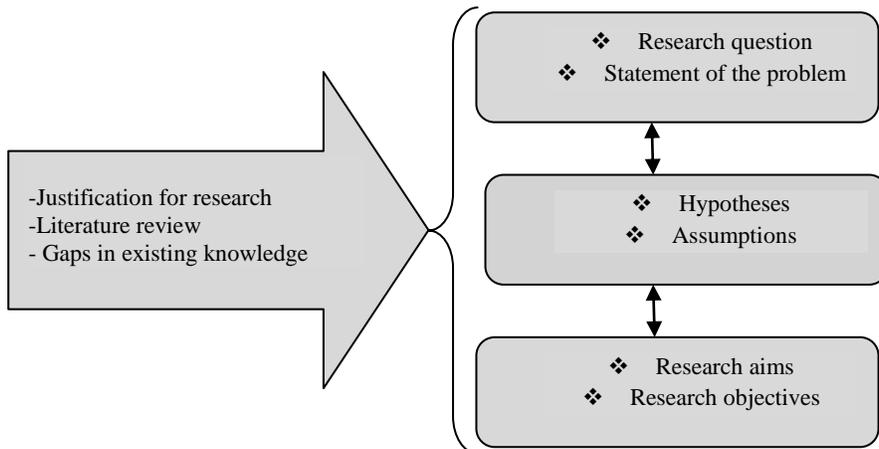


Figure 1.4: Relationship of research objectives to hypotheses

1.18 Chapter summary

The main priority of the Botswana Government after the attainment of independence in 1966 was the formulation of public policies meant to address the imbalances of underdevelopment arising from the colonial policies. Economic development was seen as the vehicle for enabling the provision of social services like education, health, housing and clean water in Botswana. The commitment of the government to supporting the private sector for the latter to play a more meaningful role in socio-economic development was emphasised. The commitment is evidenced by government efforts at facilitating public-private partnerships in various sectors including the health sector. Productivity improvement was prioritised by the government in an effort to achieve its goals through initiatives such as Total Quality Management, Work Improvement Teams and the Performance Management System. One of the key policy and strategy concerns is the need to identify the challenges and constraints that are likely to be faced in the implementation of public policies. This will facilitate a charting of the way forward in terms of enhancing policy reforms. To this end, the Vision 2016 is viewed as an important framework for national development in Botswana.

Some of the challenges encountered in the provision of health services in Botswana and the measures taken to address them were discussed in this Chapter. Reference was made to key Health Acts and policy documents that guide the provision of health services. The significance and need for evidence-based decisions in the health sector was also explored. It is commendable that the drafting of Health Acts in Botswana has been done in a framework that recognises that the health of the nation cannot be tackled only through activities that are confined to the health sector. The Health Acts reflect the element of the social determinants of health, thus offering broader solutions to health problems.

Evidence-based policy and practice already has a receptive environment due to the democratic system of government that obtains in Botswana. The need for realistic assumptions about conditions necessary for facilitating the implementation of performance improvement initiatives was looked at. The performance of the public sectors in developing countries, including Botswana, are largely characterised by a variance between objectives and reality.

The problem statement indicated in section 1.16.2 provided the rationale for the study. The statement provided the performance improvement research context related to issues of productivity in the delivery of health services. It was noted that there are comparatively high health sector expenditure levels yet it is unclear the extent to which such expenditure translates into productivity. Such a scenario, it was argued, calls for an assessment, within the Botswana context, of the major hindrances to the efficient and effective implementation of performance improvement initiatives in the health sector.

The theoretical assumptions that the initiatives have been imposed in a top-down manner, the limited knowledge of the initiatives by the health sector staff and the view that public complaints are a reflection of poor quality health services generated an argument for the research questions in this study. The assessment of the extent to which the three-fold hypotheses based on the assumptions is unique to Botswana indicated that the hypotheses can equally be applied to many other African countries which seem to face similar problems as in Botswana. Through the results of the study, a determination will be made as to the appropriateness of the theoretical assumptions. A section of this chapter indicated the linkage of the main aims of the study to the hypotheses.

Chapter Two will explore the concepts of efficiency, effectiveness, empowerment and equity and the worldwide managerial reform based on these concepts. A literature review with special reference to performance improvement initiatives studies conducted in Africa and in other continents will be conducted.

CHAPTER TWO

2. LITERATURE AND THEORY FRAMEWORK

2.1 Introduction

This chapter will discuss the concepts of effectiveness, efficiency, empowerment and equity and explore the world-wide managerial reform related to these concepts. The concepts constitute the quality criteria for assessing health management policy and practice. The way in which efficiency and effectiveness relate to productivity will be examined. The discussion on empowerment will make reference to some variations of power and how they relate to the performance improvement initiatives. References to “equity” will be in the context of the health services employees and health care consumers. Emphasis will be placed on why the health sector needs to take seriously issues of organisational efficiency and the issue of making trade-offs in considerations of efficiency, effectiveness, empowerment and equity will be discussed. The effect of vested interests in the management of health services and issues of health governance will be examined. The chapter will also include a literature review with regard to research on performance improvement initiatives in the health sector.

2.2 Effectiveness, efficiency and productivity

2.2.1 Effectiveness

According to the Glossary of Project Management terms (2004), ‘effectiveness’ refers to a measure of the ability of a programme, project or task to produce a specific desired effect or result that can be qualitatively measured. Effectiveness, therefore, measures the quality of meeting objectives. Roberts (1994:19) defined effectiveness as ‘how well the process actually accomplishes its intended purpose,’ from the customer’s point of view. Pryor (2008) identified some effectiveness measures that included how well the output of the process meets the requirements of the end user or customer. Generally, the literature indicates that effectiveness is about doing the right things. Some signs of ineffectiveness would, therefore, be defective products and services that do not meet the quality standards expected by customers hence leading to customer complaints. It is incumbent upon organisations to make a situation analysis of their current performance levels in terms of effectiveness so that they can take measures to uproot causes of poor performance. Organisational measures to achieve effectiveness have to take into consideration

the strategic direction of the organisation in order to attain success. With an ever enlightened customer to deal with, the providers of health services need not only be concerned about the efficiency of their internal processes but about whether they meet the needs of their customers in the provision of health care. For the organisation to be guaranteed of success, it has to be adaptable to the changing environment in which it operates.

Sahni (2009) describes the characteristics of an effective organisation by stating that the criteria for effectiveness can be classified into tangible or inorganic criteria and intangible or organic criteria. The author noted that the literature identifies tangible criteria as quantitative measures of an organisation such as relative performances in finance, sales, manufacturing, purchasing and profits. In a hospital setting, management effectiveness could be measured in terms of factors such as bed occupancy, revenue, profits, inpatient and outpatient admissions, the number of surgical operations and the number of deliveries. In the measurement of efficiency, however, Peacock *et al* (2001) observe that benchmarking studies that measure hospital efficiency in gross terms such as the total number of patient cases, patient days, or performed surgeries risk making biased comparisons, especially against health institutions that treat a large number of severely ill patients.

Some authors maintain that intangible criteria are more reliable hence the preference for organisational effectiveness to be measured on the extent to which the organisation increases its own worth to its members and to society in general. In a hospital, effectiveness would be evaluated in terms of the extent that it promotes societal health, helps to sensitise communities against diseases, and improves the general quality of life of community members. Other examples of intangible criteria include: the extent of members' identification with organisational objectives; their levels of motivation; the extent of teamwork; the extent to which members feel that their contributions are appreciated by management; the adequacy of the communication process and the leadership qualities of the senior officers.

Brown (cited in Sahni 2009) believed that it was difficult to make a determination of the effectiveness of an organisation just by examining the results. It was noted that results were not of much help in determining organisational effectiveness due to the difficulty of ascertaining causal factors or a cause and effect relationship. In such circumstances, aspects such as the speed and efficiency with which management decisions are made were important for effectiveness assessments. Sahni, (2009:3) summarises the criteria for organisational effectiveness as the 'extent that the goals of the individual members, groups, and the total organization are integrated.'

A Herman Miller publication (2004) defines effectiveness as the amount of physical output for each unit of productive input. The publication stated that effectiveness with regards to organisations encompasses productivity and noted that the problem with effectiveness measures are due to the difficulty of defining output for non-manufacturing service activities commonly thought of as ‘white collar’ or ‘knowledge work.’ In the health sector, knowledge workers undertake problem-solving activities and draw on complex bodies of knowledge to solve work-related problems. The challenge of measurement, in service organisations, such as the Ministry of Health, is that it is not easy to quantify all components of the productivity mix. Due to the interdependence of efforts of knowledge workers, their contribution to overall organisational effectiveness poses challenges because no single measure can easily account for the outcomes. It is notable that in organisations, every employee contributes to organisational effectiveness, even though depending on skills, experience and rank, some employees may play a bigger role than others. Measurement of the effectiveness of knowledge workers, which is necessary to direct human capital towards identified organisational goals, can be done through involving them in the identification of the measures so that they have ownership of them, establishing a culture of trust that gives employees freedom to control their work processes and creating conducive conditions of work in general.

The Adizes website (2010:1) notes that to be effective means ‘... to produce that for which the system was established. It means to provide the desired function.’ For an organisation to be said to be effective, it is noted, there is need to try out different solutions until the right one is found, hence mistakes can be tolerated in the process. Such mistakes are not viewed negatively since making choices necessarily involves making mistakes which can be considered as a waste of energy. In the long run, however, being innovative can be rewarding to the organisation as this is required to keep pace with the changing needs of clients. An assessment of the effectiveness of an organisation involves ascertaining whether clients come back for more services and in the case of a monopolistic organisation, whether clients would come back, given a choice.

2.2.2 Efficiency

‘Efficiency’ is measured by the volume of output achieved for the input used. When activities are said to have been carried out efficiently the understanding is that there will have been a prudent use of resources, which are often limited, with results being achieved at minimum cost. The efficient use of resources is achievable through systematic planning and adherence to standards and procedures. Heyne (n.d.) writes that to economists, ‘efficiency is a relationship between ends and means.’ He goes on to state that an activity is regarded as inefficient if the desired results can be achieved with less inputs or if the inputs used can produce more desired outputs. In the Adizes website, (2010:1) efficiency was described as ‘....

the way in which you carry out a process. It is measured by how many units of input are needed to produce one unit of output.’ A system was said to be efficient if it can carry out its process with the minimum energy possible and this required that entities be organised, systematised, and programmed. Characteristics of an efficient organisation are the existence of a prescribed system which spells out in detail when, where, how and with whom to do what and this is done with a minimum energy wastage with little room for mistakes.

Peacock *et al* (2001) examine two types of efficiency in relation to the health sector, that is, technical efficiency and allocative efficiency. They noted that in the context of attaining health outcomes, technical efficiency is achievable through the application of cost-effective care procedures with the least inputs. Allocative efficiency, on the other hand, is achieved through the selection of a set of technically efficient health programmes that will produce the best possible health improvements for communities. The authors note that this definition of efficiency is specific to health services since health care efficiency is assessed in terms of achieved outcomes rather than outputs produced. They state that the measurement of efficiency in the health sector is complicated by health and health service specific characteristics hence the need to adapt and modify efficiency concepts and evaluation techniques in the study of health care efficiency. The evaluation of health services based on health outcomes is partly due to market anomalies such as the limited knowledge that consumers of health services have about the care that they receive. It is noted, for example, that costly medical procedures may have little effectiveness when the benefits to the recipients of services are considered. Peacock *et al* stated that in the health sector, efficiency improvements can yield considerable resource savings or expansion of services to cater for more community members and that the lack of expertise in evaluation techniques can present a barrier to the use of efficiency measures and impede the management of health service resources.

Greenberg (2006) reports on the proceedings of a conference held in Wisconsin, United States of America the purpose of which was to discuss the issue of efficiency in health care delivery. The consensus at the conference was that while it was generally acknowledged that the American health care system did not operate in an efficient manner, it was challenging to improve efficiency without an agreement on what constitutes efficiency, how to measure it and what needed to be done in order to improve on efficiency levels. The conference participants noted that efficiency in health care is challenging to define mainly because efficiency is a relative term and the type of elements of health care delivery that are valued are influenced by different individuals’ perspectives. The perspectives may, for example, be those of purchasers, health service consumers or providers of health services who may have different ideas on what constitutes quality care. Public and private purchasers were concerned about getting value for

money for the health care benefits that they paid for, providers preferred to measure efficiency based on the processes that they were engaged in, while consumers had negative ideas about health services that were viewed as being provided cheaply as they felt that 'cheap' implied low quality. It was noted that in spite of significantly high health care expenditures, there was no significant health improvement in the health of the nation which meant little impact on beneficiary outcome. Cost and quality were not correlated since some lower cost health institutions produced high quality care while some high cost health facilities produced low quality care. Conference participants could not state with certainty what and how many health care service inputs were required to produce the greatest amount of efficiency.

2.2.3 Productivity

Hope, Sr. (2000:125) defines productivity as the effective and efficient use of resources to achieve outcomes. Productivity is viewed as a ratio to measure how well an organization converts inputs into goods and services. The inputs or resources that are converted to outputs include labour, materials and machines. The Accel-Team [2004] noted that productivity can be improvement made by: achieving more output for the same input; achieving the same output from less input; achieving much more output for slightly more input; and getting slightly less output for significantly less input.

Field (2002) states that essentially, productivity is a ratio to measure how well an organization converts input resources, that is labour, materials or machines, into goods and services. The author noted that the ratio of inputs to outputs or the cost per good or service is not, on its own, a measure of how efficient the conversion process is. He presented a Productivity Conceptual Model (see Figure 1.1) in which the roots represent the inputs to the system, the trunk the conversion process and the foliage and fruits denote the system's outputs.

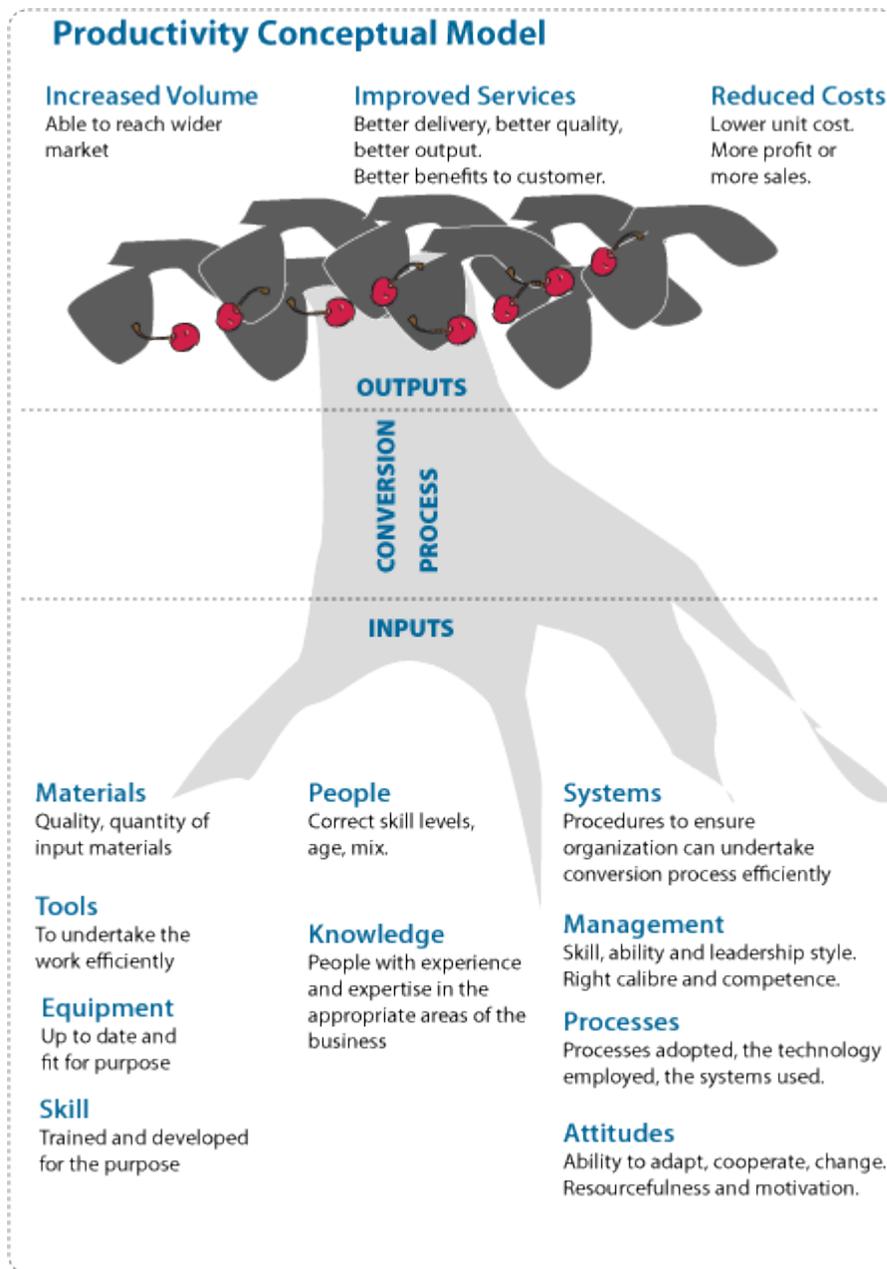


Figure 2.1: Conceptual model of productivity

(Source: Field R. H. G., 2002:1)

In a health service institution, the inputs would include a mix of technical personnel skills and leadership as well as medical equipment required to carry out day to day health service delivery duties which would go through a conversion process to, ideally, provide affordable and accessible services to the institution's catchment population.

Field (2010) stated that in order for an organisation to achieve effectiveness, it needs to successfully respond to environmental factors. He noted that because organisations operate under different environments, there are various models for determining organisational effectiveness whose development is dependent on two dimensions, that is, the organisation's internal focus in relation to its external focus and its emphasis on flexibility versus control. Flexibility in organisational operations enables the entity to quickly adapt to environmental changes while control tends to support more maintenance of the status quo. Innovative activities are more valued in organisations characterised by a flexible management style while those that emphasise the importance of control, stability and predictability have more routine activities but face major challenges with regards to managing change. Effectiveness requires that an institution be concerned with the feelings, needs, and development of its human resources rather than just be task oriented. In the case of a health institution, when it is effectively in control of its internal dynamics, it stands a better chance of satisfying its most important constituents, that is, its stakeholders who include patients and the community at large.

A Herman Miller publication (2004) notes that productivity has been a human concern for centuries. It states that the Chinese philosopher Mencius (372–279BC) wrote about conceptual models and systems that would be classified in modern times as production-management techniques and as such, early thinking about productivity remains relevant to this day. As for effectiveness, what has become more complex is the measurement of production. It is generally acknowledged that in traditional productivity measures the unit of analysis in the measurement of productivity was the individual which, however, may be irrelevant in measuring the productivity of knowledge work because increases in individual productivity does not necessarily translate into the productivity of the organization. What matters most, in organisational settings, is the productivity of the team which becomes the unit of analysis. Managers need to aim for the implementation of activities that lead to the achievement of overall organisational goals and this requires that special attention be paid to issues of organisational design, the harnessing of technological developments at work, and the effectiveness of human resource management and staff working conditions.

Organisations need to focus on implementing the critical activities that will lead to success and make optimum use of time. Miller (2010) concurs with this view as he states that there is need to gauge employee productivity through productivity indicators or metrics, also known as the critical success factors, which will depend on the nature of the services provided by the organisation or the corporate objectives. The identification of key performance indicators facilitate the measurement of progress towards the attainment of organisational goals. Productivity, therefore, depends on an organisation

eliminating the trivial or non-essential tasks to concentrate on the vital ones through the stream-lining of organisational work processes.

Wehrich and Koontz (cited in Kabumba, 2005:3) state, with reference to productivity in the African context, that: ‘... the urgent need for productivity improvement is recognized by government, private industry, and universities’. The author also referred to a publication by the United Nations Economic Commission for Africa [UNECA] [1991:1] which stated that ‘...increased productivity holds the key to economic wealth and high standards of living in general, and ... improved public service productivity is an important factor in promoting and sustaining socio-economic growth and development.’ Organisations, both in the public and private sector aim at delivering results by focusing on ways to enhance their productivity levels.

Kabumba (2005:7) made a distinction between skill work, which tends to be more physical, and knowledge work, which involves less physical effort, and noted that the measurement of productivity tends to be problematic in service provision due to this distinction. Skill work, such as that done by technicians, is easier to measure while knowledge work, an example of which is management, is not easy to measure. It is generally accepted that productivity measures are particularly difficult to apply in service industries such as in the health sector due to the complexity of measuring service outputs. Nevertheless, it is still possible to determine how well the resources of a service organisation are being used in the production of its services. It has been noted that the difficulty of measuring knowledge work is no excuse for failing to promote productivity in service sectors since even in these sectors it is possible to identify hard workers and those whose level of commitment falls short of organisational expectations.

In order to achieve productivity targets, organisations need to have the requisite resources including a skilled and committed workforce. Productivity measures are necessary for planning, monitoring, and improving performance as well as for the development of long-term organisational strategies. Such measures play a role in the motivation of staff as they help to identify the level of financial incentives to be paid for high productivity.

2.3 Relationship between efficiency, effectiveness and productivity

Kelly (2001) writes that efficiency means saving time, money and effort. He states that usually it is not feasible to achieve both efficiency and effectiveness, hence an organisation has to decide which of the two criteria is more important, depending on the organisational goals. The implication is that some

organisations will place more emphasis on efficiency over effectiveness while others will value the latter more. One can, on the one hand, deduct that since health service organisations are in the business of saving lives or improving life quality, more effort is bound to be directed at achieving effectiveness rather than make savings on inputs where efficiency and effectiveness are not achievable at the same time. On the other hand, efficiency and effectiveness need not be compared in terms of which of the two is more important. This is because effectiveness relates more to the attainment of desired goals while efficiency has more to do with the process of attaining those goals. The reality is that resources, whether financial, material or human are often limited and it is necessary for the health service organisations to conduct activities efficiently and effectively. While there may be consensus among policy makers on the need to rationalise the allocation of resources through prioritisation of health services, the criteria for making priorities is contentious.

It is acknowledged that the achievement of effectiveness in the operations of an organisation does not necessarily mean that its processes are being efficiently carried out. The two concepts are related not interchangeable since it is possible to have two similar organisations achieving identical goals but with one doing so using less resources than the other. In this scenario, both will be effective in the sense that they achieved their intended goals but the one achieving goals with less resources will be more efficient. On the other hand, it is possible to have organisations being highly effective but without a corresponding efficiency in their processes. This can be possible in situations where there is more concern with the ends rather than the means, resulting in the achievement of goals but this being accompanied by wastages in the management of resources. An organisation can also be primarily concerned with prudence in the management of inputs at the expense of achieving positive outcomes from its operations, in which case operations would be efficient but with little to show in terms of intended tangible results.

Peacock *et al* (2001) state that the concepts of productivity and efficiency are commonly used interchangeably to describe the comparative performance of units of production. It was noted that the two concepts are related but not identical. The authors described productivity as a gross concept measurable by the ratio of products to inputs. Efficiency was explained as being a component of productivity.

2.4 Empowerment

Nanette (1999:3) defines empowerment as ‘a multi-dimensional social process that helps people gain control over their own lives.’ An important element in this process is its ability to instil in people the capacity to implement changes by acting on issues that they define as important in their lives. Central to the concept of empowerment is the issue of power which is defined in terms of individuals’ or groups’

ability to have their will prevailing regardless of the will of others. In this study, there is a departure from the view of power as being primarily about control and domination. Rather, as noted by Nanette (1999:2), power can also be viewed as not being absolutely a zero-sum but as having aspects that, in relationships, can be characterised by collaboration, sharing and mutuality. The above views on empowerment apply equally to organisational employees and clients of health sector organisations.

2.4.1 Variations of Power

The International Online Training Program On Intractable Conflict (1998:1) in an article entitled “The Nature of Power” simply defined power as “the ability to get what you want ...”. critique of many performance improvement initiatives tends to categorise them as purposive in the sense that they have set goals and targets that may not be congruent with those of the interests of the users or implementers of the initiatives. Purposive systems are associated with a type of power that is often referred to as “power-over” since this kind of power usually comes from threat or force. Senior management are, for example, in a position to force subordinate staff to comply with requirements of implementing initiatives even if they may not agree with the manner of implementation. In organisations, such control is through the use of formal authority.

“Power-over” is distinct from “power-to” which is the ability to do something on one’s own or based on ones’s abilities through qualities such as intellect or knowledge. The literature identifies a third kind of power relationship referred to as “power-with” which is the ability to work with other people and cooperatively achieve goals. The International Online Training Program On Intractable Conflict (1998:1) defines “power-with” as “the power of consensus--the power of people working together to solve a common problem”. Heron (1981:9), in making a distinction between “power-over” and “power-with” explained the latter as meaning “power with my choices, power with others, power with processes that I choose to apprehend in the world”. He related this to the making of autonomous choices which emanate from a well-informed grasp of the relevant facts of particular situations as well as values and norms which one will have freely accepted and committed to.

The most ideal kind of power relations, with regard to the implementation of performance improvement initiatives in organisations would be the “power-to” and the “power-with” where people are give some latitude to think and decide on the best way of carrying out work. The “power-over”, however, can be resorted to in times of emergency or where situations require that quick decisions be made, with little time for consultations.

The difference between the “power-over” and the other types of power relationships is metaphorically described in the article by Chapman (2009) in which he refers to the graphic illustration by Plsek involving the throwing of a rock and a bird. In the article, Chapman writes that “When the object being thrown is a rock, a mechanistic lump of matter, then Newton’s laws of motion and gravity allow us to calculate with great precision the exact force and angle required to get the rock to land in a predetermined place. However it is not possible to predict the outcome of throwing a live bird in the same way, even though the bird’s motion through the air is ultimately governed by the same laws of physics.” The point is that a bird is a complex adaptive system, as distinct from a mechanical rock, that can respond adaptively and non-linearly to environmental changes and decide where it will land.

Human beings in organisations, by virtue of falling under the category of complex adaptive systems, need to be afforded the opportunity to freely think about ways of implementing performance improvement initiatives rather than be subjected to top-down management systems, with all decisions made by senior management. Plsek pointed out that using the mechanical model on humans is akin to tying the bird’s wings, weighting it with a brick and then throwing it. A more useful strategy to achieve objectives would be to take into account the properties and behaviour of the concerned system rather than resort to control measures. Chapman (2009:17) stated that human systems are characterised by “unpredictability” and “uncontrollability” hence the need for a manager to adopt a learning-by-doing approach. Similarly, Seddon (2003), after researching the causes of failure of change initiatives, advocated for service organisations to change from command and control management systems or the power-over methods as described above to a systems design in the management of work to achieve improvements in performance. The management styles advocated for by Chapman and Seddon are the kind that appreciate the contributions of all stakeholders in an organisation.

2.4.2 Employee empowerment

Empowerment in the context of organisations can be regarded as the process of enhancing the capacity of individuals or groups to participate in major organisational decisions that affect them. The aim of participative management is to improve staff commitment to change. Fernandez and Moldogaziev (2009:3) observe that two distinct theoretical perspectives can be identified in the discussion of employee empowerment, these being the psychological and theoretical perspectives. They note that employee empowerment, from a managerial perspective is a relational construct that explains how managers share their power and authority with their employees, who are viewed as being powerless. The psychological construct, on the other hand, views employee empowerment as an internal cognitive state with enhanced

feelings of self-efficacy or increased intrinsic task motivation. Fernandez and Moldogaziev (2009:7) view the two perspectives as 'complementary pieces of a conceptual puzzle' since they only represent qualitatively different phenomena.

Doughty (2009) identifies some of the situations in organizations that can be evidential of lack of employee empowerment and these included circumstances when employees are not treated with respect, are exposed to arbitrary discipline and have their opinions dismissed without the necessary consideration by management. Doughty (2009:2) states that employees in such situations 'tend to be resentful, unmotivated and unproductive.' A more desirable situation, he notes, would be to have employee empowerment which contributes to a positive organizational culture that fosters mutual trust and respect between employees and management. Employees need to be given the opportunity to implement their ideas for the benefit of the organisation without relieving management of the authority to make strategic decisions. Doughty (2009:15) explains this situation by stating that employee empowerment is not about power but about productivity. He cautions against the type of consultation of employees in the workplace that does not translate into employee ownership and control of the work process but is in the interest of management.

The World Bank (2002) stated that empowerment involves the development of societies in such a way that their capacity to make choices that lead to the attainment of desired actions is enhanced. This idea can also be applied to organisations in that through empowerment, organizational efficiency and fairness have a better chance of being realised since stakeholders have the opportunity to influence decisions that affect their lives. The freedom of choice that organisational members will be accorded will be such that it is exercised within the limits of the organisational rules and regulations. Access to information and participation in decision making are some of the main requisites for the empowerment of individuals in organisations. Mutual trust is also an important element for the success of employee empowerment efforts since individuals are expected to be working for the good of the organization as a whole. Giving employees the responsibility for participating in decisions that determine their future in organizations improves their job satisfaction and self-esteem and helps them to identify with the goals of the organisation that they are a part of. Employee empowerment requires an openness of mind on the part of management which recognizes the value not only of listening to employees but also of approving those of their suggestions that advance the interests of the organisation. It is noteworthy, though, that employee empowerment does not relieve management of the ultimate responsibility for setting the strategic direction of organisations. This makes team-work an important feature of organisations where both management and employees are willing to pool their efforts to improve work performance.

Thomas and Velthouse (cited in Ongori 2009) developed a model which portrayed employee empowerment as being based on four dimensions that intrinsically motivate individuals on the job. The first dimension is meaningfulness which refers to the meaning of a value of a task goal, the second is competence, which is an individual's belief in his or her capability to perform tasks effectively, the third is self-determination or autonomy in the execution of work processes, and fourth is the perception of the extent to which an individual can influence work outcomes. The model states that an individual should experience all four dimensions of empowerment in order for an individual to be empowered. It is, therefore, the responsibility of management to create an enabling environment for the existence of empowerment in their organisations.

Ongori (2009) noted that a good leader in an organisation should be able to tap into the thoughts expressed by subordinates and inspire them by developing their strengths through training. He refers to the work by Kirwan (1995) who argued that there are four key ingredients for an organisational empowerment programme to succeed and these are outlined below:

- i. management support for employee empowerment
- ii. the need for management to take empowerment programmes seriously
- iii. management appreciation for ideas emanating from employees
- iv. setting up a system of team leaders, programme coordinators and evaluation committees to evaluate the progress of empowerment.

Ongori observed that in this era of globalisation, employee empowerment is necessary for the success and survival of organisations as it has a number of benefits. The advantages of empowerment include making employees feel that they are vital to organisational success through their involvement in decision-making as well as enhancing the employee commitment to the organisation and creating a sense of belonging. In addition, employee empowerment can make work more meaningful for employees through their participation in creating their own destiny. Through empowerment, there can be an increase in job satisfaction which contributes to organisational effectiveness and efficiency through more improved work performance.

Heathfield (2010) identifies some principles for employee empowerment which include a demonstration by management that people are valued as human beings, the sharing of leadership vision, mission and strategic plans through assisting employees to experience that they are part of the organisation and sharing the most important goals and direction with employees and allowing them to accomplish them

without management interference. She also outlines some factors that she believes contribute to a failure to effectively empower employees. Among the factors are the paying of lip service to employee empowerment by managers through half-hearted empowerment efforts, management not fully facilitating the mechanisms by which employees make decisions about their jobs and second guessing the decisions of staff who are supposed to have been empowered through constant changing of their decisions, thus undermining their faith in their personal competence.

Employee empowerment is a necessary part of organisational life and the literature indicates the various means of ensuring its existence in institutions through measures that include effective communication, availing development opportunities for individuals, recognizing the worth of staff through appropriate reward systems and seriousness in the consideration of the opinions of employees for improving the implementation of work activities.

2.4.3 Patient empowerment

Bos *et al* (2008) described ‘patient empowerment’ as a situation whereby citizens are encouraged to actively participate in the management of their own health. Bos *et al* (2008:1) observed that ‘patient empowerment is considered as a philosophy of health care that proceeds from the perspective that optimal outcomes of health care interventions are achieved when patients become active participants in the health care process.’ A necessary condition for patients to participate in the management of their health care is that there should be a transparent system whereby patients have access to the information that they need to be able to make rational healthcare decisions.

Organisational efforts at achieving the empowerment of patients emanate from the realisation that individuals are primarily responsible for their own health. With information about their medical condition at their disposal, patients are in a better position to ask health workers relevant questions about their health and thus make more informed decisions which contribute to them receiving more appropriate health care. The information given to patients, especially about the side-effects of medications should be in a language that they understand. The literature indicates that quite often, the relationship between the receivers of health care and the health providers of health care is unequal since the latter have the more advantageous position of having acquired professional knowledge and control of health resources which renders the former powerless. The relationship between the two tends to be skewed in favour of the health professionals with the clients further disadvantaged by virtue of their physical or mental condition.

The problem of disempowerment can be worsened during hospital admissions where some patients feel that in addition to being 'stripped' of their personal possessions (for safekeeping) they are also deprived of their personal identities and individual human rights, for example, through having their names substituted by codes, such as bed numbers. The dignity of patients may be eroded in the process. Patients need to know that in spite of the condition that has brought them into contact with the health service providers, they are still regarded as human beings with rights which have not been made any less important by the misfortune which befell them. Where it is not detrimental to the effective delivery of health services, the realisation of individual needs and preferences should be facilitated by the health professionals. It is important that such facilitation be extended to cover issues of privacy and cultural or religious beliefs.

It is noteworthy that a holistic view of patient empowerment is that the empowerment is not restricted to the individual making choices about their health care but also applies to decisions about their social situations at large. Efforts to change individuals' lifestyles without their involvement in the making of crucial decisions have the risk of ending in failure.

2.5 Equity

2.5.1 Equity in relation to health service employees

According to WikED (2006:1) Equity Theory is a theory of 'social justice according to which people perceive a situation as fair when their own ratio of outcomes to inputs is the same as those of others with whom they compare themselves.' In an organisational setting, the outcomes are the benefits such as salary and recognition arising from inputs which are the perceived contributions including seniority, education, skills and effort. According to the theory, management should strive to maintain a fair balance between inputs and outputs to ensure a productive relationship is achieved with the employee, with the overall result being contented, motivated employees. Fowler (2006:1) observes that the theory is built on the belief that employees become de-motivated if they think that their inputs are greater than the outputs. Internal Equity refers to fair compensation with respect to how different positions within an organization relate to each other while External Equity describes competitive compensation that takes the market value of a job into consideration.

Garret (2005:14), expounding on Rawls' theory of justice, wrote that 'access to the privileged positions is not blocked by discrimination according to irrelevant criteria' and that 'responsibilities ---- should be distributed according to ability -- '. Even though this comment applied to society in general, it is specifically applicable to organisational settings as well. The employees may react to any perceived imbalance through a number of ways including a reduced effort, disgruntlement, being difficult employees, making demands on management for improved conditions of service or by seeking employment in other organisations. The job inputs considered by employees include time, effort, skill, ability, loyalty and personal sacrifice while the job outputs encompass benefits such as salaries, perks, security, recognition, further training and development as well as responsibility and career advancements such as promotions.

It is apparent that the benefits that employees expect from the work-place cover a wide range of issues besides monetary gains. This, therefore, suggests that the factors that motivate employees are more than just the salary and allowances of a financial nature. Of significance is that there should be a fair balance between what employees perceive as having been what they put into their jobs and what they get in return as rewards for performance. The fairness or equity is measured by each employee through a comparison of the factors mentioned above as representing the inputs with the outputs in relation to the inputs and outputs of other employees working under similar circumstances. The emphasis on how equity is perceived is not, therefore, dependent on an employee's individual circumstances alone but on a comparison of that ratio with the ratio of work colleagues. One can interpret this scenario to mean that the perceptions that employees have about the ratio of other employees is not always based on fact since there are other factors like rumours or gossip that may help to shape such perceptions. Rumours of this nature, which have the potential to destabilise the work environment may be countered through transparency on the part of managers regarding personnel policies.

An organisation's human resource policies, if not viewed as equitable, can have a negative impact on its image and contribute to a high staff turnover as well as adversely affect its efforts towards recruitment and employee productivity. It is noted that perceptions of inequity in the form of an individual being aware that s/he is overpaid does not normally lead to dissatisfaction on his/her part because such a situation has less tension compared to a situation where an individual has perceptions of inequity arising from the belief that they are underpaid. Studies have indicated that individuals react differently to perceptions of inequity depending on the location of the referent others. When perceptions of inequity are, for example, based on comparisons with staff in other organisations, staff members are more inclined to quit employment and make efforts to join the higher paying organisations. When the perceived

inequity is regarded as being based on internal comparisons, employees tend to remain on the job with a reduction of their inputs. While employee perceptions regarding equity issues are expected to differ, it is generally accepted that internal consistency is achievable when employees believe that the remuneration for each job is depended on its worth to the organisation, which can be determined through a job evaluation. The level of skill and amount of responsibility required to perform activities for each job would assist in assessing its worth.

An important contribution of Equity Theory is that it offers an explanation as to why employees satisfied with their work situation at one period can later be demotivated without any change to their work conditions simply because they may have learnt that their colleagues under similar circumstances are enjoying a better output to input ratio. This should alert managers to the fact that lack of transparency in handling matters of employee promotions and salary rises can have the effect of de-motivating other employees.

2.5.2 Equity in relation to health care consumers

Equity in health, viewed from the point of view of ‘consumers’ of health services, is to do with perceived fairness in access to health resources. Health inequities refer to differences in health status that are traceable to unequal economic or social conditions which, because they are avoidable, are unfair. The Equity Network (EQUINET) (2010) viewed health equity as addressing disparities in health status that are unnecessary. The Network noted that in Southern Africa, such disparities relate to racial groups, rural-urban set-ups, socio-economic status, gender, age and regional or geographic background. Cited as some of the priority areas for attaining equity in health systems were the following;

- i) the establishment of people-led, people-centred health systems that empower and value community members
- ii) the introduction of fair, sustainable and equitable financing for health so as to promote the universal right to health
- iii) ensuring the availability of adequate, well-trained, equitably distributed and motivated health workers.

The achievement of health equity, therefore, is mainly concerned with equity motivated interventions that seek to allocate health resources preferentially to societal groups that are the least privileged.

Persad *et al* (2009:1) note that in health care and in other social sectors, 'scarcity is the mother of allocation' because demand often exceeds supply. Controversy always surrounds attempts to equitably distribute health resources and it is generally acknowledged that no single method can allocate the resources in a manner that can be regarded as just by all members of society. In order to minimise controversy, a number of principles are often combined in the quest to attain a more acceptable outcome in the allocation of health resources. The problem, especially in developing countries, is further compounded by the lack of reliable or evidential data for decision-making, as would be the case with poverty indicators in that there is often a dearth of updated information.

Equity mechanisms are normally introduced by governments as a reflection of the political will to improve the access to health services by the majority of citizens, with particular concern for societal groups that would otherwise not be able to benefit without assistance, for example, the poor, aged, minorities and mentally ill. Measures to improve access to health may include the introduction of compulsory health insurance, pre-payment schemes, fee exemptions as would be the case with infants and the elderly, and free medical care for communities. Other mechanisms to achieve equity may encompass general government subsidies resulting in an overall reduction in user fees, subsidies based on geographic characteristics and the provision of equity funds for vulnerable groups. General government subsidies have the effect of reducing user tariffs for whole populations while geographically based subsidies take into consideration that fact that some regions may be economically disadvantaged due to varying factors such as rough terrains, bad roads and exposure to natural disasters.

Efforts to achieve health equity may also include the provision of incentives, financial or otherwise, to health staff who work in regions that tend to be underprivileged and are shunned by health employees. Equity funds serve the purpose of incentivising institutions or authorities that provide health services to vulnerable societal groups that cannot access services due to the inability to pay for direct user fees. Free medical care in developing countries has often faced major challenges because of the narrow resource base of most of the countries, thus forcing them to consider cost recovery in health services provision as a more viable option.

Examples abound in Africa attesting to the difficulty faced by countries in their efforts to equitably allocate health resources. In South Africa, Philip (2004) observed that the country has one of the most inequitable societies in the world as far as the distribution of health resources is concerned. This arises from societal disparities, even in the post-independence period, due to large differences in income and the distribution of key social services. The differences, which are also reflected in the health sector, are largely attributed to the systematic discrimination against some racial groups, especially the majority

blacks. Philip (2004) indicates that there is a need to measure and monitor the allocation of resources relative to need within provinces. Briscoombe, *et al*, (2010) in their examination of Kenyan efforts at achieving the equitable allocation of health resources found that the allocation of health sector financial resources remained centralised and was based mainly on the previous years' budget allocations rather than on the health needs of communities. The researchers concluded that the allocation of health sector funds in Kenya has not addressed regional disparities in health access. Semali and Minja (2005) conducted research in Tanzania where they analysed needs-based activities the purpose of which was to equitably allocate health resources in the country. The research revealed that health services are not equitably distributed between geographic areas and that urban districts had better health care access than rural areas. There were also large regional differences in the level of health care funding with the anomaly that districts that were economically better-off received slightly more resources from the Ministry of Health.

2.5.3 Problem of deciding on morally relevant values

The methods of resource allocation are complicated by the fact that there are no value-free criteria for basing allocations on. Persad *et al* (2009) discuss a number of principles that can be used for making health allocation decisions. The principles include making decisions on whether to prioritise: the worst-off or sickest people first; the youngest; the largest number of people; people with a better prognosis or life years; and instrumental value allocation which prioritises specific individuals to facilitate future usefulness. Prioritising the sickest first in the allocation of health resources would include people needing organ transplants, for example those with heart and liver ailments who may be treated at high cost even though the prognosis may not be good. During the NDP9 period, the Botswana Ministry of Health had a difficult time trying to convince citizens that medical conditions requiring organ transplants could not be prioritised due to a shortage of financial resources. Patients needing organ transplants had to go to South Africa for such services.

Youngest-first health resource allocation has also been criticised for ignoring prognosis and excluding elderly citizens who also have the right to life. Age has also been criticised for being a non-medical criterion. Prioritising resource allocation decisions on the basis of saving the largest number of people is said to have the advantage that it avoids the moral complications of having to compare individual lives. It can also be argued that the right to life is by itself an important factor to be considered in saving lives even though the prognosis may be poor. With regard to instrumental value allocation, decisions on the value of individuals can be very controversial.

It is apparent that no single principle can encompass all relevant values for the achievement of an equitable allocation of health resources. The general consensus among researchers is that a combination of various methods is necessary to attain an 'acceptable' level of equity in resource distribution. The onus is on health policy makers to ensure that the public understands the basis on which the allocation of health resources is made through the formulation of transparent allocation measures.

This study highlights the need for policy makers and managers to understand the importance of issues of equity in relation to health employees. There is also a need to ensure that health resource allocation systems equitably consider the welfare of patients or consumers in terms of access to health services since health systems are mainly about the recipients of health services. Health policy makers and managers have to appreciate that processes aimed at improving individual or group conditions of service for employees and introducing equity mechanisms for the welfare of patients may actually generate more problems for health organisations than they attempted to fix because organisations are systems whose different components interact for the good of the whole.

2.6 Importance of organisational performance in health sector

Berman (1995:15) defines the health sector as 'the totality of policies, programmes, institutions, and actors that provide health care --- .' He observed that for the health sector to attain its objectives a number of strategies have to be in place and these include the strengthening of management, priority setting for assured interventions, decentralisation and enhancing the role of private providers in national health systems.

Bornstein (2001:6) states that performance improvement is 'a methodology for improving the quality of institutional and individual performance'. Rosenberg *et al* (2001:7) wrote that performance improvement is founded on the belief that 'to improve human performance, one must manage the performance improvement system, which must be the core of an organization's human resource efforts. Service providers need to understand their organisational systems and processes in order to improve them. According to Rosenberg *et al*, performance improvement mechanisms also focus on clients so as to meet their needs and expectations. The requisites for performance improvement initiatives to succeed are listed by Rosenberg *et al* (2001: 7-8) as the need for stakeholder agreement on the aims of the initiatives, the identification of performance gaps, implementation of the improvement initiatives and an evaluation of the implementation process.

On being asked about the constraints that they experience in the attainment of organisational objectives, most managers tend to mention the lack of resources of a financial, material and human nature. Kanani *et al* (1988) suggest a departure from this commonly held position by noting that several constraint analysis exercises show that, to a large extent, constraints have a non-resource aspect. This is an important revelation since even where resources are in short supply, other deficiencies are often present at the same time, for example, complex administrative procedures, inappropriate staff attitudes, and lack of management capacity to implement performance improvement initiatives. A valid argument exists for assuming that organisational performance improvement does not depend on pouring resources into programmes since there may be need to address other equally crucial areas such as strengthening the managerial capacity of relevant organisational staff. A publication by the Population Information Program (2002:1) states that: 'Performance Improvement is useful in resource-poor settings because it focuses attention on often-neglected causes of performance problems, such as unclear expectations or infrequent feedback, that need not be costly to correct.' The publication also noted that performance improvement techniques are necessary for solving problems and helping staff members to undertake new tasks or adjust to new standards of work.

Alavi and Yasin (2008) states that the apparent reluctance of service organizations to utilize quality improvement based strategies and practices is difficult to understand, especially in the context of the increased significance of the demands of customers. The researchers encouraged decision makers, based on the findings of a study that they had conducted, to commit organisational resources toward the effective implementation of quality improvement initiatives. They concluded that investing in quality improvement was not only justified, but also necessary in a changing competitive environment. The health sector needs to articulate a clear vision for quality and develop frameworks for quality improvement. The overall health sector goal should be to have continuous evaluation of health practices, programmes and policies that attain desired results while also concentrating on areas that need improvement.

Generally, a focus on performance improvement initiatives facilitates the use by the organization of systematic, evidence-based or best practices for resolving workplace problems rather than resorting to trial and error methods that may prove to be costly and ineffective. The value of systematic methods of tackling work performance problems is that the institutional context of the performance problem is identified and the requisite stakeholder consensus for problem solving achieved. The organisational members have the opportunity to reflect on the mission, goals, strategies, and culture of the organization which add up to increase the preparedness of the organisation to better attain its mandate. Effectively run

performance improvement programmes empower staff to develop the culture of identifying problems and seeking solutions either as individuals or as teams. Staff have clarity as to what their job is and are motivated by the awareness of how they contribute to the attainment of the overall institutional goals. The communication process between supervisors and their subordinates is enhanced through agreement of performance targets and the means by which they should be achieved. With periodic performance reviews, weaknesses in the performance process can be identified timeously and corrective measures taken to close any performance gaps. This introduces an element of objectivity and reduces the chances of employees feeling that their supervisors victimise them, in instances of poor performance, based on the supervisors' whims. Health care institutions can, through the application of performance improvement measures, be better placed to respond to clients' demands for quality services.

Health managers need to concern themselves with issues of improving the performance of their organisations so that they can achieve their mandate, which is to deliver efficient and effective health services to their target populations. Health service managers need to enhance the knowledge and skills of their staff for them to do a good job. They also have the obligation to coach them on what is expected of them so that they meet organisational expectations. Health managements, however, need to be critical in analysing the causes of inefficient or ineffective institutional performance since poor performance is rarely ever solely attributed to the employee's shortcomings in skills and knowledge but to other factors as well in the health system. The other factors that have a bearing on performance are the internal and external determinants such as motivation, incentives, environmental factors, resources, and leadership amongst others. Training, which was traditionally assumed to be the solution to organisational performance problems, is, by itself, inadequate. The analysis of performance issues by health managers should yield information that sheds light on how to bridge the gap between the current organisational performance and the desired level of performance. Bridging the performance gap requires that the management takes an active role in managing the institutional performance improvement systems.

Casto (2009) writes that in today's competitive health care market, customers have high expectations of quality health services. Health care organisations are expected to have ongoing performance improvement programmes since these are critical to the sustainability of their institutions. Cherian (2010:1), writing about customer care in a business environment states that: 'A repeat customer is the result of a relationship you have built up through excellent customer service.' This statement is, to a large extent, equally true for health institutions in the health sector with exceptions where the patients really have no choice but to go back to the same health facility. Since health facilities have the aim of improving the quality of life of their clients, managers have to ensure that this is made possible by

offering the best possible service which will make the clients happy to make repeat visits should there be need.

Wadhwa (2002) made observations with regard to the Australian health care system, which can be applied to other countries' health systems, that as the health care industry strains national financial resources, it has increasingly come under pressure to provide evidence of quality service and quality improvements. Wadhwa (2002:1) noted that: 'the current health care consumer is better educated and the best informed it has ever been.' The health care consumer is thus in a position to make more informed demands on the health system which has to respond to client requests for access to care, information regarding treatment options and participation in their own health care and treatment decision making process. Health care managers need to break with past traditions whereby health care system management was seen as supply driven and inefficient because it kept clients away from the product design, development and the delivery process. In the present era of health services management, where the customer may play a more pronounced role in influencing health care decisions, managers should adapt and be proactive in shaping the health system to meet the new quality focus through performance improvement initiatives.

Performance improvement principles are important for health managers as they emphasise the importance of teamwork, systems and processes, customer focus and measurement of work performance. The advocacy for teamwork takes into cognisance that organisational members have individual contributions to make to the overall success of their institutions and are inclined to participate more in the implementation of plans that they have assisted in developing. The emphasis on systems and processes is important for managers as it alerts management to the need for taking the lead in coordinating organisational efforts so that the various elements in the organisation understand how they interrelate with each other for the achievement of a common goal which is to meet the clients' expectations. The need for measurement in the management of performance is important from a managerial point of view as it brings to the fore the value of having reliable information which is evidence-based to facilitate the analysis of processes, identify problems, develop strategies and implement them and conduct evaluations in order to close the gap between the current performance and the ideal performance level.

Massoud (2001) points out that experience with implementing improvement initiatives in different settings, such as engineering and manufacturing, has contributed to a better understanding of how initiatives can be applied to the healthcare field. Health managers can take advantage of advances made in the development of the performance improvement methodology and its further application to a wide range of circumstances as well as the integration of evidence-based medicine in clinical quality

improvement activities to make adaptations for improving health management in general. The context of health services management is ever changing and this requires managers to keep pace with the new development in their management styles. The need to update performance improvement methods was aptly captured in the words of Berwick, (cited in Massoud 2001:13) when he stated that: 'Every system is perfectly designed to achieve exactly the results that it achieves.' This means that if the performance management system is flawed then the results of the performance will not be satisfactory since the system will not have evolved in line with environmental conditions. Health managers need to satisfy themselves that their performance management systems match the requirements of the work environment by identifying outdated processes for the achievement of optimum performance levels. Heiby (2001) states that it is generally accepted that the performance of health workers can, in addition to other factors like training, be influenced by the nature of the health system in which they find themselves. Health managers need to change the health system so that it supports improved compliance with evidence-based guidelines.

Coe (2004), in a review of a book by Kristin Baird, observes that health care has become big business, hence the need for improved performance in dealing with health care clients. Coe quoted statistics that indicated that: it is six times more costly to attract a new customer than it is to retain an existing one; a satisfied customer only tells five other people; an unhappy customer tells approximately twenty other people; and it only takes thirty seconds for a customer to form an opinion. In the light of such information, health managers have an obligation to ensure that the performance of their organisations is of a standard that adequately satisfies the recipients of health care. Coe (2004:1) states that: 'It is a fact--customer service expectations in health care are high, which creates a huge challenge for health care workers. We must make an exceptional impression on every customer, every time.' If health managers are to meet the high expectations of their customers, then they need to rise to the occasion and create an enabling environment for their staff to perform their customer-focused duties with the diligence required.

At a 2010 Beryl Institute Conference in Dallas with the theme 'Power of Impressions' one of the major conclusions was that as health services clients are required to spend more of their own money on health care, they will consider the entire spectrum of value, from access and expertise to service, convenience, and price. The Conference discussed research findings by management consultants, Katzenbach Partners, based on a survey of 1,003 Americans, that indicated that more than half of the participants said that they chose health facilities based on whether they believe employees understand their needs. The authors argued that improved customer service can lead to major improvements in the health care system because it had the potential to contain cost by limiting no-show appointments, the inefficiencies caused by switching providers, such as duplicated tests, and the inconveniences of malpractice suits. They further

noted that better customer service increased the satisfaction not only of patients but also of health care providers, contributing to the retention of key personnel. The conference recommended that health care providers should transform their organisations to focus on patient problems, provide innovative solutions and make the health system more efficient and effective. Health managers were encouraged to manage health care organisations in a way that made them responsive to clients' needs. The health facilities that failed to address patients concerns through customer focused initiatives risked losing business through their customers switching to providers that were more accommodating of customer needs.

According to Scientific Research Publishing (2010) knowledge gathered through satisfaction surveys is necessary for, amongst other uses, addressing the problems of patient access to health services and defining measures of performance. The health sector needs information on its customers' perceptions regarding the services received so as to constantly deliver higher levels of patients' satisfaction. Leaders of organisations in the health sector have an obligation to be concerned about the quality of service that they provide because of the special circumstance of their customers, that is, in the absence of medical training, the customers are less qualified than their providers to make decisions about the technical competence of health professional. Health staff, therefore, need to safeguard the interests of the patients so that they receive the best care possible. The requirement for management to prioritise the needs of clients is important since at times patients and managers have different perceptions of what constitute quality services, mainly because managers tend to be too optimistic about the service that they provide. The gap in the perceptions between the providers of services and the clients can be closed by a process whereby the former systematically determine patients' needs and prioritise activities to attain higher levels of performance.

Lande (2002), commenting on the importance of performance improvement initiatives, stated that health programmes that enable and inspire staff to do their best have the effect of also improving the quality of care provided. The importance of this observation for managers is that they need to realise that their staff need to understand what is required of them at the workplace as well as whether they are actually meeting organisational expectations.

Lande (2002:3) further states that 'Performance Improvement encourages use of evidence-based 'best practices.' In place of trial and error, it offers a systematic approach.' An important requirement for the success of performance improvement initiatives is the aspect of their inclusiveness through the empowerment of organizational members to work together to assess their work circumstances and look for opportunities of improving service provision to their customers. This means that health managers, by

prioritising performance improvement, can be more analytical in addressing the problems that affect the efficiency and effectiveness of their operations.

Evidence indicates that despite the Abuja Declaration of 2001 where African countries pledged to allocate at least 15% of their national budgets to the health sector, in most of them the allocation to the health sector is still far below that target. Kabeera (2010) quotes an Africa Public Health Alliance report that revealed that thirty-two out of fifty-three African Union member states invested below \$20 per capita in the health sector which is less than half the World Health Organisation recommended minimum. The report showed that some countries performed well with Rwanda having a health sector budgetary allocation of 18.8% followed by Botswana with 17.8%. On the lower side, Burundi was second from last with 2.4% and Somalia had the lowest percentage of a negative zero. According to the Africa Health Dialogue, Kenya allocated about 5.5% of total Government expenditure to the health sector in the 2010-2011 financial year. Through performance improvement initiatives, resource-poor environments, such as those commonly found in African health sectors, can benefit by focusing on priority activities in order to provide services that need not be costly to implement.

Health managers need to take seriously the implications of poor service delivery by their institutions. Institutions that are primarily profit driven and those that are guided by motives other than profit are faced with the same challenge of having to provide quality services to their clients to guarantee their sustainability. Ignoring the quality dimension in health service provision can only be done at the risk of health institutions losing clients.

2.7 Worldwide managerial reform based on efficiency, effectiveness, empowerment and employment equity

2.7.1 Efficiency and effectiveness

Mills (1995:1) states that there is general ‘concern over the efficiency of public sector health services in developing countries.’ The concern, she noted, arose from weaknesses associated with allocative as well as technical efficiency as the governments make efforts to provide accessible health care to their citizens for the purpose of maximising their health status. A major weakness noted by Mills in her paper is that although the issue of inefficiency in the public health sector can be addressed in terms of health outcomes, data on health status and expenditure are too poor to draw firm conclusions, hence the reliance on proxy

indicators. One of her observations was that the mix of public sector interventions is often inefficient in terms of technical and operational efficiency.

Mills (1995:5) noted that a major concern in developing countries was the low staff productivity in the public sector coupled with ‘a gross lack of the complementary resources that would enable them to practise.’ Some of the countries where there were quoted instances of technical inefficiency then were Nigeria and Uganda, with the latter, in particular, cited as having been in a situation whereby the level of health personnel could be reduced by 30% without impacting negatively on the quantity or quality of services. In Tanzania, many facilities were reported in one region as having fallen below the standard that might reasonably be expected both structurally and in process quality.

An observation by Mills (1995:5) was that ‘the evidence of greatest inefficiency comes from the poorest countries in Africa, ...’ making it difficult to generalise the findings, with the added problem that there is no conclusive evidence that the private sector performs any better. Some of the explanations for inefficiencies in the health sector management were attributed to: the dominance of the medical profession with little management training in health decision making; the inadequacy of information on costs and effectiveness thus rendering the health policy making process weak; public bureaucracies which do not offer incentives for resources to be used efficiently; weak planning and management structures; and poor staff remuneration contributing to low staff motivation.

Changes such as decentralisation of planning and management and organisational restructuring are often recommended to improve efficiency even though the efficiency gains are not guaranteed. Other recommendations for improving efficiency and effectiveness include allowing the local levels to retain all or most of the revenue that they collect to increase the resources available for use in providing health services. Mills (1995:11) quotes experiences of the Dominican Republic and the Bamako Initiative where this measure was reported as having been helpful in enhancing effectiveness, productivity and staff morale. Suggestions for governments to make improvements in the policy making process have also been made as a way of improving the efficiency and effectiveness of health service delivery. Other suggestions for attaining efficiency and effectiveness and thus meeting the goal of providing quality services to communities include improvements in planning and management systems within the health sector.

According to Crouse, *et al* (2010:5) ‘public health agencies ... are under pressure to meet new levels of efficiency and effectiveness’ since they are required to improve the quality of care and services provided

to patients and the public. These authors note that many organisations find it difficult to meet these demands because they do not turn the huge data collected into information to facilitate the measurement of processes, outcomes and quality of services. Crouse, *et al* (2005:6) quote a study by Price Waterhouse and Coopers' Health Research Institute which reported that about \$1.2 trillion of the \$2.2 trillion that the United States spends on healthcare is wasted. However, an American health care provider known as The Veterans Health Administration (VHA) is reported as having improved on its efficiency and effectiveness levels by having measures in place for workers to monitor their own performance and being held accountable for their actions. To improve on efficiency, organisations need to set key performance indicators so that they can monitor their operations. The efficient use of resources, necessary for the attainment of organisational goals, is also dependent on good management practices. Without appropriate management practices, inefficient and ineffective organisational operations occur due to the non availability of evidence of effective service outcomes.

A World Health Organisation (2010) publication on 'Assessing the effectiveness and efficiency of health service delivery' outlines indicators that include the following as signs of inefficiencies in health care delivery: lack of policy direction, with proliferating priorities, programmes and initiatives; poor quality standards of the provided care; proliferation of crises and emergencies; and disease outbreaks despite the previous application of supposedly effective control measures. Other signs of inefficiencies in health care delivery were stated as: duplication and overlapping of services and functions; replication of initiatives; ambiguity of functions and duties; disproportion between tasks and allocated resources; under-use of available inputs, including human resources; widespread waste and pilferage; and the abundance of broken-down equipment which is not repaired because of lack of funds, spare parts or technical skills.

Rice (2005) noted that the obstacles to efficient and effective reforms in the health systems of most countries are mainly due to: the lack of management engagement of the leaders of all stakeholders in the implementation of reforms resulting in lack of support and ownership of performance initiatives; leaders lacking agreement on how to measure the results or goals of reform; unclear reform goals; lack of leadership continuity among policy leaders resulting in inconsistent and unstable policies; policy makers lacking a formal plan to design then implement needed reforms; and policy leaders being too concerned about re-election to implement the required but difficult reforms.

Yale and Murphy (2007) report on a United Kingdom and United States of America study that focused on the health systems costs that arise from the failure to deliver effective health care as well as an assessment of the barriers to effective health services delivery. The key findings of the study were that generally, effective health care is the exception rather than the rule, ineffective care costs billions of dollars, and

non-financial incentives such as performance monitoring can lead to the improvement of staff performance.

Gittens-Gilkes (2009) observes that governments are faced with a situation whereby the cost of health care keeps rising yet at the same time the public increasingly demands high quality care but at an affordable price, a situation which calls for health managers to improve efficiency and effectiveness in the health sector to attain the goal of improving productivity. In the quest to achieve this goal, governments are guided by principles of equity, efficiency, effectiveness, quality, sustainability and social participation. Gittens-Gilkes, in the same publication quoted examples of countries in the Caribbean where attempts to improve productivity in the health sector were made. Some of the reforms, as in St. Vincent and the Grenadines (SVG) were a direct result of public complaints about poor health service provision.

The snag in the public health sector is the difficulty of defining the meaning of productivity and how it can be measured. Ruh, (cited in Gittens-Gilkes, 2009:2) notes that assessing the productivity in organizations that provide services is difficult because ‘once the service is performed, the evidence disappears.’ Nevertheless, productivity can be measured by the extent to which organizational goals are achieved and the efficiency of the organizational operations to ultimately provide satisfactory service to clients. Productivity is, however, dependent on employee motivation which can be achieved through employee remuneration that is based on performance set against organisational objectives. Gittens-Gilkes (2009:2) wrote that ‘a job low in motivation will lead to indifference.’ The challenge for public health institutions in achieving productivity is that they have to achieve quality care with limited resources as well as maintaining a motivated workforce.

Currstine *et al* (2007), writing about the challenges faced by governments of the OECD countries observed that their public sectors are under pressure to improve public sector performance and at the same time control the growth of expenditures. They noted that the citizens of these countries, as is the case elsewhere, are demanding that their governments be made more accountable for the management of public funds. The authors concluded that there is no blueprint for enhancing the efficiency of the public sector. The lack of a blueprint has contributed to the diversity of approaches adopted by the OECD countries for reforming their public sectors, including decentralization of functions, introducing competitive arrangements, streamlining budget practices, procedures and workforce structures as well as size. The authors stated that there was limited empirical evidence of the impact of reforms due to the countries’ lack of resources to conduct evaluation of programmes, the absence of a database of measures

of performance prior to the reforms, the complexity of measuring performance with regard to efficiency and effectiveness in the public sector and the difficulties of attributional factors or the effects of direct institutional reforms on efficiency from external influences. They proposed the following as possible solutions to the performance problems of the OECD public sectors:

- decentralization of political power and responsibility for managing budgets to sub-national governments
- the application of appropriate human resources management practices
- improving the scale of operations in sectors like education and health.

The OECD countries are reported to have benefited from the use of performance information for decision making in the following ways:

- it generated a sharper focus on results in the individual countries
- it provided more accurate information on government aims and priorities
- it emphasized the importance of planning and provided the evidence for what was working and what was not
- it improved transparency by availing more reliable information to the public.

The OECD revealed that human resource management practices are an important influence on the performance of the public sector with aspects such as employee satisfaction and morale being regarded as the most important factors affecting performance. While the monetary incentives that include salaries were important, the non-monetary incentives were equally necessary for the improvement of employee performance in the public sector. A draw-back in the use of performance information was that it was mainly used in the internal management of departments and agencies in the public sector but less so in political budgetary decision making processes or by the majority of political actors. Overall, the research evidence in the OECD showed that there were fewer success stories than had been claimed by practitioners due to difficulties related to how to improve the measurement of activities and the quality of information as well as the influence of many external factors on efficiency and productivity. According to Curristine *et al* (2007), there were also problems of reforms being driven by ideological factors and management fads rather than by matters related to efficiency concerns. In many cases, practitioners had a vested interest in the success of the reforms and tended to over-state their impact while governments, which had launched the reforms with much enthusiasm, had devoted few resources to evaluating them.

Some of the lessons learnt from the experiences of the implementation of reform initiatives in the public sector of the various countries mentioned above include the following:

- the design of public sector reform needs to be developed with a clear understanding of how the information collected will be used. In this regard, it is important to identify the end user(s) so as to have clarity as to the use of whatever information is collected.
- success in the implementation of public sector reforms is dependent to a large extent on the support of political and administrative leaders.
- the capacity of Ministerial departments and implementation agencies needs to be strengthened through relevant training and development mechanisms.
- outputs are easier to measure than outcomes hence there tended to be a narrow focus on efficiency and much less emphasis on effectiveness hence the needs of citizens were not always addressed.
- it is advisable to have a few targets to avoid information overload which makes it difficult to focus on critical priority areas.

2.7.2 Employment equity

Andreychuk (2007) reported on the findings of a study by the Standing Senate Committee on Human Rights to assess the extent of employment equity in the Canadian Federal Public Service with regards to cases of alleged discrimination in hiring and promotion practices. The issue of employment equity was important to the Public Service as the largest employer in the country and as such, it had to serve as a model for businesses in other sectors. In addition, according to Andreychuk (2007:3) employment equity was seen as critical for ‘strengthening public institutions and improving the quality of the public service as a whole.’ The Employment Equity Act which was effected in 1996 required employers to make an analysis of their workforces, review their employment systems, policies and practices and to remove barriers to employment equity. The Committee reported that there was much that still needed to be done to improve the working conditions of women, Aboriginal peoples and persons with disabilities. While the Committee acknowledges that some initiatives were in place to improve the working conditions, they were not being implemented effectively. Hence, the need for strengthened leadership, the development of concrete measures for the implementation of the Public Service action plan on employment equity and the removal of systemic barriers in the human resource management process.

Andreychuk (2007:13) notes that a 2006 performance report revealed that 'only five government departments received an 'acceptable' employment equity rating, four were seen as 'requiring attention' while all others were described as having 'opportunity for improvement'. Most of the barriers to achieving employment equity were linked to resistance to change due to historical reasons. It was also a significant finding of the Committee that progress in the achievement of employment equity depended much on changes to organisational culture. Andreychuk (2007:23) stated that the general observation of the Committee was that employment equity was not yet a reality in the Canadian Federal Public Service and that 'the government is not moving quickly enough and that the situation must be rectified.'

Sloane and Mackay (1997) reviewed employment equity and minority legislation in the UK over a period covering two decades since the 1970s and explored the fundamental question of the extent to which employment equity legislation had been successful in the elimination of discrimination against minority groups. These authors observed that most of the previous empirical work had focused on explaining earnings differentials without dwelling much on employment equity issues. McColgan (2004) examined issues of employment equity in the UK public and private sectors where it was noted that Government had taken measures towards mandatory pay auditing and the introduction of race targets in the public sector. They stated that proponents of employment equity had urged the Government to extend similar obligations to the private sector since employment equity was equally important in the private institutions.

Moleke (2006) commenting on the South African situation, observed that judging by the trends, the dominance of whites in management positions, especially in the private sector, was likely to continue, more than ten years after the attainment of political independence. He stated that the labour market was still racially divided in favour of the whites as was evidenced by statistics which showed that blacks, who constituted more than two thirds of the South African workforce, continued to hold low and semi-skilled positions in most organisations. While South Africa has a history of political and social discrimination in virtually all aspects of life which was advantageous to whites, it is disturbing to note that the discrimination has continued with little to show that the problem is being addressed. Moleke (2006:5) concluded that equity legislation alone was not adequate to address the problem of lack of employment equity. Instead, management practices that emphasised a holistic approach to human resource development were equally important, in both the public and private sectors.

Jongens (2006) wrote that following its transition to a democratically run government, the Republic of South Africa had the aim of changing a previously inherently discriminatory society into an equitable and productive one by using the provisions of the labour legislation. Controversial issues were being tackled

in organisations, such as whether they should replace white executives with black executives who may not have had the opportunity to prove themselves for the sake of complying with legislation. What could not be denied was the existence of systemic discrimination in South African organisations with poor management commitment to equity issues resulting in them having difficulties of retaining black people. Jongens (2006:12) stated that the ‘inflated expectations of black employees and the negative attitudes of many white employees and managers have not helped the process.’ Weaknesses of accountability, communication and feedback on reform processes characterised many of the organisations in the country.

2.7.3 Employee empowerment

Doughty (2009) states that in the United States of America there were legislative and administrative struggles over rules pertaining to employee empowerment, at stake being the issue of whether employee empowerment programmes that permitted employees to participate in employee committees for developing policies and practices were legal. Of major concern was whether the employee empowerment programmes would not assume the role of company unions. Such empowerment programmes were seen as a disguise through which management could manipulate employees to achieve goals that only benefited the former, thus circumventing the collective bargaining process. Doughty (2009:1) advises against such practices that serve the purpose of deceiving workers into acquiescing in their own oppression.

Peters (cited in Fernandez and Moldogaziev, 2009) wrote that the more employees are empowered at the workplace the more they are likely to be willing to work harder and treat their clients well since they will be appreciative of the good treatment that they also receive from management. Employee empowerment contributes to innovative behaviour by employees which helps to improve organisational performance. Fernandez and Moldogaziev reported on activities of the United States Office of Personnel Management (OPM) which collected information on the employee empowerment practices of sharing information, rewards, resources, and authority. These practices, with the exception of giving employees rewards on the basis of performance, were seen to motivate employees to seek better ways of performing their duties. Performance based rewards tended to encourage employees to adhere to traditional ways of conducting business instead of taking risks through innovations at the workplace.

Marchington (2001) cited participative management as a form of employee empowerment that can be achieved through practices such as communication that flows upward and downward in an organisation as well as via financial involvement, task-based participation and team working. These practices are cited as

being facilitators of employee empowerment because participative management aims to eliminate the factors that contribute to the powerlessness of employees at the workplace. Marchington noted, however, that the extent to which participative management can be said to be an effective vehicle for empowering employees is debatable because what may be seen as empowering from the employer's point of view may not be regarded as such from the point of view of the employees. The employees have to believe that the efforts to have them participate in organisation decision making are worth their while. Participative management should be assessed within its particular context in order to understand the real aims for its introduction within organisations. Altshuler and Zegans (cited in Fernandez and Moldogaziev 2009) found that in the American and Canadian public organisations, employees who were more likely to initiate innovations were career civil servants at the middle manager and front-line employee levels since they understood the needs of clients by virtue of being more in contact with them, unlike the senior managers. The managers at the middle and front-line levels were more proactive in granting discretion to lower level employees which worked well to motivate them to perform at higher levels.

Edwards (2010) observed that empowerment can vary in degree and scope through the various levels of an organisation. He gave an example of the Kanban system set up by Toyota in the 1950s regarding decisions made in planning, production, service and human resources. The Kanban system was an integral part of implementing the 'just in time' (JIT) philosophy which had the purpose of controlling inventory, reducing waste and achieving continuous improvement in the manufacturing process. The system, it was noted, started with decisions that involved quality control and this enabled employees to determine production levels in terms of when to start, slow down and stop production to meet customer demands. Employees were included in decision making through substantive consultation, rather than lip service consultation, of those directly involved with task performance.

The consultation process in the Kanban system was characterised by joint decision-making, hence the empowerment was not just a rubber stamp. Due to the empowerment of employees, the Kanban had the advantage of reducing costs and waste by improving the production flow. There was better management of inventory levels which further reduced overhead costs and ensured that products were delivered in time. In deciding to empower the employees, the Toyota management had realised that manufacturing was not just about the mechanics of production. Control was placed in the hands of the operators who were better placed to determine the level of production since they were quite knowledgeable of the daily work operations. Through empowerment of employees, the company was able to improve the responsiveness to changes in customer demands. Empowerment in the Kanban became an effective tool for reinforcing education and training, increasing mutual respect among employees, generating

enthusiasm, increasing dedication to the achievement of common organisational goals, lowering absenteeism and improving productivity. Yet another crucial advantage of the Kanban empowerment process, as noted by Edwards (2010), was that it minimised resistance to change among employees because they actually participated in the decision-making process and hence identified with the process.

From the foregoing, it is apparent that there is no blueprint for managerial reform based on the concepts of efficiency, effectiveness, empowerment and equity at the workplace. The lessons that one can learn are that countries need to adapt reform strategies to their local situations and that reform approaches should be dependent on evolving local circumstances. With regards to improvements in productivity, they can be realised more by addressing problems of bureaucracy, streamlining management practices and taking action to ascertain that communication flows in organisations are effective.

2.7.4 Efficiency, effectiveness, employee empowerment and employee equity - any room for trade-offs?

According to Yoe (2002) the definition of a trade-off is ‘giving up one thing to get another.’ Trade-offs can also be defined in terms of alternatives that are sacrificed when choices are made in decision making processes. The understanding is that all other things that could have been done instead are trade-offs, mainly because the reality of life is that due to scarcity of resources, we are not in a position to have everything that we want. Hence, we have to give up some things in order to gain others. A decision on what to trade off is based on an assessment of the cost in relation to the benefit of each option available for consideration. The making of decisions presents decision-makers with situations whereby they continually have to make trade-offs since using resources for one thing leaves fewer resources to undertake other ventures. Related to the concept of trade-offs is that of opportunity cost, which is defined as the next best option among the trade-offs.

A pertinent question considered in this study is the extent to which trade-offs can be made in assessing the importance of efficiency, effectiveness, equity at the work-place and the empowerment of employees in the health sector. The complexity of the health sector, which is described in section 2.5, is due to the multiplicity of various stakeholders that include policy makers, health managers, employees, and suppliers of goods and services and other interested parties whose opinions have to be brought on board in making decisions about health services provision. In a less complex setting, it can be argued, decision making would not have to be justified to anyone other than the body making the decisions. The values of the different stakeholders may be in conflict, hence a compromise may be necessary in the formulation of

processes for implementing efficiency, effectiveness, equity and empowerment in health institutions. For example, the application of equity policies and empowerment of employees, while a desired part of the work setting on the part of employees, may be seen as an erosion of the authority and power that often lies at the strategic apex in most organisations. While stakeholders are expected to be concerned about organisational effectiveness in the attainment of set goals, the efficiency or means by which the goals are achieved may also have to be satisfactory to management in terms of the sustainability of processes.

If it is acknowledged that trade-offs mean that more of one equals less of another, how much more can be acceptable of each of the principles of efficiency, effectiveness, equity and empowerment in relation to each other? What factors should management take into consideration in the management of such trade-offs? More importantly, are there any grounds for trade-offs in the application of these principles in health institutions? In addressing these questions, one needs to bear in mind that decisions often necessitate the selection of choices from among alternative options. Such decision making is often not easy, especially in instances where decision criteria are in conflict. With specific regard to the principles, the issue to consider is whether in the health sector, having more of effectiveness will mean less of efficiency and vice versa or whether more of empowerment may have some negative effect on any of the other factors.

Cases can be quoted whereby health institutions are run efficiently but without a corresponding achievement in effectiveness. In the same vein, institutions can be effectively run without being efficient in the management of their resources. To illustrate these points, the Adizes website (2010) describes a scenario whereby everything in an organisation is well organised with manuals and standard operating procedures so that everyone knows what to do and when and how to do it and work is conducted with little energy wastage. While the organisation follows its rules and policies religiously it, however, satisfies few needs because the clients' needs have changed over time unlike the organisational systems. Clients, for example, are required to fill out useless forms and to wait for an unnecessarily long time for products or services. Such a bureaucratic organisation would be ineffective even though it adheres to systems designed for efficiency. In order to be effective, the organisation would have to reorganise its operations in order to keep abreast with the clients' changing needs and as such, the higher the rate of change, the more the organisation has to make efforts to synchronise efficiency with effectiveness.

The decision making process with regard to these issues has to reflect the value system of the senior management tasked with setting strategies for institutions in the health sector. The thrust of the argument here is that managements need to pay equal attention to matters of efficiency, effectiveness, equity and empowerment in their health organisations. Both efficiency and effectiveness are important for

organisational sustainability in spite of the commonly held view that a system that places much emphasis on efficiency runs the risk of lacking innovative processes due to the limited choice available for conducting work and hence becomes less effective in the long run. Management needs to strike a balance between efficiency and effectiveness.

The application of efficiency, effectiveness, equity and empowerment in the health sector need not have zero-sum game properties where if one gains then another loses. The situation can be a non-zero sum but with all these factors making gains. The choice of empowerment does not have to depend on the considerations for internal equity. Some authors, for example, Kanarick (2008), while acknowledging that equitable human resource practices, particularly in remuneration, are necessary for the motivation of employees, have argued that creating a fair work environment should be considered secondary to the process of achieving organisational effectiveness and efficiency. The achievement of organisational efficiency and effectiveness is intertwined with a motivated workforce and hence the two cannot be separated. The decision making process concerning efficiency, effectiveness, equity and empowerment calls for a systematic and transparent approach that will take into account the characteristics of the health institution under consideration. Empowerment of employees, for instance, makes it necessary for management members to rid themselves of the thinking that they can wholly control the work environment without the input of the employees.

There does not seem to be any evidence to indicate that the webs of relationships among stakeholders in which organizations are portrayed and the manner in which the various stakeholders vie for the dominance of their opinions should detract from health sector efforts to implement policies that uphold efficiency, effectiveness, internal equity and empowerment of employees. Patient care need not be traded off with costs or efficiency since the goals of an institution or what it is capable of doing in terms of service provision should be clearly outlined from the onset. Both efficiency and effectiveness can only be realised through the efforts of the human resources whose motivation depend a lot on their perceptions of the seriousness with which management in health sector organisations facilitate internal equity and employee empowerment processes. In their attempts to satisfy the needs of different stakeholders, health institutions can still strive to introduce processes that emphasise the importance of efficiency, effectiveness, equity and empowerment as they are outlined in this study. The differences of the stakeholders, be they funders or clients, need to be reconciled in ways that are mutually beneficial for the parties concerned.

2.8 Effect of vested interests on the management of health services

An article entitled ‘Depression & pharmaceutical vested interests’ (2010:1) stated that ‘pharmaceutical companies in America would love to put every man, woman, and child on drugs. And the good doctors, and minions of the pharmaceutical companies are on board with that idea. ... But lets bring in the insurance companies because they will drop anybody that does not take their prescription medicine. And the only one losing in the process is the average American who is pumped up full of drugs because government, doctors and insurance companies are waging a conspiracy against Americans.’ Subedi (2010:131) noted that the President of the Association of Pharmaceuticals Producers of Nepal (APPON) acknowledged that pharmaceutical companies have been known to bribe doctors so that they prescribe their drugs, even though such drugs’ efficacy may not have been proven. This indicates that medical staff, pharmaceutical and insurance companies are not always self-less in their dealings with the public. The bottom line is that the importance of aspects of efficiency, effectiveness and equity in the provision of health services is, at times, relegated in favour of profit making by an influential system comprising of commodity and service providers. Subedi (2010) wrote that this primary concern with profit maximisation is pathogenic because it puts profit before people. The pharmaceutical industry, and by projection, the health system can be vulnerable to corruption and unethical practices consequently impacting negatively on initiatives that are aimed at improving the quality of health services provided to clients.

Simons (2010) observed that counterfeit drugs are being supplied to African nations, with the possibility of one in three medicines being fake, causing widespread suffering and death. According to Simons (2010:1) the World Health Organisation (WHO) efforts to tackle the threat are being thwarted by some pharmaceutical associations and lobbied governments which are more concerned with vested interests than African patients. Although developing countries are also members of the WHO, they have negligible pharmaceutical sectors hence the proliferation of counterfeit drugs. Simons (2010:2) wrote that the Organisation for Economic Cooperation and Development (OECD) recently estimated that up to 75% of the world's counterfeit drugs come from India, with the greater proportion of these ending up in Africa. Countries and pharmaceutical associations with vested interests even threaten to derail attempts at controlling the production of counterfeit drugs at World Health Assembly meetings where decisions are based on consensus and as such can be blocked by a small group of dissidents.

Philips (2008:1) wrote that in spite of requisite clinical trials, recent reports revealed that 106 000 people died from adverse drug effects that had been prescribed by doctors on the advice of pharmaceutical

companies in the USA. Statistics indicate that half of the advisory panel members in the research into drugs are consultants to pharmaceutical companies thus raising concern that decisions regarding post clinical trials would be skewed in favour of commercialism rather than the health of communities. Phillips, in the same publication, reports on findings of a study which showed that trials funded by non-pharmaceuticals tend to have a 50% chance of the results being regarded as favourable whereas pharmaceutical funded ones often have up to 90% of the results accepted. This obvious self interest tends to have an overall negative effect on the health systems' attempts to implement performance improvement initiatives.

Emanuel (2009) described some of the vested interests that influence the nature of the American health system. He noted that in the United States of America, large parts of the health system are owned by investors, through private health insurance, hence the system behaves like a profit-driven industry. The commercialisation of the health system, where records indicate that investors own about 20% of non-public general hospitals, almost all specialty hospitals and walk-in clinics has profound implications for the delivery of health services because to remain competitive, many not-for-profit hospitals promote their services just like their for-profit counterparts through advertising their facilities and services to the public. In such circumstances, medical care assumes characteristics of just another trade commodity, thus increasing health costs because health institutions concentrate on providing profitable rather than effective services, hence those who can pay for services benefit at the expense of those who cannot afford to pay. This scenario raises questions of the extent to which services are accessible to the majority in need of them. Such negative characteristics of the health system could have been given impetus by the American Medical Association (AMA) which declared in 1980 that medical practice was both a business and a profession even though it had previously urged health practitioners to refrain from entering financial arrangements with drug and device manufacturers.

Health systems have stakeholders that include manufacturers, wholesalers, retailers, prescribers, sales representatives, regulators, policy makers, researchers and health staff or implementers of health services. This complexity of the health system is, therefore, suitable for the application of systems thinking because the stakeholders involved are numerous, diverse and have different objectives which, in many instances, tend to be in conflict. Systems thinking, with its ability to analyse the network of interactions among the various stakeholders is ideal for finding the way forward in this apparent 'jungle.'

2.9 Health governance

The United Nations Development Programme (UNDP) (cited in Siddiqi, *et al*, 2006) described good governance as the exercise of political, economic and administrative authority in the management of a country's affairs at all levels through mechanisms, processes and institutions through which citizens and groups articulate their interests and exercise their legal rights and obligations. On a broad scale, good governance refers to the process whereby the political leadership of a country runs, controls, influences, and manages public affairs by cooperation between legislative, judicial and executive powers for the public interest of society. With specific reference to the health services, good governance refers to the delivery of quality health services to communities with particular attention to under-privileged social groups who are not in a position to access health services. Siddiqi, *et al* (2006:7) outlined the five UNDP principles of good governance as: legitimacy and voice, direction, performance, accountability and fairness. When applied to the delivery of health services, these principles can be interpreted as follows;

1. Legitimacy and voice; stakeholders in the health system have to participate in decisions that affect them.
2. Direction; the stewardship role is the responsibility of the Ministry of Health which sets the strategic direction through policy formulation and ensures implementation and evaluation of activities are conducted.
3. Performance; the process of delivering health services should be characterised by the optimum use of resources to produce results that meet the needs of target populations.
4. Accountability; this emphasise the need for transparency in operations of the institutions set up for the purpose of delivering health services.
5. Fairness; the need for equitable distribution of health services

Siddiqi *et al* (2006:5) outline ten principles of health governance based on an adaptation of the five UNDP principles of good governance to assess governance of the health system in Pakistan. In addition, the framework used incorporated key parameters relevant to health as articulated by different agencies,

such as the WHO's domains of stewardship, the Pan American Health Organization's (PAHO) essential public health functions and the World Bank's framework of governance. The ten principles were stated as follows;

i) Strategic vision

Leaders have the responsibility for planning the strategic direction for effective health and human development.

ii) Participation and consensus orientation

Communities should be allowed to participate in decision making regarding their health, either directly or through legitimate institutions. Good governance of the health system facilitates the bringing on board of differing interests to achieve consensus on health policies.

iii) Rule of law

Legal frameworks pertaining to health, especially the laws on human rights related to health, should be applied in a fair and impartially manner.

iv) Transparency

Transparency in a health system is largely dependent on the ease of stakeholder access to information for important health issues. Adequate information is required to monitor health activities.

v) Responsiveness

Institutions and processes should be designed to serve all stakeholders so that policies and programmes can be responsive to the health and non-health needs of clients.

vi) Equity and inclusiveness

All stakeholders should have fair opportunities to improve or maintain their health and well-being.

vii) Effectiveness and efficiency

Processes and institutions should attain results that meet client needs while making the best use of resources.

viii) Accountability

Decision-makers, whether in the public or private sector should be accountable to the public, as well as to institutional stakeholders.

ix) Intelligence and information

Evidence for informed decisions is dependent on intelligence and information, which are essential for a good understanding of a health system.

x) Ethics

Important principles of health care ethics include respect for autonomy, nonmaleficence, beneficence and justice. The ethics also extend to health research in recognition of the need to protect the rights of patients.

It is generally acknowledged that while the health governance principles are noble, the challenge for governments is to ensure commitment to these principles by health policy makers in order to contribute to better health outcomes. Commitment to health governance principles can be achieved through availing the necessary financial and material resources for implementing health activities and evaluating the governance process in the health system.

2.10 Value of the research

It is one thing to formulate strategies for policies and yet another to actually implement those strategies. One aim of this research will be to investigate the extent to which strategies that are formulated have actually been implemented for the attainment of set objectives. Integrated in the investigation will be an examination of the process of formulating the strategies with a view to identifying problems that may contribute to poor implementation of policies. There is need for the identification of strengths and weaknesses of the health delivery system which is a network of government hospitals, clinics, health posts and mobile clinics as well as mission hospitals and private health institutions. The study, therefore, aspires to generate sound information that will be useful for guiding decision-making to improve the implementation of performance improvement initiatives in the Botswana health sector.

The value of the research lies in the fact that the health sector is, generally, seen as the foundation without which activities in other social sectors cannot be executed fully. The effective implementation of health

programmes is a necessary requirement for future development otherwise development in a wider sense will be seriously inhibited. Results from this study should help to improve decision-making in the Botswana health sector and thus facilitate the optimisation of hospital services for the purpose of maximising patients' satisfaction.

2.11 Literature review

2.11.1 Introduction

Performance improvement initiatives are meant to enhance work performance and they are often introduced in organisations at high cost with much time spent on orienting organisational members to the new initiatives. Scholarly articles and publications that provide an overview of research on organisational performance improvement in the health sector were reviewed. Established procedures in different countries on the formulation, implementation and evaluation of performance improvement initiatives were assessed to identify their strengths and weaknesses. The literature review was guided by the purpose of the study and it helped to enlarge the knowledge of the investigator about the topic being developed. A literature search has also been done on publications on Evidence-Based Policy and Practice. The review provided a contextual framework for the research, indicating how the research fits into the existing body of knowledge, and flagging strengths and weaknesses or gaps in previous publications which this study will attempt to fill.

2.11.2 Comment on the health services management research traditions

2.11.2.1 Selected studies conducted in Africa

Dieleman, *et al* (2006) conducted an exploratory qualitative study in Mali in order to describe the factors motivating and demotivating health workers and matched the motivators with the implementation of performance management. The research methodology involved; determining what motivates and demotivates health workers: identifying which performance management activities were used and to what extent and how they were perceived by health workers and their managers; how the performance management activities matched with motivating factors. In-depth interviews and group discussions were conducted with the aim of identifying the range of motivating and demotivating factors and to explore staff perceptions on performance management. The sources and methods were triangulated by interviewing health workers and their managers at district, regional and central level and community

health centre committees. A total of twenty-eight individual interviews were held consisting of 12 health workers, 13 managers and 3 village committee members. In addition group discussions were conducted, four with health workers from teams working at commune level and four others with health workers at district level. The data analysis was through the Epi Info software.

The study findings were that the main motivators of health workers were related to responsibility, training and recognition besides the salary. It was noted that these main motivators could be influenced by performance management through job descriptions, supervision, continuous education and performance appraisal. It was revealed that performance management was not optimally implemented in Mali because: job descriptions were either not present or inappropriate; there was inadequate staff supervision with only 13% of interviewees having met their supervisors at least four times in a year; and there was no analysis of training needs. The majority of the employees perceived the appraisals as subjective with no other methods in place to show recognition of staff for work done. The researchers concluded that it was important for performance management strategies to be adapted or improved upon so as to influence staff motivation and that this could be done by matching performance management activities to motivators identified through the research.

The study by Dieleman, *et al*, has two aspects that are relevant to the main subject of this thesis on the implementation of performance improvement initiatives, that is, the issue of staff motivation and the methods of data collection through in-depth interviews and focus group discussions (FGDs) of which the latter was used with members of the public. The perceptions of sampled health sector staff on management efforts to motivate them was explored in this thesis since staff motivation is critical to the success of performance improvement initiatives implementation. While the planning for introducing performance improvement initiatives in an organisation may have been meticulously worked out, the organisational efforts could falter due to the lack of acceptance of the initiatives by staff tasked with implementing them. In addition to the in-depth interviews and the FDGs, triangulation through the use of different methods and the stratification of respondents according to regional levels of operation are also applicable to this thesis.

Dieleman and Harnmeijer (2006:21) observed that while critical to the performance of an organisation, the function of human resource management was a ‘neglected aspect in the health policies and plans of many health sectors in low-income countries’. Kolehmainen-Aitken (cited in Dieleman and Harnmeijer 2006:24) writes that ‘Managers must be able to supervise and motivate their staff, ensure appropriate tools and resources, and identify performance gaps and address these’. Martinez and Martineau (cited in

Dieleman and Harnmeijer: 2006) show that comprehensive performance management systems are almost non-existent in developing countries, with the performance improvement tools either outdated or poorly understood and, in some instances, management lacking the skills to implement them properly. Marquez and Kean (cited in Dieleman and Harnmeijer: 2006) argue that supervision and support are important for the enhancement of quality services. Staff require appropriate skills 'to work in teams and to solve and implement solutions' (Dieleman and Harnmeijer 2006:29).

A study on clinical practice in seven developing countries found that 75% of clinical cases were not adequately diagnosed, treated or monitored (Disease Control Priorities Project: 2007). The study concluded that the process of providing healthcare is often inadequate. More importantly, study results showed that higher spending on health service provision does not guarantee better care. Some of the provisions that can be applied, even in an environment of obvious resource limitations include the measurement of quality and feeding the information back into the system and the use of evidence-based criteria to link quality of care to outcomes (Disease Control Priorities Project: 2007:3).

The Marquez and Kean study and the clinical practice study reported above reached a similar conclusion in stating that efforts at improving performance often do not achieve the desired results. Marquez and Kean concluded that substantive evidence of the effectiveness of performance improvement strategies was limited while the Disease Control Priorities Project indicated that channelling funds towards health care services is not a guarantee of successful implementation. In systems thinking terms, this would require an identification of the causes of failure to attain objectives, rather having to deal with the symptoms of the problems.

According to Rawlins, *et al*, (2003:24) a study by the Training in Reproductive Health (TRH) Project in Kenya examined healthcare facilities providing family planning and reproductive health services to determine the factors contributing to high performance. The findings indicated that the exemplar sites had strong management or leadership, adapted to rapid and turbulent changes and held regular staff meetings to discuss performance problems and explore creative solutions.

In a study that evaluated changes in service quality and community involvement in forty-five health facilities in four districts of Senegal, Suh *et al* (2007) used checklists to assess quality in four areas of service delivery, namely infrastructure, staff and services management, record-keeping, and technical competence. The results showed that formative supervision contributes to the improvement of the quality

of health services. In addition, the involvement of community representatives and local health committees in the activities of health facilities was seen to be crucial.

Furth (2006) conducted a pilot study on performance-based incentives in two health districts in Lusaka, Zambia. The objectives of the study were to test the effects of financial and non-financial awards on health worker motivation and to assess the impact of performance-based awards on health centre performance. The study was significant in that it confirmed previous studies that reported on the need for strong, functioning management systems to enhance performance. Key to success in health services provision were leadership support, staff motivation, and staff incentives, especially the non-financial incentives such as recognition for work done. The importance of leadership in the implementation of performance improvement strategies is corroborated by the Healthcare Financial Management (2004:2) which states that ‘the way to improve performance must be facilitated by leaders ...’ The results of the studies reported by Rawlins, *et al*, Suh, *et al*, and Furth have similarities in that they emphasised the importance of the role of management even though they focused on different managerial aspects. The Zambian study by Furth, in particular, corroborated findings reported in the research referred to above by Dieleman, *et al*, (2006) which revealed that staff incentives need not necessarily be financial since non-financial measures could also be implemented by management to boost the morale of staff.

A Zanzibar health care worker productivity study conducted by Ruwoldt, *et al*, (2007) had the objective of providing the Ministry of Health and Social Welfare with information on the productivity levels of health care workers and identifying and selecting interventions to support improved productivity in the provision of health services. The benefits of productive work processes were stated as greater efficiency, reduced workload intensity and a higher quality of care. The study design was modelled after a 2000 health worker time use study that had been conducted in Tanzania by the World Bank. Through the observation of health care workers, the productive and non-productive uses of time were documented coupled with interviews of the health workers. At least one facility from each of the country’s ten districts was sampled resulting in 24% of the 126 public sector health facilities being selected for the study. The data analysis involved the use of Epi Info. Sixty-six (66%) of the sampled workers were females with just over a third of them (23) being nurses. There were only 2 doctors who, together with Clinical Officers, represented 11% of the sample. Paramedics comprised 26% of the sample. The study results showed that on average, health workers spent 61% of their observed on-the-job time doing productive activities and 27% of the observed time doing unproductive activities. Unproductive time while waiting for patients was significantly high at 20%, the equivalent of a full day in a 40-hour work week.

The conclusion of the study was that productivity may be influenced by patient management procedures, staffing patterns, supervision, training opportunities and the general work environment. It was also pointed out that health worker productivity was dependent on a comprehensive change process with all stakeholders willing to embrace the proposed change. Information on the purpose, benefits and anticipated results of the change needs to be disseminated to all staff involved in the change process after which the stage would be set for successful intervention. The study findings, which underlined the value of effective managerial processes, were in tandem with those of research reported by Rawlins, *et al*, Suh, *et al*, and Furth mentioned above, even though the methodology of conducting the research by Ruwoldt, that is, observation, was different.

Martinez, (2001:29) writes that research has revealed that only a handful of health systems, be they public or private, in developing countries use performance management systems and that in most of the countries, performance management is 'made up of a set of disconnected policies and practices'. The author further states that performance management initiatives tend to be limited by inappropriate organisational design or poor management systems (Martinez 2001). He notes that the health systems could benefit from some of the most common incentives to improve staff performance which include clear criteria for promotion, a good working environment and opportunities for staff career advancement (Martinez 2001:33).

2.11.2.2 Selected studies conducted outside Africa

Barden (2004) reported on research into performance improvement conducted in the United Kingdom National Health Service (NHS) at the Harrogate Management Centre (HMC). The findings suggested that the most successful initiatives are not sophisticated methods formulated at the top but those designed at the frontline. The extent to which performance improvement initiatives are jointly designed by both senior managers and staff was regarded as crucial to the success of the implementation process. Of key importance was the communication styles used in discussing and evaluating performance objectives. Although most of the initiatives that were studied involved the Balanced Scorecard, the evidence collected during interviews indicated that the findings could be applied to other performance improvement techniques ranging from activity-based management to the European Foundation for Quality Management (EFQM) model.

The HMC study findings countered the argument that targets that are set for employees by senior management tend to be very demanding and thus difficult to attain. The findings suggested that if staff

were asked to set their own targets, they could be up to 20 per cent more demanding than those set for them by top management. This raised the question of why the setting of targets is often an area of dispute between managers and their subordinates and the answer seemed to lie in that employees are less worried about the difficulty of attaining targets but about their relevance or lack of it. Of note was that employees are better placed to set their own targets because they are more knowledgeable of the details of work to be performed than their supervisors and they are more aware of the extent to which they can stretch themselves in the process of achieving the targets set. This, however, did not mean that the contribution of senior management was not important. On the contrary, the HMC study revealed that employees actually valued more management involvement in improving performance, not in the conventional areas that senior managers address, but by contextualising performance improvement through measures such as: explaining to staff the purpose of initiatives, that is, how in whole systems terms such improvements would improve results; providing resources such as finances to facilitate the achievement of the results; and providing a framework for informed decision making at all organisational levels. Managers were expected to create an enabling environment that empowered employees to perform at optimum levels. An important distinction was that performance management was not something done to staff but with them.

The specific lessons from the study included the following:

- a) performance management systems and initiatives should be designed by groups comprising both senior managers and their subordinates
- b) senior managers must acknowledge that they sometimes know less than their subordinates about the extent to which processes can be improved
- c) senior managers must be clear about what their contribution to performance improvement will be, that is, the provision of guidance to subordinates regarding the management of performance.
- d) senior managers have to rethink the notion of targets and realise that jointly negotiated targets stand a better chance of being achieved
- e) effective communication is critical to the success of performance improvement initiatives
- f) improved performance comes neither from the top nor from the bottom but from the recognition that senior managers do not have to know best, but do have to know who can perform best and in what areas.

As was noted in the studies conducted in African countries (Dieleman, *et al*, (2006), Furth (2006) Rawlins, *et al*, (2003), Suh, *et al*, (2007)) even though the Barden research was conducted in a different setting outside Africa, it still pointed to the value of having strong managerial systems in place for performance improvement initiatives to stand a chance of successful implementation. The importance of strong management practices is mirrored in the studies by Torres and Guo (2004), Sheikholeslam (2004), Sanchez (2005) and McPhee (2006). Torres and Guo described several approaches for implementing quality improvement initiatives using a Six Sigma programme and assessing the views of patients. One of the key findings is that in order to be successful, quality improvement techniques have to involve collaborative efforts by all health-care professionals and managers. McPhee (2006) observes that some of the organisational requisites for a successful implementation of programmes and initiatives are organisational self-awareness, the need for support from the leadership and an understanding of the interaction between policy development and implementation. These are important requisites since organisations need to be cognisant of their strengths and weaknesses for the purpose of building on their strengths and addressing their weaknesses. McPhee and Amonoo-Lartson *et al* (1993) share the view that there is need for involving implementers in the policy formulation process to facilitate the commitment of stakeholders during the implementation stage. Although the authors make valid points about the need for involving stakeholders, the importance of leadership support and commitment to programme implementation cannot be over-emphasised since the leadership is ultimately accountable for the outcome of the implementation process.

Sheikholeslam *et al* (2004) have views that are in agreement with those of the afore-mentioned authors when they write that the successful planning and implementation of work strategies require the identification of individuals who will play a role in the implementation of plans so as to gain their cooperation for effective outcomes. They also mention the value of supervision and evaluation for the successful implementation of interventions. The emphasis placed by the authors on the processes of supervision and evaluation is pertinent due to the need for control measures to be effected timeously during the implementation of strategies.

Sanchez *et al* (2005) conducted a descriptive study of the implementation of the EFQM excellence model in the Basque health service in Spain. The objective of the study was to describe the EFQM model as a common framework for quality management in a regional health care service. Interviews were conducted with staff and clients in thirty-one organisations comprising of hospitals, primary care organisations, mental health institutions and emergency services. Excellence in organisational characteristics such as leadership, employees, policy and strategy, resources, and processes was identified as necessary for the

attainment of quality services. The results of the study showed, in particular, that the overall patients' satisfaction was higher than 89%.

Alavi and Yasin (2008) conducted a survey in the United States of America to shed light on the role of quality improvement initiatives in healthcare operational environments. The performance improvement initiatives included total quality management (TQM), just in time (JIT), continuous improvement (CI), job reengineering (JR), process reengineering (PR), organizational restructuring (OR), and benchmarking (BM). A survey-based research methodology was used in the study with factor analysis used to extract relevant factors representing environmental changes and strategic options of relevance to health care organisations. The research instrument consisted of 84 questions of which 80 utilised a Likert-type scale, while four were open-ended. Thirty nine organisations representing different sections of the healthcare industry such as biotech laboratories, pharmaceutical firms, and institutions providing medical devices to healthcare providers or patients were included in the sample. Percentages were used to assess the extent of implementation and effectiveness of quality improvement initiatives. The findings indicated that most of the organisations under study had achieved operational and strategic benefits following the implementation of quality improvement initiatives. In addition, the results supported the view that the changing competitive environment justifies the investment in quality improvement.

Borenstein *et al* (2004) conducted research which yielded results that differed from the research carried out by Alavi and Yasin mentioned above. The purpose of their cross-sectional cohort study was to determine the impact of quality improvement initiatives on measures of performance within managed care organisations. The study involved a national sample of seventy nine quality improvement activities from fifty managed care organisations that reported data to the National Committee for Quality Assurance in order to be accredited from 1999 to 2000. The main outcome included the association between reported quality improvement after a period of at least twenty two months and seven quality improvement strategies utilised, including provider financial incentives, provider education, provider feedback and patient education. Reported performance scores were compared between organisations with and without a quality improvement activity for quality domains that included adolescent immunisations, breast cancer screening, cervical cancer screening, childhood immunisations and comprehensive diabetes care. The results indicated that among the seven types of quality improvement strategies, higher reported performance rates were only recorded in financial incentives to providers. The results suggested that many of the commonly used quality improved strategies were ineffective in improving health care across many quality domains.

The Public Health News Center (2008) released results from assessments conducted by researchers from the Johns Hopkins Bloomberg School of Public Health and the Indian Institute of Health Management Research which showed improvements achieved in Afghanistan's health sector through the use of the Balanced Scorecard. The surveys covered households in rural areas of twenty-nine of the country's thirty-four provinces. Through teamwork and the encouragement of innovative problem solving ideas, health facilities were able to increase the availability of essential drugs and family planning supplies, improve quality of patient care and patients' satisfaction.

The Actuate Corporation (2008) reported on a synoptic public sector study of over one thousand public sector organisations world-wide which revealed that organisations that implement the principles of strategic performance management significantly outperform those that do not. The global study, which included national health organisations was concluded in early 2008. The research results indicated that merely having a set of performance objectives and measures in an institution does not necessarily guarantee improved performance. Success depends on how well the overall performance management process is managed.

Ozturk (2006) reported on the findings of research conducted in Turkey which had the aim of: assessing the extent to which ISO certified government hospitals actually implemented new management measures; finding out whether the quality and performance improvement initiatives in Turkish government hospitals via ISO 9001 certification lead to improved performance; determining the impacts of national and organizational culture on Turkish results based improvement initiatives; and finding out how political forces both, external and internal, affected the implementation and success of the management reforms. The researcher noted that Turkish public sector organisations had, since the 1990s, been searching for better ways of improving their effectiveness, efficiency and service quality through the ISO 9001 certification.

A qualitative analysis of forty six semi-structured interviews indicated that customer feedback, employee participation in the decision making process and employee training were more common in certified hospitals than at non-certified hospitals. The study results, however, showed that certified hospitals were not more likely to implement performance measurement or reward and recognition systems. There was no significant difference between the performances of the two groups in the categories of bed occupancy rate, the number of outpatients per physician, the number of surgical operations per physician, and the crude death rate. The results were attributed to the impact of organisational culture which had negative influences such as low power sharing practices among hospital employees, weak performance

measurement practices and reward mechanisms and the non-availability of long-term strategic plans. The performance of the Turkish hospitals was also negatively affected by political struggles in the external environment between the bureaucratic elites who supported centralised public administration and the reformist government that was promoting decentralised public administration. The internal political alignments were, on the other hand, characterised by a decrease in the doctors' power within Turkish hospitals. Overall, the management reforms that were implemented did not lead to major improvements in measured performance.

It is noted that while the report from the study by Alavi and Yasin, the Public Health News Centre and the Actuate Corporation (2008) indicated that performance improvement initiatives were beneficial, this was at variance with the results from the study by Borenstein and Ozturk mentioned above in which the conclusion was that performance improvement initiatives did not necessarily lead to better performance by organisations implementing them. This brings to the fore a pertinent question, that is, “under what conditions can performance improvement initiatives that have been proved to work in one country be replicated elsewhere, as in African settings?” This suggests the need for further research to explore the circumstances that are conducive to the introduction of initiatives which will have been successfully implemented in other regions.

Arah *et al* (2003) explored the development of performance indicators for monitoring, assessing and managing health systems to achieve effectiveness, efficiency, equity and quality in the United Kingdom, Canada, Australia and the United States of America. Their study also included the World Health Organisation and the Organisation for Economic Co-operation and Development. The methodology used was an examination of ‘the health, performance frameworks, indicator quality, and management documents ...’ (Arah 2003:3).

The United Kingdom performance framework was conceptually based on the Balanced Scorecard and organisational performance indicators had to reflect a balanced picture of performance, outlining the main aspects of service user, internal management, continuous improvement and the financial perspective. Indicators of effectiveness were health care that is appropriate, timely and complied with agreed standards. In the quality assessment, quality was defined as ‘doing the right things, at the right time, for the right people, and doing them right – first time’ (Arah, 2003:6).

In Canada, effectiveness was regarded as a domain of health system effectiveness where the overriding aim was the realisation of better health for the nation through improved health care and where health care interventions ‘achieve the desired results’, (Arah 2003:8). Quality improvement initiatives involved two basic strategies of ‘continuous quality improvement and certification/accreditation’ (Arah 2003:9)

In Australia, effectiveness was regarded as subsuming ‘the domains of quality, appropriateness, access and timeliness’ (Arah 2003:11). With regard to quality issues, a health system was considered to be performing well if it was ‘delivering high quality interventions in a cost-effective manner’ (Arah 2003:11). The United States of America, according to the study, defined ‘effectiveness’ as the provision of services ‘in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome(s)’ (Arah 2003:13). In the assessment of quality, multi-level reporting was commissioned to track the progress of health care quality at the national, state and local levels. The working definition for ‘quality’ was ‘the degree to which health services --- increase the likelihood of desired health outcomes and are consistent with current professional knowledge’ (Arah 2003:14).

As per the acknowledgement of Arah *et al*, the methodology had weaknesses in that the retrieval of information was biased since some important internet hyperlinks could not be accessed. There was also much room for speculation as to the implications of policies due to the ‘vagueness and questionable reliability of published official data, ...’ (Arah 2003:19). Although the study locations had some general agreement as to the meaning of ‘performance’ it is noteworthy that ultimately, the meaning of the term takes particular significance depending on the country selected. This suggests that performance improvement initiatives cannot be regarded as generic but need to be adapted to suit the socio-economic and political circumstance of each health sector setting.

Grol (2006) conducted research on quality development in health care in the Netherlands, a country where the Quality in Institutions Act of 1995 provided a framework for quality assurance and improvement. The Act mandated that professions or organisations in health care ‘set standards for optimal care to develop strategies for monitoring and improving care; and create systems to enable public reporting to the health care inspectorate ... and to patient organisations’. (Grol 2006:5). Some of the key lessons identified in this research included the need for striking a balance between external, authority-driven systems for quality development and professionally led systems; the necessity of integrating separate quality improvement initiatives within a single quality improvement system to avoid confusion; and the recognition that sustained change requires long-term strategies and support (Grol 2006:9).

Cunningham (2005) conducted a study on innovation in the public and private sectors in six European countries, that is, Ireland, The Netherlands, Spain, Sweden and the United Kingdom. The study was prompted by the observation that innovation is not perceived to occur to the same extent within the public sector context as it does in the private sector. The research methodology ‘was to map the development of an innovation within the context of the public health sector and to examine the factors that stimulate, drive, facilitate, resist and disseminate innovation ...’ (Cunningham 2005:6). The study noted that an innovation can have a number of elements including a new design of service products and production processes, new or altered ways of delivering services or interacting with clients or solving tasks, new or improved ways of interacting with other organisations, and new world views and strategies. Innovations or initiatives generally arose out of the need to solve specific service related problems or concerns.

The study acknowledged that the innovation process is an iterative and complex process. Issues explored in the study included the identification of the role of initiatives introduced, whether the initiatives were developed proactively or reactively, and where recognition of the need for particular innovations originated. Performance targets were identified as being a driver for and facilitator of the innovations. Of note was that service innovation solutions are mainly developed outside the public sector and then transferred into the public sector through imitation. Observations were that service level innovations in the public sector are politically influenced by organisational politics, dominant values and belief systems. It was also revealed in the study that the involvement of the end user in an innovation process is often meant to widen the acceptance base of the innovation in an organisation.

Major challenges identified in the study by Cunningham (2005) include how to create an open communication platform between policy-makers and other stake holders at policy level with professionals and other actors at the operational level as well as how to make complex policy innovation processes more manageable. There were also barriers imposed by a large and complex set of organisational hierarchies which, in many instances, militated against the establishment of clear channels of communication thus contributing to divisions or verticalisation of functions according to professions. Some barriers to the progress of implementing innovations were entrenched management procedures and viewpoints leading to resistance to change.

The study also reported on the problem of risk aversion, a type of resistance to change whereby employees were unwilling to adopt new, untested or unproven practices. Contributory factors for the failure to attain some targets were the absence of capacity for organisational learning with lack of experience in the management of change and the fact that the introduction of initiatives was not, in some

cases, evidence-based. Generally, factors responsible for the success of initiatives included a consistent system of review and evaluation of implementation, the existence of a political will at national level, support for initiatives by senior health officers such as Chief Medical Officers, and the introduction of initiatives as a series of phased pilot projects to minimise the overall level of risk and contain it to a regional or local level. The pilot projects also enabled the experimental phases to respond to regional and local problems and conditions. Successes were also attributed to the existence of a capacity for innovation through committed officers who were able to drive forward the innovation process through a willingness to experiment and try new approaches as well as positive attitudes towards teamwork and independent thinking. A crucial factor for the success of initiatives was the engagement of stakeholders through ongoing dialogue during the introductory and implementation stages. Measures were put in place to ensure that stakeholders still shared the same vision and that the lessons learned were being disseminated quickly.

The studies conducted by Grol and Cunningham referred to above, while noting that performance improvement initiatives can help enhance organisational performance, also revealed a major weakness of many initiatives in the sense that they tend to be of a top-down nature. Senior officials in organisations often push down reforms to the lower level cadres. Loo (2009:1) writes that this “deliverology”, associated with Michael Barber, who headed the Prime Minister’s Delivery Unit during the years 2001-2005 with the aim of improving productivity in the British public service, had a coercive approach. The performance improvement reforms imposed structural changes on organisations to achieve efficiency of operations. Later attempts to re-shape deliverology to sustainable improvement through measures that were more customer-responsive indicated a dissatisfaction with the results of centre-driven performance improvement initiatives. This suggests that organizational members such as health sector employees that will be responsible for the implementation of performance improvement initiatives need to be involved from the on-set in discussions about the need for introducing initiatives and how such initiatives will assist in the attainment of organizational goals. Employee involvement would assist in the avoidance of further dysfunctional behavior arising from the very initiatives that were meant to offer solutions to performance problems.

The systems thinking-based Vanguard Home Page which chronicles Seddon’s works describes the means for improving performance in service industries through a three-step process of managing change termed the “Check-Plan-Do”. The method is described as presenting opportunities for employee involvement in management decisions. During the initial “check” stage, analytical questions would be asked about the purpose of introducing performance improvement initiatives. Employee involvement in the “Plan” stage

would enrich the process of identifying the organizational areas that need changing for enhanced performance and the “Do” stage facilitating the implementation of planned activities with monitoring mechanisms to keep the organisation focused on the mission to be accomplished. The value of checking the system first lies in that it allows for the identification of the advantages and disadvantages of improvement initiatives before they are adopted or adapted and it minimizes the problems associated with traditional top-down approaches which result in wholesale implementation of initiatives imposed by management, often with disastrous consequences for institutions implementing them. Indeed one can argue that the missing link in the association of the Performance Management System and the Plan-Do-Study-Act Methodology as outlined in Figure 1.2 is the lack of “check”.

Solesbury (2001) argues that since the 1997 election into power of the Labour Government in the United Kingdom the agenda has moved on to a concern with policy development and policy delivery with an equal concern for practice to be based on evidence. The success of policies is determined in terms of the effectiveness of measures taken in policy formulation, implementation and evaluation. Campbell *et al* (2007:15) argue that the use of evidence is important for the success of policies since evidence assists to ‘inform risk assessment and programme management and helps to avoid policy failure.’ Campbell *et al* also mention that evidence is useful in policy formulation, implementation and evaluation as it gives a more detailed understanding of the situation.

Shimkhada *et al* (2008) published the results of a study that was conducted in the Philippines to assess the level of policy improvements introduced through the National Health Sector Reform Agenda. The reform policies were aimed at increasing access to personal health services and improving the quality of health care provided at hospitals. The investigators state that because public policies affect whole populations, there is a growing demand that decision-making for public policies be evidence-based. A notable finding in this study was that ‘there was little scientific information on the effectiveness of even the most basic reform policies considered in the Philippines and other parts of the world’ (Shimkhada *et al* 2008:4). The investigators add that the ‘evidence base for policies, both inside and outside the health sector, is certainly weak when compared to evidence required for decision-making in other areas, such as clinical medicine’.

Decision makers are more concerned with ‘electoral interests, financial implications, and views of particular communities or groups’ (Shimkhada *et al* 2008:8-9). There are also barriers to communication between researchers and policy makers due to what Shimkhada *et al* (2008:9) explain as ‘differences in priorities, language, means of communication, integration of findings and definition of the final product

of research'. The investigators argue that in spite of the challenges to evidence-based policy making, there is need to assess the impacts of performance improvement initiatives through the collection of baseline data before and after the introduction of the initiatives.

Dieleman and Harnmeijer (2006) investigated the efficacy of initiatives for improving health worker performance in a number of countries including Malawi, South Africa, Rwanda and Morocco. The methodology involved a literature search through the PubMed, Medline and Cochrane reviews as well as an assessment of electronic journals. Dieleman and Harnmeijer (2006:3) state that one of the elements to success in improving health worker performance is the development of 'approaches that are evidence-based, to inform policy-makers as to which interventions are successful under which circumstances ...'. The World Health Organisation definition of performance, which is considered to be 'a combination of staff being available, competent, productive and responsive' (Dieleman and Harnmeijer (2006:5) was adopted by the investigators. The indicators stated in the definition are of a qualitative and quantitative nature.

2.12 Chapter summary

The concepts of efficiency, effectiveness, productivity, equity and empowerment were defined in this chapter. The productivity conceptual model was outlined to show the relationship of outputs to inputs. The difficulty of measuring productivity, especially in the public sector, was explored. Reasons for the health sector to prioritise the institutionalisation of measures for guaranteeing the high performance of their organisations were indicated.

The chapter included an assessment of the worldwide managerial reform based on the concepts of efficiency, effectiveness, empowerment and employment equity. The available evidence indicates that, generally, attempts at managerial reforms, especially in developing countries have suffered setbacks due to a combination of factors that include a lack of management skills, ineffective policy directives and a lack of political will to spearhead the reforms. It was concluded in this chapter that it does not appear to be prudent to sacrifice any one of efficiency, effectiveness, empowerment and employment equity for the others through trade-offs since these concepts are not necessarily mutually exclusive. The effects of vested interests in the management of health services, for example, insurance and pharmaceutical interests, some of which tend to increase the costs of providing health services were noted.

The literature review provided the background and knowledge base with regard to the study. The assessment of the literature revealed a varying set of opinions as to what constitutes the best strategy for achieving the effective implementation of performance improvement initiatives. The main research articles assessed in the literature review were found in health services journals that had a focus on management issues.

The Dieleman *et al* (2006) study in selected African countries described the factors motivating and demotivating health workers with respect to the implementation of performance management. The study had triangulation of the methods of data collection as one of its strengths as it used in-depth interviews and focus group discussions as well as the involvement of health workers and their managers at the community, district, region and the national levels. Although the design was thoughtful and appropriate, the research could have, given the information needs, benefited more from having a larger sample of health workers than managers since by virtue of being at the operational level, the employees were bound to have more detailed or richer information about the experiences of implementing performance management activities. The study recommendations that performance management strategies needed to be improved in order to enhance staff motivation may pose problems of substantiating a cause-and-effect relationship.

The Dieleman and Harnmeijer (2006) investigation of the efficacy of initiatives for improving health worker performance in selected African countries used indicators of a quantitative and qualitative nature in the form of the availability of staff, their competence, productivity and responsiveness. The combination of quantitative and qualitative indicators was advantageous in that the data complemented each other for a more credible research report documentation. It is noted that while the methodology yielded useful information on health worker performance, it was, however, overly dependent on a literature search, a weakness which could have been addressed through the balancing of the literature search with additional data collection methods to gather information from primary sources. This weakness may partly explain the conclusion of the researchers that substantive evidence of the effectiveness of the performance improvement strategies was limited in the countries where the study was conducted. The basis of this conclusion does not seem to be adequately supported.

The Zanzibar health care worker productivity study by Ruwoldt *et al* (2007) minimised the risk of sampling bias by sampling at least one facility from each of the country's ten districts. Data collection was done through the observation of the behaviour of the health workers and interviews but it is not known the extent to which the observers' presence might have had an effect on the outcome of the study.

In the absence of measures to reduce the influence of the respondent effect, there is a risk that the results could have been compromised by participants giving misleading answers to impress the interviewers. In addition, it is not clear the extent to which the problem of observer bias was minimised.

The Alavi and Yasin (2008) survey that was conducted in the United States of America to assess the impact of performance improvement initiatives in the health care industry covered 39 organisations representing a wide range of sections such as biotech laboratories, pharmaceutical companies and medical service institutions. The inclusion of a wide range of sectors had the strength of minimising sampling error which would otherwise have led to a difference between the sample and the population. The use of open-ended questions was important because it meant that there was more freedom for the study participants to express themselves.

Arah *et al* who explored the development of performance indicators for monitoring, assessing and managing health systems in order to attain efficiency, effectiveness equity and quality in various countries employed a methodology that examined management documents in their collection of data. Besides the problem of bias arising from the failure to access some internet hyperlinks there was also the draw-back of a lack of standardisation in the definitions of the indicators used because efficiency, effectiveness equity and quality were measured differently in each of the countries. While the meaning of the terms took particular significance depending on the country selected, the reliability of the resultant data for decision-making is in doubt especially because, as per the admission of the researchers, the official data was questionable.

The literature search partially shed light on the problem under study. What has not come out clearly from the literature review is why some health sector organisations still experience problems of poor implementation despite having access to performance improvement strategies that will have been proven to be effective elsewhere. Additional research is required to probe further the issues pertaining to the requisites for the effective and efficient implementation of health sector performance improvement initiatives, hence the need to undertake this study with delimitation to sections of the health sector in Botswana. Its uniqueness will be a combination of insights from Systems Theory and Evidence Based Policy and Practice ideas through which an attempt will be made to fill the gap identified in the literature review. The study is expected to have an impact through building on the existing body of knowledge and forming the basis for further research and enabling individual practitioners to enhance their practice and contribute to evidence-based practice. This chapter laid the ground work for a link from the theory and literature review to the research design and methodology which is outlined in Chapter Three.

CHAPTER THREE

3. RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

The research is informed by a set of management theories that fall under the category of the Human Relations Movement. The Human Relations Movement theories took into consideration the needs of the employees at the work-place unlike the earlier Scientific Management Theory in which, generally, employees were rewarded or punished depending on how well they performed standardised tasks. In the latter theory, emphasis was on strong lines of authority and control in organisations.

The central theme of the study is the assessment of the efficiency and effectiveness of the introduction of performance improvement initiatives in the Botswana public health sector. The extent to which empowerment and equity, as defined in sections 2.2 and 2.3, are applied in the public health sector is also explored. The study sought to find out in what ways and to what extent the global shift in Evidence-Based Policy and Practice has been realised in the health sector in Botswana. The evidence examined related to effectiveness, efficiency, equity and empowerment in the delivery of health services. The study explored the extent to which the perceptions of implementers (health sector staff) and consumers (patients and community) were either congruent or at variance with those of the policy makers regarding the efficacy of the performance improvement initiatives.

3.1.1 Methodological approach

This was a descriptive health systems study that attempted to systematically assess the efficiency and effectiveness of performance improvement initiatives that were introduced in the public and private health institutions in Botswana. The investigator did not make any efforts to control the study participants but made attempts to understand the overall participants' environment in order to understand how the participants viewed their setting. This is at variance with the Positivist paradigm which places emphasis on empirical testing through mainly quantitative measures.

This research examined the respondents' actions in a narrative and descriptive way to more closely represent the situation as per their experiences; hence the phenomenological leaning of the study. Phenomenology, as Burger (2005:1) argues, has principles that have much utility in organisational change efforts. The research process included recommendations on how to improve the implementation of organisational plans and better manage change. As Burger (2005:4) further notes, the notion of change is inherent in the phenomenological movement.

Abdellah and Levine (1986) identified two types of research settings, that is, the highly controlled settings and the natural settings. In the former, an example can be in a laboratory environment where the purpose of research is experimental or explanatory. The weaknesses of this type of setting, in the case where humans were to be involved, is that the subjects could resist the research environment that they are not used to and this, coupled with the Hawthorne effect could make it difficult to apply the findings to the real world. In the natural setting, as was the case in this study, the environment was uncontrolled, with real-life situations. The only controls were limited to the selection of the study subjects, the data collection and the analysis. The study was non-experimental, but descriptive and explanatory. The investigator's role was to record observations and data collected which translated into the reality as seen through the eyes of the study participants. Traynor (2007:2) wrote that the qualitative researcher is interested in 'illumination and understanding NOT causal determination or prediction.' In addition, she stated that the researcher looks beyond the superficial to search for purpose, meaning and context. In searching for purpose in this study, an examination was made of why and how respondents rationalise what they do and what they believe makes the health institutions functional or dysfunctional. Since the interactions with respondents was done in their natural setting, the study process was more factually descriptive of the respondents' situation and as such, the findings were more applicable to the real world. The study process was flexible to the complexities of real life. General research questions were outlined but as data collection and analysis proceeded, more specific questions emerged resulting in a more focussed study process which took into account the perspective of the study participants.

The study subscribes, in particular, to the Soft Systems Methodology (SSM) which, as Jackson (2005) notes, embraced the pluralist problem context which acknowledges that it is not possible to assume easily identifiable, agreed-on goals due to the multiple values and beliefs of the various stakeholders involved in organisations. Jackson (2005:23) points out that Soft Systems Thinkers opted for a solution that made 'subjectivity central, working with a variety of world views during the methodological process.' The implication is that it is necessary to accommodate the various worldviews that individuals have in organisations. Different worldviews facilitate the structuring of discussions based on the implications of

the different perspectives. Due to the different values and beliefs of stakeholders in the health sector, leaders have the task of appropriately managing disagreements and conflicts to ensure the efficient delivery of services of an acceptable quality to clients. Issues of equity and empowerment in the pluralist set-up of organisations were explored in relation to how they play a role in achieving the effective delivery of health services.

According to Chapman (2004:74), Soft Systems Methodology “is a structured way to establish a *learning system* for investigating messy problems.” “Messy problems” or “messes” were a reference to problems whereby there was a lack of agreement on what the problems were and what goals to set in order to solve the problems. With such problems, the application of mechanistic approaches to solve them stands little chance of success. Chapman (2009:3) further elaborated that SSM is “an approach that explicitly recognises the pluralistic views and goals present in social and organisational issues.” Social phenomena are not amenable to mechanistic methods of solving problems because people often have opinions that differ. Systems thinking recognises that it is not advisable to assume a uniformity of thinking among individuals in a group due to the individual differences regarding values, beliefs and interests. Systems approaches explore purposes that stakeholders want to pursue in an organisation and this is done with the realisation that individuals may have different purposes from the officially stated organisational version.

Jackson (2005) noted that the systems methodology, after the Second World War, advocated interactive planning, that is, a planning process that involved a wide participation of people in matters that affected them. Interactive planning was described by Jackson (2005) as having three principles, that is, the participative principle where there is involvement of all stakeholders in planning, the continuity principle whereby plans need to be constantly revised due to changing values and circumstances and the holistic principle which involves interactions between the parts of a system.

Some writers have debated the merits and demerits of combining the quantitative and qualitative methods of research in a study. Giarelli (cited in Boaduo 2005) observes that qualitative and quantitative data complement each other for meaningful research report documentation. Oka and Shaw (2000) state that quantitative researchers may be able to conduct surveys without direct contact with the objects of study while qualitative researchers often venture into the natural fields of the people whom they study and hold face-to-face interviews. With specific reference to qualitative researchers, Oka and Shaw (2000) further note that it is necessary for the researchers to be aware of the influence of philosophy on the research strategies to be used to avoid confusion when analysing qualitative data. This view is in agreement with that of Murphy *et al* (1998:58) who argued that in qualitative research, unlike in quantitative studies,

proposed solutions to methodological problems are intertwined with philosophical assumptions and as such, what may be an appropriate solution from one position may be flawed from another. Dick (1998:2) adopts a different position as he finds it 'hard to view different philosophies as competitors.' since they are just approaching issues from varying perspectives even though the reality is the same. He maintains that moving between different perspectives often improves understanding of the subject under study. Trochim (2002) sees no value in engaging in a serious qualitative-quantitative debate, a debate that he considers to be really much ado about nothing. His argument is that qualitative data can also be assigned meaningful numerical data.

In spite of the complementarities in the qualitative and quantitative research approaches, research tends to be guided by certain underlying assumptions of the researcher as to what constitutes valid research. Myers (1997) notes that the most important philosophical assumptions relate to the underlying epistemology which guides the research. Epistemology 'refers to the assumptions about knowledge and how it can be obtained' (Myers 1997:3). Orlikowski and Baroudi (cited in Myers 1997) propose three philosophical positions or paradigms based on the research epistemology, that is, the positivist, critical and interpretive. According to Myers (1997) qualitative research can be positivist, interpretive or critical. Myers (1997) notes that positivism assumes that reality is objectively given and can be described by measurable properties that are independent of the researcher. On the other hand, critical researchers assume that people can consciously act to alter their social and economic circumstances but their ability to do so is hampered by factors like social, cultural and political domination. Critical research then aims at helping to change the *status quo* by contributing to the elimination of the causes of alienation and domination. Interpretive research, which this study aligns to, involves interacting with the participants in their natural setting. The areas of focus that were explored were guided by the objectives of the study. They are outlined in Table 3.1 below.

3.2 Areas of focus and study variables

AREA OF FOCUS	PERFORMANCE MEASURE
Initiation of performance improvement Initiatives	Proportion of respondents aware of reasons for introducing performance improvement Initiatives
Type of performance improvement Initiative	% of relative application of performance improvement initiatives
Value	% of respondents who regard performance improvement initiatives as useful in the delivery of services
Evaluation of performance improvement Initiatives	Frequency of reviews
Implementation snags	Types of problems experienced in implementing performance improvement initiatives
Patients level of satisfaction	% of patients satisfied with provision of health services
Efficiency	% of respondents who regard performance improvement initiatives as useful in the delivery of services
Effectiveness	% of respondents who regard performance improvement initiatives as useful in achieving targets/objectives
Equity	% of respondents who regard organisational operations as fair
	% of respondents who regard accessibility to health services as fair
Empowerment	% of respondents who regard organisational operations as empowering to staff and clients through participatory decision-making

Table 3.1: Areas of focus and study variables

3.3 Data collection techniques

Varkevisser *et al* (1993) noted that research can combine a number of data collection techniques through a process termed triangulation. In this study, triangulation helped to show how the different methods of data collection, that is, in-depth interviews, self-administered questionnaires and Focus Group Discussions supported or contradicted one another. Through triangulation, the different methods used to study the same phenomena have the effect of balancing each other out to give a more realistic and truthful account of results. Kennedy (2009:3) states that ‘the problem with relying on just one method is to do with bias.’ He argues that using mixed methods is useful in that it captures more detail and also minimizes the effects of bias by ensuring a balanced research study. Bailey-Beckett and Turner (2009:3) agree with the above views on triangulation when they state that different methods when used for gathering data ‘complement and verify one another.’

Through triangulation, the data collection methods mentioned below complemented each other to reflect the respondents’ perceptions. The mixed methods in this study were used in the form of using *different data collection methods* and also through the collection of data from *different sources*. Both qualitative and quantitative research techniques were used to maximize the quality of the data to be collected. The qualitative research techniques produced information that was recorded in a narrative form while the quantitative research techniques provided data that could be counted and expressed numerically in a table or chart.

3.3.1 Primary sources of data

3.3.1.1 Interviews

Kvale (1996:14) defines interviews as “... an interchange of views between two or more people on a topic of mutual interest, ...” Boyce and Neale (2006:1) regard interviews as “a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation.” As a data collection tool, interviews involve a systematic pattern of talking and listening between the interviewer and the interviewee to enable the former to collect research data from the latter. A commonly quoted advantage of the interview over other data collection techniques such as mail surveys is that the interview provides the interviewer the opportunity to probe or ask the interviewee to elaborate on issues as necessary.

Data collection in this study was done through direct in-depth interviews of patients and health workers. Through interviewing, selected stakeholders were orally questioned to elicit information that clarified the area under study. The interviews were a combination of two types, one with a high degree of flexibility (unstructured) with open-ended questions where an interview schedule was used and the other being less flexible (structured) in that there was a list of questions with fixed responses where the investigator was more confident about the expected answers. One of the advantages of using interviews for collecting information was that they allowed for the clarification of questions during the question and response sessions.

Self-administered questionnaires

Self-administered questionnaires are a data collection technique that involve the collection of data through questionnaires, with the questionnaire filled in by the respondent in the absence of the investigator. Some of the generally recognised benefits of using self-administered questionnaires are that they have the potential to reach a large number of would-be respondents and, in the process, guaranteeing the anonymity of the respondent. Self-administered questionnaires have also been known to be helpful in collecting data from a large number of respondents in a relatively cost effective way with reduced interviewer bias. One of the notable disadvantages of self-administered questionnaires is that the investigator has no control over who actually completes the questionnaire. Self-administered questionnaires have also been criticised for their often low response rates. Williams (2003:9) notes that studies indicate that self-administered questionnaires may have a response rate that is reduced by up to 20% compared to an interviewer-based survey, with a “ ... response rate of 75% ... considered to be extremely good.”

Although this data collection technique has been criticised in some circles for its limitations in capturing forms of information such as emotions or feelings and the difficulty of telling how truthful respondents were being, self-administered questionnaires were used to collect data from conveniently selected policy makers in the Ministry of Health due to the difficulty of meeting the officers personally to interview them, because of their busy schedules. The questionnaires were personally delivered to the secretaries of the policy makers in the Ministry.

3.3.1.2 Focus Group Discussions

Gibbs (1997:1) describes Focus Group Discussions (FGDs) as group research involving “organised discussion with a selected group of individuals to gain information about their views and experiences of a topic.” Morgan (cited in Gibbs, 1997:1) notes that although focus groups are a form of group interviewing, a distinction can be made between the two in that group interviewing involves interviewing a number of people simultaneously, with emphasis placed on questions and responses between the researcher and participants whereas focus groups are reliant on the interaction within the group guided by topics supplied by the researcher. The discussions and comments made by the participants are based on their personal experiences. Morgan and Krueger (cited in Gibbs, 1997:2) note that focus groups are particularly useful in, among other instances, situations where there are power differences between the participants and decision makers or professionals. The focus groups were selected for use in this study because the health sector has the potential for exhibiting power differences, with health professionals often wielding more power than their clients due to their medically based knowledge.

Six FGDs were conducted and they facilitated the discussion of the perceptions that the selected groups of people or stakeholders had on the quality of health services provided by the health institutions nearest to them. The investigator guided the discussions so as to arrive at a decision with wider participation of the group members. The use of FGDs was selected because it was useful in gathering the views and recording the attitude and opinions of the community representatives on the quality of health services provided by the health institutions nearest to them.

Purposive or convenience sampling was used to select the group members from the vicinity of the sampled hospitals, excluding people in positions of power or authority. The participation of the group members helped in the formulation of strategies for change regarding the provision of health services. The familiarity of the investigator with the local conditions, that is, the cultural practices, religious beliefs and power structure helped in the selection of the participants for more meaningful group discussions. Each group, with members who were within the same age ranges, had a minimum of eight and a maximum of twelve participants. The discussions were mainly based on open-ended questions covering a written list of themes. The questions allowed the participants to express their thoughts and feelings based on their specific situations. Questions that gave a “yes” and “no” answer were kept to a minimum. (see Annex 4 for discussion guide).

3.4 Sampling

Often, research focuses on such a large population that, for practical reasons, it is only feasible to include some of the constituents of the population or sample in an investigation. In this study, the following questions were considered in making a decision about the sampling method to use;

1. What was the study population from which the investigator wanted to draw a sample?
2. How were the facilities to be selected?

A multi-stage sampling design was used to select the study samples in accordance with the nature of the study population that included public and private health institutions, public and private health professionals as well as the health care consumers (patients). The selection of the hospitals to be included in the study was through Stratified Random Sampling.

3.4.1 Determination of sample size for health institutions

To determine the accuracy of the results, the study aimed for a 95% confidence level from the Google search engine sample size calculator. The health facilities under study in the public sector were stratified by level of operation, that is, according to whether they are Primary, District, or national Referral facilities. A fourth stratum, comprising of private health facilities, was included. Systematic sampling was then used to select a sufficient number of hospitals from each stratum for government hospitals.

There are three Referral Hospitals, seven Government District Hospitals and sixteen Primary Hospitals. The population of the public hospitals is, therefore, twenty-six. Based on a 95% confidence level and a confidence interval of 25, a total of ten public hospitals were included in the study. This translated to one referral hospital, three district hospitals and six primary hospitals. A Table of Random Numbers was used to facilitate the selection of the government hospitals to be included in the study. The Gaborone Private Hospital was selected by virtue of it being the only private hospital of its size (referral) in the country at the commencement of the study in 2006. Since then, there has been an additional private hospital in Gaborone, the Bokamoso Private Hospital which started operating in 2010. In addition, there are three private or mine hospitals in Botswana, two of which are run by Debswana and one run by BCL Mine. The study included two of the mine hospitals, that is, the BCL hospital and a Debswana hospital to make the sample more representative. The government hospitals were listed alphabetically in each stratum as indicated in Table 3.2 below;

REFERRAL HOSPITAL	DISTRICT HOSPITAL	PRIMARY HOSPITAL
Lobatse Mental Hospital	Athlone	Bobonong Hospital
Nyangagbwe Referral Hospital	Deborah Retief Memorial Hospital	Gantsi Hospital
Princess Marina Hospital	Mahalapye Hospital	Goodhope Hospital
	Maun Hospital	Gumare Hospital
	Scottish Livingstone Hospital	Gweta Hospital
	Sekgoma Memorial Hospital	Hukuntsi Hospital
	Selebi-Phikwe	Kasane Hospital
		Letlhakane Hospital
		Mmadinare Hospital
		Masunga Hospital
		Palapye Hospital
		Rakops Hospital
		Sefhare Hospital
		Thamaga Hospital
		Tsabong Hospital
		Tutume Hospital

Table 3.2: List of Hospitals by Level of Operation

The sample size of government hospitals was determined to be ten (10). To determine the sample size of hospitals in each stratum, the ratio of hospitals was multiplied by the sample size (10) as follows;

Referral level: $3/26 \times 10 = 1.15$

District level: $7/26 \times 10 = 2.69$

Primary level: $16/26 \times 10 = 6.15$

This translated to one (1) referral hospital, three (3) district hospitals and six primary hospitals to be selected.

The investigator used the values of his birthday (25/12/1965) to facilitate the random selection of the column from the table of Random Numbers which was used to select the hospitals for inclusion in the study. The procedure used was the addition of the individual digits as follows:

25121965: translates to $2+5+1+2+1+9+6+5=31$:

31 translates to $3+1=4$ hence the fourth column in the Table of Random Numbers (see annex 6) was selected for use in identifying the random start.

3.4.2 Selection of the random start in each stratum

3.4.2.1 Referral hospitals

Since there are three referral hospitals, the first figure between 1 and 3 in the fourth column was selected. The first figure was 3. This corresponded with the third hospital listed in Table 3.2 under the referral hospitals, that is, Princess Marina Hospital.

3.4.2.2 District hospitals

To determine the sampling interval (**K**), the total number of district hospitals was divided by the sample size of district hospitals, that is, $7/3= 2.33$, rounded to 2. Column four of the Random Number Table was used to locate the first figure between 1 and 2 which happened to be 2, thus the random start was at 2 that corresponds to Deborah Retief Memorial Hospital (DRMH). Since the sampling interval was 2, the other district hospitals were selected systematically by identifying every second hospital after DRMH in the list shown in Table 3.2 above.

3.4.2.3 Primary hospitals

To determine the sampling interval (**K**), the total number of primary hospitals was divided by the sample size of primary hospitals, that is, $16/6= 2.66$, rounded downwards to 2 to facilitate the selection of the required number of hospitals in the strata. Column four of the Random Number Table was used to locate the first figure between 1 and 2 which happens to be 2 thus the random start is at the second hospital, that is, Gantsi Primary Hospital. Since the sampling interval is 2 the other primary hospitals were selected systematically by identifying every second hospital after Gantsi Primary Hospital in the list shown in Table 3.2.

3.5 List of hospitals selected for inclusion in the study

REFERRAL HOSPITAL	DISTRICT HOSPITAL	PRIMARY HOSPITAL
Princess Marina Hospital	Deborah Retief Memorial Hospital	Gantsi Hospital
	Maun Hospital	Gumare Hospital
	Sekgoma Memorial Hospital	Hukuntsi Hospital
		Letlhakane Hospital
		Masunga Hospital
		Rakops Hospital

Table 3.3: Hospitals selected in study

3.6 Selection of respondents (staff)

The various key personnel were considered for participation in the study. The SAGE Dictionary of Social Research Methods (2011) defines elite interviewing as the use of interviews to study those at the ‘top’ of any stratification system, including those in sport, academia, social status, religion, beauty or whatever. Elite interviewing in this study applied to the policy makers or senior management at the Ministry of Health Headquarters.

The methodology fused the concepts of Efficiency, Effectiveness, Equity and Empowerment to find solutions to the problems outlined in the research questions. The perceptions of various stakeholders regarding issues of efficiency, effectiveness, empowerment and equity in relation to the performance improvement initiatives were sought. The concepts of efficiency and effectiveness were explored in relation to the implementation of the performance improvement initiatives while equity and empowerment applied to implementers (health workers) and health service consumers (patients and community members). Respondents were selected at various levels, that is: policy makers consisting of senior management at the Ministry of Health Headquarters; implementers composed of health workers from various professions such as medical officers, pharmacists and nurses; health service consumers in the form of patients admitted in various hospitals which were included in the sample; community level where focus group discussions facilitated the collection of information to deepen the study through triangulation. The various respondents are depicted in figure 3.1 below;

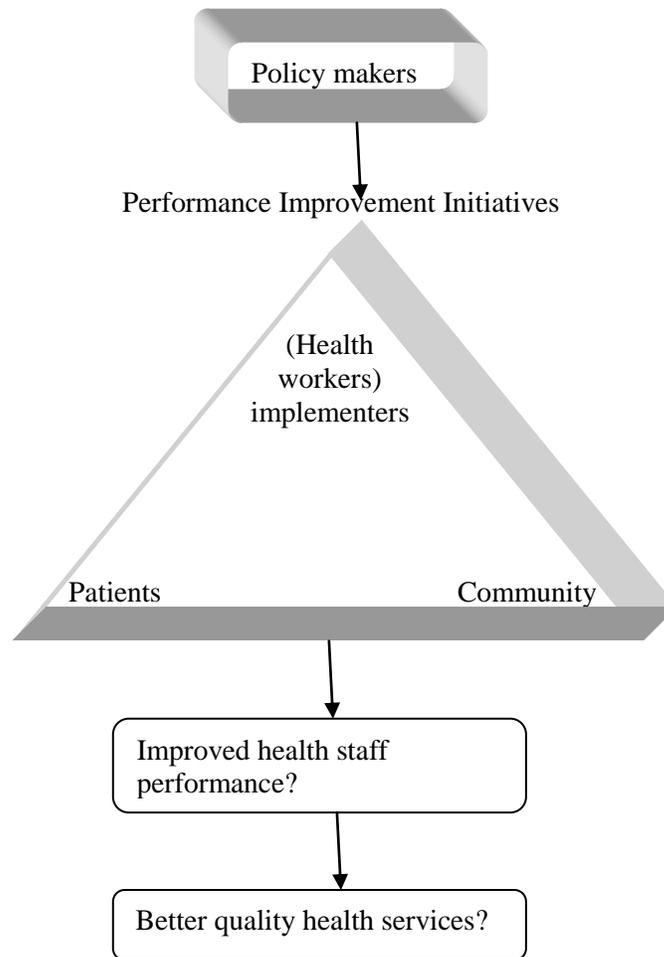


Figure 3.1: Stakeholders considered for participation in study

3.6.1 Purpose of selecting the stakeholders at the policy, implementation and consumer levels

An analysis of the formulation, implementation and evaluation of the performance improvement initiatives in this study took into account the various stakeholders, namely policy makers or senior management at the Ministry of Health Headquarters, the service providers represented by implementers of the initiatives or health workers and consumers made up of patients and community members. In the case of senior management and health workers, their behaviour or practices at the work-place can be shaped by the way in which they understand their roles in relation to the performance improvement initiatives. According to a 2008 EQUINET publication, experience shows that it can be more difficult to manage institutional and other barriers to implementation than to design new policies and programmes.

It was noted in section 2.8.2.2 on the discussion of deliverology that most policy initiatives tend to be imposed on the operational level staff by top management. The selection of policy makers and policy implementers of different professions for inclusion in the study was meant to assess the extent to which the two levels' representatives have similar or varying perceptions of the way in which the initiatives should be implemented. The policy makers were selected particularly because they have the authority to introduce changes through the performance improvement initiatives while the implementers, by virtue of being at the operational level, play a critical role of influencing the nature of implementation which may lead to success or failure of the initiatives. The study examined the extent of knowledge or awareness of the initiatives on the part of the implementers and how they feel their effectiveness and efficiency could be enhanced. The examination shed light on the implementers attitudes to the performance improvement initiatives thus allowing for a bottom-up perspective on efficiency and effectiveness.

Ultimately, the health services should benefit its clients or the recipients of services. It was intended in this study to have patients as participants in the research process in order to assess the health services from the patients' perspective. The study assessed the patients' perception of the health care that they received. It was not the purpose of this study to provide data on clinical outcomes or the competency of medical staff, but, rather, to provide information on important aspects of health care from the perspective of patients. In-patients interviewed would have been admitted for at least two nights at the time of the interview, to afford the patients time to adjust to the hospital environment. The number of wards in each hospital and the number of patients in the selected wards were determined. Hospital beds were enumerated. Five percent (5%) of the total number of patients in each hospital was systematically selected to be interviewed. If a bed that was not occupied was selected, it was substituted with the bed either on the right or left of it. Systematic sampling was used to select the in-patients to be interviewed in each hospital. Convenience sampling was used to interview out-patients.

Patients and community members, like implementers, can have perceptions about health services delivery which indicate their views on the efficiency and effectiveness with which performance improvement initiatives are implemented. The 2008 EQUINET publication further notes that weak accountability in the health sector is often associated with unrealistic expectations about the role of community members in decision making regarding health matters. The perceptions of patients and community members were sought in order to gain insights to enable the investigator to make recommendations for enhancing decision-making on equity issues and empowerment of these social groups. Equity and empowerment considerations were also applicable to health workers.

In summary, the course of implementing performance improvement initiatives in an organisation may vary significantly from the initial organisational intention, with unintended consequences. The selection of respondents from representatives of policy makers, health workers, patients and community members at large helped to explore the perceptions held by each of these groups concerning various aspects of health services delivery. Samples of the interview schedules for each of the stakeholder groups are attached as Annexes 3 (b), 3 (c), 3 (d) and 4.

3.6.2 Selection of respondents among policy makers

Table 3.4: Proposed senior management participants in Ministry of Health

Level	Department	Role	(N = 13)
National	Minister	Policy Approval	1
National	Top Management Team (TMT)	Policy Formulation	3
National	Heads of Departments	Policy Interpretation	9

Convenience sampling was used to select the respondents from among the policy makers. The respondents were selected in accordance with their roles in the Ministry of Health headquarters. Thirteen respondents in the Ministry of Health were targeted for self-administered questionnaires as indicated in Table 3.4.

3.6.3 Selection of respondents among health workers

The proportion of the study population (expected frequency) for respondents in a non-managerial capacity (nurses, doctors and paramedics) to be included in the study was determined using the *EPI INFO Statistical Programme Sample Size and Power in Descriptive Studies*. Sixty-five study respondents were selected based on a study population of 2045, a 95% confidence level, an expected frequency of 20%, with a worst acceptable result of 9%. It was noted that there would be different totals of the health professions in the various hospitals because hospitals differ in size. The sample size of each hospital was determined by obtaining the grand total of all hospitals included in the study and then multiplying the ratio of each hospital by the total sample size (65) to determine the sample size of each hospital.

3.7 Sample distribution of health sector performance improvement initiatives policy implementers by institution and professional stratum (n=65)

Table 3.5: Determination of sample size for each hospital

Name of Hospital	N=	# of Doctors	# of Nurses	# of Paramedics
BCL Mine Hospital	1	$5/31*1 = 0$	$22/31*1 = 1$	$4/31*1 = 0$
Deborah Retief Memorial	8	$4/177*5 = 0$	$153/177*5 = 6$	$20/177*5 = 2$
Gantsi Primary	2	$5/65*2 = 0$	$56/65*2 = 2$	$4/65*2 = 0$
Gumare Primary	2	$2/67*2 = 0$	$61/67*2 = 2$	$4/67*2 = 0$
Gaborone Private	5	$9/131*3 = 1$	$82/131*3 = 2$	$40/131*3 = 2$
Hukuntsi Primary	4	$2/62*2 = 0$	$52/62*2 = 3$	$8/62*2 = 1$
Letlhakane	2	$2/65*2 = 0$	$56/65*2 = 2$	$5/65*2 = 0$
Masunga	2	$1/62*2 = 0$	$53/62*2 = 2$	$8/62*2 = 0$
Maun	7	$5/194*5 = 0$	$167/194*5 = 6$	$22/194*5 = 1$
Orapa Mine Hospital	5	$11/120*3=1$	$84/120*3=2$	$25/120*3=2$
Princess Marina	21	$87/726*19 = 2$	$566/726*19 = 17$	$73/726*19 = 2$
Rakops	1	$1/43*1 = 0$	$35/43*1 = 1$	$7/43*1 = 0$
Sekgoma Memorial	5	$5/214*5 = 0$	$185/214*5 = 4$	$24/214*5 = 1$
GRAND TOTAL	65	4	50	11

Stratified sampling was used to determine the categories of staff involved in the implementation of health policies. The staff was divided into three strata, that is, medical doctors, nurses, and paramedics to ensure equitable representation of all cadres. The paramedics comprised of staff in the form of Laboratory Technicians, Pharmacists, and Pharmacy Technicians. In all instances, the size of the sample in each stratum was selected in proportion to the size of the stratum to achieve proportional allocation. The selection of staff to be interviewed within each stratum was based on systematic sampling. The population of each stratum was arranged alphabetically based on employees' surnames to minimise bias in the selection process.

3.8 Selection of respondents (patients)

It is noted that ethical and legal concerns are important issues to consider in research involving human participants. Such considerations are equally, if not more important, where the human participants are patients whose privacy and dignity needs to be protected. The exclusion criteria were minors, seriously ill or the physically or mentally incompetent patients. There was no inclusion of patients whose condition rendered them unable to give informed consent. The advice of the care givers was sought in this regard. Convenience sampling was used to select the patients for inclusion in this study. Patients were selected at the point of discharge, that is, the out-patients department. Five percent (5%) of the total number of discharged and out-patients in each hospital was systematically selected to be interviewed. (see sample distribution of patients' interviews in Table 3.6)

Table 3.6: Sample distribution of patients' interviews by selected institutions (n=110)

Number	Name of hospital	Total OPDs Discharged +	Number of patients to be interviewed
1	BCL Mine Hospital	40	2
2	Deborah Retief Memorial	202	10
3	Gantsi Primary Hospital	161	8
4	Gumare Primary Hospital	122	6
5	Gaborone Private Hospital	119	6
6	Hukuntsi Primary Hospital	114	6
7	Lethakane	37	2
8	Masunga	42	2
9	Maun	243	12
10	Orapa Mine Hospital	154	8
11	Princess Marina Hospital	654	34
12	Rakops	86	4
13	Sekgoma Memorial Hospital	209	10
	TOTAL	2183	110

Princess Marina Hospital had the largest number of patient interviews. The BCL Mine Hospital and the Masunga Primary Hospital had the least number of patients. (Refer to Annex 5 for the field –work diary)

Table 3.7: Sample distribution of Focus Group Discussions by selected institutions (n=13)

Number	Name of Hospital	No of FGDs
1	BCL Mine Hospital	1
2	Deborah Retief Memorial	1
3	Gantsi Primary Hospital	1
4	Gumare Primary Hospital	1
5	Gaborone Private Hospital	1
6	Hukuntsi Primary Hospital	1
7	Letlhakane	1
8	Masunga	1
9	Maun	1
10	Orapa Mine Hospital	1
11	Princess Marina Hospital	1
12	Rakops	1
13	Sekgoma Memorial Hospital	1
	TOTAL	13

Table 3.7 above indicates the planned number of Focus Group Discussions to be conducted. The intention was to conduct a focus group discussion for each hospital.

Figure 3.2 below depicts the planned breakdown of the sub-samples and their sizes.

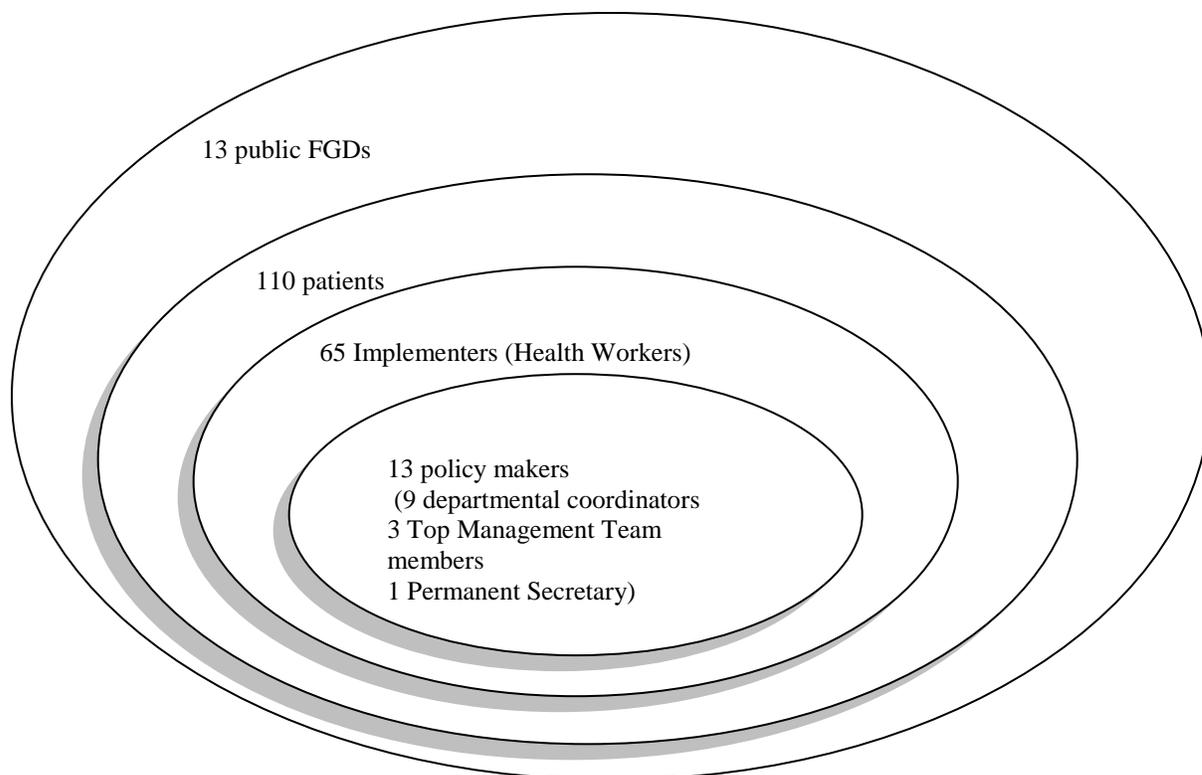


Figure 3.2: Outline of plan for data collection

3.9 Reasons for choosing stratified random sampling

The population of health facilities was divided into categories or strata whose characteristics contributed to varying results depending on each sub-population. It was expected that through Stratified Random Sampling, any such variations would be accounted for through the selection of a sample that was representative of the population from each stratum. The Stratified Random Sampling was also selected because the population under study was heterogeneous, hence the categorisation according to level of operation.

Stratified Random Sampling facilitated an understanding of the sub-groups or strata within the population. As a probability sampling method, simple random sampling also ensured that all units in the study population had an equal chance of being included in the sample. The stratification was ideal because the variables were simple to work with.

3.10 Plan for analysis and interpretation

3.10.1 Introduction

The analysis in this study started from a review of the research goals, in order to more easily organise the data and focus the analysis. The EPI Info was used for data entry and analysis. The EPI Info was selected largely due to the fact that it is a health based analysis tool and because of the ease with which entering and editing data could be done.

3.10.2 Brief comparison of computer-assisted qualitative data analysis software (CAQDAS)

The literature on Comparison of Computer-Assisted Qualitative Data Analysis Software (CAQDAS) indicates that CAQDAS has become ever more popular in social research. With the advent of CAQDAS, much of the organising of data for analysis can be done more efficiently. Celia and Gibbs (2005) note that analysis software packages facilitate the coding and retrieval of text and also enable faster execution of functions like searching. The software environment is dynamic and while new programmes are being developed, there are also new versions of the same package being released on a regular basis.

Konig (2007) notes that some data analysis software packages have notable disadvantages, for example, NVivo uses a non-standard Windows interface, while N6, Kwalitan and MAXqda have an archaic interface. Barry (1998) supports the view that NUD.IST and ATLAS/TI are some of the leading qualitative data analysis tools. With regard to NUD.IST, Barry (1998) notes that its strengths are a more structured organisation, project management functions and sophisticated searching. ATLAS/TI, on the other hand, has advantages like a visually attractive presentation and its ability to process audio and visual data. Some of the weaknesses of ATLA/TI include a less attractive interface and the fact that there are several steps to each process executed. Commenting on NUD.IST, Kerlin (2002:1) noted that while it is a useful tool for analysis, 'learning to use NUD.IST effectively can be challenging'.

Yaffee (2004) observes that it is easier to merge and to concatenate datasets with the Statistical Analysis System (SAS) than with SPSS. The advantages of SPSS over SAS, however, include easier data entry and a more attractive output presentation. Yaffee (2004:2) writes that SPSS 'continues to develop new and interesting statistical procedures, and is probably the most widely used statistical package in

universities ...’ Hom (2006) notes that yet another analysis software, Stata, tends to be weak on the analysis of variance (ANOVA), in spite of its strength in other areas including regression analysis.

The statistical programme that was commissioned by the World Health Organization is the Epi Info programme. It was designed for epidemiologists and it is useful for audience surveys. Some of the advantages of Epi Info are that it can work on old computers because it is a DOS programme, it produces quick results even on slow computers, and it is one of the easiest statistical programmes to use, even easier than SPSS. Dean (2007:3) states that Epi Info “uses Microsoft Windows standards such as Microsoft Access Databases, HTML, and ESRI shapefiles, and can import and export common database formats for compatibility with SAS, SPSS, Stata, ArcView, Excel, and other popular database and statistics programs.” Using the programme, one is able to design and implement a new database system in less than an hour. Epi Info is capable of integrating database design, data entry, data management, tabulation, a wide range of epidemiologic statistics and graphing. Other advantages reported by Bigelow (1998) are that Epi Info accommodates in a single software package the components of word-processing, data management and analysis.

In this study, the selection of the software for analysis was based on the suitability of the software for the methodology and its ease of use. Epi Info was selected because it is user-friendly. To facilitate the analysis, a description of the informants was done in the data processing as well as in the reporting of the findings. Information on the key informants and the basis of the decision to select them was provided although in an anonymised form. The interpretation of data included descriptions of the context of intentions and meanings related to actions undertaken by the subjects under study.

Myers (1997:9) argues that ‘all qualitative modes of analysis are concerned primarily with textual analysis.’ In as much as hermeneutics can provide the philosophical base for interpretivism, it can also suggest a way of understanding textual data. The study involved interpreting the meaning of text to achieve what Taylor (cited in Myers 1997:9) refers to as bringing to light ‘an underlying coherence or sense’. Myers (1997:9) states that ‘the idea of a hermeneutic circle refers to the dialectic between the understanding of the text as a whole and the interpretation of its parts, ...’ In this study, analysis sought to gain insights into linkages or relationships between individuals, the units or departments where they are located and their organisations as a whole.

It was anticipated that the data obtained in this study could be, in the words of Taylor (cited in Myers 1997:9) ‘incomplete, cloudy, seemingly contradictory - in one way or another unclear.’ The data obtained from the research participants was cloudy and contradictory. The interpretation of the data aimed to make the data more coherent, whilst remaining truthful.

Reporting of the results was done in accordance with their significance. The analysis involved reading through the data collected and organising comments into similar categories. The categories were labelled and effort made to identify what McNamara, (1999:1) termed ‘patterns, or associations and causal relationships in the themes, ..’ Codes were used to count frequencies or, as Goetz and LeCompte (1984) note, to conduct enumeration. Dey (cited in Boaduo 2001) notes that categorisation brings together observations which could be similar or different in some aspects. Categorisation provided a basis for regularising or putting information in its proper context. This classification achieved the purpose of facilitating the identification of associations between different variables. Boaduo (2001) points out that this allows the researcher to accurately analyse and interpret data depending on the classified groupings of questionnaires or interviews and the responses from them. Bearing in mind the purpose of questions, categories of respondents’ input that seemed to belong together were coded with key words. The responses were then listed per code to facilitate interpretation of the data.

The data was displayed visually using charts and tables to facilitate its interpretation. Narrative descriptions were also used to explain the data. For open-ended questions, the analysis was focussed to look at how respondents answered each question. This facilitated the identification of consistencies and differences. The data from each question was put together. The connections and relationships between questions were then explored. An initial list of codes was created, to be refined in the field. This was congruent with suggestions from authors like Miles and Huberman (1994:58) who advocate the descriptive or interpretive coding of data through the creation of an initial ‘start list.’ The actors in this study were the Government of Botswana, management and staff of health facilities, and patients.

3.11 Ethical considerations

‘Ethics’, in research practice, are generally understood to be a set of principles that govern appropriate conduct. In order to conduct responsible research, this study took into consideration the rights of respondents. The ethical considerations included the following:

- observing the need to obtain permission from the relevant authorities to carry out the research
- seeking the informed consent of respondents, who were informed about the aims of the research. No pressure of any kind was applied to induce individuals to be participants in the study
- assuring respondents that the information obtained from them would be confidential and that it would not be used to harm them in any way. At the end of the study, any information that may reveal the identity of individuals who participated in the study would be destroyed with exceptions where participants would have given their consent in writing for such information to be included in the final report. The anonymity of informants would thus be assured.
- exercising ethical responsibilities by being respectful to respondents and the avoidance of questions that could be embarrassing to the study participants. This contributed towards the protection of the dignity of respondents.
- fitting into the respondents' schedule in terms of appointments for interviews
- the consent form included a statement informing participants that they are free to withdraw from the study at any time
- taking into consideration the cultural sensitivities of the participants to the research.

This study accorded with the research ethics as stipulated by the World Health Organisation, the Botswana Ministry of Health and the University of Kwazulu-Natal (UKZN). The World Health Organisation Research Ethics Review Committee requires that all research involving participation by humans be conducted in a way that that upholds the dignity, safety and rights of the participants. The Botswana Ministry of Health's Health Research and Development Committee (HRDC) makes it mandatory for researchers to guarantee the protection of study participants and minimise their exposure to risk of harm, discomfort, or inconvenience. It is also one of the explicit requirements of the HRDC that permission be sought from authorities where data will be collected. The UKZN Research Ethics Policy dictates that researchers should protect the autonomy of respondents and ensure that they are not stigmatised or victimised as a result of their participation in research. The University also requires that access to confidential information of research participants be with their consent and that participants should not be required to commit acts which might diminish their self-respect or cause embarrassment to

them. Researchers have to indicate the measures that they will take to protect vulnerable groups such as persons who are mentally impaired and those who are highly dependent on medical care.

3.12 Strengths and weaknesses of research design and methodology

In this study, the research design and methodology were largely influenced by the nature of the research hypotheses, the research questions and the level of resources available for conducting the study. The issues addressed in the hypotheses with regard to the limited knowledge on the performance improvement initiatives in the health sector and the apparent low quality of health services provided were potentially sensitive subjects which required some rapport between the interviewer and the study participants. A notable weakness of the probability samples was that the investigator had to travel long distances to the different hospitals because the distribution of the population was widely scattered. A strength of the methodology was that ethically, it did not violate any of the respondents' right to privacy and informed consent.

The responses of the participants were realistically captured in a narrative way which closely mirrored the situation on the ground in accordance with their experiences. The methodology made it easier to search for purpose by probing why and how respondents give meaning to whatever actions they take at the workplace. In addition, the chosen methodological approach enabled the process of making the research questions more focused. As indicated in Section 3.4, a multi-stage sampling design was used to select the study samples of which the study population included public and private health institutions, public and private health professionals as well as the health care consumers (patients).

The selection of the hospitals for inclusion in the study was through the Stratified Random Sampling. The stratification of the health facilities ensured that at least some hospitals from each of the three levels of operation, that is, the Primary, District, and national referral levels would be included in the study in addition to the fourth stratum which was made up of private health facilities. The multi-stage sampling design made it possible for an appropriate number of health facilities to be identified from the large study population of hospitals while simultaneously attaining depth of the data which was an area of interest in the study.

The mainly qualitative nature of the study allowed for the use of smaller samples than would have been required in a study that was largely quantitative. While the smaller samples may have had the weakness of making it difficult to generalise conclusions from the findings, larger samples would have been

unwieldy, making it difficult to collect and analyse data. Smaller samples had the additional advantage of making it possible to complete the study with a limited budget. The sampling frame was complete without extraneous elements and for the staff and patient respondents, the method of selection minimised the risk of duplicating their names. The weakness of the methodology employed in the study is the difficulty of generalising the conclusions from the findings to a larger environment due to the smaller samples used since they can be viewed as unrepresentative.

The sampling plan minimised sampling bias by reducing the possibility of selecting units that only had particular characteristics. All units had the chance of appearing in the sample. With reference to the selection of staff, for example, the method of selection eliminated the risk of only selecting locals since expatriates were also interviewed. The systematic selection of staff to be interviewed, with the staff listings generated on the days that the investigator visited the hospitals, had the advantage of ensuring that staff were available to participate in the study. In a few cases, though, the process of systematically selecting staff for interviews was hampered by non-availability of some staff after they made arrangements to swap work shifts without the prior knowledge of management. In such instances, the next officer whose name appeared in the staff list was selected to participate in the study. The multi-stage sampling strategy helped to identify appropriate sample sizes with a reduction on measurement errors to yield valid and reliable information.

The use of open-ended or unstructured interviews facilitated the probing of the hypotheses issues and the phrasing of questions in the best way possible depending on how the interview process developed. The unstructured questions gave the respondents the freedom to express themselves. It was possible, through the unstructured questions, to probe deeper into the initial responses of the participants to get more detailed or rich responses to the questions. The disadvantage of the unstructured questions was that they yielded varied responses, the content of which took time to analyse. The closed or structured questions, on the other hand, despite providing little flexibility to the respondents, had the advantage of allowing for easier quantification of information for purposes of comparison. The use of Focus Group Discussions was helpful in obtaining different perspectives which afforded the investigator the opportunity to gain insights into the community respondents' shared understanding of the quality of health care provided in health institutions. Responses from FGDs corroborated, in the main, the patients' responses regarding the quality of services provided. An analysis of the responses from these two groups revealed that there was a belief the quality of service had improved since the introduction of performance improvement initiatives in the health sector.

Overall, the methodology selected in this study was based on considerations such as resources available for conducting the research, the most appropriate methods for exploring issues outlined in the hypotheses and the nature of the research questions. It was possible, through this methodology, to effectively capture the ‘voice’ of the respondents.

3.13 Limitations of the study

Limitations of the study were mainly due to logistical problems. The investigator economised on the limited resources at his disposal in order to complete the study. The constraints of financial resources compelled the researcher to resort to a pragmatic but valid population sample.

A challenge that was faced in the study was encountering information, in some instances, that was of poor quality, contradictory, or incomplete. This problem was addressed through a delineation of the relevant research questions, a rigorous search of the literature relating to the questions and an appraisal of the evidence. The appraisal determined the significance of the information gathered.

The research process was also affected by the fact that it was conducted in conjunction with the investigator’s other normal employment duties. The research was planned such that it fitted into the schedule of the duties of the work-place. In some instances, official leave was taken to enable the researcher to proceed with the study.

One of the difficulties of finding solutions to the problems indicated in the research questions related to the difficulty of securing responses from top management team members in the Ministry of Health, such as the Minister of Health, the Permanent Secretary and the Deputy Permanent Secretaries. The input of these officers would have been beneficial to offer insights into the problem under study from their strategic point of view. Nevertheless, it was possible to gather information for analysis from officers in other ranks.

In spite of the investigator following the appropriate protocols, it was not easy to access private health facilities in order to conduct the research because the relevant authorities to grant permission for the study were not always available to do so. The difficulty of securing the authority tended to delay the progress of the study. The investigator had to resort to skills of persuasion, coupled with much patience, to finally get the research completed.

3.14 Chapter summary

Both qualitative and quantitative methods of research were used in the study. The hospitals in the public sector were stratified according to the three operational levels of Primary, District, and Referral and these were complemented by a fourth stratum, consisting of private health facilities. The methodology in this study fused the concepts of efficiency, effectiveness, equity and empowerment to shed light on the issues raised in the research questions.

Different data collection techniques as well as collection of data from different sources contributed to more realistic findings. The methods of data collection were self-administered interviews for the senior managers, interviews for the patients, who formed part of the consumers and Focus Group Discussions for community members who formed the second part of the consumers. The purpose of selecting the different groups for inclusion in the study was to facilitate the process of triangulation. Respondents were selected according to their anticipated roles in the study. The senior management in the Ministry of Health provided input from the point of view of the policy makers, the health workers gave insights from the angle of the implementers of the performance improvement initiatives and the consumers of health services were included by virtue of being recipients of the health services.

Ethical considerations were given priority by the investigator in his interactions with the study subjects. The consent of the respondents to participate in the study was sought, with their confidentiality assured through measures such as coding of questionnaires and not recording the names of individuals. Some operational difficulties in conducting the study related to the delays encountered in securing permission from the relevant health facility authorities. The Epi Info, Version 6 was used for data entry and analysis due to its ease of application.

Some notable strengths of the research design and methodology of the study are that the study respected the rights of respondents to privacy and informed consent and the experiences of respondents were realistically captured in their settings. The methodology adopted minimised bias in the selection of the respondents and health facilities for inclusion in the study. Weaknesses of the research design and methodology lay in the fact that probability samples gave the investigator no choice but to travel to far-flung areas to conduct the research and the fact that the smaller samples used made it difficult to generalise the conclusions from the findings to a larger environment.

Chapter Four will present the study findings.

CHAPTER FOUR

4. PRESENTATION OF RESULTS

4.1 Introduction

This section describes the process of data processing and presents information on the nature of the responses from the participants. The views of the respondents are presented in the form of tables and charts for ease of reference. The presentation of the results is in accordance with the areas of focus outlined in Table 3.1. In order to focus the analysis, it was appropriate to start with a review of the research goals. This process involved an assessment of what data had been collected for the research objectives and whether the data was complete and accurate. The data was summarised to facilitate analysis. The interpretation of data included the contextualisation of the meanings that respondents gave to their actions.

The broad objective of the study was to make an assessment of the performance improvement initiatives introduced for improving the quality of health services delivery in the Botswana health sector. The specific objectives assessed and examined the various quality indicators of effectiveness, efficiency, empowerment and equity as they are applied to different groups of interest in this study, that is, the implementers of the performance improvement initiatives at the operational level and the consumers of health services made up of patients and community members.

The interviews of health staff and patients were conducted at the respective hospitals for logistical reasons. Focus Group Discussions with community members were held within the locality of hospitals selected in the study. Both the FGDs and the interviews were conducted during the period 14 May 2012 to 22 June 2012. The sample size of government and private hospitals had been determined to be ten and three respectively. The sample size in each stratum of referral, district, primary and private hospitals was systematically determined as 1, 3 and 6 and 3 respectively.

Table 4.1: Study participants response rates

CATEGORY OF PARTICIPANT	TARGETED NUMBER OF PARTICIPANTS	DATA COLLECTION METHOD TARGET		RESPONSE RATES
		In-depth interview	Focus Group Discussions	
Policy makers	13	5	-	38%
Implementers (health workers)	65	65	-	100%
Consumers (patients)	110	110	-	100%
Consumers (community members) [FGDs]	13		6	46%

The overall response rates for senior management, health workers, patients and community members are indicated in Table 4.1. It was not possible to obtain all the questionnaires from the senior management in the Ministry of Health apparently due to their busy schedules. It was also not possible to conduct all 13 targeted Focus Group Discussions due to logistical difficulties. All the targeted interviews for the health workers and the patients were achieved.

The selection of staff for questionnaires and interviews was done on the basis of a sample of staff using a staff list generated on the day of the visit, with the assistance of supervisors, at each institution to ensure that those sampled were on duty. The fact that all those sampled were on duty on the days that the investigator visited the hospitals contributed to the high response rate.

4.2 Data presentation on policy makers

A total of 13 senior managers at national level were selected for the assessment of PIIs at policy maker level. Only 5 out of the targeted sample size responded. The sampled respondents were in professional grades D1 (3) and D2 (2).

Table 4.2: Frequency of policy makers by department (n=5)

Department	Frequency	Percent
Clinical Services	2	40
Corporate Services	2	40
Monitoring & Evaluation	1	20
Total	5	100

The 2 Corporate Services respondents are directly responsible for the launch and interpretation of policies implemented by line ministries in the public service. The top management participates in decisions for adopting policies, and passes them to the coordinators who link it directly to the implementers, in this case, the health workers at hospitals. The M&E Officers then follow up the policies in the form of routine reviews. The Clinical Services are housing the medical and nursing personnel, who are the prime implementers of health care delivery policies. The department includes the pharmaceutical services, which form one of the many medical support services that participated in the assessment of the performance improvement initiatives (PIIs) in this study.

Table 4.3: Frequency of policy makers by length of service (n=5)

Duration in Service (years)	Frequency	Percent
1 to 4 years	1	20
5 to 9 years	2	40
10 to 19 years	1	20
20+ years	1	20
Total	5	100

The policy makers were assessed for the length of their services in relation to the PIIs launched so far to improve performance within the line ministries. The longest serving was 35 years, the shortest, 4 years, with a mean service period of 14 years and median of 8 years.

Table 4.4: Frequency of policy makers by knowledge and awareness of PIIs (n=5)

Known Types of PIIs launched	Frequency	Percent
PBRS	4	80
WITS/PMS	1	20
Total	5	100

All the respondents were familiar with the performance improvement initiatives. The respondents also confirmed that the PIIs known to them had a monitoring mechanism used to review the exercise from time to time.

4.3 Monitoring and evaluation of PIIs towards provision of high quality health services

Four (4) of the respondents identified the Performance Based Reward System (PBRS) and described its tracking system as a regular review, applied after every 3 calendar months of each year, to measure the progress in achieving goals set by individuals and their supervisors.

The PBRS tracking system was considered as successful, using the quarterly supervisor-to-subordinate reviews against set objectives and measurable targets. There was less certainty as to the extent of implementation of WITS and PMS. The PBRS appeared to hold more currency. On the tracking method for functionality, effectiveness and efficiency of PIIs, the general consensus was that the following mechanism was applicable:

- Drawing the work plan with set targets --→ subordinate with supervisor
- Quarterly Review of plans and targets --→ subordinate with supervisor
- Review outcomes and utilization --→ supervisor and senior management

The aim of the tracking method as stated by policy makers is to measure the individual performance of the health worker towards attaining work-related goals and reward the individual accordingly. The Vision 2016 alignment with the improvement initiatives was assessed. Four of the respondents felt the initiatives were aligned to the Vision 2016 while the fifth was not sure.

4.4 Effectiveness of PIIs towards delivery of quality health services

Table 4.5: Frequency of policy makers by most effective PIIs (n=5)

Currently Most Effective PII	Frequency	Percent
PBRS	4	80
WITS/PMS	1	20
Total	5	100

The PBRS is now considered the most effective PII first introduced in the public sector in 2000.

Table 4.6: Frequency of policy makers by reasons for PIIs effectiveness (n=5)

Reason for Effectiveness of PII	Frequency	Percent
PBRS User friendly	3	60
PBRS - New and better approach	1	20
WITS addresses terminal benefits problems	1	20
Total	5	100

The most common PII in the public sector (PBRS) was considered user-friendly (3) and a better approach (1). WITS was said to be useful in facilitating the processing of staff terminal benefits.

Table 4.7: Frequency of policy makers by strengths of PIIs (n=5)

Strengths for PIIs	Frequency	Percent
Individual accountability	3	60
Self tasking	2	40
Improves objective supervision	2	40
Systematic monitoring & evaluation	2	40

The respondents felt that the strengths of the PIIs were that the initiatives introduced more individual accountability at work, (3), more focussed individual planning (self-tasking) (2), introduced objectivity in supervisory work (2) and enhanced systematic monitoring and evaluation of progress (2).

Table 4.8: Frequency of policy makers by weaknesses of PIIs (n=5)

Weaknesses of PIIs	Frequency	Percent
Weak M & E for PIIs	3	60
Unclear goals	3	60
Poor training on PIIs	2	40
Lack of resources for follow-up	2	40

The respondents identified the weaknesses of the PIIs as weak monitoring and evaluation mechanisms, unclear setting of goals, poor staff training on implementation of the PIIs and a lack of resources for following up on their implementation.

4.5 Empowerment of implementers by policy makers

Table 4.9: Frequency of policy makers by PII implementer empowerment (n=5)

PIIs Implementer Empowerment	Frequency	Percent
PII training decentralization	4	80
PBRS training manuals	3	60
PBRS refresher course for reviewers	2	40
PII M & E	1	20

The majority of policy makers included in this assessment claimed decentralization of PIIs (4) to implementer level as a form of empowerment. Training manuals (3) were also distributed for reference at implementer level. Formal monitoring and evaluation for PIIs was the least mentioned (1), after PBRS refresher courses for supervisors which were mentioned by 2 out of 5 senior managers.

4.6 Internal equity in relation to health workers (initiative implementers)

Table 4.10: Frequency of policy makers by equitable rewarding of health workers (initiative implementers) (n=5)

PIIs Implementer Empowerment	Frequency	Percent
Poor Rewarding	3	60
Fair Rewarding	2	40
Total	5	100

As noted in Table 4.10, three (3) of the respondents were of the opinion that the implementers were poorly remunerated.

4.7 Findings on assessment of PIIs among health worker implementers

Health workers, who are the implementers of the performance improvement initiatives at service delivery level, were assessed on the knowledge and awareness of the initiatives being implemented at their institutions, their perceptions of the quality of care they deliver, their empowerment to deliver effective and efficient services and the equity in their remuneration packages.

4.7.1 Demographic Data

Table 4.11 Distribution of PII implementer respondents by service centre (n=65)

Hospital	Ownership	Locality	Frequency	Percent
BCL	Private	Urban	1	1.5
DRM District Hospital	Government	Rural	8	12.3
Gaborone Private Hospital	Private	Urban	5	7.7
Gantsi Primary Hospital	Government	Rural	2	3.1
Gumare Primary Hospital	Government	Rural	2	3.1
Hukuntsi Primary Hospital	Government	Rural	4	6.2
Masunga Primary Hospital	Government	Rural	2	3.1
Maun District Hospital	Government	Rural	7	10.8
Orapa Mine Hospital	Private	Urban	5	7.7
Princess Marina Hospital	Government	Urban	21	32.3
Rakops Primary Hospital	Government	Rural	1	1.5
Sekgoma Memorial Hospital (District)	Government	Rural	5	7.7
Letlhakane Primary Hospital	Government	Rural	2	3.1
Total			65	100

A total of 65 health workers at the performance improvement initiative implementation level were selected and interviewed from 13 systematically sampled health institutions. The health workers were

interviewed to assess their knowledge and awareness of the initiatives and elicit their opinions on the effectiveness and efficiency with which the initiatives are implemented in their day to day work. Of the 13 hospitals, 10 (77%) were government health facilities serving the public, while the remainder were privately owned.

Of the 65 health workers selected for the study, 54 (83%) were public service employees, and 38 (59%) were stationed in the urban localities. Primary hospitals situated in rural areas contributed 12 (19%) of PII's implementer study subjects.

Table 4.12: Distribution of health worker respondents by age group and sex (n=65)

Age group (years)	Female	Male	Total
20-29	11 (64.7%)	6 (35.3%)	17 (26.2%)
30-39	8 (40.0%)	12 (60.0%)	20 (30.8%)
40-49	10 (66.7%)	5 (33.3%)	15 (23.1%)
50+	5 (38.5%)	8 (61.5%)	13 (20.0%)
Total	34 (52.3%)	31 (47.7%)	65

The majority of health workers (31%) were in the 30 to 39 years age bracket, followed by the younger generation slightly above a quarter (26%) of the sample. There were more younger females (65%) in the 20-29 age bracket, alternating sequentially between the gender in ascending order, ending with more older (62%) males in the 50+ age stratum.

Table 4.13: Frequency of selected health worker respondents by profession (n=65)

Profession	Number	Percent
Doctor	4	6.2
Intern Medical Officers	1	1.5
Laboratory Technician	1	1.5
General Nurse	46	70.8
Pharmacy Technicians	10	15.4
Pharmacist	2	3.1
Psychiatric Nurse	1	1.5
Total	65	100

Above two-thirds (71%) of the health worker professionals were General Nurses serving in hospitals, followed by Pharmacy Technicians (15%). There were 4 doctors heading some of the institutions, 2 pharmacists and 1 Laboratory Technician also selected for interview in this study.

4.7.2 Health workers knowledge and awareness of PIIs

All 65 health worker respondents knew and participated in one or more performance improvement initiatives in the course of their service at the work place.

Table 4.14: Frequency of health worker respondents by type of PII known (n=65)

Type of PII known	Number	Percent
Balanced Scorecard (BSC)s	5	7.7
Joint Performance Management System (JPMS)	5	7.7
Performance Based Reward System (PBRs)	54	83.1
Shop Floor Improvement Management System (SFIMS)	1	1.5
Total	65	100

The majority of health workers (83) interviewed knew the PBRs policy used to improve performance at the work-place in the public sector, while those in the private sector used various other initiatives. In addition to those, 8 of them (12%) mentioned PMS and another 7 (11%) had known WITS. None mentioned Total Quality Management as an initiative that they implemented.

Table 4.15 Distribution of health worker respondents by hospital and type of PIIs known (n=65)

Institution	BSC	JPMS	PBRS	SFIMS	Total
BCL	0 (0.0)	0 (0.0)	0 (0.0)	1 (100)	1 (1.5)
DRM	0 (0.0)	0 (0.0)	8 (100)	0 (0.0)	8 (12.3)
GPH	0 (0.0)	5 (100)	0 (0.0)	0 (0.0)	5 (7.7)
Gantsi	0 (0.0)	0 (0.0)	2 (100)	0 (0.0)	2 (3.1)
Gumare	0 (0.0)	0 (0.0)	2 (100)	0 (0.0)	2 (3.1)
Hukuntsi	0 (0.0)	0 (0.0)	4 (100)	0 (0.0)	4 (6.2)
Masunga	0 (0.0)	0 (0.0)	2 (100)	0 (0.0)	2 (3.1)
Maun	0 (0.0)	0 (0.0)	7 (100)	0 (0.0)	7 (10.8)
Orapa	5 (100)	0 (0.0)	0 (0.0)	0 (0.0)	5 (7.7)
PMH	0 (0.0)	0 (0.0)	21 (100)	0 (0.0)	21 (32.3)
Rakops	0 (0.0)	0 (0.0)	1 (100)	0 (0.0)	1 (1.5)
Sekgoma	0 (0.0)	0 (0.0)	5 (100)	0 (0.0)	5 (7.7)
Letlhakane	0 (0.0)	0 (0.0)	2 (100)	0 (0.0)	2 (3.1)
Total	5 (7.7)	5 (7.7)	54 (83.1)	1 (1.5)	65 (100)

The greater proportion (83) of health workers were civil servants who knew of the PBRS as a performance improvement initiative. The different private hospitals employees mentioned various policies suitable for their environments, namely the Balanced Scorecard, the Joint Performance Management Systems and the Shop Floor Improvement System.

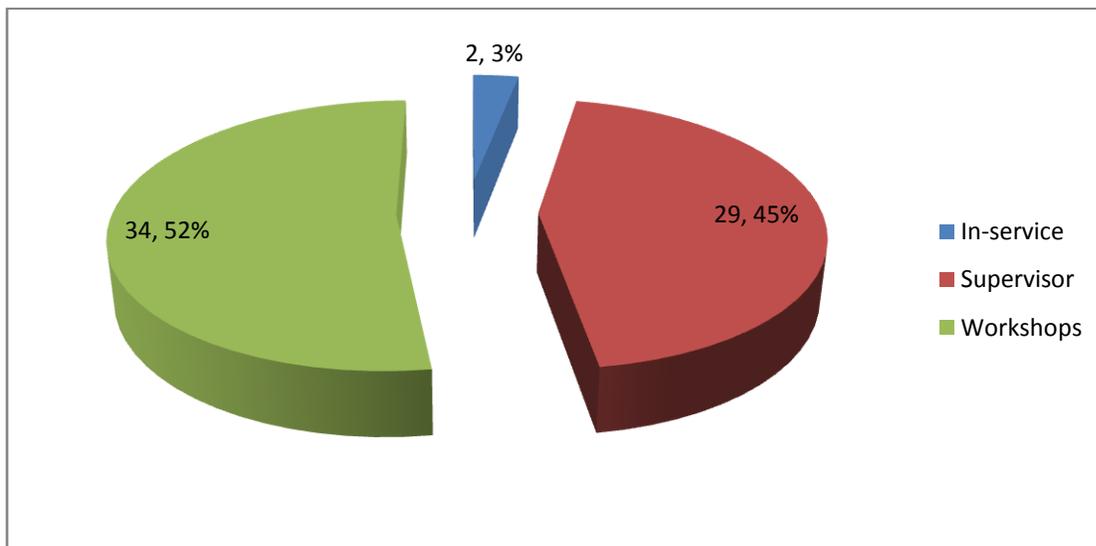
Table 4.16: Distribution of health worker respondents by age group and type of PIIs known (n=65)

Age (years)	BSC (%)	JPMS	PBRS	SFIMS	Total
21 – 29	3 (17.6)	3 (17.6)	11 (64.7)	0 (0.0%)	17 (26.2)
30 – 39	1 (5.0)	2 (10.0)	16 (80.0)	1 (5.0)	20 (30.8)
40 – 49	1 (6.7)	0 (0.0)	14 (93.3)	0 (0.0)	15 (23.1)
50+	0 (0.0)	0 (0.0)	13 (100)	0 (0.0)	13 (20.0)
Total	5 (7.7)	5 (7.7)	54 (83.1)	1 (1.5)	65

Chi square = 11.48
 Degrees of freedom = 9
 p value = 0.24405656

The distribution of health workers by age group was tested. The p-value was > 0.05.

Chart 4.1: Distribution of health worker respondents by source of PIIs knowledge (n=65)



The major sources of PIIs were workshops (35%) and seminars conducted to train the implementers on the application of the various policies. This was followed by on the job non-formal one-on-one information dissemination.

Table 4.17: Health worker respondents by source of PIIs knowledge and hospital ownership (n=65)

Source	Private	Public	Total
In-service Training	2 (100)	0 (0.0)	2 (3.1)
Supervisor Guided	5 (17.2)	24 (82.8)	29 (44.6)
Workshop Training	4 (11.8)	30 (88.2)	34 (52.3)
Total	11 (16.9)	54 (83.1)	65

Chi square = 10.46
 Degrees of freedom = 2
 p value = 0.00534346 <---

In the public health sector 56% of the health staff were informed about performance improvement initiatives through workshops compared to 37% in the private sector which conducted some in-service training as well.

Table 4.18: Health worker respondents by age group and source of PIIs knowledge (n=65)

Age (years)	In-service	Supervisor Guided	Workshop Training	Total
21 – 29	2 (11.8)	12 (70.6)	3 (17.6)	17 (26.2)
30 – 39	0 (0.0)	9 (45.0)	11 (55.0)	20 (30.8)
40 – 49	0 (0.0)	5 (33.3)	10 (66.7)	15 (23.1)
50+	0 (0.0)	3 (23.1)	10 (76.9)	13 (20.0)
Total	2 (3.1)	29 (44.6)	34 (52.3)	65

Chi square = 16.03

Degrees of freedom = 6

p value = 0.01360941 <---

The majority of younger health workers (71%) learnt about PIIs at the workplace, while their immediately older counterparts (30-49) frequently attended workshops (60% mean).

Table 4.19 Health worker respondents by PII type and source of PIIs knowledge (n=65)

Type of PII	In-service	Supervisor Guided	Workshop Training	Total
BSC	0 (0.0)	3 (60.0)	2 (40.0)	5 (7.7)
JPMS	2 (40.0)	2 (40.0)	1 (20.0)	5 (7.7)
PBRS	0 (0.0)	24 (44.4)	30 (55.6)	54 (83.1)
SFIMS	0 (0.0)	0 (0.0)	1 (100)	1 (1.5)
Total	2 (3.1)	29 (44.6)	34 (52.3)	65

Chi square = 26.42

Degrees of freedom = 6

p value = 0.00018575 <---

Table 4.19 (p-value = 0.0001) shows that the greater number of public sector employees (56%) learnt about PBRS through workshops and that JPMS was almost evenly distributed by source of information.

4.7.3 Knowledge of monitoring and evaluation mechanisms for PIIs

All (65) health workers from both sectors confirmed that the reviews were regular and formally conducted. The reviews were, generally, through: an evaluation of planned objectives; a review of measurable target; and a reflection on achievements or failures attained during the review period.

4.7.3.1 Assessment of PIIs effectiveness from the point of view of implementer respondents

Table 4.20 Health worker respondents by ownership and perception of PIIs usefulness (n=65)

Ownership	PIIs useful	PIIs not useful	Total
Private Sector	11 (100)	0 (0.0)	11 (16.9)
Public Sector	50 (92.6)	4 (7.4)	54 (83.1)
Total	61 (93.8)	4 (6.2)	65

All private sector respondents (100%) and an overwhelming majority of public sector respondents (93%) sectors indicated that the different types of PIIs implemented at their place of work were useful in improving the quality of health services provided in Botswana.

Table 4.21 Frequency of health Worker respondents by elaboration on usefulness of PIIs (n=65)

Reason for PIIs usefulness	Number	Percent
PIIs guide work targets	25	38.5
PIIs are work plan measuring tool	10	15.4
PIIs monitor individual performance	9	13.8
PIIs are Government policy to be implemented	6	9.2
PIIs direct individual work plans	5	7.7
PIIs stimulate day to day focus	4	6.2
PIIs are supervision tools	2	3.1
<i>PIIs are not useful</i>	4	6.2
Total	65	100

The statements on Table 4.21 reflect the views of the respondents as to why they thought the initiatives were useful in improving work performance. The 4 health workers who felt the PIs are not useful for improving their performance, described them as ‘a routine exercise’ done periodically.

Table 4.22 Health worker respondents by quality of services offered and hospital ownership (n=65)

Quality of Health Services at Work Place	Private	Public	Total
Deteriorated	0 (0.0)	2 (100)	2 (3.1)
Improved	11 (31.4)	24 (68.6)	35 (53.8)
Static	0 (0.0)	24 (100)	24 (36.9)
Not sure	0 (0.0)	4 (6.2)	4 (6.2)
Total	11 (16.9)	54 (83.1)	65

Chi square = 11.35

Degrees of freedom = 3

p value = 0.00997996 <---

Above half (54%) of the health worker respondents felt that the quality of health services delivered at their health facilities had improved over the years. In the private sector, all health workers (11) reported that they had observed an improvement in health service provision. On the other hand, 2 respondents from the public service had a difference of opinion, labelling the quality of the health services as ‘deteriorated.’ It is noted that above one third (37%) of the respondents described the health services, mainly delivered through the public health facilities, as static.

Table 4.23 Health worker respondents by reasons for static quality of health services (n=24)

Reasons for <u>static</u> health service delivery system	Number	Percent
Poor equipment and facilities for quality services	11	45.8
Poor working incentives and rewarding	6	25.0
Low individual commitment	4	16.7
No accountability at all	3	12.5
Total	24	100

For the health service systems described as static, around 46% were hospitals with outdated machinery, old linen and poor hospital diet. About a quarter (25%) attributed the lack of improvement in the quality of health services to poor payment of workers and bad working conditions.

Table 4.24 Health worker respondents by reasons for improved quality of health services (n=35)

Reasons for <u>improved</u> health service delivery system	Number	Percent
Provision of basic essential hospital equipment	15	42.9
Introduction of individual work plans	11	31.4
Availability of essential drugs including ARVs	7	20.0
New health programmes (HIV/AIDS, TB, etc)	2	5.7
Total	35	100

The main reasons given by respondents for regarding the health service delivery system as improved were linked to better equipment and material provision (43%) for the hospitals. The reasons given for deteriorated structures (2) in government institutions mainly included adherence to old hospital equipment, and poor local capacity building.

Table 4.25 Health worker respondents by opinion of how to improve quality of health services (n=24)

Opinion on improvement in performance to achieve objectives	Number	Percent
Employer to avail more resources for performance	13	20.0
Formal training of health workers on PIs/public relations	12	18.5
Employer to improve/maintain good working conditions	9	13.8
Improve essential drug stocks including ARVs	9	13.8
Improve PIs ownership by implementers through training	7	10.8
Reward performers with better salaries	5	7.7
Upgrade/install new hospital equipment	3	4.6
Access to specialists	2	3.1
<i>Do not know</i>	4	6.2
Total	65	100

Around 13 (20%) indicated the need for more resources in their day to day work to improve their performance. The need for an improvement in drug stocks and the introduction of better working conditions was mentioned by both sectors. Formal training on PIIs was mentioned by 19% of respondents while 11% indicated that there was a need for ownership of the PIIs. There was also a call for the improvement in the remuneration of employees with 8% mentioning this as an important requirement.

Table 4.26 Health worker respondents by opinion on how to enhance the efficiency and effectiveness of PIIs (n=65)

Enhancement Opinion	Frequency	Percentage
Effective Training for Implementers	17	26.2
Regular PBRs Follow-up	13	20
Reward Employees	9	13.8
PIIs Implementer Ownership	6.	9.2
BSC Regular M&E	5	7.7
Employee Commitment	4	6.2
JPMS Refresher Training	3	4.6
Neutral PIIs Reviewers	3	4.6
JPMS Regular Follow-up	2	3.1
More Operational Resources	2	3.1
Effective Employee Motivation Plans	1	1.5
Total	65	100.0

The majority of health worker respondents suggested on more effective training for implementers (31%), which should be backed by regular follow-up plans (23%) in both private and public health sectors. An improvement in remuneration and the introduction of more attractive working conditions was mentioned by 14% of the respondents.

Table 4.27 Health worker respondents by type of health sector on how to enhance the PIIs (n=65)

List of opinions on how to enhance the efficiency and effectiveness of PIIs	Private	Public	Total
BSC Regular M&E	5 (45.5)	0 (0.0)	5 (7.7)
Employee Commitment	0 (0.0)	4 (7.4)	5 (6.2)
JPMS Regular Follow-up	2 (18.2)	0 (0.0)	2 (3.1)
JPMS Refresher Training	3 (27.3)	0 (0.0)	3 (4.6)
More Operational Resources	0 (0.0)	2 (3.7)	2 (3.1)
Effective Employee Motivation plans	0 (0.0)	1 (1.9)	1 (1.5)
Neutral PIIs Reviewers	1 (9.1)	2 (3.7)	3 (4.6)
Regular PBRS Follow-up	0 (0.0)	13 (24.1)	13(20.0)
PIIs Implementer Ownership	0 (0.0)	6 (11.1)	6 (9.2)
Reward Employees	0 (0.0)	9 (16.7)	9 (13.8)
Effective Training for Implementers	0 (0.0)	17 (31.5)	17(26.2)
Total	11(100)	54 (100)	65 (100)

An assessment of the health workers by type of health sector shows that both the public and private health sectors mentioned the need for more effective PIIs training to enhance their usefulness (private = 27%, public = 32%). Regular follow-up of the programme emphasized on 3 different policies, while payment of good salaries and all other motivational incentives (17%) were echoed by the public service health workers.

4.7.3.2 Efficiency of health service delivery through PIIs

Table 4.28 Health workers by currently used PIIs and institutional ownership (n=65)

Ownership	BSC	JPMS	PBRS	SFIMS	Total
Private	5 (45.5)	5 (45.5)	0 (0.0)	1 (100)	11 (16.9)
Public	0 (0.0)	0 (0.0)	54 (100)	0 (0.0)	54 (83.1)
Total	5 (7.7)	5 (7.7)	54 (83.1)	1 (1.5)	100

The majority of respondents (83%) included in this study were public health service employees who were currently using the PBRS performance improvement policy at work place. The various institutions in the private sector applied different policies. All (65) health worker respondents were appraised formally four times each year to assess their achievements of set objectives.

Table 4.29 Health worker respondents by perception of consequences of a poor performance appraisal and hospital ownership (n=65)

Poor Performance Action	Private	Public	Total
Caution	0 (0.0)	9 (100)	9 (13.9)
Discuss outcomes	6 (30.0)	14 (70.0)	20 (30.8)
No Promotion	5 (100)	0 (0.0)	5 (7.7)
Just silent	0 (0.0)	31 (100)	31 (47.7)
Total	11 (16.9)	54 (83.1)	65

Chi square = 35.13

Degrees of freedom = 6

p value = 0.00000407 <---

Asked what happens when they produced bad results, a greater proportion of public health workers' supervisors (57%) just kept quiet and filed the review forms, while in the private sector, 54% of respondents noted that the employer would discuss the low performance with them with 46% mentioning that they could even be deprived of benefits such as promotion opportunities. Nine (9) (17%) of the public sector supervisors would caution the poor performer on his/her low job output.

Table 4.30 Health worker respondents by perception of consequences of a good performance appraisal and hospital ownership (n=65)

Good Performance Action	Private	Public	Total
Encourage/Incentives/Reward	7 (53.8)	6 (46.2)	13 (20.0)
Discuss on outcomes	0 (0.0)	13 (100)	13 (20.0)
Promotion	4 (66.7)	2 (33.3)	6 (9.2)
Just silent	0 (0.0)	35 (100)	35 (53.8)
Total	11 (16.9)	54 (83.1)	65

Chi square = 55.52+-

Degrees of freedom = 6

p value = 0.00000000 <---

The majority of civil service supervisors (54%) would just be “silent” in the event that the appraisal of an employee was positive. In the private health sector, a similar proportion (54%) would encourage or materially reward the employee for a job well done, therefore marking a significant variation on practice (p-value < 0.05) during the performance reviews.

Table 4.31 Health worker respondents by perceived PII weaknesses of PII (n=65)

PIIs Weaknesses	Frequency	Percentage
No rewards	14	21.5
None	13	20.1
Just Gvt Policy/Routine exercise	12	17.7
Low salaries	6	9.2
Low Appreciation	3	4.6
Low Reviewer knowledge	3	4.6
Favouritism	3	4.6
Little Resources	2	3.1
Not User Owned	2	3.1
Poor PBRS Training/Follow –up	2	3.1
Total	65	100.0

The absence of rewards of individuals who excelled during the performance reviews was considered by 22% of the respondents as one of the major weaknesses (22%) in conducting performance appraisals.

One fifth (20%) of the health workers interviewed felt the PII used at their work place had no weaknesses at all.

A total of 12 (18%) of the study subjects expressed a general concern that PIIs are “just a routine government exercise.”

There were other weaknesses revealed which included low salaries, low reviewer knowledge and favouritism.

4.7.3.3 Empowerment of health workers for service delivery

Table 4.32 Health workers by type of health sector and involvement in planning (n=65)

Hospital	Involved in Planning?		Total
	Yes	No	
Private	5 (45.5)	6 (54.5)	11 (16.9)
Public	24 (44.4)	30 (55.6)	54 (83.1)
Total	29 (44.6)	36 (55.4)	65

Chi-Squares P-values

Uncorrected: 0.00 0.95101857

Mantel-Haenszel: 0.00 0.95139634

Yates corrected: 0.07 0.78615584

Fisher exact: 1-tailed P-value: 0.6033474

2-tailed P-value: 1.0000000

Above half (55%) of the health workers included in this study were not involved in the planning for health services. There was no difference in the distribution of respondents in the public and private health sector with the probability value being more than 0.05.

4.7.3.4 Equity in rewarding of health workers

Table 4.33 Health worker respondents by opinion of extent to which remuneration is equitable (n=65)

Facility Ownership	Good Remuneration		Total
	Yes	No	
Private	3 (27.3)	8 (73.7)	11 (16.9)
Public	6 (11.1)	48 (88.9)	54 (83.1)
Total	9 (13.8)	56 (86.2)	65

Chi-Squares P-values

Uncorrected: 2.00 0.15719941

Mantel-Haenszel: 1.97 0.16042897

Yates corrected: 0.88 0.34944400

Fisher exact: 1-tailed P-value: 0.1709013

2-tailed P-value: 0.1709013

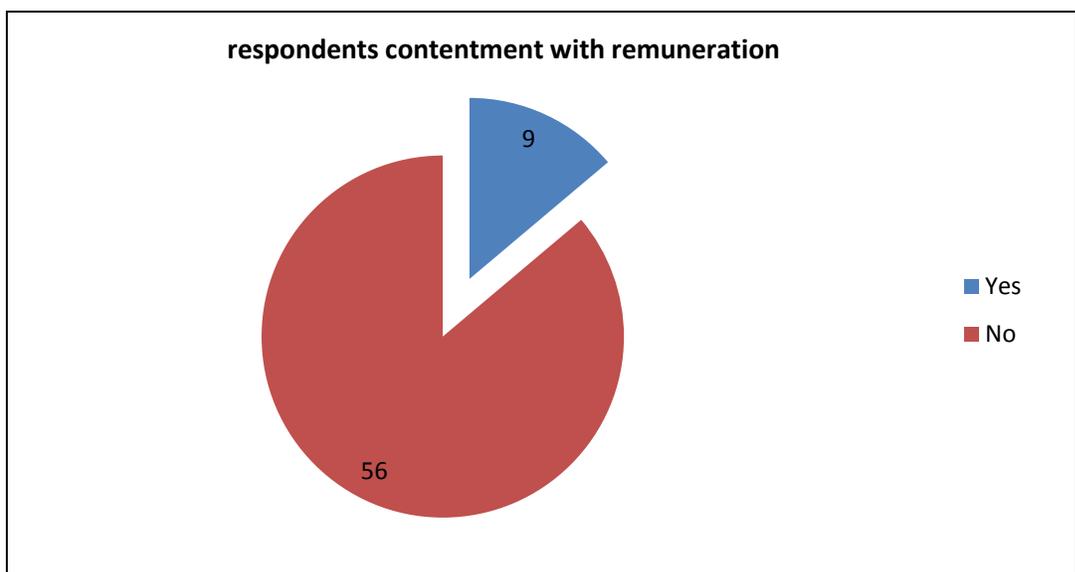
Equity in rewarding employees by professional grade was assessed during this study. When asked if they were equitably rewarded, 56 (86%) from both sectors felt there was no equity in the reward system. Nearly 9 out of every 10 hospital workers were of the opinion that they were under-paid in the public sector, while 7 shared the same sentiments in the private health sector.

Table 4.34 Health worker respondents by reason for perception held regarding lack of equity in remuneration (n=65)

Reasons for Remuneration Perception	Frequency	Percentage
Low salaries	20	30.8
Low salaries & poor conditions of service	12	18.5
poor working conditions	16	24.6
PIIs reviews not aligned to salaries	7	10.8
<i>Good service conditions</i>	<i>5</i>	<i>7.7</i>
<i>Acceptable salary scale</i>	<i>4</i>	<i>6.2</i>
Poor equipment	1	1.5
Total	65	100

Nearly three-quarters (74%) of the total sample studied expressed disappointment on their low salaries (31%), poor service (18.5%) and working conditions (10.8%) as well as bad working conditions (14%) as the main reasons for inequitable rewarding of their work. It was noted that 7.7% of the respondents, on the other hand, enjoyed good service conditions, while 6% were happy with the level of their remuneration.

Chart 4.2 Health worker respondents by satisfaction with remuneration (n=65)



Asked if they were content with the work, service conditions, incentives and the employee rewards, 9 out of 65 were content, and of those, 3 said the package covers their basic needs, while the rest (6) felt that it matched their current professional grade.

On the other hand, 56 of the 65 health workers were not pleased with their salaries and work conditions. The majority (24) complained of poor working conditions, followed by low salaries (22), poor service conditions (6) and poor management (6).

Table 4.35 Health worker respondents by type of health sector and perception of remuneration (n=65)

Facility Ownership	Content with remuneration		Total
	Yes	No	
Private	3 (27.3)	8 (73.7)	11 (16.9)
Public	6 (11.1)	48 (88.9)	54 (83.1)
Total	9 (13.8)	56 (86.2)	65

Chi-Squares P-values

Uncorrected: 2.00 0.15719941
Mantel-Haenszel: 1.97 0.16042897
Yates corrected: 0.88 0.34944400
Fisher exact: 1-tailed P-value: 0.1709013
2-tailed P-value: 0.1709013

The health workers shared a common feeling of dissatisfaction with their remuneration packages in the public and private health sectors. There was no statistical difference (p-value 0.17)

4.8 Performance improvement initiatives assessment through interviews: Patients

Table 4.36: Distribution of patients' responses by type of hospital (public and private hospitals) {n=110}

Hospital	Frequency	Percent
Public	94	85
Private	16	15
Total	110	100

As shown in Table 4.36 above, a total of 110 patients composed of admissions and out-patient cases had their views about the quality of health services sought in the health sector. There were 94 patients from public hospitals and 16 from private hospitals representing 85% and 15% of the patients interviewed, respectively.

Table 4.37: Distribution of hospitals by name and frequency of patients' responses {n=110}

Name of Hospital	Frequency	Percent
Marina	34	30.9
Sekgoma	10	9.10
Maun	12	11.0
DRM	10	9.10
Letlhakane	2	1.81
Hukuntsi	6	5.50
Gumare	6	5.50
Gantsi	8	7.30
Masunga	2	1.82
Rakops	4	3.64
GPH	6	5.50
BCL	2	1.82
Orapa	8	7.30
Total	110	100

Table 4.37 shows that Princess Marina Hospital, by virtue of it being the largest referral hospital in the country had the majority of institutional respondents (31%). The Letlhakane, Masunga and BCL hospitals had the least number of patients.

Table 4.38: Distribution of patients' responses by age group

AGE GROUP	FREQUENCY	PERCENTAGE
20 and below	6	6
21-29	22	20
30-39	26	24
40-49	14	13
50-59	13	12
60+	29	26
TOTAL	110	100

Table 4.38 above shows that most of the patients interviewed were in the age group of 60 years and above. In contrast, the least number of patients was in the age group of 20 years and below. The 30-39 years age group also had a high number of patients with 22 of them having been interviewed.

4.8.1 Effectiveness and efficiency

Chart 4.3: Factors patients disliked in health services received

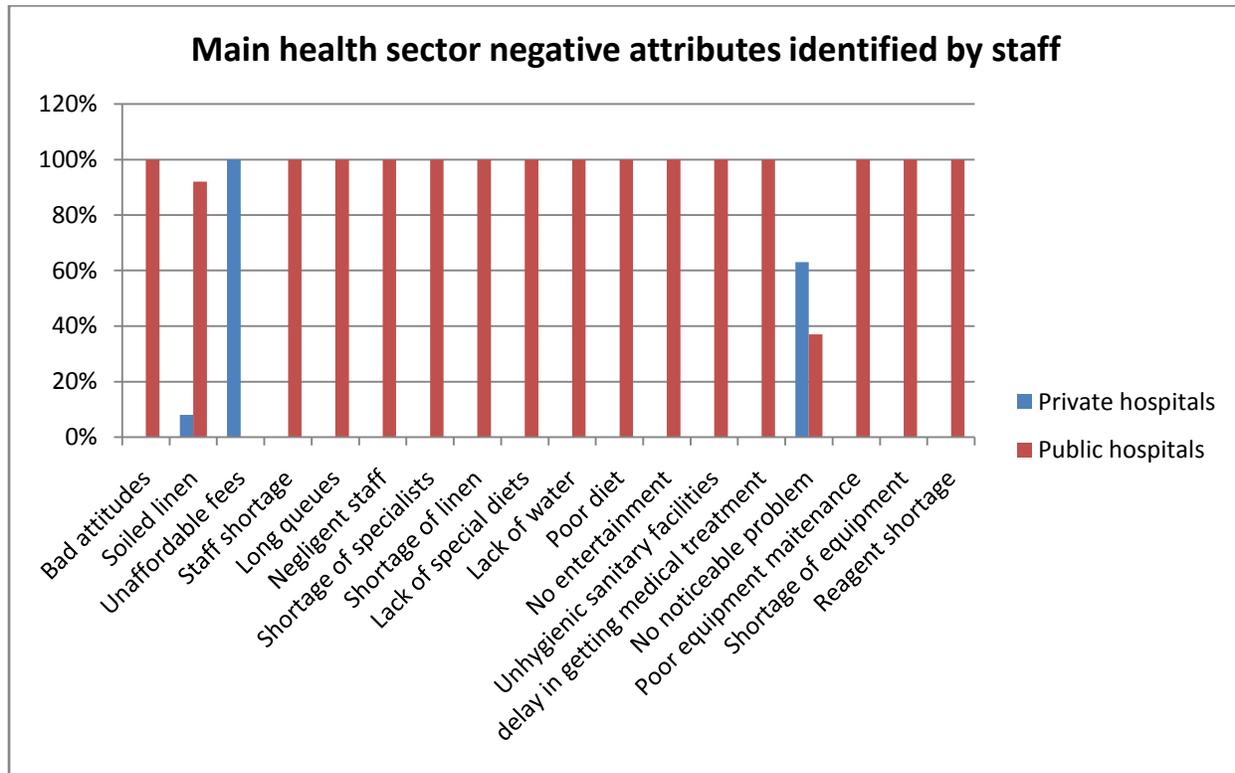


Chart 4.3 displays the factors that patients identified as having displeased them in the health services that they received. The bulk of the negative factors are applicable to the public health sector where issues such as bad staff attitudes, shortage of staff, long queues, shortage of linen, unhygienic sanitary facilities and delays in getting medical treatment were mentioned. The main complaint about private health services was that the services are unaffordable due to high user fees.

Chart 4.4: Perceptions of patients on level of community satisfaction with health services

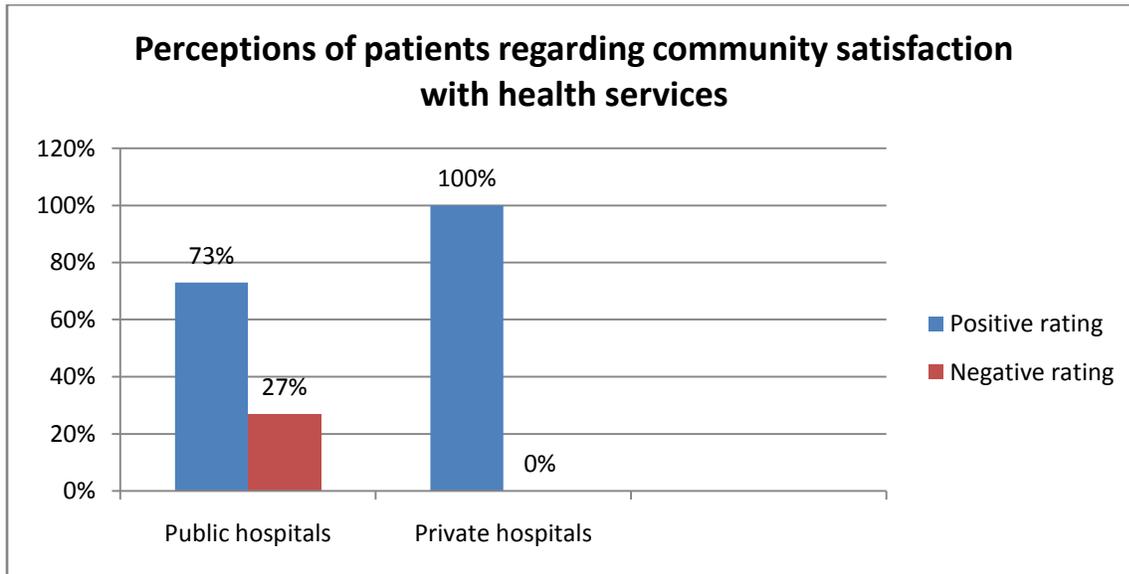


Chart 4.4 shows the perceptions of patients on the level of community satisfaction with health services that they receive. The patients were responding to the question, “Is your community satisfied with the way that they are treated by the health workers when they visit health facilities to seek treatment?” Seventy-three percent (73%) of public patients gave a positive rating of the services while all the 16 patients that accessed private health sector services gave a positive rating.

Chart 4.5: Patients rating of health services in public and private hospitals

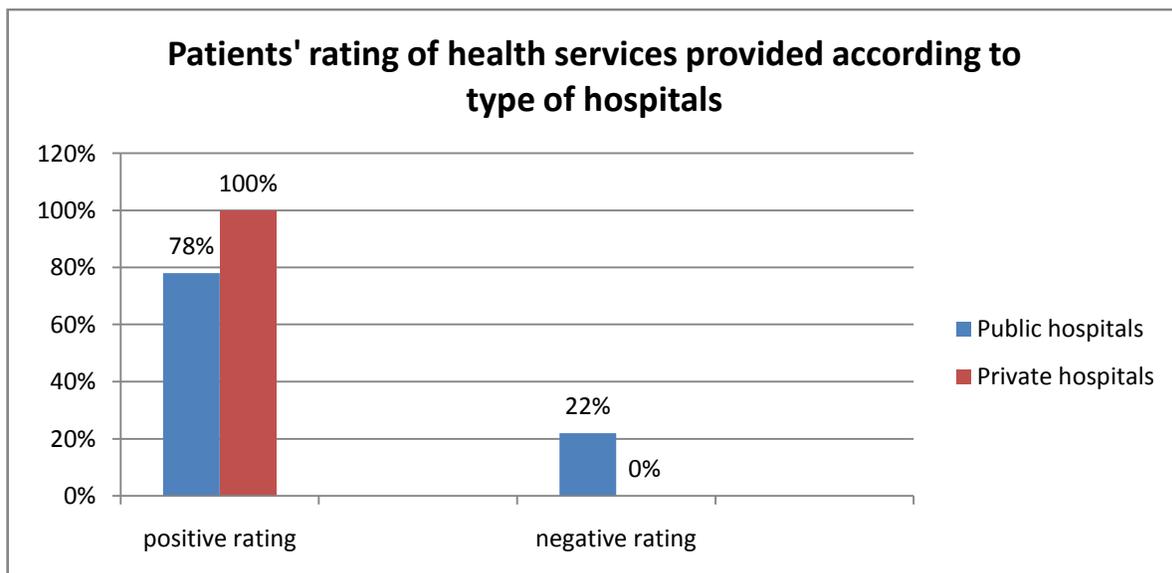


Chart 4.5 shows the perceptions of patients regarding the quality of services in the public and private hospitals. The patients were responding to the question, “In your opinion, are the health services delivered to the people as per their expectations?” In the public health sector, 78% of the 94 patients expressed satisfaction with the quality of health services provided whereas in the private health sector, all the 16 patients interviewed were satisfied with the quality of services received.

4.8.2 Empowerment

Chart 4.6: Measures taken by patients to deal with institutional problems by age group

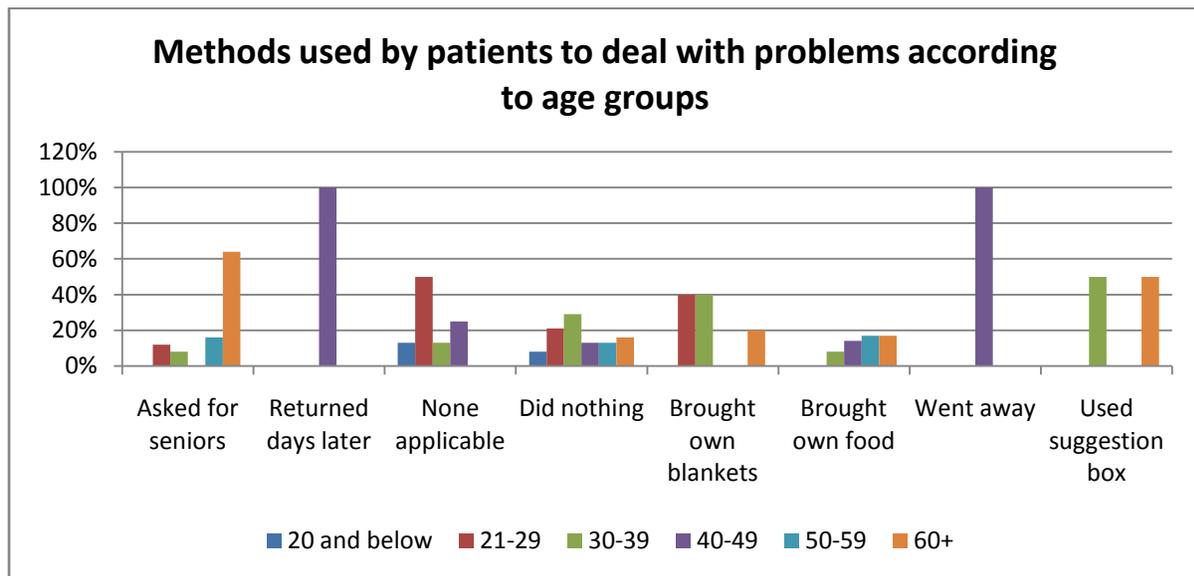


Chart 4.6 shows the methods used by patients in different age groups to address the problems that they came across in the hospitals where they sought medical treatment. A range of methods were mentioned by the respondents, that is: requesting to talk to seniors for assistance, going away and returning on a different day, doing nothing and simply accepting the situation, bring own blankets where there were shortages of these, having relatives bring food to the hospital where food quality was not acceptable, leaving the hospital to seek treatment elsewhere and using suggestion boxes to seek remedies.

4.8.3 Equity

The majority of respondents stated that health services had become more accessible and affordable. The accessibility had been enhanced through government efforts of constructing more health facilities that were within reach while the affordability was through user fees that the majority of community members

could raise. In general, communities were having access to “better medicine”, ‘better services” and “good facilities”.

4.9 Performance Improvement Initiatives Assessment through Focus Group Discussion: Community Members

4.9.1 Deborah Retief Memorial Hospital (DRMH)

Table 4.39 Effectiveness of current DRMH health delivery system based on Focus Group Discussion (n=12)

FGD Guide	Discussion Outcomes	Score	Summary
General community view of health service delivery by local hospital	Health workers good attitudes	5 out of 12	Service Quality 42 * 100/72= <u>58%</u> OR Mean Score 42/6 = 7 <u>out of 12</u>
	Hospital cleanliness and conducive health care environment	7 out of 12	
	Hospital good state of functional facilities	9 out of 12	
	Availability of essential drugs and logistics	9 out of 12	
	Availability of essential manpower	7 out of 12	
	Expected comprehensive services package	5 out of 12	

Table 4.39 reflects a measure, according to community members, of the current effectiveness of the health delivery system at the Deborah Retief memorial Hospital. The hospital scored lowly on health workers attitudes and comprehensiveness of health services package with the best scores being for the functionality of facilities and availability of essential drugs.

Table 4.40 Efficiency and consistency of DRMH health delivery system 5 years ago based on FGD (n=12)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on comparison of Health Service delivery today to 5 years ago	Health workers good attitudes	7 out of 12	Service Improvement 43 * 100/72= <u>59%</u> OR Mean Score 43/6= 7 <u>out of 12</u>
	Hospital cleanliness and conducive health care environment	5 out of 12	
	Hospital good state of functional facilities	9 out of 12	
	Availability of essential drugs and logistics	10 out of 12	
	Availability of essential manpower	7 out of 12	
	Expected comprehensive services package	5 out of 12	

*Static

In comparison to five years ago, the community rated the health services provided by the hospital as static, with the current score of the health service delivery being rated at 59% then, compared to 58% currently.

Table 4.41: Equity in the distribution of health services by DRMH to local community based on FGD (n=12)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on equity of health service distribution to local community	All essential health services <i>accessible</i> to any locals	9 out of 12	Equity $39 * 100 / 60 = \underline{\underline{65\%}}$ OR Mean Score $39 / 5 = \underline{\underline{8 \text{ out of } 12}}$
	All comprehensive health services <i>afforded</i> by any locals	8 out of 12	
	All preventive health services <i>provided</i> to any locals	12 out of 12	
	All specialist health services accessible to any locals	5 out of 12	
	All programmatic health services accessible to any locals	5 out of 12	

The community rating of the extent of equity of the DRMH health services was 65% based on the accessibility and affordability of the services. The participants were all in agreement that the preventive health services have a good coverage in the community.

Table 4.42: Community empowerment in the management of health services based on FGD (n=12)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on community empowerment on health care systems	Community awareness of <i>health public relations officer</i>	2 out of 12	Empowerment $14 * 100 / 60 = \underline{\underline{23\%}}$ OR Mean Score $14 / 5 = \underline{\underline{3 \text{ out of } 12}}$
	Community representation in the health board/council	3 out of 12	
	Community involvement in health service planning	3 out of 12	
	Community linkage to health service delivery funding	1 out of 12	
	Community formal improvement consultation interface	5 out of 12	

The involvement of the community in funding decisions rated the lowest of all the parameters to measure empowerment.

Group Recommendations on Health Service Delivery Improvement

- i) Government to increase health sector budget allocation to match private hospitals
- ii) Address the health worker conditions of service urgently and train on public relations
- iii) Replace old hospital equipment, facilities and improve diet
- iv) Provide and stock essential and programmatic drugs efficiently
- v) Empower the community through routine health service planning consultations

4.9.2 Gantsi Primary Hospital

Table 4.43: Effectiveness of current Gantsi Primary hospital health delivery system based on Focus Group Discussion (n=11)

FGD Guide	Discussion Outcomes	Score	Summary
General community view of health service delivery by local hospital	Health workers good attitudes	5 out of 11	Service Quality $35 * 100/66 = \underline{53\%}$ OR Mean Score $35/6 = \underline{6 \text{ out of } 11}$
	Hospital cleanliness and conducive health care environment	6 out of 11	
	Hospital good state of functional facilities	7 out of 11	
	Availability of essential drugs and logistics	5 out of 11	
	Availability of essential manpower	6 out of 11	
	Expected comprehensive services package	6 out of 11	

Gantsi Primary Hospital was rated at 50% effectiveness of health services by the community. The hospital had the lowest score on health workers’ attitudes and the highest on the functionality of facilities.

Table 4.44: Efficiency and consistency of Gantsi primary hospital health delivery system 5 years ago (n=11)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on comparison of Health Service delivery today to 5 years ago	Health workers good attitudes	4 out of 11	Service Improvement 33 * 100/66= 50% OR Mean Score 33/6= 6 out of 11
	Hospital cleanliness and conducive health care environment	6 out of 11	
	Hospital good state of functional facilities	6 out of 11	
	Availability of essential drugs and logistics	5 out of 11	
	Availability of essential manpower	7 out of 11	
	Expected comprehensive services package	5 out of 11	

* Improvement

Table 4.44 indicates that five years ago the service delivery at Gantsi was rated at 50%, compared to the 53% current rating. This rating signifies an improvement in the delivery of health services according to the community rating.

Table 4.45: Equity in the distribution of health services by Gantsi Primary Hospital to local community based on FGD (n=11)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on equity of health service distribution to local community	All essential health services <i>accessible</i> to any locals	10 out of 11	Equity 39 * 100/55= 71% OR Mean Score 39/5= 8 out of 11
	All comprehensive health services <i>afforded</i> by any locals	10 out of 11	
	All preventive health services <i>provided</i> to any locals	11 out of 11	
	All specialist health services accessible to any locals	3 of 11	
	All programmatic health services accessible to any locals	5 out of 11	

Equity was rated at 71% in the provision of the hospital services based on the outcomes of accessibility and affordability of health services.

Table 4.46: Community Empowerment in the management of health services based on FGD (n=11)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on community empowerment on health care systems	Community awareness of <i>health public relations officer</i>	0 out of 11	Empowerment 9*100/55= 16% OR Mean Score 9/5=2 out of 11
	Community representation in the health board/council	3 out of 11	
	Community involvement in health service planning	2 out of 11	
	Community linkage to health service delivery funding	1 out of 11	
	Community formal improvement consultation interface	3 out of 11	

Community empowerment was rated at 16% for Gantsi Primary Hospital. Community awareness of health education activities of the hospital had the lowest rating.

Group Recommendations on Health Service Delivery Improvement

- i) Government to improve hospital management
- ii) Recruit and train more local health staff
- iii) Improve hospital facilities and diet
- iv) Motivate staff by improving working conditions
- v) Enrol more HIV patients for ARVs
- vi) Government to increase funding for rural hospitals

4.9.3 Maun Hospital

Table 4.47: Effectiveness of current Maun Health delivery system based on Focus Group discussion (n=10)

FGD Guide	Discussion Outcomes	Score	Summary
General community view of health service delivery by local hospital	Health workers good attitudes	3 out of 10	Service Quality $35 * 100/60 = \underline{58\%}$ OR Mean Score $35/6 = \underline{6 \text{ out of } 10}$
	Hospital cleanliness and conducive health care environment	7 out of 10	
	Hospital good state of functional facilities	9 out of 10	
	Availability of essential drugs and logistics	8 out of 10	
	Availability of essential manpower	3 out of 10	
	Expected comprehensive services package	5 out of 10	

The Maun District Hospital was rated at 58% service quality through the Focus Group Discussion with the state of functionality of facilities and the availability of essential drugs scoring the highest points. The lowest scores were recorded in the health workers attitudes and the availability of friendly manpower.

Table 4.48: Efficiency and consistency of Maun health delivery system 5 Years ago based on FGDs (n=10)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on comparison of Health Service delivery today to 5 years ago	Health workers good attitudes	4 out of 10	Service Improvement $35 * 100/60 = \underline{58\%}$ OR Mean Score $35/6 = \underline{6 \text{ out of } 10}$
	Hospital cleanliness and conducive health care environment	4 out of 10	
	Hospital good state of functional facilities	9 out of 10	
	Availability of essential drugs and logistics	9 out of 10	
	Availability of essential manpower	4 out of 10	
	Expected comprehensive services package	5 out of 10	

* Static

In comparison to five years ago, the results of the Focus group Discussion show that service delivery has been static at Maun Hospital with a service delivery score of 58% then and at the time of conducting the group discussions.

Table 4.49: Equity in the distribution of health services by Maun Hospital to local community based on FGDs (n=10)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on equity of health service distribution to local community	All essential health services <i>accessible</i> to any locals	9 out of 10	Equity $40 * 100/50=80\%$ OR Mean Score $40/5=8 \text{ out of } 10$
	All comprehensive health services <i>afforded</i> by any locals	8 out of 10	
	All preventive health services <i>provided</i> to any locals	10 out of 10	
	All specialist health services accessible to any locals	7 out of 10	
	All programmatic health services accessible to any locals	6 out of 10	

Equity in the provision of health services at Maun was rated at 80% in the group discussion. The parameter on the provision of preventive health services and accessibility of all essential health services to locals received the highest score with the lowest score recorded for accessibility to all programmatic health services.

Table 4.50: Community empowerment in the management of health services based on FGDs (n=10)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on community empowerment on health care systems	Community awareness of <i>health public relations officer</i>	3 out of 10	Empowerment $14*100/50=28\%$ OR $14/5=3 \text{ out of } 10$
	Community representation in the health board/council	3 out of 10	
	Community involvement in health service planning	1 out of 10	
	Community linkage to health service delivery funding	1 out of 10	
	Community formal improvement consultation interface	6 out of 10	

The Maun District Hospital had a 28% community empowerment in the management of health services score with community involvement in health service planning rating the lowest. Community formal improvement consultation interface had the highest score.

Group Recommendations on Health Service Delivery Improvement

- i) Government to put more resources to bigger referral institutions
- ii) Improve hospital management and public relations (read and act on suggestion box)
- iii) Increase departmental staff (nurses, pharmacy etc)
- iv) Maintain stocks of essential drugs such as TB/ARV/HIV drugs

4.9.4 Orapa Mine Hospital

Table 4.51: Effectiveness of current OMH health delivery system based on Focus Group Discussion (n=8)

FGD Guide	Discussion Outcomes	Score	Summary
General community view of health service delivery by local hospital	Health workers good attitudes	8 out of 8	Service Quality 42 * 100/48= 88% OR Mean Score 42/6 = 7 out of 8
	Hospital cleanliness and conducive health care environment	7 out of 8	
	Hospital good state of functional facilities	7 out of 8	
	Availability of essential drugs and logistics	7 out of 8	
	Availability of essential manpower	7 out of 8	
	Expected comprehensive services package	6 out of 8	

The Orapa Mine Hospital had a score of 88% for the quality of services that it provides at the time of the group discussions. Health workers attitudes were given a high rating with all the other parameters of measurement under the discussion outcomes being awarded a score above 50%.

Table 4.52: Efficiency and consistency of OMH health delivery system 5 years ago based on FGDs (n=8)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on comparison of Health Service delivery today to 5 years ago	Health workers good attitudes	6 out of 8	Service Improvement 37 * 100/48= 77% OR Mean Score 37/6= 6 out of 8
	Hospital cleanliness and conducive health care environment	7 out of 8	
	Hospital good state of functional facilities	7 out of 8	
	Availability of essential drugs and logistics	5 out of 8	
	Availability of essential manpower	6 out of 8	
	Expected comprehensive services package	6 out of 8	

* Improvement

A comparison of the provision of health services by the Orapa Mine Hospital showed that there had been an improvement in the provision of health care compared to five years ago. The improvement was in the form of nine percentage points from 77% to 88%.

Table 4.53: Equity in the distribution of Health Services by OMH to local community based on FGDs (n=8)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on equity of health service distribution to local community	All essential health services <i>accessible</i> to any locals	5 out of 8	Equity 28 * 100/40= 70% OR Mean Score 28/5= 6 out of 8
	All comprehensive health services <i>afforded</i> by any locals	5 out of 8	
	All preventive health services <i>provided</i> to any locals	8 out of 8	
	All specialist health services accessible to any locals	5 out of 8	
	All programmatic health services accessible to any locals	5 out of 8	

The group discussion resulted in a 70% score awarded to Orapa Mission Hospital for equity in the provision of health services to the community. All the parameters under the discussion outcomes had a mark of more than 50%.

Table 4.54: Community empowerment in the management of health services based on FGD (n=8)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on community empowerment on health care systems	Community awareness of <i>health public relations officer</i>	8 out of 8	Empowerment 29*100/40= 73% OR Mean Score 29/5= 6 out of 8
	Community representation in the health board/council	4 out of 8	
	Community involvement in health service planning	4 out of 8	
	Community linkage to health service delivery funding	5 out of 8	
	Community formal improvement consultation interface	8 out of 8	

Community empowerment in the management of health services was scored at 73% for the Orapa Mine Hospital. The mean score was 6 out of 8.

Group Recommendations on Health Service Delivery Improvement

- i) Mine authorities to align with new government health programmes
- ii) Accept public patients who are relatives of mine worker through his medical scheme
- iii) Maintain high standards of professionalism at hospital

4.9.5 Princess Marina Hospital

Table 4.55: Effectiveness of current PMH health delivery system based on Focus Group Discussion (n=12)

FGD Guide	Discussion Outcomes	Score	Summary
General community view of health service delivery by local hospital	Health workers good attitudes	5 out of 12	Service Quality 43 * 100/72= 60% OR Mean Score 43/6 = 7 out of 12
	Hospital cleanliness and conducive health care environment	7 out of 12	
	Hospital good state of functional facilities	10 out of 12	
	Availability of essential drugs and logistics	10 out of 12	
	Availability of essential manpower	6 out of 12	
	Expected comprehensive services package	5 out of 12	

The Princess Marina Hospital was given a score of 60% for its service quality at the time of the group discussions. The hospital scored the lowest marks on health workers' attitudes and the expected comprehensive health services package. The highest scores were attained in the functionality of facilities and the availability of essential drugs and logistics.

Table 4.56: Efficiency and consistency of PMH health delivery System 5 years ago based on FGD (n=12)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on comparison of Health Service delivery today to 5 years ago	Health workers good attitudes	5 out of 12	Service Improvement 40 * 100/72= <u>56%</u> OR Mean Score 40/6= <u>7 out of 12</u>
	Hospital cleanliness and conducive health care environment	5 out of 12	
	Hospital good state of functional facilities	10 out of 12	
	Availability of essential drugs and logistics	10 out of 12	
	Availability of essential manpower	7 out of 12	
	Expected comprehensive services package	3 out of 12	

* Improvement

The result of the group discussion showed an improvement of four percentage points for Princess Marina Hospital at the time of conducting the group discussion compared to five years ago. The level of service improvement was from 56% to 60%.

Table 4.57: Equity in the distribution of Health Services by PMH to local community based on FGDs (n=12)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on equity of health service distribution to local community	All essential health services <i>accessible</i> to any locals	11 out of 12	Equity 43* 100/60= <u>72%</u> OR- 43/5= <u>9 out of 12</u>
	All comprehensive health services <i>afforded</i> by any locals	10 out of 12	
	All preventive health services <i>provided</i> to any locals	12 out of 12	
	All specialist health services accessible to any locals	5 out of 12	
	All programmatic health services accessible to any locals	5 out of 12	

Equity in the provision of health services at Princess Marina Hospital was rated at 72% based on the discussion outcomes shown in Table 4.57 accessibility to health services and the provision of preventive health services were given the highest scores.

Table 4.58: Community empowerment in the management of health services based on FGDs (n=12)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on community empowerment on health care systems	Community awareness of <i>health public relations officer</i>	2 out of 12	Empowerment $12 \times 100 / 60 = \underline{20\%}$ OR $16 / 5 = \underline{2 \text{ out of } 12}$
	Community representation in the health board/council	2 out of 12	
	Community involvement in health service planning	2 out of 12	
	Community linkage to health service delivery funding	4 out of 12	
	Community formal improvement consultation interface	2 out of 12	

Community empowerment at Princess Marina Hospital had a score of 20%. All the parameters under the discussion outcomes scored a mark below 50%.

Group Recommendations on Health Service Delivery Improvement

- i) Government to solve health workers problems
- ii) Involve all stake holders in planning
- iii) Create interface between health workers and community through PR
- iv) Provide resources to upgrade basic facilities and hospital diet
- v) Prioritize ARVs for the needy
- vi) Collect hospital fees effectively to pay health workers

4.9.6 Sekgoma Memorial Hospital

Table 4.59: Effectiveness of current SMH Health delivery system based on Focus Group Discussion (n=10)

FGD Guide	Discussion Outcomes	Score	Summary
General community view of health service delivery by local hospital	Health workers good attitudes	3 out of 10	Service Quality $39 * 100/60 = \underline{65\%}$ OR Mean Score $39/6 = \underline{7 \text{ out of } 10}$
	Hospital cleanliness and conducive health care environment	6 out of 10	
	Hospital good state of functional facilities	9 out of 10	
	Availability of essential drugs and logistics	7 out of 10	
	Availability of essential friendly manpower	7 out of 10	
	Expected comprehensive services package	7 out of 10	

The Sekgoma Memorial Hospital was awarded a service delivery score of 65% as a measure of effectiveness. The health workers attitudes and the state of functionality of health facilities received the lowest and highest scores respectively.

Table 4.60: Efficiency and consistency of SMH Health delivery system 5 years ago based on FGDs (n=10)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on comparison of Health Service delivery today to 5 years ago	Health workers good attitudes	3 out of 10	Service Improvement $32 * 100/60 = \underline{61\%}$ OR Mean Score $32/6 = \underline{5 \text{ out of } 10}$
	Hospital cleanliness and conducive health care environment	7 out of 10	
	Hospital good state of functional facilities	5 out of 10	
	Availability of essential drugs and logistics	5 out of 10	
	Availability of essential friendly manpower	6 out of 10	
	Expected comprehensive services package	6 out of 10	

* Improvement

In comparison to five years ago, the Sekgoma Memorial Hospital showed an improvement in health services delivery. The hospital was rated at 65% at the time of the group discussions compared to 61% five years ago.

Table 4.61: Equity in the distribution of health services by SMH to local community based on FGD (n=10)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on equity of health service distribution to local community	All essential health services <i>accessible</i> to any locals	10 out of 10	Equity 35 * 100/50= 70% OR 35/5= 7 out of 10
	All comprehensive health services <i>afforded</i> by any locals	10 out of 10	
	All preventive health services <i>provided</i> to any locals	6 out of 10	
	All specialist health services accessible to any locals	5 of 10	
	All programmatic health services accessible to any locals	4 out of 10	

The equity score for Sekgoma Memorial Hospital was 70% according to the group discussions. The accessibility to essential health services for all locals and the provision of preventive health services recorded the highest scores with the accessibility of programmatic health services attaining the lowest score.

Table 4.62: Community empowerment in the management of health services based on FGD (n=10)

FGD Guide	Discussion Outcomes	Score	Summary
Group opinion on community empowerment on health care systems	Community awareness of <i>health public relations officer</i>	2 out of 10	Empowerment 20*100/50= 40% OR 20/5=5 out of 10
	Community representation in the health board/council	3 out of 10	
	Community involvement in health service planning	6 out of 10	
	Community linkage to health service delivery funding	1 out of 10	
	Community formal improvement consultation interface	8 out of 10	

Community empowerment at the Sekgoma Memorial Hospital was given a score of 40% as a result of the group discussion with community linkage to health service funding scoring the lowest mark. The community formal improvement consultation interface was given the highest score.

Group Recommendations on Health Service Delivery Improvement

- i) Government to motivate staff through good salaries and supportive package
- ii) Provide relevant drugs required by clients
- iii) Read suggestion box comments and suggestions and use them
- iv) Improve basic facilities such as linen and diet

4.10 Chapter summary

This chapter presented the findings of the study visually displayed through tables and charts for ease of reference. The findings relate to the responses obtained from the different groups that were selected for participation in this study, namely the policy makers in the Ministry of Health, the implementers of the performance improvement initiatives who are the health workers and the consumers of health services who were split into patients and community members.

Respondents from amongst the policy makers were selected through convenience sampling while health workers were selected through systematic sampling from the hospitals that were sampled in this study. The criteria used to select the patients was to identify 5% of the patients at each hospital composed of out-patients and discharged patients. The Focus Group Discussions consisted of groups of community members conveniently selected from the vicinity of the hospitals. It was not possible to do group discussions in all the targeted hospitals due to logistical constraints.

The respondents provided information that helped shed light on the various areas being probed in relation to the quality indicators of effectiveness, efficiency, equity and empowerment. Recommendations were made by each of the sub-sets of respondents on how to enhance the effectiveness and efficiency of service provision. The findings presented in this chapter form the basis for the critical analysis of the research process in Chapter Five and for the recommendations presented in Chapter Nine.

CHAPTER FIVE

5 CRITICAL ANALYSIS OF THE RESEARCH PROCESS

5.1 Introduction

This section sought to attach meaning and significance to the analysis through an assessment of the key points or important findings. The five step process as outlined by Taylor-Powell and Renner (2003) provided the general structure leading to the interpretation of the data. The structure involves the following steps: get to know your data, focus the analysis, categorise information, identify patterns and connections within and between categories, and interpretation. The data was reviewed to gain an in-depth understanding of it while keeping the purpose of the analysis in mind, which meant relating the analysis to the objectives of the study. The information was categorised according to the variables that were used in displaying the results. Patterns that emerged within and between the variables were identified to facilitate the interpretation.

Trends and patterns that emerged from the different responses were identified through a comparison of the responses for similarities and differences. The process involved an identification of associations and causal relationships between variables. The investigator looked for evidence that recurred and was common to different respondents. This included the identification of ideas that recurred even if they were stated in different words. The assessment zeroed in on the frequency of the comments as well as the extensiveness of the comments that is, the proportion of different respondents who shared the same view about an issue. It was also important to check for consistency in the responses as a measure of reliability. The context of the responses was also taken into account to help clarify whether the respondents had the same issue in mind.

In summary, to facilitate the search for enlightenment, the following procedure was followed:

- a) comparison and contrasting of results obtained from the various respondents who participated in this study.
- b) assessment of what was previously known and then confirmed by the study.

- c) assessment of what was previously known and then challenged by the study.
- d) Assessment of ideas that either challenged or confirmed the investigator's assumptions.

Mittman (2001) notes that an important requirement for analysis in qualitative research is an *a priori* hypothesis and a formal framework guiding the analysis. The framework of the critical research analysis in this study was in accordance with the hypotheses, that is performance improvement initiatives were imposed in a top-down manner in the Botswana health sector with the noble belief that they were valuable in contributing towards the achievement of the goals of Vision 2016; there is limited knowledge on the part of the health workers at the operational level regarding the usefulness of the performance improvement initiatives and this contributes to their low uptake of the initiatives in the Botswana health sector; the frequency of complaints by health services consumers is a reflection of the poor quality of health services provided in the health sector in Botswana.

5.2 Analysis and interpretation of policy makers findings

5.2.1 PII description and processes

5.2.1.1 Health service quality

All (5) policy makers and interpreters confirmed awareness of performance improvement initiatives as a means to improve the delivery of *high quality of health services* to the communities in Botswana.

There was general consensus that the purpose of PIIs was to facilitate the processes for achieving the long set goal of Vision 2016 (Health for All). The policy maker respondents also confirmed that the PIIs known to them had a monitoring mechanism used to review the exercise from time to time, particularly after every 3 months for PBRS which is currently in play.

The aim of the tracking method as stated by policy makers is to measure the individual optimum performance of the health worker towards high quality of health service delivered, and reward the individual accordingly. It was not, however, clear how the rewarding was done, or if any had been done based on the performance of individual health workers.

5.2.1.2 Effectiveness of PIIs towards delivery of high quality health services

The Performance Based Reward System (PBRS) is now considered the most effective PII in the public health sector. It was more fashionable than any other performance improvement initiative. It was considered user-friendly and a better approach, while WITS and PMS were the path-finder strategies used to address terminal benefits (long term rewards), and measure individual performance measurement annually. This was reflected in a statement from one policy maker that, “The PBRS is way ahead of other initiatives in terms of facilitating the achievement of work objectives.”

The policy makers felt that the strengths of the PIIs were; individual responsibility (3), individual planning (2), informed supervision (2) and regular formal monitoring and evaluation of progress. It was evident that PBRS is the initiative that is currently most actively implemented in the Ministry of Health and the public service in general.

5.2.1.3 Efficiency of PIIs towards delivery of high quality health services

The weakness on monitoring and evaluation of PIIs (3) were noted from the policy makers’ point of view. Unclear individual goals (3) could be an indicator of short-comings in the process of training staff on performance improvement initiatives. One policy maker stated that, “individual employee goals tend to be muddled.” Respondents amongst health workers mentioned the lack of resources for both training and follow-up as a contributing factor. With still a sizable number of known weaknesses from the policy making point of view, only partial efficiency of the PBRS in particular has been captured through monitoring and evaluation systems.

5.2.1.4 Empowerment of implementers towards delivery of high quality health services

The majority of policy makers included in this assessment claimed decentralization of PIIs (4) to implementer level as a form of empowerment. Training manuals (3) were also distributed for reference at implementer level. Formal monitoring and evaluation for PIIs was the least mentioned (1), after PBRS refresher courses for supervisors which were mentioned by 2 out of 5 senior managers.

The absence of rewards, incentives, salary increments, promotions and other means of career development after individuals achieve the desired goals is a major weakness in the implementation of the initiatives.

5.2.1.5 Equitable rewarding of policy implementers for high level performance

It was clear from the selected policy makers and interpreters that policy implementers were poorly rewarded (3), subjecting most of them to a fair rewarding system which does not align with their professional and performance levels.

5.3 Analysis and interpretation of implementers findings

5.3.1 Knowledge and Awareness of PIIs among implementers of performance improvement initiatives

The majority of health workers interviewed pointed out that the PBRs policy is used to improve performance at the work place in the public health sector, while those in the private used different systems. In addition to PBRs, 8 respondents in the public health sector (12%) mentioned PMS and another 7 (11%) acknowledged WITS as a performance improvement initiative that was implemented at their health facilities. There was no mention of TQM as an initiative that was being applied at the work place. The different PIIs used in the private sector included BSC, JPMS and SFIMS.

The distribution of health workers by age group was tested. The resultant p -value > 0.05 indicated that there was no significant difference in the knowledge of PIIs according to the ages or the professions of the of the respondents.

5.3.1.1 Source of knowledge on PIIs

The major sources of PIIs were workshops (34.5%) and seminars conducted to train the implementers on application of the various policies. This was followed by on the job non-formal one-on-one (29.4%) information dissemination, mainly through supervisors. The method of introducing PIIs among the sectors varied significantly, with government majoring on out of station workshops (55.6%) while the private sector accounted for 36% of the workshops, with in-service training featuring prominently.

A significant variance was noted in the manner of introducing the initiatives to the staff when comparing the public and the private sector (p -value = 0.005), where the public sector (56%) were informed through workshops compared to 37% in the private sector. The private sector had, in the main, a personalised

training approach in the introduction of PIIs. It was scientifically true (*p-value* = *0.0001*) that PBRs, which was known by the majority of public health sector employees (56%) had been learnt through workshops compared to other types of PIIs.

Authors such as Sheikholeslam *et al* (2004) point out the value of supervision and evaluation for the successful implementation of management interventions. It was noted in the literature review that supervision and evaluation are necessary for control measures to be effected timeously during the implementation of performance improvement strategies. The respondents in the private sector, comprising of health workers and consumers, were unanimous in stating that the services provided in the private sector had improved over the past five years. This raises the question of whether the personalised form of coaching employees on the introduction of new initiatives is not better than passing on information through workshops, perhaps appropriately termed “talk shops’ in some circles. The findings in this study seem to confirm that better performance results can be obtained through the closer attention to detail that is a feature of one-to-one coaching.

The majority of younger health workers in the 20-29 age group (71%) in the public health sector learnt about PIIs at the workplace, while their immediately older counterparts (30-49) frequently attended workshops (60% mean) on performance improvement initiatives. There was a scientific confirmation (*p-value* = *0.01*) that the older health workers had more opportunities for attending workshops on PIIs than the younger implementers. This observation seems to confirm the generally held view by the respondents that work-related benefits such as staff development or further training are not based on staff needs but on length of service, hence contributing to perceptions of unfairness at work. There was no statistical difference (*p-value* > 0.05) in the distribution of health workers by professional qualifications and source of knowledge about performance improvement initiatives.

5.3.1.2 Knowledge of Monitoring and Evaluation Mechanisms for PIIs

The findings indicate that 92% of the respondents had their performance reviewed quarterly. All the respondents from the public and private health sector stated that their reviews were regular and formally conducted. The monitoring was mainly through the supervisors meeting with their subordinates to review progress of implementation of work activities.

The areas assessed during the meetings between supervisors and their subordinates were the evaluation of planned objectives in relation to actual achievements. Discussions dwelt on measures to address

weaknesses and build on strengths of the subordinates. It is noted that, overall, the mode of evaluation of initiatives was similar in the public and private sector.

5.3.2 Assessment of PIIs effectiveness based on implementers' views

5.3.2.1 Usefulness of PIIs

Respondents in both the public and private health sectors stated that the different types of PIIs implemented at their place of work were useful in enhancing the quality of health services provided. One nurse in a public hospital mentioned that without the PIIs, “we would be operating like headless chickens.” This opinion came from 93% of public health sector respondents and 100% of private health sector interviewees. Overall, 61 health worker respondents were of the opinion that the performance improvement initiatives were useful in that they helped them to perform their duties better. This observation suggests an overwhelming confidence in the effectiveness of the performance improvement initiatives applicable to particular health facilities as far as the respondents were concerned.

5.3.2.2 Quality of health services

Above half (53.8%) of the health worker respondents felt that the quality of health services delivered at their hospitals had improved over the past five year period. In the private health sector, all health workers (11) stated that there had been some service improvement. Two respondents from the public health service, however, had a difference of opinion, labelling the quality of services as having ‘deteriorated’.

Above one third (36.9%) of the health services, mainly delivered through the public health facilities were described as static. There was significant evidence of variation (p -value >0.05) in the quality of services, with the private sector viewed as performing better than the public sector, according to the respondents included in this study.

5.3.2.3 Static quality of health services

In the hospitals where the quality of services was described as static, about 46% were hospitals reported to have outdated machinery, old linen and poor hospital diet. About a quarter (25%) attributed the failure to improve on health service quality to poor payment of workers including bad working conditions.

5.3.2.4 Improved quality of health services

The main reasons for regarding the quality of health services as having improved, according to the respondents, was due to the availability of better equipment and material resources for the hospitals labelled as having enhanced their service quality. A nurse stated that, “we now have the tools of the trade to enable us to do our work.”

5.3.2.5 Deteriorated quality of health services

The reasons given for considering the service quality as having deteriorated in the identified hospitals were similar to those of where the quality was said to be static, that is, the presence of old hospital equipment, and poor facility maintenance in general. The problems of poor equipment and facilities were identified mainly in the public health sector.

5.3.3 Health worker opinions to improve delivery of quality services

Twenty percent (20%) of the respondents indicated the need for more resources to be provided so that they could perform their daily duties better. The need for improving on drug stocks and the introduction of good working conditions was mentioned by interviewees in both health sectors. The interviewees recommended formal training on PIIs (18.5%) and measures to be put in place for the attainment of more ownership of PIIs by implementers (10.8%). The respondents also recommended that improvements be made on their remuneration (7.7%) in order to motivate staff and enhance their performance. A government hospital employee dispensing drugs stated, with regard to the perceived low remuneration, that, “we are tired of earning peanuts.”

5.3.4 Health worker opinions on enhancement of health service quality

About 31% of the health worker respondents suggested that there be more effective training for implementers which should be backed by regular follow-up or refresher plans in both private and public health sectors. Increased remuneration and more attractive working conditions identified as areas needing attention in general.

The need for more effective training on the implementation of PIIs was mentioned by respondents in the public and private hospitals, with 24% and 27% in the public and private sectors calling for this, respectively. The recommendation for improved working conditions, including better remuneration packages was common to both the public and private health staff.

5.3.5 Contribution of PIIs to efficiency of health service delivery

The majority of health worker respondents (83) included in this study were public service employees who were currently using the PBRS performance improvement policy at the work place. The different institutions in the private sector applied various policies. All (65) Health Worker respondents, were appraised formally four times each year, to assess their achievements of set objectives. Asked what happens when they scored lowly during performance appraisals, the majority of public health workers (57%) stated that the resultant score was of no consequence since no action was taken based on the assessment of their performance. The action taken in the private health sector contrasts with that of public health sector supervisors because in the former, the consequences of non-performance can be sanctions on the employee, including denial of promotion prospects. There was, therefore, a significant difference in the handling of poor performance results in the public and private hospitals as is reflected in a p-value of 0.000004.

If a low appraisal score is largely of no consequence to employees in the public health sector, a similar situation obtains with good appraisal scores. Fifty-three percent (53%) of the public health sector respondents stated that an award of high scores during performance appraisal did not necessarily result in rewards to employees. The lack of action taken based on the appraisal scores marks a major weakness of the performance improvement initiatives in the public health sector which is attested to by comments from some of the respondents to the effect that the PIIs are “just a routine government exercise” or are “theoretical” or that the initiatives have not been able to do away with ‘favouritism’ at work. Fifty-four

percent (54%) of respondents in the private health sector reported that good performance scores following appraisals were appreciated and rewarded. There was, therefore, a significant variation on practice in the public and private hospitals as was noted by a p-value of < 0.05 .

In the literature review to this study, it was pointed out that Furth (2006) conducted a pilot study on performance-based incentives in Zambia the objective of which was to test the effects of financial and non-financial awards on health worker motivation. The results of the study tallied with previous studies in revealing that staff incentives, especially the non-financial incentives such as recognition for work done were important for the effective delivery of health services. This view was in agreement with ideas held by Martinez, (2001) who stated that the most common incentives to improve staff performance are related to a good working environment and opportunities for staff career advancement. These observations were confirmed in this study on the health sector in Botswana where the majority of respondents expressed their dissatisfaction with their conditions of service. The reasons they gave for their dissatisfaction included poor equipment, poor physical infrastructure and the shortage of staff which contributed to them being over-worked. It is to be noted that most of the respondents were of the opinion that the performance improvement initiatives were effective in enhancing the quality of health services provided by their hospitals yet, at the same time, the health employees themselves were not happy with their conditions of service. *This observation suggests that the performance improvement initiatives in the health sector are effective but not necessarily efficiently implemented because the efficiency of staff is compromised by poor conditions of service including perceived low staff salaries.*

There is an apparent need for the hospital authorities to address the conditions of service in addition to implementing the performance improvement initiatives more seriously to avoid a situation whereby they are considered to be a mere formality by the health employees.

5.3.6 Empowerment of health workers

In the literature review for this study, one of the requisites for the success of performance improvement initiatives was listed by McPhee and Amonoo-Lartson *et al* (1993) as the need to involve implementers in the policy formulation process to facilitate the commitment of stakeholders during the implementation stage. It was significant that a high proportion of staff in both the government and the private hospitals (55%) indicated that they do not participate in the planning for the health services that they provide. All the respondents who claimed that they were not involved in the planning process expressed the wish to be part of the planning activities in their hospitals.

Question 15 in the Interview Schedule Number 1 for health workers in this study reads ‘Do you participate in the planning for the health services that you provide?’” The findings on the weaknesses related to staff participation in health service planning shed light on this question with regard to ‘empowerment’ in that it can be concluded that there is much room for improvement as far as the empowerment of health sector staff is concerned. In systems thinking terms, there is need for staff to be afforded the opportunity to participate in decision making, through interactive planning, in matters that affect them. Borrowing from the systems thinking concept of holism, the lack of full-fledged participatory planning mechanism translates to failing to acknowledge the importance of the interactions between the parts of a system that is the organisation. If the most challenging problems faced by the hospitals are to be tackled effectively, team synteegrity should be seen to be a feature of their management styles.

The observations noted above regarding the lack of empowerment of health sector staff bring to mind the general criticism of the deliverology approach, which was discussed in section 2.8.2.2 as it applied to the British public service where performance improvement reforms that were imposed from above proved to be unsuccessful. It was noted that although the reforms were well meant, they largely failed because of the lack of buy-in by the staff who supposed to implement them. Such a development supports the observation made by Rosenberg (2002) where he stated the requisites for the success of performance improvement initiatives as stakeholder agreement on the aims of the initiatives, identification of gaps in performance and an evaluation of the implementation process. The critical “check” stage that authors such as Seddon (2003) would recommend, where potential implementers are involved in an analysis of the purpose of introducing reforms in organisations appears to be one of the missing factors in the manner in which performance improvement initiatives were introduced in the Botswana health sector.

5.3.7 Equity with regard to health workers

It was noted that 56 (86%) respondents in the public and private health sectors felt they were under-rewarded, with nearly 90% of hospital workers claiming to be under-paid in the public sector and 74% in the private hospitals claiming the same. There was no significant difference in the opinions of health sector-wide respondents regarding their views on the extent to which their remuneration was equitable as was noted in Fisher’s exact 2 tailed probability value of > 0.05 . Only 14% of the respondents in the public and private hospitals expressed satisfaction with their remuneration and conditions of service.

The observation on the demotivating effect of perceived low salaries supports the views reported in section 1.8 which discussed the general public sector management challenges that included a general declining public service morale due to low salaries. Other challenges were linked to declining public service ethics, appointments based on patronage and the shortage of physical facilities such as office space. The perceived low salaries, it was noted in this study, were coupled with poor working conditions in general in the health sector.

The health sector perceptions of the lack of equity, especially in the public health sector, seem to have been given impetus by the fact that most of the respondents thought that their organisational reward systems were not based on fairness. There was a general belief that long-serving members were the ones sent for further training and that 'higher performers' were not always rewarded. Some openly said that 'there is favouritism of some employees.' These findings shed light on question 13 of the Interview Schedule Number 1 for health workers which read "Do you think that staff of your profession are fairly remunerated, compared to other professions in your organisation?". The findings are suggestive of the lack of internal equity.

5.4 Analysis and Interpretation of consumers' findings

Ultimately, the impact of performance improvement initiatives has to be measured by the extent to which the recipients of services express their satisfaction or dissatisfaction with the services. The perceptions of patients regarding the quality of services in the public and private hospitals were assessed in this study. In a response to the question, "In your opinion, are the health services delivered to the people as per their expectations?" 78% of the patients in the public hospitals expressed satisfaction with the service quality while all the 16 patients interviewed in the private health sector were appreciative of the services received. A common response was, "the services are okay." The apparent satisfaction that the patients had in the health services that they received is further reflected in the fact that the majority of them indicated that should they fall ill again, they would not mind being re-admitted in the same hospitals. The willingness of patients to be re-admitted in an institution should they fall sick again is either an indicator that they were satisfied with the quality of health care rendered or that if they were not satisfied, the quality of care was not so poor as to make the patients wish to be admitted elsewhere in future.

The high rate of reported patients' satisfaction with service delivery tallies with the results of the study that was conducted by the University of Botswana Department of Population Studies (2008:51) which

reported that ‘86% of in-patients were satisfied with services they received at health facilities.’ This high positive rating of health services is mirrored in other international studies of a similar nature. Qureshi *et al* (2009) reported results of patients’ satisfaction study at the Lala Ded Hospital in Kashmir, India where 72% of the patients rated the services as good, 8% as average and 20% as not satisfied. The KwaZulu-Natal Department of Health (2008) also reported high patient ratings during a 2008 patients’ satisfaction study at Addington Hospital in which 90% of the patients stated that they were satisfied with the quality of care provided in the wards. Similarly, the National Research Corporation (2009) reported results of an in-patients’ satisfaction survey at the American Cedars-Sinai Medical Centre where 70% of the patients said that they would recommend the medical centre to their friends and relatives. The research by Sanchez *et al* (2005) that was quoted in the literature review of this study indicated that 89% of the patients in the Basque health service in Spain were satisfied with the health services provided to them. The evidence in this study revealed that the majority of health sector workers were of the opinion that the performance improvement initiatives practiced at their hospitals were effective while the conclusion from Focus Group Discussions was that service quality had generally improved over the past five years, more especially in the private health sector.

The results in this study as well as the other studies quoted above confirm the observation by Cohen *et al* (1996) that remarkably high levels of patients’ satisfaction with health services are often reported in patients’ satisfaction surveys. It has been noted in various studies that the high ratings could be as a result of valid patients’ perceptions or weaknesses in either the study design or its conduct as when the wording of questions influences the responses. As noted in section 3.12, measures were taken to minimise these weaknesses. One can agree with the conclusion by Cohen *et al* (1996) that policies meant for improving the delivery of health services should not have an over-reliance on negative patient responses to gain information about clients’ views since this may provide a misleading picture. Overall, the caution by Abramson (1994:52) that ‘if patients or public are satisfied with their health care, this does not necessarily mean that their care is of high quality’ is worth noting.

5.4.1 Efficiency of PIIs

In a response to the question, ‘Is your community satisfied with the way that they are treated by the health workers when they visit health facilities to seek treatment?’ 73% of public patients were of the opinion that the community was satisfied with the services provided while all the 16 patients that accessed private health sector services stated that their communities were satisfied. The measures of efficiency included

the waiting time before being served in hospitals, the availability of drugs and other medical sundries and the general professionalism of health staff when attending to patients.

It was noted in this study that while the PIIs registered some effectiveness in improving the health service quality, the efficiency of operations was compromised by poor staff attitudes arising, from, among other factors, demotivation due to perceived low salaries and poor conditions of service. The bulk of the issues that the respondents complained about, however, did not require additional financial resources. The remarks by the then Botswana Ministry of Health Deputy Permanent Secretary quoted in 'The Voice' newspaper of 18th December, 2009 that he discovered that most problems reported at one of the referral hospital were not connected to shortage of resources supports this view. Despite the ever-changing management landscape, the observation made by Kanani *et al* (1988) that several constraint analysis exercises showed that constraints have a non-resource aspect is still valid. The findings in this study are that the effectiveness of the initiatives did not necessarily mean that there was efficiency in their implementation. There is need for more efficient methods of managing work processes.

5.4.2 Patient empowerment

It was noted in section 2.2.3 that one way of empowering patients is for the health system to facilitate their participation in decision-making regarding their treatment through the provision of relevant information to them. The majority of patients interviewed in this study revealed that treatment was explained to them before they received it. This suggests that patients are empowered as far as the imparting of information on their treatment is concerned.

Empowerment of patients can also be through being treated in a humane manner by the health care providers. Chart 5.6 reflects the methods used by patients to address the problems that they came across in the hospitals where they sought medical attention. It is disconcerting that a large number of patients indicated that some of the methods they used were to leave the hospital to seek treatment elsewhere or going away and returning on another day or just "doing nothing and simply accepting the situation". The findings of the study reveal that there was a general need for staff to improve on their attitudes towards patients, which would contribute to an improvement in patient empowerment. While it is acknowledged that perceived poor conditions of service and poor remuneration may affect staff performance, the patients still have the right to expect services of an acceptable quality from the health system.

5.4.3 Health equity

It was mentioned in section 2.3.2 that health equity, as far as clients of health services are concerned, has to do with perceived fairness in access to health resources and the elimination of inequities that are avoidable, such as those due to unequal economic or social conditions since these are inherently unfair. The analysis of patients' responses in this study does not only consider the frequency of comments made or their extensiveness in terms of how many people mentioned a particular issue. The analysis also took into account what Krueger (1998) refers to as the intensity or depth of feeling with which the comments were made. The specificity of responses, based on experiences of the patients was also given more weight than the vague and impersonal ones. As such, a passionate statement made by one patient in a public hospital to the effect that 'the hospital demands payment before treatment even when one does not have the money to pay' can be viewed as an appeal for the health authorities to improve client access to health services by addressing inequities due to differences in economic circumstances. Similar comments were made by two other patients who indicated that there was need to 'give food and treatment then demand payment later.' Yet another patient, expressing similar feelings in a private hospital stated that 'the hospital fees are too high, they should be made more affordable even though service is good.'

Ideas suggesting the perceived existence of health inequities were expressed by some patients in relation to the distribution of human resources and the inadequacy of health facilities. Two patients decried the shortage of doctors by appealing for authorities to 'increase the number of doctors' while yet another asked for 'an increase in the number of staff.' Requests for the health system to address inequities due to the lack of health facilities were expressed through patients' who saw the need to 'increase the number of beds' and 'expand facilities to reduce overcrowding.'

Through Focus Group Discussions, though, it was noted that about 80% of the community members around the hospitals selected for inclusion in this study were said to have easy access to health facilities. A number of factors that affect access to services, such as the distance to travel to health facilities and the user fees were not a hindrance. The major threat to the equitable provision of health services would seem to be the perceived negative staff attitudes towards patients.

5.5 Performance Improvement Initiatives Assessment through Focus Group Discussion: Community Members

5.5.1 Quality of health services received

A total of 6 hospitals were assessed for possible PIIs outcomes in the form of high quality health services. Five (5) of the 6 institutions were public hospitals. Out of the 5 government hospitals, 2 were primary hospitals, the other 2 were district hospitals and the fifth was a referral hospital at the tertiary level. The private health facility is a mine hospital.

Groups of individuals located around the hospital area within a radius of not more than 300 metres were invited for the group discussions. After getting their consent the group of not more than 12 members of balanced age and sex were introduced to the topics using a focus group discussion guide with 5 main topics, based on the following indicators:

- Effectiveness of current health care delivery system package
- Efficiency of the health care delivery system over time
- Empowerment of the health care consumers
- Equitable reception of comprehensive health care delivered
- Community recommendations for improving health delivery system

5.5.2 Effectiveness of current health care delivery system package

A comprehensive health care package consisting of the basic essential expectations was used as a golden standard to guide the Focus Group Discussion (FGD) of the conveniently selected group of community members.

5.5.3 Professionalism and staff attitudes

The professionalism and staff attitudes towards patients were part of the discussions among the six selected hospitals. An average vote score of 6 out of every 10 was recorded from the 6 Focus Group Discussions. It was clear from the different groups, except for Orapa Mine Hospital, that the health worker attitudes towards patients were not considered as pleasant. The groups felt that nurses and other

paramedic staff were so much used to queues that they would not, for example, stand up to attend to less than 5 patients waiting to be served. This was reflected in statements such as “the health workers wait for patients to first form long queues before they attend to them.”

5.5.4 Hospital cleanliness and conducive health care environment

It was noted that although some hospital buildings were old, cleanliness was rated at about 80%, with the private hospital and one of the government primary hospitals ranking higher than the rest. Bed linen and patient diet at some public institutions were identified as being below the public expectations.

5.5.5 Hospital equipment, age, state and functionality

Except for the mine hospital, which was said to be better equipped, government hospital equipment availability, for example, for X-ray and laboratory purposes, was reported to be at around 70% of community expectations, although it was not possible to measure its functionality. The mining community was content with the equipment used at Orapa Mine.

5.5.6 Essential drugs availability and basic logistics

All FGDs stated that the availability of commonly used drugs was at around 90%, with the exception of a few special prescriptions that are purchased from private pharmacies. ARV drugs for HIV/AIDS were still not sufficient to enrol all the eligible patients. It was also not easy to come up with a specific stock level from the community, but all groups claimed around 95% of positive health worker attitudes at TB and AIDS consultation clinics within the hospitals.

5.5.7 Essential professional and friendly manpower

The required number of health workers was said to be almost sufficient, but their professional conduct was reported as leaving a lot to be desired. The staff attitudes were rated lowly, in general.

In summary, the quality of health care delivered by public institutions was rated at 57% while that of private health centres was 88%.

5.5.8 Efficiency of the health care delivery system over time

A similar assessment was done at each area, seeking a comparative picture of the health care delivery system in the past 5 years.

5.5.8.1 Deterioration of service quality

In general, deterioration of the quality of health services was characterised by dilapidation of hospital infrastructure, poor hospital management, bad staff attitudes and a shortage of essential drugs compared to the past 5 years. One participant stated that, "we miss the good old times."

5.5.8.2 Static quality of health services

Two government hospitals had the quality of their services rated as static during the discussions. This was an indicator of the lack of effectiveness of the performance improvement initiatives implemented at the health facilities.

5.5.8.3 Improved quality of health services

Three hospitals, 1 private and 2 public, were singled out as having achieved significant improvements in their service delivery. There were some service delivery gaps, though, such as the insufficiency of ARV drugs stocks, shortage of specialists and minimum recreational facilities.

5.5.9 Community empowerment in health care delivery ownership

The topic on community responsibility in health care promotion and service management was explored in all the 6 groups as indicated below;

5.5.9.1 Community interface with health care systems

In all the 5 public health facilities, there was little knowledge of the community link with the health delivery system. A few members remembered the use of the suggestion box. Of the 5

public health institutions, an average of 25% community empowerment was estimated, leaving the rest three-quarters with no rights to contribute, complain or advise on the quality, effectiveness and efficiency of services received. On the private sector, the knowledge of a communication channel using the mine public relations was noted at around 70%, suggesting that most of the community members knew where to go in the hospital should they need assistance.

5.5.9.2 Community representation in the hospital boards

The mine hospital scored higher than the other hospitals regarding the affording of the community the opportunity to be heard.

5.5.10 Equitable distribution of health services to the community

Around 80% of the community were said to have easy access to health facilities. This came out of a debate with close consideration of distance to the health centre, cost of consultation, religious and cultural beliefs, transport availability and the quality of health services delivered. The following points were noted regarding the accessibility of services.

- **Programmatic services** – around 80% of TB/HIV+ patients needing enrolment for ARVs were said to have access to those facilities.
- **Specialist services** - an estimated 70 out of every 100 patients seeking specialists services in and outside Botswana could afford to access such services.

It is estimated from this assessment that the equitable distribution of health services to the general public in Botswana could range from 60% - 80% of the total catchment population as described by the selected focus groups in the 6 health facility catchment areas.

5.5.11 Summary of observations cutting across the four sample groups

The policy makers and health workers were in agreement that the performance improvement initiatives were successful in improving the provision of the quality of health services. In the public hospitals, PBRS was singled out as the most successful of the initiatives implemented. This is attested to by the fact that 4 out of 5 policy makers indicated that PBRS was the most effective of the initiatives while 93% of

health workers in the public sector mentioned PBRS as the most successful. All 11 health workers in the private health sector regarded the initiatives at their institutions as useful. There was less confidence in the success of implementation of other initiatives such as TQM and WITS. A common feature in the weaknesses identified by policy makers and health worker was the lack of resources to make the implementation of initiatives more successful. A comparison of the views of the policy makers, the health workers and the patients shows that 78% of public hospitals' patients gave a positive rating of the health services they received while all patients in private hospitals stated that health services met the expectations of the people. The Focus Group Discussions, on the other hand, rated the quality of services at 57% in public hospitals and 88% in private hospitals. The analysis of the views of the policy makers, health workers, patients and the community at large show an appreciation of the quality of health services in the health sector despite some weaknesses in the implementation process that impact negatively on efficiency.

Equity issues related to employee remuneration were problematic as far as the health workers were concerned and this was supported by the policy makers where 3 of the 5 respondents stating that there were problems of inequity in the remuneration of employees. The patients and community members, however, gave a positive rating for the equitable provision of health services. Fifty six percent (56%) of health workers in the public hospitals and 6 out of 11 in the private hospitals claimed non-involvement in planning, suggesting a lack of effective empowerment. Policy makers, in contrast, were of the view that health workers were empowered through various mechanisms such as the decentralisation of training on the performance improvement and initiatives and the holding of refresher courses for the supervisors at the operational level. Patients and community members had similar views on empowerment, indicating that a lot needs to be done to empower them through involvement in decision making on issues that affect their health.

5.6 Chapter summary

This chapter presented an analysis of the findings outlined in Chapter 5. The responses from the respondents were compared and contrasted. It was noted that generally, the opinions of the policy makers, health workers, patients and community members are that there has been an improvement in the provision of quality health services since the introduction of the performance improvement initiatives in Botswana.

The analysis shows that there has been a moderate improvement in the quality of services suggesting that the initiatives have achieved some effectiveness even though the efficiency may have been hampered by some operational problems such as the shortage of resources for implementation, the perceived poor conditions of service and poor remuneration for health workers which impact negatively on their efficiency. While complaints of internal inequity were registered among health workers and supported by policy makers, patients and community members were generally satisfied with the efforts taken by health services providers to provide equitable health services. There were problems with the empowerment of health workers, patients and community members which need to be addressed.

Chapter Six will review the hypothetical assumptions and research objectives in this study.

CHAPTER SIX

6. REVIEW OF HYPOTHETICAL ASSUMPTIONS AND RESEARCH OBJECTIVES

6.1 Introduction

This Chapter reviews the three-fold hypotheses and the research objectives regarding whether the hypothetical assumptions were sustained or not and whether the questions were answered. The hypothetical assumptions are important because they guided the research. The assumptions facilitated the process of data collection in order to resolve the research problem. The assumptions in this study were, briefly, that: the performance improvement initiatives under study were introduced in a top-down manner; there is limited knowledge on the part of the health workers at the operational level regarding the usefulness of the improvement initiatives with the consequent low uptake of the initiatives; and the frequency of complaints by health services consumers reflects the poor quality of health services provided in the health sector in Botswana.

A comparison of literature findings with the study findings pertaining to the study assumptions and the research questions is presented in a tabular form.

6.2 Recap on study assumptions and research questions

Table 6.1 below shows, respectively, a brief summary of the main literature review findings in relation to the assumptions and questions of the study with comments of whether they were confirmed by the study.

Table 6.1: Comparison of literature review findings in relation to study assumptions

Assumptions	Literature Findings:	Study Findings:	Confirmed/Denied
<p>Assumption 1. performance improvement initiatives were imposed in a top-down manner in the Botswana health sector with the noble belief that they were valuable in contributing towards the achievement of the goals of Vision 2016</p>	<p>Authors such as Grol (2006), Cunningham (2005) and Loo (2009) note that authority-driven innovations tend to have minimum impact due to lack of buy-in by implementers.</p>	<p>While senior Ministry of Health officials were of the opinion that implementers of PIIs had been empowered through “decentralisation” of the initiatives to lower levels, 55% of the implementers indicated that they were not involved in planning for health services.</p>	<p>Confirmed</p>
<p>Assumption 2: there is limited knowledge on the part of the health workers at the operational level regarding the usefulness of the performance improvement initiatives and this contributes to their low uptake of the initiatives in the Botswana health sector</p>	<p>Literature indicates that research, generally, shows that success of performance improvement initiatives depends on employees’ acceptance of new performance requirements.</p>	<p>Staff were largely knowledgeable of the usefulness of the PIIs in spite of poor uptake of the initiatives - staff described them in terms such as ‘theoretical,’ and “just a routine government exercise.” Perceived poor conditions of service compromised staff efficiency, not limited knowledge.</p>	<p>Denied</p>
<p>Assumption 3: the frequency of complaints by health services consumers is a reflection of the poor quality of health services provided in the health sector in Botswana.</p>	<p>1. Authors such as Chirairo (2008) observed that the public, private and parastatal sectors in Botswana were facing challenges of implementing change for the improvement of performance and service delivery.</p> <p>2. The NDP9 (2004-2009) stated that one of the challenges faced by the government was the as yet unmet public expectation for more improved services since the introduction of PMS.</p>	<p>An average of 94% of the health sector staff considered the PIIs as useful in improving the quality of services, an average of 89% of patients in the health sector were satisfied with the quality of services and FGDs rated the quality of service as 57% and 88% in the public and private hospitals respectively.</p>	<p>Denied</p>

Table 6.2: Comparison of literature review findings in relation to study questions

Research questions	Literature Findings:	Study Findings:	Confirmed/Denied
<p>Research question 1: What are the expectations of the policy makers on the outcomes of the PIs implementation?</p>	<p>Authors such as Borenstein <i>et al</i> (2004) and Ozturk (2006) note that performance improvement initiatives do not necessarily lead to improved performance by organisations implementing them.</p>	<p>There was congruency in the expectations of policy makers and implementers of performance improvement initiatives. There was a common view shared that the initiatives were meant to improve health service quality. Evidence suggests that the initiatives in Botswana are useful.</p>	<p>Denied</p>
<p>Research question 2: To what extent are the health sector staff aware of the existence of the performance improvement initiatives and what are their perceptions on the effectiveness and efficiency of the initiatives?</p>	<p>Literature indicates that implementers of initiatives need to be taken on board in the introduction of new programmes in order to enhance chances of success in implementation.</p>	<p>The health sector staff were knowledgeable of the existence of the initiatives and they believed that the initiatives were useful in improving the quality of health services. The effectiveness was, however, hampered by perceived poor conditions of service.</p>	<p>Confirmed</p>
<p>Research question 3: What are the opinions of health staff regarding internal equity and their empowerment to implement performance improvement initiatives?</p>	<p>1. Equity: Authors such as Fowler (2006) observed that the Equity Theory is founded on the idea that staff become de-motivated if they perceive their inputs to be greater than the outputs. Internal Equity refers to fair compensation regarding how different positions in an organization relate to each other.</p>	<p>1. Equity: the majority of respondents in this study were of the view that management in their institutions did not award work-related benefits fairly. Reasons for the dissatisfaction with the award of benefits included: benefits not based on performance; long-serving staff were the ones sent for further training; and there was favouritism of some employees.</p>	<p>1. Equity Confirmed strongly</p>

	<p>2. Empowerment: a) Employees</p> <p>Empowerment with regard to employees can be regarded as the process of enhancing the capacity of individuals or groups to participate in major organisational decisions that affect them in order to improve staff commitment to change.</p>	<p>2. Empowerment: a) Employees</p> <p>In this study, 55% of respondents indicated that they were not involved in the planning process, suggesting a lack of empowerment.</p>	<p>2. Empowerment (a) Employees</p> <p>Findings of study revealed short-comings in employee empowerment.</p>
<p>Research Question 4: What are the perceptions of the health service consumers regarding the quality of services in the wake of the introduction of performance improvement initiatives?</p>	<p>Researchers such as Cohen <i>et al</i> (1996) and Sanchez <i>et al</i> (2005) reveal that remarkably high levels of patients' satisfaction with health services are often reported in patients' satisfaction surveys.</p>	<p>As noted under assumption 3 above, the majority of patients expressed their satisfaction with the quality of services they received.</p>	<p>Confirmed</p>
<p>Research Question 5: What are the opinions of health service consumers on the fairness of access to health care and what empowerment mechanisms are in place to facilitate such access?</p>	<p>- Literature shows that in most developing countries, access to health services is often hampered by factors such as distances travelled to reach health facilities, high user costs and negative staff attitudes.</p> <p>- in most developing countries, health services consumers are not fully involved in the making of decisions that affect them, such as in health service provision.</p>	<p>- The majority of health service consumer respondents indicated that generally, there was equity in health services provision with services being affordable and accessible. Reservations were mainly expressed about negative staff attitudes.</p> <p>- Patients were empowered as far as matters such as being informed about medical treatment administered to them was concerned but on a larger social scale, there was need for more involvement of patients in decision making for health service provision.</p>	<p>Denied</p> <p>Confirmed</p>

6.3 Chapter summary

The hypotheses and the research questions were examined in this chapter with a view to finding out the extent to which the assumptions of the study were sustained and whether there was confirmation of the issues raised in the hypotheses and the questions. Some of the issues were confirmed and others denied as is reflected in Tables 6.1 and 6.2.

Some of the important observations are that: policy makers were of the opinion that health staff were empowered through the decentralisation of the performance improvement initiatives to the health workers whereas the latter indicated that they were largely not part of the health service planning process, thus revealing a weakness in the empowerment mechanisms; health staff were generally knowledgeable of the existence of the initiatives but this did not necessarily translate to an enthusiastic uptake of the initiatives because of other problems related to poor conditions of service and salaries that were regarded as inequitable by the health staff; and patients and community members were, in the main, satisfied with the health services provided to them.

The claim by implementers of health services that they are, to a large extent, not part of the service planning process is suggestive of top-down approaches of management on the part of the senior management staff. The revelation that health staff were knowledgeable of the existence of the performance improvement initiatives but did not seem to take them up actively indicates that much more needs to be done by senior management to motivate the implementers to adopt the initiatives and make them a success. It is debatable the extent to which the satisfaction levels expressed by patients and community members can be relied upon to conclusively make a decision as to the quality of health services that they received.

Chapter Seven will present the policy and practice implications, based on the analysis of the findings in this study.

CHAPTER SEVEN

7. POLICY AND PRACTICE IMPLICATIONS

7.1 Introduction

The findings and subsequent analysis in this study have specific, evidence-based implications for policy-makers and practitioners or leaders in the Botswana health sector. The findings and their analysis can inform both policymakers and practitioners about effective measures to take in the implementation of performance improvement initiatives.

The gap that exists between research or evidence in general and policy makers as well as practitioners is well documented in the literature. Vincent (2006) writes that there is a gap between intended research beneficiaries and the individuals who actually conduct the research, hence there is a need to bridge the gap by strengthening the networking between researchers, policy makers and practitioners in order to achieve dialogue throughout the research process. The claim that a strengthened relationship between researchers and policy makers is desirable has been frowned upon in some quarters due to concerns that policy makers may, because of the political clout that they wield, exert an unfair influence over researchers to the extent of inducing biased results.

The formation of the 'Getting Research into Policy and Practice' (GRIPP) website, funded by the UK Department for International Development (DFID), is meant to address the divide between these actors by documenting strategies by which researchers can ensure that their work has an impact on policy and practice. The implications for policy and practice in this study have been drafted with the observation by Young (2009) in mind to the effect that policy processes are rarely ever linear and logical as they tend to be influenced by their values, experiences and judgement as well as pressure groups and the resources available rather than evidence alone.

The summary of the study findings in this chapter is guided by the research questions of the study. The study findings were significant in different ways such as in their predictability, the way in which they confirmed previously understood situations and how, in some ways, they were unexpected. It is, for example, generally assumed that conditions of service are better in the private health sector than in the public health sector and staff in the latter tend to think of 'greener pastures' with reference to employment in the private sector. It was significant that respondents in this study complained of poor working

conditions in both the public and the private health sector. The areas of concern that were identified by staff were similar for the public and private health sector with mention made of problems such as staff shortages, limited opportunities for career mobility and unfair management allocation of staff benefits.

It was expected that the consumers of health services would rate the quality of health service provision lowly because the health sector staff were, generally, unhappy with their conditions of service and remuneration that was considered to be low. The expectation was that the health service providers would have their efficiency and effectiveness negatively affected because they were disgruntled. The consumers of health services were, however, generally satisfied with the quality of health services in the public and private hospitals. It was a revelation that although the health service delivery system in Botswana can be said to be effective, the efficiency of operations leaves much room for improvement.

7.2 Summary of significant study findings and their implications for policy and practice

The following are the most important findings of the study;

7.2.1 Expectations of the policy makers on the outcomes of the PIIs implementation

The policy makers' expectations of the performance improvement initiatives was that they would contribute towards the attainment of better quality services for the nation and facilitate the process of achieving the long-term goals of health for all as defined in Vision 2016. It was revealed in this study that the performance improvement initiatives were moderately effective in the public health sector, with a higher rating in the private health sector. The efficiency of the initiatives was, however, compromised by practical problems arising from perceptions of poor conditions of service and low remuneration on the part of the implementers of the initiatives at the operational level.

It is significant that although the implementers of the initiatives generally believed in their usefulness, they, at the same time described the initiatives in terms such as 'theoretical'. The implication for policy and practice is that policy makers in the Botswana health sector need to reinforce the mechanisms for ensuring that implementers of new initiatives have ownership of them. Senior managements need to inculcate in the staff the importance of the initiatives through continuously emphasising the benefits of embracing the changes brought about by the initiatives. Health managers have to develop the necessary

skills for effectively coordinating the implementation of the performance improvement initiatives. The introduction of performance improvement initiatives should go beyond the initial phase of planning for health services and be seen through the implementation stage to ensure that they achieve their intended objectives.

At the policy making level, there is need for reinforcing monitoring mechanisms that will identify operational level deviations from the agreed policy direction. It is necessary for policy makers to ascertain that health policies support planning, implementation and evaluation of performance improvement initiatives. The knowledge obtained through the process of tracking the implementation of the initiatives should be shared with the staff for effective use. Through formative and summative evaluation of the performance improvement process, information can be obtained to continuously improve the implementation of reform initiatives.

7.2.2 Health sector staff awareness of performance improvement initiatives and perceptions on their effectiveness and efficiency

It was noted that all 65 health sector worker respondents knew at least one performance improvement initiative used at work, with 83% in the public health sector mentioning the Performance Based Reward System. Knowledge of the purpose of the initiatives was, however, not the only necessary factor for the successful implementation of the initiatives. The implications for policy and practice is that there is already a fertile ground for reinforcing the implementation of the initiatives especially in the light of the belief by the staff that the initiatives are effective and efficient. It is to be noted, though, that the consumers of health services corroborated the effectiveness aspect but cast doubt on their efficiency. The policy makers need to turn their attention to the factors that compromise the efficiency of operations at the implementation level.

It is understood that the performance improvement initiatives were introduced in Botswana because they had proved to be a success in countries such as Singapore. Policy makers and practitioners need to evaluate the evidence available to them, be it research based, judgemental or experiential, as to the efficiency and effectiveness of the performance improvement initiatives with a view to contextualising them in the Botswana environment rather than apply them wholesale. It may be that the work environment in the countries from which the initiatives are 'imported' differ from those in the recipient country hence the need to have the initiatives tailor-made for local conditions to allow for flexibility at the local level.

In order to understand the most challenging managerial problems with regards to the implementation of performance improvement initiatives in the Botswana health sector, the health service delivery problems should be approached from a holistic perspective. The unique individual and organisational characteristics of the Botswana health system should be taken into consideration in the introduction of initiatives for improving performance. Each component of the health system should be viewed as having systemic influences, whether positive or negative, on the health system at large.

7.2.3 Opinions of health staff regarding internal equity and empowerment to implement performance improvement initiatives

Eighty-six percent (86%) of health sector workers were of the opinion that there was no equity in the awarding of benefits. A major concern in the Botswana health sector was the perceived poor working conditions and apparent inadequacy of the employees' remuneration. At the practitioner level, especially in the public sector, there may not be much that individual health service managers can do about complaints related to low salaries. Positive management interventions are, however, possible in addressing other staff concerns of a non-financial nature which require appropriate management styles that take into account the divergence of views characteristic of organisational members.

Jackson (2005) observed that the systems thinking view of organisations is that social systems are purposeful in the sense that they can generate their own purposes from within the system which may be at variance from those that managers have in mind. A distinction is made with the kind of components or parts that engineers deal with which are termed 'purposeful' because they are designed for the attainment of goals set by the engineer. Systems thinking, therefore, approaches issues of leadership from a holistic viewpoint and not the traditional mechanistic one where leaders are considered to be the citadel of ideas and plans for shaping the direction of organisations. Marlette (1999) acknowledged systems thinking as one of the schools of thought that advocate a paradigm shift from a mechanistic to a holistic world view with profound implications for the exercise of leadership.

The responses of staff interviewed in this study show that individuals value recognition at the work-place and that they prefer a system where their opinions are taken on board in the development of organisational strategies. The implication for practitioners in the health sector is that, in general, the machine image of the mechanistic world view is unlikely to achieve success in the performance of leadership or managerial functions. Employees have feelings and purposes which health sector management practitioners need to be familiar with for the effective running of organisations.

More than half of the health worker respondents indicated that they are not empowered by the various managements to participate in planning decisions. The implications for management practitioners in the health sector is that there is need to facilitate the well-being of staff through intrinsic motivation factors and empowerment through measures such as participative decision making. The need for management practices to be seen as fair by the staff cannot be over-emphasised. Botswana is renowned for its democratic traditions and the implications for policy and practice are that such traditions need to be cascaded to the organisational levels where accountability and transparency of governance can be supported by evidence-based decisions, notwithstanding the source of the evidence.

7.2.4 Perceptions of the health service consumers regarding the quality of services following the introduction of performance improvement initiatives

It was noted that although the majority of health worker respondents expressed dissatisfaction with their conditions of service, most of the health services consumers, on the other hand, indicated that they were largely satisfied with the services provided. One can conclude that the performance of staff, and hence patients' satisfaction, could even be increased if the conditions of service for the staff were to improve.

The implications for practice are that the health sector management needs to take advantage of the existing positive ratings in patient' satisfaction with the health services that they receive and reinforce improvements in the conditions of service of the health staff. It would be folly, however, for policy makers and practitioners to base decision making only on the positive ratings of patient satisfaction surveys since, as noted in section 5.4, in the reference to Abramson (1994), the fact that patients or the public are satisfied with health services is not necessarily a reflection of the high quality of that service.

7.2.5 Opinions of health service consumers on the fairness of access to health care and empowerment mechanisms to facilitate such access

The majority of patients and community members indicated that they had no problems accessing health services. Health practitioners need to ensure that this positive development is sustained. There were notable snags, however, in the interface of the consumers with the health service authorities as is noted in the fact that respondents among the consumers indicated that they dealt with health care delivery problems from a position of weakness such as doing nothing about the problem, leaving to seek treatment elsewhere and going away and returning on a different day.

The apparent lack of mechanisms for empowering consumers of health services, in a world where the consumers are increasingly becoming aware of their rights, has far-reaching implications for policy makers and practitioners. The practice of dialoguing with health service clients to obtain their opinions is in tandem with international requirements, so as to improve access to care and information regarding the available treatment options. According to a 2002 Hong Kong Medical Journal, the shift from the biomedical to the patient empowerment type of care has precedence in health systems such as those of the United Kingdom where a 2001 publication on 'Involving patients and the public in healthcare' emphasised the need for a greater involvement of patients in decisions about their health care. The publication outlined proposals for implementing the vision of patient-centred care in the National Health Service (NHS).

Health policy makers in Botswana need to draw up patient empowerment legislation that reinforces health professionals and patients' interactions for the mutual benefit of both parties. Such legislation would further facilitate the right of patients to self-determination and control over decisions pertaining to their health as is currently the case in countries such as the United States of America.

7.3 Chapter summary

In spite of the gap that often exists between researchers and policy makers and practitioners, there are notable implications for policy and practice in the Botswana health sector. Policy makers and practitioners have the responsibility of ensuring that their decision making processes are evidenced based and that they consider the long-term consequences of their decisions. Health policy makers and practitioners need to develop skills for dealing with the dynamic complexity that is characteristic of the health sector.

Performance improvement initiatives that are imported from other countries should be adapted to local cultural conditions. Health managers need to be cognisant of the purposeful nature of social systems and make efforts to achieve congruency between the organisational goals and the individual ambitions of organisational members. The importance of developing effective communication strategies within organisations cannot be over-emphasised. Formative and summative evaluation of the performance improvement process can facilitate the implementation of reform initiatives. The success of improvement initiatives is dependent to a large extent on improved working conditions of staff. There is need to streamline organisational structures and processes. Liaison mechanisms need to be put in place to facilitate dialogue between practitioners at the operational level and policy makers. Chapter Eight will present the agenda for future research.

CHAPTER EIGHT

8 AGENDA FOR FUTURE RESEARCH

8.1 Introduction

Chapter Seven presented the policy and practice implications of the findings in this study dwelling on the key quality indicators of efficiency, effectiveness, empowerment and equity. The findings of the study confirmed operational problems in the health sector service delivery with regards to efficiency, effectiveness, equity and empowerment in relation to the implementation of performance improvement initiatives. The purpose of this chapter, on the agenda for future research, is to highlight the potential areas of research, based on the findings in this study. The agenda for future research will facilitate the identification of conceptual weaknesses in the formulation, implementation and evaluation of performance improvement initiatives in the Botswana health sector through highlighting potential areas of research and priorities for action. The future research priorities will help to fill in gaps in the current knowledge about performance improvement initiatives in the Botswana health sector.

The suggestions for future research have been structured in terms of issues pertaining to contextualisation of performance improvement initiatives, human resource management issues, mutual monitoring mechanisms, acknowledgement of failures, diversity of staff, extent to which client views contribute to health outcomes, and drivers of patients' perceptions of the health institutions' performance.

8.2 Future research proposal

8.2.1 Contextualisation of performance improvement initiatives

It was noted in Chapter 1 that performance improvement initiatives such as PMS, WITS TQM and PBRS were reported to have worked well in other countries before their introduction in Botswana. This study has revealed that although there were successes in terms of effectiveness of implementation of performance improvement initiatives, such success was just above average in the public health sector.

Bowen and Zwi (2005:2) argue that 'fundamental to the transfer of evidence into policy and practice is diffusion, the process by which an innovation is communicated over time among members of a social system ...' They noted that studies of innovation in health care organisations proposed that the diffusion

process helps in understanding the way in which organisational members receive, adopt, and adapt evidence as well as the organisational factors that hinder or facilitate the adoption or implementation of the evidence. Also important to the understanding of how ideas are diffused are the interests and values that are prevalent in organisations since they influence the extent to which proposed changes are accepted. Bowen and Zwi (2005) further stated that the extent to which individual, organisational and system level values influence the acceptance or rejection of new ideas is largely unexplored in the literature and that the importance of values in determining the lack of action on health inequity has been inadequately researched.

More empirical work is required to assess the reasons why initiatives which have been applauded elsewhere do not seem to have the same level of success in the areas where they are transplanted to. Future research may examine the ways in which performance improvement initiatives may be contextualised in the new settings. An exploration of organisational culture within the framework of the cultural issues at the national level could be useful. The research could examine the set of deeper level assumptions and beliefs shared by health staff within their environmental settings. The research could indicate the extent to which there could be a difference between the stated and the tacit values of the health sector organisations. Such research could provide insights into how performance improvement initiatives could be better contextualised in the broader national development agenda of Botswana through an identification of the most important drivers of performance at institutional, national and international levels.

8.2.2 Human Resource Management issues

It was noted in this study that the majority of respondents were aware of the reasons for the introduction of the performance improvement initiatives yet the evidence available showed that there were still problems with their implementation. It is widely acknowledged that human resources are the most important element for the organisational attainment of strategic and short-term goals. Future research could examine further the reasons why there is an apparent lack of staff interest in actively taking up performance improvement initiatives and ensuring their success considering that their intended purpose is acknowledged as noble. Studies might examine the relationship between human resource sensitivity to the performance improvement initiatives and the effectiveness of personnel under stressful conditions arising from working conditions. This kind of deepened research could also be widened to include more cadres, such as lower level staff in the form of drivers, cleaners, and nurse aides, than were identified as participants in this study.

8.2.3 Mutual monitoring mechanisms

It was noted that the norm in the health sector is to have senior staff monitoring the work of their subordinates and rating their performance based on agreed plans. Some respondents, however, pointed out what they termed, 'poor leadership style' as a de-motivator at the workplace. Future research could provide useful insights on the applicability of additional performance review mechanisms such as peer reviews and subordinate-supervisor reviews in Botswana. Peer groups tend to have a greater social awareness of each other and supervisors could gain helpful hints about their own performance from information supplied by subordinates. Such review mechanisms may prove useful in providing balanced performance review systems even though, ultimately, the top management is primarily responsible for setting the strategic direction of their health institutions.

8.2.4 Acknowledgement of failure

The top management in health institutions, generally, tended to applaud the introduction of performance improvement initiatives as a success story while the juniors were keen to identify performance problems related to poor conditions of work. Top management, therefore, tended to gloss over potential problem areas and this was more evident in the private health sector where management appeared more reluctant to have the investigator gain access to interview employees with the possibility of publishing potentially embarrassing information about organisational performance. There is, however, far more to learn if future studies were to highlight failed attempts at improving performance rather than concentrate on telling 'success' stories which may not be backed by information on the ground. This would bring balance to the present documentation of performance improvement initiatives that takes a strong advocacy role.

Systematic investigation and analysis of failures would pave the way for giving direction on what needs to be done to achieve successful implementation of performance improvement initiatives. It is noted here that such research could be fraught with difficulties considering the reluctance of top management to chronicle what could be regarded as failures on their part. A useful starting point, however, could be to do an in-depth examination of initiatives which are no longer actively implemented with a view to mapping directions for future performance improvement interventions.

Ackoff (2006:2) made an important point when he argued that, ‘We can learn from mistakes if we identify and correct them. Therefore, organizations and individuals that never admit to a mistake never learn anything.’

8.2.5 Diverse complexity

Welbourne and Mejia (1995) stated that literature suggests that team outcomes such as productivity and creative solutions are influenced by group membership of staff involved in the implementation of programmes. An observation in this study was that the health sector has a diversity of groups arising from the different professions employed to deliver health services in the form of nurses, doctors and various paramedic groups. Future research may examine how the diversity of such staffing patterns influence the formulation, implementation and evaluation of performance improvement initiatives. This is significant given that the effectiveness of work teams, as in the WITS initiative, may depend much on how team members in a heterogeneous work environment are assigned roles. Cox (cited in Welbourne and Mejia 1995) argued that greater intra diversity stimulates flexibility, change and innovative decision-making which enhances the team performance.

In spite of the localisation policy in the Botswana health sector where expatriates are gradually replaced by nationals, expatriates are likely to continue playing a major role in the delivery of health services in this sector. The presence of expatriates further increases the diversity of the health sector staff. Could it be that less diverse groups could have more closely knit cultural patterns, with less time required to adapt to each other, hence facilitating mutual understanding and quicker decision-making through more effective communication? This brings to the fore the systems thinking observation that problems are more difficult to manage in an environment characterised by change and diverse complexity, particularly where the participants in decision-making are either unitary or pluralistic in nature. Whereas in a system where participants are unitary in their relationship a common purpose would prevail, a more pluralistic workforce would need more compromises in the decision-making process due to the need to iron out differences in the approach to problem solving. There may be need to develop performance measures based on the structure of work organisation. Whether the heterogeneous nature of the workforce in the health sector has a bearing on the outcomes of performance improvement initiatives could, therefore, be the subject of future research.

8.2.6 Extent to which clients' views contribute to health outcomes

One of the findings in this study was that patients were generally satisfied with the service that they received from health care providers. What was not clear from the study was the extent to which clients or patients contribute to the health delivery process through active involvement in the decision-making process regarding the health services that they receive. It is noted that the health professionals in the health sector are expected, by virtue of their training, to take the lead in matters of deciding the best possible care to be rendered to patients. The health practitioners cannot afford, however, in this era where the literacy levels are higher than ever before, to consider their clients as passive recipients of health services. Their involvement in matters to do with their health needs to extend beyond having medications explained to them before they receive them to actual participation in the formulation of decisions regarding the best possible course of health services that they can expect from the health system. One need not be a patient first before interacting with the health system.

In Botswana, health is regarded as a public good and measures to improve customer care are not meant for financial profit making but rather for the purpose of improving the general health of the nation. This is attested to by declarations such as in the Vision 2016 which has the aim of having a healthy nation by the year 2016. To this end, additional research is needed to provide concrete directions regarding how health policy makers can enhance the value of contributions by members of the public through having their views incorporated in the formulation, implementation and evaluation of health services. Population surveys can be conducted to gather and analyse data for decision-making. A mix of quantitative and qualitative research methods can yield numerical data and narratives to facilitate managerial improvements of health service delivery. In the absence of such research, health policy makers and health practitioners may continue to be looked upon as the citadel of knowledge even in matters as personal as individuals' health status.

8.2.7 Drivers of patients' perceptions of the health institutions' performance

One of the findings in this research was that patients, generally, rated the services that they received from health care providers highly. Comparisons with other studies in other settings, not only in Botswana, revealed that the norm is for patients to indicate high satisfaction levels with health services provided to them. Such positive ratings are made in spite of reports in the media and other public fora about low standards of performance in health institutions and the need to improve service provision. Bolton *et al* (2007) have a valid point when they state that when a customer has repeated interactions with the same

firm but encountering different employees across service occasions, his/her responses distinguish between the offending employee and the organisation such that satisfaction or dissatisfaction is dependent on the customer's perception of the prevalence of failure in the organisation. In the same publication, these authors suggest that customers are less likely to attribute the failure to the organization (and hence be dissatisfied with it) when they have had excellent prior experiences with the organisation.

In the light of the above, there is need for further research into drivers of customer perceptions of the value propositions of institutions in the health sector. Regular surveys could facilitate the tracking of any changes in patients' perceptions about the performance of health sector organisations that may occur over time to enable policy makers and practitioners to improve service planning and management. Researchers could draw on theory from other fields such as sociology, psychology and anthropology.

8.3 Chapter summary

This chapter has identified areas that the investigator considers to be pertinent as future topics of research interest. It was noted that the areas include more empirical work to assess the reasons why initiatives which have been successful elsewhere tend to have less impact in different environments, the need to explore reasons why there is an apparent lack of staff interest to actively embrace performance improvement initiatives that will be having a noble purpose, and the drivers of patients' perceptions of the health institutions' performance. There was no space in this study to dwell at length on some important areas such as performance improvement change interventions, benchmarking, employee engagement, reward and motivation but it may be the case that the health service can learn from initiatives in other arenas of work.

Table 8.1 below summarises the future research agenda.

Table 8.1: Future research agenda

RESEARCH AREA		POSSIBLE ISSUES FOR EXPLORATION
1	Contextualisation of performance improvement initiatives	<p>This study has revealed that there was moderate improvement in the quality of public health services provided in Botswana since the introduction of performance improvement initiatives.</p> <ul style="list-style-type: none"> - need for an in-depth, empirical study exploring reasons why performance improvement initiatives that are reported to have worked well in other countries do not seem to succeed in the countries to which they are imported. - in Botswana context, need an examination of the diffusion process to facilitate understanding of how health sector staff receive, adopt, and adapt evidence as well as the organisational obstacles to the diffusion. - examine the ways in which performance improvement initiatives may be contextualised in the new settings, looking at organisational culture.
2	Human Resource Management Issues	<p>The study showed that in spite of an acceptable level of health sector staff knowledge/awareness of the existence of the performance improvement initiatives in Botswana, the implementation of the initiatives was not at a level that can be considered to be optimum.</p> <ul style="list-style-type: none"> - need to examine further the reasons why there is an apparent lack of staff interest in accepting performance improvement initiatives and ensuring their success considering the fact that their intended purpose is acknowledged as useful. - studies might examine the relationship between human resource sensitivity to the performance improvement initiatives and the effectiveness of personnel under stressful conditions due to poor working conditions.

	RESEARCH AREA	POSSIBLE ISSUES FOR EXPLORATION
3	Mutual monitoring mechanisms	<p>The norm is to have senior staff monitoring the work of their subordinates and rating their performance.</p> <ul style="list-style-type: none"> - research could provide useful insights on the applicability of peer reviews and subordinate-supervisor reviews to provide balanced performance review systems.
4	Acknowledgement of failure	<p>The top management in health institutions, generally, applauded the introduction of performance improvement initiatives while the juniors were keen to identify performance problems related to poor conditions of work.</p> <ul style="list-style-type: none"> - need systematic investigation and analysis of failures to give guidance on means of achieving successful implementation of performance improvement initiatives. - in-depth examination of initiatives which are no longer actively implemented with a view to mapping directions for future performance improvement interventions.
5	Diverse complexity	<p>The Botswana health sector has a diversity of local and expatriate professions comprising of nurses, doctors and paramedics.</p> <ul style="list-style-type: none"> - research may examine how the diversity of staff influences the formulation, implementation and evaluation of performance improvement initiatives in a health sector environment characterised by a pluralistic workforce and diverse complexity.

	RESEARCH AREA	POSSIBLE ISSUES FOR EXPLORATION
6	Extent to which clients' views contribute to health outcomes	<p>The study showed that patients were generally satisfied with service provision. It was not clear, however, the extent to which clients or patients contribute to the health delivery process through active involvement in decision-making.</p> <ul style="list-style-type: none"> - future research, through population surveys and a combination of quantitative and qualitative research methods can yield data to facilitate health sector decision making.
7	Drivers of patients' perceptions of the health institutions' performance	<p>The study findings revealed that patients, generally, as is the trend internationally, had a high rating of the services that they received from health care providers. The high ratings were in spite of numerous concerns raised through reports in the media and other public fora about low standards of performance in health institutions and the need to improve service provision.</p> <p>there is need for further research into drivers of customer perceptions of the value propositions of institutions in the health sector to monitor clients/patients perceptions for more efficient and effective health service provision.</p>
8	Outcome of performance improvement initiatives	<p>The study dwelt more on the process of implementing performance improvement initiatives rather than on their outcomes. Future research could concentrate on the extent to which performance improvement initiatives facilitate the achievement of set health targets.</p>

CHAPTER NINE

9 CONCLUSION AND RECOMMENDATIONS

9.1 Introduction

This chapter will briefly summarise the main points in this study and present the recommendations. While the introduction in Chapter One served as a road map for the study, this chapter will be a recapitulation of the major ideas through a presentation of the research process, covering the problem statement and methodology as well as the findings. Recommendations will then be made to health sector policy makers and practitioners with regard to the formulation, implementation and evaluation of performance improvement initiatives.

9.2 Summary of research process

The study was prompted by concerns in Government circles including the Office of the President as well as in the media about poor performance in the provision of public services in general and in the health sector in particular. Views were expressed that in spite of the introduction of performance improvement initiatives there did not seem to be much improvement in productivity thus raising national concerns about dissatisfaction with the provision of health services to the public. The investigation of the extent to which performance improvement initiatives are effectively and efficiently implemented in the provision of health services in Botswana involved assessing the evidential base for sustaining the three-fold hypothesis that: performance improvement initiatives were imposed in a top-down manner in the Botswana health sector with the noble belief that they were valuable in contributing towards the achievement of the goals of Vision 2016; there is limited knowledge on the part of the health workers at the operational level regarding the usefulness of the performance improvement initiatives and this contributes to their low uptake of the initiatives in the Botswana health sector; the frequency of complaints by health services consumers is a reflection of the poor quality of health services provided in the health sector in Botswana.

Four key quality indicators, that is, efficiency, effectiveness, empowerment and equity were explored in relation to staff and patient perceptions in the health sector. The performance measures in the study included the proportion of respondents who were knowledgeable of the purpose of the performance

improvement initiatives, the extent to which the initiatives were regarded as useful in the delivery of health services, the type of problems encountered in the implementation of initiatives and the percentage of respondents who viewed organisational operations as fair and empowering to staff.

Data collection was triangulated through the use of different data collection methods as well as collection of data from different sources. The leaning of the study was towards qualitative research but quantitative research techniques were used where appropriate to enhance the quality of the data collected. Primary and secondary sources of data were used to collect data. The selection of the study samples was through a multi-stage sampling, with health institutions categorised according to level of operation and type, that is whether public or private. Respondents consisting of staff and patients were selected from the public and private health institutions.

The findings showed that about 55% of respondents in the health sector (both public and private health institutions) said that they do not participate in the planning for health services, raising questions about the level of their empowerment to implement performance improvement initiatives. Health staff were aware of the existence of the initiatives, yet there were inadequacies in their implementation. There was much room for improvement in the attainment of employment equity with the respondents expressing negative opinions about the fairness of management decisions with regard to matters of promotions, training and staff welfare in general. Equity in the distribution of health services to consumers was rated positive but there were significant weaknesses identified with regard to the empowerment of the health service consumers.

The broad objective of the study was achieved in that an assessment of the performance improvement initiatives introduced for the purpose of improving health service quality was made covering the policy makers at the Ministry of Health, the implementers in the public and private hospitals and the consumers of health services made up of patients and the general public. Evidence was explored in this Botswana focussed study to determine the perceptions and attitudes towards policies with regard to senior management, service providers and clients (patients and community members) to obtain information on the extent to which policy interventions relating to performance improvement initiatives were successful.

To facilitate the achievement of the broad objective, specific objectives and questions were developed and addressed.

9.3 Recommendations

Based on the findings in this study, the following recommendations are presented;

9.3.1 Need to address conditions of service of health sector staff

The staff in the public and private hospitals were unanimous in lamenting their “poor conditions of service”. In view of the finding that the efficiency of the implementation of performance improvement initiatives was not up to acceptable standards, in spite of moderate successes in the effectiveness of implementation, the relevant authorities need to take measures to address the plight of the workers regarding their conditions of service. If health sector staff consider their conditions of service as “poor”, the expectation is that they will be demotivated and continue to perform below their optimum level.

9.3.2 Strengthen community interface with health service providers

It was noted that the community interface with the health facilities that provide services was weak, thus contributing to some of the problems associated with the lack of empowerment of communities in health decisions that affect them. There is need for more concerted efforts to incorporate the views of the health services consumers for the betterment of the provision of health services through a strengthening of the community interface with health service providers.

9.3.3 Improve facilities management

The efforts made by the government to increase the number of health facilities since the attainment of political independence are acknowledged. Such efforts contributed to gains in the equitable provision of health services to the nation. There is need, however, to match these developments with the skills for managing the health facilities, particularly in the public health sector to minimise occurrences whereby patients and community members complain about issues such as poor hospital diets and shortages of linen. This recommendation is in view of the observation that most problems in health facilities are not connected to the shortage of resources.

9.3.4 Review staffing levels

A number of health employees in the public hospitals indicated that they were over-worked and that this tended to de-motivate them. It is recommended that periodic evidence based reviews be made of the ideal staffing levels in the hospitals with a view to systematically matching the work load with the appropriate staffing levels as necessary.

9.3.5 Involve all stakeholders in planning

The majority of health sector employees stated that they were not involved in planning for the health services that they provide. There is need to improve the ownership of health initiatives and programmes through the empowerment of health employees who are primarily responsible for implementing identified activities.

9.3.6 Need for government to benchmark with private health sector

It was noted in this study that the average rating of the service quality attained in the private hospitals was 88% while it was 57% in the public hospitals. The Ministry of Health needs to benchmark with the private hospitals and learn from the private sector best practices as necessary.

9.3.7 Inculcated values that uphold the rights and dignity of patients

A general concern expressed by health services consumers was that the attitudes of health staff left a lot to be desired. In spite of the aforementioned perceived poor conditions of service, the clients of the providers of health services deserve to be treated with due respect and dignity especially because health is a basic human right. Health workers, therefore, need to be inculcated with values that uphold the rights and dignity of patients under their care at all times.

9.3.8 Integrate the performance improvement initiatives

The Performance Based Reward System was identified as the most widely implemented initiative in the public health sector. It was evident, however, that employees in the health institutions that were included in the sample for this study were not always in agreement as to which performance improvement initiatives were applicable in their work-places. In order to have all employees at the same wave length,

there is need to integrate separate quality improvement initiatives within a single quality improvement system to avoid confusion.

9.3.9 Need to contextualise performance improvement initiatives

Policy makers and practitioners should be wary of just adopting initiatives that are said to have worked well elsewhere and merely transplant them to a new setting. The organisational culture in the new environment to which initiatives are being introduced needs to be analysed so that the new initiatives are adapted and appropriate action taken with regard to their implementation. The process of introducing new performance improvement initiatives should take into consideration the ‘adopt’, ‘adapt’, ‘act’ and “check” stages.

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Annexures

Annexure 1: Sample - letter for request to conduct research interview

P. O. Box 30905
Tlokweng
Botswana

...../...../...../

.....
.....
.....
.....

Dear Sir/Madam

REQUEST TO CONDUCT RESEARCH INTERVIEWS

The author of this letter is conducting a study in the Botswana health sector (government and private hospitals) that will contribute towards the attainment of a doctoral qualification. It is also anticipated that the study will generate information that will be useful for guiding decision-making to improve the implementation of performance improvement initiatives in the health sector.

The study involves assessing health services from the perspective of the care givers and the in-patients. It is not the purpose of this study to provide data on clinical outcomes or the competency of medical staff.

The study will involve interviewing a few staff members and patients with regard to the delivery of health services at your institution. The purpose of this letter is to formally request for permission to conduct the study. Should your permission be granted, the interviews are likely to be conducted between the 12th November and the 12th December 2008. The exact dates will be communicated to you.

Attached is a copy of the Consent Form that will be used in the study as well as the letter from the Ministry of Health granting the permission to conduct the study.

Your support will be appreciated.

Yours sincerely,

KACHINGWE Lasting Ketsile (Mr)

(contact – cellphone: 71467259)
e-mail: kachingwe@gmail.com

Annexure 2: Sample - response from one of the facilities granting approval for research

TELEPHONE: 2489633 FAX: 2489674

MASUNGA PRIMARY HOSPITAL

PRIVATE BAG 14

MASUNGA

Reference: 3/25



Republic of Botswana

DATE:

TO: L.K.Kachingwe
P. O. Box 30905
Tlokweng

RE: REQUEST TO CONDUCT RESEARCH INTERVIEWS

Reference is made to your letter dated 30th October 2008 concerning the above mentioned request.

We have seen both the consent forms used in the study as well as the Ministry of Health granting you the permission to conduct the study.

Permission is therefore granted to conduct the research interviews between 12th November and 12th December 2008 in Masunga Primary Hospital.

Thank you.

Dr C Simpemba
Chief Medical Officer.

Annexure 3: Consent form from investigator to potential interviewee

CONSENT FORM

This serves to request you to grant me permission to hold a brief interview with you for the purpose of eliciting your opinion with regard to the study that I am undertaking. The investigator appreciates in advance the time that you will take to provide the required information. The study will contribute towards the attainment of a doctoral qualification by the investigator. It will also generate information that will be useful for guiding decision-making to improve the implementation of performance improvement initiatives in the health sector. The investigator hopes that the information will go a long way towards attaining this objective.

You are assured of the confidentiality of the information that you will provide. The information provided will be used exclusively for the purpose of the study. Data collected from you will be coded in order to protect your identity. Your name will, therefore, not be connected with your data. Any additional information concerning the study results will be provided to you at its conclusion, upon your request.

Please note that you are free to withdraw from the study at any time. Should you be willing to participate, please sign your name below, indicating that you have understood the nature of the study and that your inquiries concerning the study have been answered to your satisfaction.

You may contact Dr. Kriben Pillay (Programme Director) of the Leadership Centre, University of KwaZulu-Natal, Republic of South Africa for further details concerning this study on e-mail address Pillaykri@ukzn.ac.za or telephone number 00 27 31 260 8300.

Name of participant: _____ Name of investigator: _____

Signature of participant: _____ Signature of investigator: _____

Date: _____

Date: _____

Address of participant:

Annexure 4: Self-administered Questionnaire for Senior Management in the Ministry of Health

**SELF-ADMINISTERED QUESTIONNAIRE FOR SENIOR MANAGEMENT IN THE
MINISTRY OF HEALTH**

STRATUM NO.: 01

DEPARTMENT CODE:

SUBJECT: Action Strategies for Enhancing the Implementation of Performance Improvement Initiatives Within the Health Sector In Botswana.

INVESTIGATOR: Mr L. K. Kachingwe {MA HMPP, BSc (Admin) PgDip (HSM)}

PURPOSE: PhD Degree/generation of information for enhancing decision-making in the implementation of performance improvement initiatives.

INSTITUTION: University of Kwazulu-Natal, Leadership Centre

Demography

Position: _____ Department: _____

Duration in health sector: _____

1. Are you aware of the performance improvement initiatives (PII) that were introduced in the Ministry of Health? [YES] [NO]
2. Out of Total Quality Management (TQM), Work Improvement Teams (WITs) and the Performance Management System (PMS), which one is actively being monitored and evaluated.

TQM []

WITs []

PMS []

3. In your opinion, has the monitoring and evaluation been successful in tracking the effectiveness of PIIs at the level of implementation? [YES] [NO]

4. If the answer to 3. above is “Yes”, how has the effectiveness been tracked?

.....
.....
.....

5. The Vision 2016 will have run its course in four years’ time. In your opinion, how are PIIs in your Ministry contributing to the attainment of the Vision 2016 goals?

.....
.....
.....

6. (a) Of the three initiatives (TQM, WITs and PMS) which do you think has been most effective in improving the delivery of health services? Tick the appropriate section below;

- i) TQM []
- ii) WITs []
- iii) PMS []

(b) Elaborate on your response to (a) above

.....
.....
.....
.....

7. (a) Mention any two strengths that you have noted in the management of the PIIs

- (i)
- (ii)

(b) Mention any two weaknesses that you have noted in the management of the PIIs

(i)

(ii)

8. How would you rate the level of equity in the access of health services by the economically well off and the poor members of the community?

.....
.....
.....
.....

9. How are the health staff at the policy implementation level empowered to improve their performance in your organisation?

.....
.....
.....

10. What do you think needs to be done to enhance the implementation of the performance improvement initiatives in your organisation?

.....
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.....

END

THANK YOU FOR YOUR TIME AND ATTENTION

Annexure 5: Interview Schedule Number 1 for Health Workers

STRATUM NO.: 02

HOSPITAL CODE:

INTERVIEW SCHEDULE NUMBER 1 FOR

HEALTH WORKERS

SUBJECT: Action Strategies for Enhancing the Implementation of Performance Improvement Initiatives
Within the Health Sector In Botswana.

INVESTIGATOR: Mr L. K. Kachingwe {MA HMPP, BSc (Admin) PgDip (HSM)}

PURPOSE: PhD Degree/generation of information for enhancing decision-making in
the implementation of performance improvement initiatives.

INSTITUTION: University of Kwazulu-Natal, Leadership Centre

A. DEMOGRAPHY

Hospital: _____ Geographical setting: Urban [] Rural []

Public [] Private [] Age of respondent [] Sex of respondent []

Duration of service: Profession:

**B. KNOWLEDGE OF EXISTING PERFORMANCE IMPROVEMENT
INITIATIVES**

1. Do you know of any performance improvement initiatives (PIIs) that have been introduced at your work-place over the past decade [YES] [NO]

If the response is “NO”, go to question number 6.

If the response is "YES", name the PIIs.

- i)
- ii)
- iii)
- iv)

2. How did you come to know about the PIIs that you mentioned in question 1 above?

.....
.....
.....

3. How are the PIIs monitored?

.....
.....
.....

4. (a) Have you ever been involved in the review/evaluation of the PIIs? [YES] [NO]

(b) If the response is "YES", describe the review process

.....
.....
.....

C. EFFECTIVENESS

5. (a) Do you think that the PIIs are useful in your day to day operations at work?

[YES] [NO]

(b) Elaborate on your response to 5 (a)

.....
.....
.....
.....

6. (i) Choose the most appropriate statement in the list below that, in your opinion, best describes the quality of health services delivery at your hospital since you joined service;
- (a) Service quality has been static
 - (b) Service quality has improved
 - (c) Service quality has deteriorated
 - (d) I don't know

(ii) Elaborate on your response to question 6 (i)

.....

.....

.....

.....

7. How do you think that your performance can be improved for you to achieve your work objectives?

D. EFFICIENCY

8. What policies are in place to guide and measure your performance at work?

.....

.....

.....

.....

9. How often is your work performance appraised?

.....

.....

.....

.....

10. In your organisation, what are the results of;

(i) poor rating during a performance appraisal?

.....
.....

(ii) good rating during a performance appraisal?

.....
.....

11. What are the weaknesses of the performance appraisal system, if any?

.....
.....
.....
.....

12. How do you think that the efficiency of your work can be enhanced?

E. EQUITY

13. Do you think that staff of your profession are fairly remunerated, compared to other professions in your organisation? [YES] [NO]

Elaborate on your response:

.....
.....
.....
.....

14. Are you content with your conditions of work (equipment, infrastructure, technology, etc) [YES] [NO]

Elaborate on your response:

.....
.....
.....
.....

F. EMPOWERMENT

15. Do you participate in the planning for the health services that you provide?
[YES] [NO]

16. (a) If the response to question 13 is 'YES,' how do you participate in the health service planning process?

.....
.....
.....
.....

(b) If the response to question 13 is 'NO,' do you think it is necessary that you participate in the health planning process?

.....
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.....
.....

END

THANK YOU FOR YOUR TIME AND ATTENTION

Annexure 6: Interview Schedule Number 2 for Patients

STRATUM NO.: 03

HOSPITAL CODE:

INTERVIEW SCHEDULE NUMBER 2 FOR

PATIENTS

SUBJECT: Action Strategies for Enhancing the Implementation of Performance Improvement Initiatives
Within the Health Sector In Botswana.

INVESTIGATOR: Mr L. K. Kachingwe {MA HMPP, BSc (Admin) PgDip (HSM)}

PURPOSE: PhD Degree/generation of information for enhancing decision-making in
the implementation of performance improvement initiatives.

INSTITUTION: University of Kwazulu-Natal, Leadership Centre

District: _____ **Geographical setting:** Urban [] Rural []

Public [] **Private** [] **Age of respondent** [] **Sex of respondent** []

i) (a) Were you ever admitted in or visited a health facility for medical treatment in the
past 12 months?

[YES] [NO]

(b) Which one?

ii) For what reason were you in hospital?

iii) (a) Mention one main good thing that impressed you during your admission at the
hospital

.....
.....

(b) Mention one main problem that you were not happy with during your admission at the hospital.

.....
.....

iv) How did you seek redress for the things that you were not happy with?

.....
.....
.....
.....

v) If the problems that you were not happy with also affected other patients, how did they deal with them?

.....
.....
.....
.....

vi) In your opinion, are the health services delivered to the people as per their expectations? [YES] [NO]

Elaborate on your response to question number 6. above

.....
.....
.....
.....

vii) (a) Is your community satisfied with the way that they are treated by the health workers when they visit health facilities to seek treatment? [YES] [NO]

(b) Elaborate on your response to 7 (a) above

.....
.....
.....
.....

viii) Is there any noticeable improvement in the way health services are delivered over the past ten years? [YES] [NO]

ix) What do you think needs to be done to improve the way in which health services are provided to the public in Botswana?

.....
.....
.....
.....

END

THANK YOU FOR YOUR TIME AND ATTENTION

Annexure 7: Interview Schedule Number 3 for Focus Group Discussions

STRATUM NO.: 04

HOSPITAL CODE:

FOCUS GROUP DISCUSSIONS

SUBJECT: Action Strategies for Enhancing the Implementation of Performance Improvement Initiatives
Within the Health Sector In Botswana.

INVESTIGATOR: Mr L. K. Kachingwe {MA HMPP, BSc (Admin) PgDip (HSM)}

PURPOSE: PhD Degree/generation of information for enhancing decision-making in
the implementation of performance improvement initiatives.

INSTITUTION: University of Kwazulu-Natal, Leadership Centre

Hospital: _____ **Geographical setting:** Urban [] Rural []

Public [] **Private** []

- i) Introductions and joining
 - ii) General view of health services delivered by local hospital to the community
 - iii) Comparison of health services today to five years ago
 - iv) Opinion of group members regarding aspects of service provision that need improvement.
 - v) Discussion of possible ways of improving the areas of weakness in service provision
-

END

THANK YOU FOR YOUR TIME AND ATTENTION

Annexure 8: Field-work diary

	HOSPITAL VISITED	DATE OF VISIT
1	Sekgoma Memorial Hospital	22-23 May 2012
2	Letlhakane Hospital	26 May 2012
3	Orapa Mine Hospital	15 May 2012
4	Rakops Hospital	27 May 2012
5	Maun Hospital	1-2 June 2012
6	Deborah Retief Memorial Hospital	13-14 June 2012
7	Princess Marina Hospital	21-24 June 2012
8	Gaborone Private Hospital	17-20 May 2012
9	Masunga Hospital	16 June 2012
10	BCL Mine Hospital	14 May 2012
11	Gumare Hospital	3 June 2012
12	Gantsi Hospital	6 June 2012
13	Hukuntsi Hospital	10 June 2012

Annexure 9: Table of Random Numbers

TABLE OF RANDOM NUMBERS
39634 62349 74088 65564 16379 19713 39153 69459 17986 24537
14595 35050 40469 27478 44526 67331 93365 54526 22356 93208
30734 71571 83722 79712 25775 65178 07763 82928 31131 30196
64628 89126 91254 24090 25752 03091 39411 73146 06089 15630
42831 95113 43511 42082 15140 34733 68076 18292 69486 80468
80583 70361 41047 26792 78466 03395 17635 09697 82447 31405
00209 90404 99457 72570 42194 49043 24330 14939 09865 45906
05409 20830 01911 60767 55248 79253 12317 84120 77772 50103
95836 22530 91785 80210 34361 52228 33869 94332 83868 61672
65358 70469 87149 89509 72176 18103 55169 79954 72002 20582
72249 04037 36192 40221 14918 53437 60571 40995 55006 10694
41692 40581 93050 48734 34652 41577 04631 49184 39295 81776
61885 50796 96822 82002 07973 52925 75467 86013 98072 91942
48917 48129 48624 48248 91465 54898 61220 18721 67387 66575
88378 84299 12193 03785 49314 39761 99132 28775 45276 91816
77800 25734 09801 92087 02955 12872 89848 48579 06028 13827
24028 03405 01178 06316 81916 40170 53665 87202 88638 47121
86558 84750 43994 01760 96205 27937 45416 71964 52261 30781
78545 49201 05329 14182 10971 90472 44682 39304 19819 55799
14969 64623 82780 35686 30941 14622 04126 25498 95452 63937
58697 31973 06303 94202 62287 56164 79157 98375 24558 99241
38449 46438 91579 01907 72146 05764 22400 94490 49833 09258
62134 87244 73348 80114 78490 64735 31010 66975 28652 36166
72749 13347 65030 26128 49067 27904 49953 74674 94617 13317
81638 36566 42709 33717 59943 12027 46547 61303 46699 76243
46574 79670 10342 89543 75030 23428 29541 32501 89422 87474
11873 57196 32209 67663 07990 12288 59245 83638 23642 61715
13862 72778 09949 23096 01791 19472 14634 31690 36602 62943
08312 27886 82321 28666 72998 22514 51054 22940 31842 54245
11071 44430 94664 91294 35163 05494 32882 23904 41340 61185
82509 11842 86963 50307 07510 32545 90717 46856 86079 13769
07426 67341 80314 58910 93948 85738 69444 09370 58194 28207
57696 25592 91221 95386 15857 84645 89659 80535 93233 82798
08074 89810 48521 90740 02687 83117 74920 25954 99629 78978

TABLE OF RANDOM NUMBERS (continued)

20128 53721 01518 40699 20849 04710 38989 91322 56057 58573

00190 27157 83208 79446 92987 61357 38752 55424 94518 45205

23798 55425 32454 34611 39605 39981 74691 40836 30812 38563

85306 57995 68222 39055 43890 36956 84861 63624 04961 55439

99719 36036 74274 53901 34643 06157 89500 57514 93977 42403

95970 81452 48873 00784 58347 40269 11880 43395 28249 38743

56651 91460 92462 98566 72062 18556 55052 47614 80044 60015

71499 80220 35750 67337 47556 55272 55249 79100 34014 17037

66660 78443 47545 70736 65419 77489 70831 73237 14970 23129

35483 84563 79956 88618 54619 24853 59783 47537 88822 47227

09262 25041 57862 19203 86103 02800 23198 70639 43757 52064

Annexure 10: University of Kwazulu-Natal Ethical Clearance Approval



RESEARCH OFFICE (GOBAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL: ximbap@ukzn.ac.za

21 AUGUST 2008

MR. LK KACHINGWE (206525598)
GRADUATE SCHOOL OF BUSINESS

Dear Mr. Kachingwe

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0096/08D

I wish to confirm that ethical clearance has been approved for the following project:

“Action strategies for enhancing the implementation of performance improvement initiatives within the Health Sector in Botswana”

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully


.....
MS. PHUMELELE XIMBA

cc. Supervisor (Dr. K Pillay)
cc. Prof. G Allen
cc. Mrs. C Terblanche