AN EVALUATION OF HUMAN RESOURCES MANAGERIAL EFFECTIVENESS OF THE PUBLIC HEALTH SECTOR OF GHANA

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy in the Faculty of Humanities

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MARGARET MIEWIEN CHEBERE

SCHOOL OF ENVIRONMENT AND DEVELOPMENT
Table of Contents

Table of Contents .................................................................................................................. 1
List of Figures ......................................................................................................................... 6
List of Tables ........................................................................................................................... 8
Abbreviations .......................................................................................................................... 9
List of Appendices .................................................................................................................. 11
Appendix A: Maps showing study districts in Ghana ............................................................... 11
Abstract ................................................................................................................................... 12
Declaration ............................................................................................................................... 13
ACKNOWLEDGEMENTS ........................................................................................................ 14
Dedication ............................................................................................................................... 15
CHAPTER 1 - Introduction ....................................................................................................... 16
  1.1 HRM/D-Performance Link .......................................................................................... 18
    1.1.1 HRM/D - the Global Perspective ................................................................. 18
    1.1.2 HRM/D–performance link in health care organisations .............................. 19
    1.1.3 Contestations in HRM/D Performance Linkage ........................................ 20
  1.2 HRM/D in Developing Countries ............................................................................ 21
  1.3 HRM/D and Health Care Delivery .......................................................................... 22
  1.4 HRM/D and Health Sector Reforms: Contextual Background for research .......... 23
  1.5 HRM/D in Ghana .................................................................................................... 25
    1.5.1 Health sector reforms in Ghana ................................................................. 26
    1.5.2 Implications of health sector reforms on HRM/D in Ghana .................... 28
  1.6 Definition and Justification of the problem ............................................................ 30
    1.6.1 Objectives and Research Questions ......................................................... 31
    1.6.2 Research Questions .................................................................................... 32
  1.7 Organisation of the Thesis ....................................................................................... 32
CHAPTER 2 - Situation Analysis of Ghana Context .............................................................. 35
  2.1 Introduction and overview ....................................................................................... 35
  2.2 Country Profile ........................................................................................................ 35
    2.2.1 Background and Geography .................................................................... 36
    2.2.2 Population and population growth ............................................................ 36
    2.2.3 Political Context ......................................................................................... 37
    2.2.4 Economic Context ..................................................................................... 38
    2.2.5 Socio-cultural Context ............................................................................. 39
    2.2.6 Legislation ................................................................................................... 39
    2.2.7 General Health Status ................................................................................ 39
    2.2.8 Disease profile ........................................................................................... 40
  2.3 The healthcare system .............................................................................................. 40
    2.3.1 The structure of the Ministry of Health (MOH) ....................................... 41
    2.3.2 The Organisation of health service ............................................................ 44
    2.3.3 Structure of Delivery of Services ............................................................... 45
    2.3.4 Current Staffing Situation .......................................................................... 46
  2.4 Current National Health Policies and Proposals ......................................................... 48
    2.4.1 Vision, Mission and Goals ....................................................................... 49
    2.4.2 Capacity Development in the Health Sector ............................................. 49
    2.4.3 Policy Measures for HRD (technical and managerial) ............................ 49
  2.5 Human Resource Policies and Practices ................................................................. 50
    2.5.1 Human Resource Planning ....................................................................... 50
4.9 Conclusion .................................................................................................................................................. 106
CHAPTER 5 - Research Methodology .............................................................................................................. 107
5.1 Introduction ................................................................................................................................................ 107
5.2 Summary of research objectives and questions and methods of investigation ....................................... 108
5.3 Research Design (RD) ................................................................................................................................ 110
5.3.1 Definition of MM ..................................................................................................................................... 111
5.3.2 The Quantitative Approach ....................................................................................................................... 112
5.3.3 The Qualitative Approach .......................................................................................................................... 113
5.3.4 Challenges in the use of MM research ....................................................................................................... 114
5.3.5 Rationale for MM Research ...................................................................................................................... 115
5.4 Philosophical Perspectives ............................................................................................................................ 116
5.4.1 Critical Realism (CR) ................................................................................................................................. 118
5.4.2 Choice of methods and Philosophical Assumptions: ................................................................................. 120
5.4.3 Phenomenology ....................................................................................................................................... 123
5.5 Fieldwork process ......................................................................................................................................... 124
5.5.1 Selection of Regions and Rationale ............................................................................................................ 124
5.5.2 Role of researcher ..................................................................................................................................... 124
5.6 Research Parameters .................................................................................................................................... 125
5.6.1 Sampling Techniques for both methods ..................................................................................................... 125
5.6.2 Levels from which participants were selected .......................................................................................... 126
5.6.3 Criteria used for selecting well and less performing districts .................................................................. 128
5.6.4 Sample size ............................................................................................................................................... 128
5.6.5 Biographic Data ...................................................................................................................................... 129
5.6.6 Data collection strategies in using mixed methods: .................................................................................. 130
5.6.7 Interview process .................................................................................................................................... 130
5.6.8 Interviewing techniques ............................................................................................................................. 131
5.6.9 Document Analysis .................................................................................................................................. 132
5.6.10 Measures and Codes of the Quantitative data and their meanings ......................................................... 136
5.7 Reliability and Validity ................................................................................................................................ 137
5.8 Analysis of data ........................................................................................................................................... 138
5.8.1 Data processing ....................................................................................................................................... 139
5.8.2 Ethical Issues ........................................................................................................................................... 143
5.9 Conclusion ................................................................................................................................................... 145
CHAPTER 6 - Findings ....................................................................................................................................... 146
6.1 Introduction .................................................................................................................................................. 146
6.1.1 Response rate and regional distribution ................................................................................................... 148
6.2 Socio-demographics of Respondents ......................................................................................................... 149
6.2.1 Age ......................................................................................................................................................... 149
6.2.2 Gender .................................................................................................................................................... 150
6.2.3 Number of years in organisation ............................................................................................................. 151
6.2.4 Qualifications of respondents .................................................................................................................. 152
6.2.5 Current positions of survey and FGDs respondents (employees) ............................................................. 154
6.2.6 Professional background of Respondents ................................................................................................. 154
6.3 Section Two ................................................................................................................................................. 156
6.3.1 Research Question 1: What is the context (situation) of HRM/D in the PHS? ........................................... 156
6.4 Section Three ............................................................................................................................................... 163
6.4.1 Research Question 2: What understanding do managers and stakeholders have about HR management/development effectiveness? ................................................................. 164
6.5 Section Four ........................................................................................................ 167
  6.5.1 Perspectives on Recruitment and Selection.................................................. 167
  6.5.2 Perspectives on Performance Management (PM).......................................... 171
  6.5.3 Perspectives on Rewards Management System.............................................. 177
  6.5.4 Perspectives on Staff Development ................................................................ 180
  6.6 : Section Five ...................................................................................................... 186
  6.6.1 Challenges: .................................................................................................... 187
  6.6.2 Opportunities: ............................................................................................... 195
  6.7 Perspectives of competencies that makes one an effective manager ................. 198
  6.9 Conclusion ........................................................................................................ 198

CHAPTER 7- Discussion .......................................................................................... 200
  7. 1 Introduction: ..................................................................................................... 200
  7.2 Socio-demographics ......................................................................................... 200
    7.2.1. Response rate and regional distribution ..................................................... 201
    7.2.2 Age ............................................................................................................. 201
    7.2.3 Gender ........................................................................................................ 202
    7.2.4 Positions and Professionalism .................................................................... 203
    7.2.5 Qualifications .............................................................................................. 204
  7.3 Managerial Effectiveness (ME) .......................................................................... 205
    7.3.1 Managers’ knowledge about Organisational Goal, strategies and priorities .. 206
    7.3.2 Model of Health service delivery and policies postulated at National level .. 206
    7.3.3 Alignment of Health sector goals and strategy with HRM/D Activities ...... 207
    7.3.4 Managers’ knowledge about MMDDHS Responsibilities ......................... 209
  7.4 Managers’ Knowledge and understanding of HRM/D Activities ....................... 210
    7.4.1. Recruitment and Selection ..................................................................... 210
    7.4.2 Performance Management (PM) ................................................................. 214
    7.4.3 Rewards Management ............................................................................... 219
    7.4.4 Staff Development ..................................................................................... 223
  7.5 Perspectives of competencies that makes one an effective manager .................... 231
  7.6 Perspectives on Environmental Challenges and Opportunities ....................... 232
    7.6.1 Environmental Challenges ....................................................................... 232
    7.6.2 Opportunities ............................................................................................. 236
  7.7 Conclusion: ....................................................................................................... 240

CHAPTER 8: Conclusions ....................................................................................... 241
  8.1 Introduction: ..................................................................................................... 241
  8.2 Highlights of the review of Literature and Methodology .................................. 242
  8.3 Summary of key findings and conclusions ...................................................... 243
  8.4 Lack of Management Competency in HRM/D Activities ............................... 244
    8.4.1 Lack of Health sector strategy-HRM/D Fit ............................................... 245
    8.4.2 Lack of training for managers in management and HRM/D ..................... 246
    8.4.3 Top-down approach in policies and processes ....................................... 246
    8.4.4 Lack of resources – human, funding and logistics to implement HRM/D activities ...................................................... 246
    8.4.5 Lack of supportive supervision from central level .................................... 246
    8.4.6 Interference in HRM/D activities from superiors and politicians and lack of political commitment etc...................................................... 248
    8.4.8 Conflicting laws and regulations .............................................................. 248
    8.4.9 Lack of managers’ desire for HRM/D Activities ....................................... 249
  8.5 Limitations of the study and extended discussion and suggestions for further research ............................................................. 249
8.6 Recommendations - Implications for policy and practice ........................................ 252
8.6.1 Strategic fit of HRM/D ................................................................. 252
8.6.2 Top-down approach ................................................................. 253
8.6.3 Recruitment and Selection .................................................... 253
8.6.4 Training and Development ..................................................... 253
8.6.5 Performance management ..................................................... 254
8.6.6 Rewards Management ............................................................ 255
8.6.7 Monitoring of HRM/D policies and Implementation ..................... 255
8.6.8 Interference in HRM/D activities and lack of political commitment from superiors and politicians etc. ................................................................. 255
8.6.9 Conflicting laws and regulations ............................................. 256
8.6.10 Lack of information or use of available information on HRM/D .......... 256
8.7 Contribution to knowledge and literature ................................... 257
8.8 Concluding remarks ................................................................. 258
8.8.1 Implications for policy ............................................................ 258
8.8.2 Implications for practice ........................................................ 259
REFERENCES .................................................................................. 261
APPENDICES .................................................................................. 289
APPENDIX A: Maps showing study districts in Ghana ....................................... 289
APPENDIX B: CONSENT FORM ...................................................... 290

Word Count: 86,363
List of Figures

Figure 2.1 Structure of the MOH adapted from MOH, 2003 ..............................................42
Figure 2.2 Organisation at the district level adapted from Nyonator (2008).........................46
Figure 2.3 Health workforce distribution by Agency: Data Source, MOH (2007) ..............47
Figure 3.1 Figure 1: Parallel pathways of HRM and HRD ..............................................61
Figure 4.1 Schematic representation of the Open systems model Environment..................87
Figure 4.2 Environmental variables influencing role in driving......................................93
Figure 4.3 Conceptual Framework..................................................................................101
Figure 5.1 Stages of activities in the research process developed by Author......................110
Figure 5.2 The Analytical framework adapted from Marquart and Zercher (2001)...........139
Figure 6.1 Age class of respondents (years)....................................................................150
Figure 6.2 Gender characteristics of respondents .........................................................151
Figure 6.3 Number of years worked in the public health sector......................................152
Figure 6.4 Highest education of respondents. (Numbers on top of bars are the number of respondents) ...........................................................................................................153
Figure 6.5 Primary job responsibilities of respondents....................................................155
Figure 6.6 Manager is able to review employee’s performance regularly.........................172
Figure 6.7 Manager is able to support staff development needs.......................................182
List of Tables

Table 2.1 The Regional breakdown of the population of Ghana .................................................. 37
Table 2.2 Trend in Health Indicators over a four-year period .................................................. 40
Table 2.3 Categories of Personnel and their numbers in the PHS ........................................... 47
Table 2.4a: Doctor Population Ratio by Region, 2006 - 2009 .................................................. 48
Table 2.5b Nurse Population Ratio by Region, 2006-2009 ...................................................... 48
Table 5.1 Summary of objectives, questions and methods of investigation developed by author ........................................................................................................................................ 109
Table 5.2 Summary of MM Research Design ............................................................................ 121
Table 5.3 Some Characteristics of the study regions ................................................................. 124
Table 5.4 Details of the Sample ................................................................................................. 129
Table 5.5 Sources and Number of documents Analysed ......................................................... 132
Table 6.1 Categories and number of respondents used for the study ...................................... 147
Table 6.2 Regional distribution of Focus Group Discussants and Survey ................................ 149
Table 6.3 Qualifications of survey and FGD respondents’ regional distribution ..................... 154
Table 6.4 Showing Survey respondents’ ratings about Managers understanding .................... 158
Table 6.5 Managers know health priorities ................................................................................ 160
Table 6.6 Managers are able to take appropriate decision on recruitment .............................. 170
Table 6.7 Manager ensures employees have job descriptions .................................................. 173
Table 6.8 Recognises people based on performance ................................................................. 176
Table 6.9 Employees’ preference for material rewards .............................................................. 179
Table 6.10 Manager has requisite qualification in HRM .......................................................... 186
Table 7.1 Competencies compiled from perspectives of respondents ....................................... 232
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>5-YPOW</td>
<td>Five-Year Programme of work</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>BCG</td>
<td>Bacilli Calmette Guerin</td>
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<td>BMC</td>
<td>Budget Management Centre</td>
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<tr>
<td>CCS</td>
<td>Country Cooperation Strategy</td>
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<tr>
<td>CHN</td>
<td>Community Health Nurse</td>
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<tr>
<td>CHAG</td>
<td>Christian Health Association of Ghana</td>
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<td>CHO</td>
<td>Community Health Officer</td>
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<td>CHPS</td>
<td>Community Health Planning and Services</td>
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<td>CIA</td>
<td>Central Intelligence Agency</td>
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<td>CIT</td>
<td>Critical Incident Technique</td>
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<td>DAs</td>
<td>District Assemblies</td>
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<td>District Director of Health Service</td>
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<td>District Health Management Team</td>
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<td>DISHOP</td>
<td>District Health Systems Programme</td>
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<td>DPT3</td>
<td>Diphtheria, Pertussis and Tetanus – third dose</td>
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<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>ERP</td>
<td>Economic Recovery Programme</td>
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<td>FGDs</td>
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<td>FLM</td>
<td>Front Line Manager</td>
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<td>GAR</td>
<td>Greater Accra Region</td>
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<td>GDHS</td>
<td>Ghana Demographic Health Survey</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>Ghana Education Service</td>
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<td>GETFUND</td>
<td>Ghana Education Trust Fund</td>
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<td>Ghana Health Service</td>
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<td>Ghana Institute of Management &amp; Public Administration</td>
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<td>GOG</td>
<td>Government of Ghana</td>
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<td>Ghana Poverty Reduction Strategy</td>
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<td>Ghana Registered Nurses’ Association</td>
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<td>HDI</td>
<td>Human development Index</td>
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<td>HIPC</td>
<td>Highly Indebted Poor Country</td>
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<td>HIV</td>
<td>Human immunodeficiency Virus</td>
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<td>HRDD</td>
<td>Human Resource Development Directorate</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<td>Human Resources for Health Development</td>
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<td>HRM</td>
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<td>HRM/D</td>
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<td>HRM/DE</td>
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<td>IDRC</td>
<td>International Development Research Centre</td>
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<td>IGF</td>
<td>Internally Generated Funds</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
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<td>IMR</td>
<td>Infant mortality rate</td>
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<td>IPPD</td>
<td>Integrated Payroll and Personnel Database</td>
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<tr>
<td>LPC</td>
<td>Least Preferred Co-worker</td>
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<td>MCC</td>
<td>Millennium Challenge Corporation</td>
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<td>Ministries Departments and Agencies</td>
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<td>MDBS</td>
<td>Multi-donor Budget Support</td>
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<td>MDC</td>
<td>Medical and Dental Council</td>
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<td>Millennium Development Goals</td>
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<td>ME</td>
<td>Managerial Effectiveness</td>
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<td>MMR</td>
<td>Maternal mortality ratio</td>
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<td>Ministry of Finance and Economic Planning</td>
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<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<td>Medium Term Health Strategy</td>
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<td>NHP</td>
<td>National Health Policy</td>
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<td>National Health Service</td>
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<td>Northern Region</td>
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<td>National Redemption Council Decree</td>
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<td>OPD</td>
<td>Out-patient department</td>
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<td>Programme of work</td>
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<td>Sub-Saharan Africa</td>
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<td>STI</td>
<td>Sexually-transmitted infections</td>
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<td>SWAp</td>
<td>Sector-wide approach</td>
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<td>Under-five mortality rate</td>
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</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
List of Appendices

Appendix A: Maps showing study districts in Ghana
Appendix B: Consent Form
Appendix C: Research Instruments
Appendix D: Ethical clearance letter from Ghana Health Service
Appendix E: Introductory letters to regions
Appendix F: List of respondents
Appendix G: Competencies
Abstract
The objective of this research is to evaluate Human Resources managerial/development effectiveness (HRM/DE) of frontline managers from the perspectives of managers themselves and stakeholders in the public health sector (PHS) of Ghana. The study did this through the development of a conceptual framework which combined the use of integrated organisational and management theoretical perspectives and contextual variables.

The study employed the mixed methods research methodology which combined both empiricism and post post-positivists’ views with critical realism as the underpinning philosophy.

A total of 18 district directors of health, from two regions were purposively sampled and interviewed utilising an in-depth open ended questionnaire through the discussion. Additionally, key policy makers were interviewed and focus group discussions held and a structured questionnaire completed by another group of employees, who assessed managers’ capabilities.

Discourse analysis was used for the analysis with the aid of Nvivo 7 for the qualitative material whilst quantitative data were analysed using simple descriptive statistics. Findings were triangulated using Marquart and Zercher’s (2000) cross-over track analysis framework.

Findings show research questions were answered. Majority of district directors lack managerial competencies; are less interested in HRM/D activities, less confident of their human resource skills and less sure of the political and representational skills required of managers. In particular, it is necessary to take account of the political structure of the PHS of Ghana; significant differences exist in power, individual or group interests, values, assumptions and expectations. However, most district directors have tried to indigenise HRM/D practices as a way of motivating and retaining staff. Core Human resources managerial competencies from the perspectives of the three sampled groups have been compiled.

It is the first time such a study has been conducted in the PHS of Ghana and which has therefore made inroads in the existing literature and has contributed to HRM/D literature information in Africa particularly Ghana. It also paves the way for understanding management in the African context and perspective and specifically in health care settings. This study has gone beyond the two groups of respondents and proved that the use of multiple respondents generates rich findings and unveiled what would normally have not been possible if single respondents were used.
Declaration

I declare that no portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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ACKNOWLEDGEMENTS

This study is to crown my achievement in undertaking a Doctor of Philosophy (PhD) programme in Development Policy and Management. The successful completion of this study would not have been possible without the support of certain people. First and foremost, I would like to acknowledge with many thanks the unreserved involvement, comments and direction from my supervisors, Derek Eldridge and Richard Duncombe both of IDPM in this work.

I am also indebted to my family particularly my husband, children nieces and nephews for allowing and supporting me to undertake this study despite the discomfort caused them. My appreciation is also extended to all my friends both in Ghana and in Manchester especially Jean David for the moral support they gave me.

I cannot bring this acknowledgement to an end without the mention of the Ministry of Health/Ghana Health Service (MOH/GHS), Ghana, for nominating me for this scholarship and the Ghana Education Trust Fund (GETFUND) for offering me the scholarship.

Lastly, my thanks go to Messrs. Albert Anmawen, Obeng Asomaning and Zakaria Jnr. who assisted me to carry out the investigation as well as Nathaniel Coleman for inputting the data into SPSS. Also, to all the participants I say thank you for granting the interviews and giving rich information for the study.
Dedication

To: Christine, Fertaa and Gartaa.

You all said, “Mummy, you will be doing everyone a disservice and would have wasted everybody’s time if you do not complete the programme”. To the Glory of the Almighty and to you all, I am proud to say: “I have done it”!
CHAPTER 1 - Introduction

The purpose of this research is to evaluate and highlight the major issues and challenges in managerial capacity building regarding human resources management/development (HRM/D) at the district level in the public health sector (PHS) of Ghana. Specifically, the research evaluates managerial effectiveness (ME) as it relates to implementation of HRM/D activities as conducted by Metropolitan, Municipal and District Directors of Health (MMDDHS). Specifically, the study centres around the issues of organisational and environmental factors and how these influence managerial roles and behaviours. This is to enable the sector to draw lessons from the current constraints facing MMDDHS and to establish the importance of these as a priority focus for the sector’s efforts in improving managerial capacity for HRM/D over the coming years.

HRM/D is taking a central stage as a consequence of the recognition of the HRM/D-performance link in organisations. Thus, several studies (see section 1.2) have been conducted in this area. Most of these studies in this area however, have been in the developed world especially in the UK and USA. Therefore, the developed, transitional and developing economies have recognised the need for building capacity for human resources for public service delivery with the view to increase organisational effectiveness. Hence, it is now necessary to undertake research in HRM/D in the health sector in Africa. Despite the fact that there are limited studies in the health sector of Ghana, there is a recognition and realisation that managerial capacity at the district level is weak as evidenced by the reports and publications (Service Provision Assessment Survey, 2002 and WHO publications and reports, 2005; 2006 and 2007).

Within the health sector reforms, which were undertaken with the aim to contain cost, increase accessibility, effectiveness, efficiency, equity and quality care, the health sector of Ghana was challenged to seek new strategies and management techniques. For instance, customers’ demands for quality health care, led to the health sector to re-examine its service delivery processes. Thus the health sector, realising that the centralised management systems with its bureaucratic ways of doing things, was no longer effective and efficient began reforms alongside other public sector organisations about two decades ago.
This was to enable the PHS of Ghana to be more proactive and more responsive to clients’ demands. Accordingly, the sector scanned its internal structure and reviewed the roles and responsibilities of employees and managers in order to deliver the top quality service demanded by clients. The reforms made the district level semi-autonomous with increased managerial responsibility as managers had to combine technical duties with management of resources including HRM/D. Consequently, roles of managers at the decentralised levels as technocrats had to include strategic decision making on all resources. With the change in roles and additional responsibilities, managers had to be knowledgeable and skilful in management and in HRM/D. Premised on the reforms, the responsibility for HR activities was de-concentrated to line managers at the decentralised levels. By this action, the PHS expected a closer relationship between line managers and employees with better outcomes in service delivery. However, years down the implementation of the reforms, quality of health service continues to be poor and has been largely attributed to weak managerial capacities among others (Human Resources Policies and Strategies document, 2007 and the Quality Assurance policy briefings, 1999).

In general, the aims of the reforms as outlined above are commendable. Nonetheless, the weak capacity of managers at the decentralised levels to implement HRM/D activities effectively appears to be due to lack of prior planning to develop and involve managers. Hence, the lack of any careful consideration of how HRM/D roles should be organised to support health sector reform to enable managers and HR managers operate effectively at decentralised levels is among the challenges confronting most African countries including the PHS of Ghana as recognised by WHO (2005). Health systems can only achieve delivery of quality service and performance if the roles and competencies of managers with adequate resources are identified and aligned with health sector goals by the sector agency responsible as agreed by participants at the WHO Africa Consultative meetings in 2004 and 2005. Based on this realisation, the PHS through the Government of Ghana (GOG) in recent years embarked on plans at improving quality health service through the improvement of HRM by the appointment of HR managers in all regions and improved salaries of all health workers. With these efforts, there has not been any empirical study evaluating ME in the PHS. This is one of the reasons calling for the conduct of this study.

Designing the study and selecting the most appropriate literature for the conceptual basis of the empirical world requires some preliminary thoughts on the nature of HRM/D. In order to
explore this, the chapter is organised as follows: First, as a preliminary to the establishment of the objectives of the research, a review on the HRM-performance link globally including the developing world is undertaken and then HRM/D in health care delivery. Following from this, HRM in Ghana, the health sector reforms and its implications on HRM/D are reviewed. The problem statement is defined and justified as a result of this review. In the latter section, the objectives and research questions are stated. The chapter then outlines the organisation of the thesis.

1.1 HRM/D-Performance Link

Over the last decade, there has been an outburst of interest in the connection between the way people are managed and organisational performance (Hyde et al., 2006). Empirical studies have found significant relationships between HRM policies and practices and various performance outcomes, such as: financial turnover (Arthur, 1994; Huselid, 1995), productivity (Hoque, 1999; MacDuffie, 1995), profits (Delery and Doty, 1996; Huselid, 1995), patient mortality (West et al., 2002) and healthcare effectiveness (Borrill et al., 2000). Research evidence from Aiken et al. (1994), showed that within the US health sector, hospitals such as the ‘magnet hospitals’ able to attract and retain good nursing care demonstrated lower mortality rates.

1.1.1 HRM/D – the Global Perspective

Furthering the argument on HRM gaining increasing recognition due to the globalisation of the world economy and marketplace, Arthur et al. (1995) quoting other sources state that the effectiveness and generalization of human resource management (HRM) interventions to other cultures and economic systems needs to be investigated. Thus, the growing importance attached to HRM as a prerequisite for organisation performance has encouraged a number of empirical studies investigating the effectiveness of HRM interventions and the possible gain to organisations into different organisational outcomes and in different parts of the world. These include, health outcomes (Hyde et al., 2006; West et al., 2002), productivity (Hoque, 1999; MacDuffie, 1995), profits (Delery and Doty, 1996; Huselid, 1995) and financial turnover (Arthur, 1994; Huselid, 1995), all in UK and USA. Other scholars cited by Arthur et al. to have conducted HRM research in other parts of the world include Dachler (1983) and Wilpert (1983) who examined the role of industrial organisational psychology in Germany.

As regards HRD, Antwi et al. (2007) argue that as a result of the increasingly knowledge-base globalising economy, the development of human resources in both public and private sector organisations has become critical. As a consequence in their view, the developed, transitional and developing economies have recognised the need for building capacity for human resources for public service delivery with the view of increasing organisational effectiveness.

1.1.2 HRM/D–performance link in health care organisations

From this overwhelming evidence about the HRM-performance link in organisations and the fact that public health systems require effective HRM/D for quality health systems’ performance owing to keen perception of clients for quality care, the interest in HRM/D in health has been steadily increasing in the past two decades. This has been increasingly recognised globally by Governments, policy-makers, managers, professional organisations and clinical professionals (WHO, 2005). Hence, there have also been some studies in health looking at various aspects of health systems and service delivery. For instance, Aiken et al.'s (1994) research in the US health sector showed that hospitals able to attract and retain good nursing care in some hospitals (Magnet Hospitals), demonstrate lower mortality rates. Borrill et al. (2000) investigated effectiveness of health care and patient mortality respectively in the UK whilst Buchan (2004) examined the effect of good HRM in health. Esmail et al. (2007), Flanagan and Spurgeon (1996) and Willcocks (1998) investigated managerial effectiveness, Fritzen (2007) on strategic HRM and Hyde et al. (2006) and West et al. (2002) examined HRM on health care outcomes among others.

While there are some advances in HRM research in health in the developed countries, mainly in the UK and the USA, there are limited numbers in Africa. Despite the evidence that management development must be given higher priority for health systems, particularly at the first line of supervision (Filerman, 2003) and the critical need for managerial talent in Africa (Kassem and Moursi, 2007), studies on HRM/D in health in Africa noted during literature search in English were negligible. Again most of these studies focused on one aspect of HRM/D. For instance Mackintosh (2003) and Mensah (2002) focused on factors
affecting the retention of health workers in Malawi and Ghana respectively. Awases et al. (2004), Dovlo (2007) and Dovlo and Martineau (2002), all focused on migration in six African countries whilst Mathauer and Imhoff (2006) investigated health worker motivation in Benin and Kenya with Furth (2005) investigating performance management in Zambia. This situation is even worse still within the Ghanaian public health sector (PHS). Only one study by Mensah (2002) on factors affecting the retention of health workers and one by Marchal et al. (2010) evaluated the general management of a well performing regional hospital. As a result, it is becoming increasingly difficult to ignore HRM/D in Africa and in the health sector.

1.1.3 Contestations in HRM/D Performance Linkage

With this plethora of research in the Western world, one major problem is that, there are still some disagreements among scholars and practitioners regarding the HRM-performance link and causal association. While Wood and deMenezes (1998), did not agree with the HRM-performance link, some scholars who explored the HRM-performance link (including those in the health sector) do not claim to demonstrate a causal association (Guest et al., 2003; West et al., 2002). How and in what circumstances HRM is linked to better outcomes is still being evolved. However, Guest (1987) suggests HRM can be seen as a cosmetic measure in the sense that an organisation having a human resource department does not necessarily guarantee a change in the management of their people as asset which the concept prescribes.

Another dimension that has been added to the argument is in the field of organisational psychology. Through empirical evidence, they contend that the HRM-performance link is mediated by employee attitudes and behaviours. That is, HR practices trigger attitudes and responses in individuals and encourage them to behave in ways that are consistent with the organisation’s overall performance aims (West et al., 2002; Guest et al., 2003; Purcell et al., 2003). In spite of this link between HRM and organisational performance, HR researchers again have not agreed on particular HR practices that are better utilised to improve performance since various researchers have used different HR practices.

Fundamental to effective HRM from the ongoing, is the assumption that required performance is influenced by the set of HRM practices organisations have in place. Buchan (2004), though in support of this finding, still argues that the actual methods used to manage HRH care may in themselves be major constraints or facilitators in achieving the objectives
of health sector reform. This argument is cognisant of the fact that despite the numerous efforts and financial support from both development partners and governments provided to upscale HRH interventions, the management systems in many countries’ health systems are still ineffective (Egger et al., 2007).

The inability of HRM/HRD scholars to agree on which practices and theories to include in research has attracted the attention of scholars and practitioners (Huselid, 1995; Hyde et al., 2006; Jackson and Schuler, 1995; Scott et al., 2003; West et al., 2002; Wright and McMahan, 1992) both within and outside the health sector to look for ways to integrate HRM research. This therefore implies that the specific choice of which practices to include in HR research depends on the circumstances affecting each organisation, as well as the interplay between HR professionals and line managers. Hence, Whittaker and Marchington (2003) argued that the partnership between HR professionals and line managers in the health sector is a critical factor which helps to explain the impact of HR practices and arguably increases their chances of being implemented successfully.

1.2 HRM/D in Developing Countries

With the steady increase of studies in healthcare in the Western world owing to the recognition of HRM-link with improved health outcomes, it has been noted in the developing world and particularly Sub-Saharan Africa (SSA) that, despite the commitment to achieve health Millennium Development Goals\(^1\) (MDGs), HRH and management issues were not high on the agendas of National Governments (WHO 2000, 2004, 2004 and 2006 including Egger et al., 2007). Corroborating this, Kane and Palmer, (1995), noted that one crucial issue is often the disparity between the rhetoric of organisational contribution and reality of organisational treatment of HRM together with differences in applications of HRM (Boxall and Purcell, 2000). The deteriorating health outcomes, largely attributed to weak management capacity, have compelled researchers to analyse the situation and assign reasons for the failures. For instance, McCourt and Awases (2007) while admitting that the causes were complex, however, noted that health sector reform was undertaken without adequately preparing managers as the reason among others. Next, the importance of HRM/D in health care delivery is reviewed.

\(^1\) Reduce child mortality, Improve maternal health, Combat HIV/AIDS, malaria, and other diseases and provide access to affordable essential medicines in developing countries
1.3 HRM/D and Health Care Delivery

HRH as viewed by related literature, constitutes the most important resource of health systems globally and accounts for a substantial proportion of the health sector expenditure – about 65 - 80% of its recurrent budget in most countries (Buchan, 2004 and WHO, 2006). Although substantial health expenditure is critical for Africa due to Africa’s dwindling economic resources, HRM/D, however, can provide a direct and economically significant contribution to organisational performance if these financial resources are used to properly configure organisational human resource policies (Huselid, 1995). The aspect of dwindling economic resources has also made it more critical for the health sector of Africa which is characterized by marginal technology and inadequate human resources to develop strategies for effective HRM/D.

The central role of human resources in the delivery of health care is well documented (Buchan, 2004; Flanagan and Spurgeon, 1996; Fritzen, 2007, Kabene, 2006; Reid, 1994; Willecocks, 2006 and Wyss, 2004). For instance, Wyss (2004) stated that for any wide-ranging efforts to scale up health related priority interventions, HRH are likely to be key to success. Additionally in their view the success of any organised health programme depends upon effective management. Also, Buchan (2004) emphasizes the importance of HRM to the success or failure of health system performance and which has, until recently, been generally overlooked. Owing to the importance of effective HRM and improved health service outcomes as evidenced above, a lot of efforts have been made by the World Health Organisation (WHO) through country Governments to improve management of HRH. Notwithstanding all these efforts in the developing world, there are also serious challenges with health systems performance.

Additionally, managerial talent has been recognised as a critical national resource and in low income countries and especially in Africa and which is crucial as it helps to coordinate the needed resources, people, and processes and negotiates with various partners towards achieving health outcomes. In this regard, there has been growing emphasis on managerial competencies as a means to increase HRM/D effectiveness (Buchan, 2004; Egger et al., 2007; Kassem and Moursi, 2007 & WHO, 2006). Further, WHO (2007) also supports the notion of good leadership and management about providing direction to, and gaining commitment from partners and staff, facilitating change and achieving better health services through efficient, creative and responsible deployment of people and other resources. All these
authors in one voice attributed the failure of most health systems in developing countries especially Africa to constraints including the lack of competent managers. In spite of this realisation, there has not been any documented empirical work which provides evidence and strategies to improve HR managerial effectiveness in health. However, according to Adano (2006), health sector reform in many countries has been characterized by efforts to bring down costs and reduce gaps in coverage but there has been hardly any attempt to understand or address the HR aspects and implications of such structural changes in developing countries.

1.4 HRM/D and Health Sector Reforms: Contextual Background for research

From the recognition of HRM/D performance-link, the past two decades saw a drive for reforming public services in developed and developing countries including Ghana. HRM/D has been part of the current reforms in the management of health services. The late 1980s, witnessed several developing countries implementing health care reform programmes as encouraged by the World Bank (WB) and International Monetary Fund (IMF). These were attempts to contain cost, improve equity, effectiveness and efficiency of health services, be more consumer oriented and for the achievement of better value for money (Hunter, 1997). This was consequent to most developing countries been characterised by political and economic instability with poor health service outcomes (Aryee, Kamoche and Mekonnen and Mamman, 2004). Since public health systems require effective HRM/D for quality health systems’ performance, this was seen as an avenue to improve HRM/D. However, it was argued that in many health care reforms’ proposals in developing countries, attention to human resources are limited (Kanji et al., 1991).

Although public health systems require effective HRM/D for quality health systems’ performance, the reforms which were instituted for a positive change, failed to evaluate as a necessity how the HRM/D practices could help implement the change against indicators that define, deploy and organize the workforce (Esmail, 2007). As already stated above, a well-motivated and appropriately skilled and deployed workforce is crucial to the success of health system delivery (Buchan, 2002). This is particularly true for the health sector as health systems are labour intensive, and have specially skilled and volatile workforce. With the increasing global concerns to meet the MDGs in health, there is a need to upscale human resource capacity in health sectors. The health sector reforms therefore were seen to push this
forward. The envisaged idea of decentralisation from the reforms was to deconcentrate some functions including HRM/D to line managers. However, some researchers in health (Egger et al., 2007, Kassem and Moursi, 2007 and WHO, 2006) have all lamented the lack of managerial competence. In 2000, world leaders of low, middle, and high-income countries, again came together to review the situation. Subsequently the UN in 2000 set targets to be achieved by 2015 contained in the eight MDGs, of which three were health related as highlighted above. Following from this, three more high level fora were held; two in 2004 and one in 2005 respectively. From this date, a series of concrete actions of improved HRM emerged to improve the health of the poor by tackling some of the top communicable diseases.

Consequently, the issue of managerial talent dominated various fora and research findings. For instance, discussions held during the first and second high level fora on progress among other things focused on the HR crisis in health. Again, in 2006, the World Health day was dedicated to the issues of HRH. Despite these efforts, as admitted by Egger et al. (2007), the HRH crisis with poor health indicators are still persistent in low income countries especially SSA. Filerman (2004, p2), substantiates this finding by adding that the potential impact of the Global Fund to fight communicable diseases “...not only have they not improved, but also in many countries they are actually weaker than they were a decade ago”. He thus acknowledges that the most fundamental barrier to these new resources reaching the people who need them is the lack of competent management at all levels. Metaphorically, he likens infrastructure to people and not organograms, handbooks etc. and then concludes that an effective infrastructure is the right people in the right place against the current situation in which health systems lack people who have and use the managerial competencies that match their responsibilities.

The UN encouraged countries to invest in their HRM/D activities. Consequently, significant efforts and money from both partners and Government were directed to HRH. However, Egger et al. (2007), lament that in spite of the significant effort and money that have gone into building “management capacity” ironically, it still continues to be mentioned as a critical constraint and which raises concerns as to whether the efforts made were the right ones. Criticising the manner in which the health sector reforms were implemented, Egger et al. (2007) claim that although the importance of knowledgeable managers in HRM/D at the local level has been acknowledged by several authorities as above, the health sector reforms
that took place in the 1990s failed to adequately address HRM/D issues. Instead, various reasons including the continent’s poor economic performance with an increase in population of countries in the SSA region in the past two decades among others, have been attributed to the phenomenon (Dovlo, 2005; WHO, 2007).

In spite of the apparent lack of progress the centrality of HRM to health services and health care delivery to patients in Hyde et al.’s (2006) view has been increasingly recognised in recent years by international organisations including WHO, governments, policy-makers, managers, professional organisations and clinical professionals. This has been brought into sharp focus through recent and current health care reforms aimed at modernising the Health Management Systems of which many health systems in developing countries have been affected.

However, problems facing governments globally as a result of these reforms are that many health systems have either underperformed or failed to achieve their objectives. Although there are certain known social, cultural and economic factors, McCourt and Awases (2007), state that these constraints are complex in developing countries. Also the WHO consultative report above, highlighted a lack of leadership and management capacity constraint, especially at operational levels of both the private and public health sectors despite the time and money spent by governments and development partners to strengthen capacity in leadership and management. Thus, the report demanded that competencies, roles and responsibilities should be clearly defined and performance changes measured.

1.5 HRM/D in Ghana

HRM/D research in Ghana as stated above is very limited. However, writers such as Abdulai (2000), Aryee (2004) and Debrah (2001) among others have provided an overview of HRM practices and issues in Ghanaian organisations. First, Abdulai (2000) asserts that the Ghanaian Constitution makes provisions for proper labour practices which bind all sectors in the country. Thus this allows for groups in the society including employees to exercise their employment rights. However, due to environmental factors including culture, political and economic aspects impinging on HRM in Ghana, Aryee (2004) and Debrah (2001) described the management style to be bureaucratic and authoritative and thus threaten employee involvement in decision-making and therefore rendering the practice nonexistent. This was attributed to cultural aspect of respect for the elderly and people in authority in the society.
The performance of HRM/D activities of recruitment and selection, training, performance management and rewards management in organisations were viewed more bureaucratic and administrative in nature as compared to other countries. Using the context of Ghana, Debrah admits that the objectivity associated with the HRM practices in the developed world is largely influenced by beliefs, political, socio-economic and socio cultural factors. In his view, the extended family system permits nepotism and favouritism rather than competence during recruitment and selection as well as promotions. In deciding on which HRM practices to adopt for the study, the circumstances of the health sector and various theories were considered before making the choice.

1.5.1 Health sector reforms in Ghana

The Ministry of Health (MOH) Ghana, since its establishment in 1960 has sought to deliver quality health service to the populace through its workforce, of which managers formed the backbone. Ghana, like all other developing countries has once been characterized by political and economic instability with poor health service outcomes. The recent attention on HRM in health was largely coupled with the radical expansion of health services, technological innovations and keen perception of consumers of health service for quality health care. This brought into being the health sector reforms which are necessary steps in establishing a more equitable, efficient and responsive health care system to remedy the situation. Thus, the health sector like all other sectors in Ghana for over the past decades has been undergoing reforms in line with the ideals of the reforms cited above. The reforms are in recognition of the fact that existing organisational arrangements inhibit effective performance in the health sector. The reforms according to the Institutional Reforms (1996) document;

“…are necessary steps in establishing a more equitable, efficient, accessible and responsive health care system (p2).”

The reforms were to also provide a sound organisational framework for the growing degree of managerial responsibility that is delegated to the districts and hospitals. According to the above document (p21), themes which are important to the reforms include “clear lines of responsibility and control; decentralisation; and accountability for performance rather than inputs”. In addition it is also to reduce the discrepancies between the health workforce and the needs of the service in terms of quantity, mix and quality of the workforce among others.
Therefore there was restructuring and reorganising of health service. The health sector reforms brought HRM into sharp focus in Ghana as these reforms sought to bring about efficiency in the sector and which was not being realised. Major changes and plans for HRH were undertaken as outlined in the Human Resource Bulletin (1997) and which included among others:

- Improvement of staff/personnel utilisation and management within the GHS and Teaching Hospitals.
- A decentralised system of personnel/HR administration. The idea is to introduce greater efficiency.

The general public sector reforms including that of the health culminated in the development and passage of some legal instruments (Local Government decentralisation Act (Act, 462, 1993) the Ghana Health Service (GHS) and Teaching Hospitals’ (THs) Act (Act 525, 1996) for establishing the GHS and the THs) and the National Health Insurance (NHIS) Act (Act 650, 2003). Also, a policy was formulated by MOH to increase numbers of health staff into health training institutions from 2002 to date.

Notwithstanding these efforts, as already stated above, quality of health care was still poor and had been largely attributed to weak HRM/D. A myriad of the challenges attributed to poor HRM/D included managerial competence, inadequate human resources who are not adequately trained and equitably distributed and motivated. Accordingly, the PHS has a duty to re-examine HRM practices and managerial competence as a way of improving service delivery. This was consequent to quality health care agenda of the health sector of Ghana to its consumers and also in an effort to meet the Health MDGs as outlined by UN. This pushed HRM/D to the forefront of the PHS. Thus, it highlights the issues of HRM/D competencies of MMDDHS who are at the frontline of service implementation.

As the health sector is a labour-intensive industry, with managers at the decentralised levels forming the backbone with expanded responsibilities including HRM/D, the success of the PHS depends heavily on the transformation of the managers. Hence, decentralising HRM/D functions to managers at local levels created a lot of pressure on managers of the health industry in the developing world. This is due to high migration of health workers coupled with health sector reforms which aims to improve equity, accessibility, quality and efficiency of health. Thus, it places strain on economic resources and managerial capacities. This has brought to the fore the importance of effective management of HRH (WHO, 2007).
For majority of managers in the health sector, they have the primary responsibility for planning, coordinating and mobilising all resources for the delivery of health services to consumers in hospitals and communities both in rural and urban centres. Managers therefore need polyvalent skills and knowledge in both management and HRM/D. However, managers in general, have broad-based training in public health and are mostly not trained in HRM/D. Thus, to ensure the success of managers to deliver good health outcomes, it was the responsibility of the implementers of these reforms to upgrade the knowledge, skills and abilities of such managers on managerial and HRM/D roles to prepare them for these leadership roles as envisaged in the proposals by MOH prior to the reforms. To the contrary, this did not happen. Consequently, the PHS is currently faced with problems of maldistribution of staff, inadequate and inappropriate skill mix of staff to run its facilities. Worse still, the over centralised system of administration of the MOH being part of the larger Civil service with its bureaucracy does not reward excellence and hard work. HRM/D in the PHS has thus become an area of priority action lately as it is confronted with decreasing budgetary allocations and has to cut back on resources.

Therefore it is most timely to examine HRM/DE in the Ghanaian PHS. Accordingly, this study takes this forward to try to understand and explain factors influencing HRM/DE to fill this yawning gap.

1.5.2 Implications of health sector reforms on HRM/D in Ghana

The management systems’ reforms generally had creditable aims of improving quality of service and performance. The design of the management systems was intended to be within an established integrated decentralised health system in which health service providers and communities would plan and manage the delivery of health services (MOH, 1995). From this, it is evident that the role of managers in contributing to the success of the health system is very crucial. Regrettably, District Health Management Teams’ (DHMTs) attempts to implement health development projects and programmes have failed or underperformed (Larbi, 1998). Several years following the reforms, health services continue to be poor and largely attributed to ineffective HRM/D due to weak managerial capacity.
The following highlights both the positive and negative aspects of the reforms for line managers. Positively, the establishment of staffing norms will work towards an equitable distribution of staff especially in the rural areas. The management of the staff development function by managers will help update the knowledge and skills of those already in the service. Third, the new scheme of service will erase discrepancies in salaries and other conditions of service and match all staff equally to their counterparts in other departments of the health sector. Again, the decentralisation of HRM/D procedures will enable managers at the decentralised levels determine their staff requirements and achieve better utilisation. Finally, HRM/D issues and challenges will be addressed more promptly due to the proximity between employees and managers.

Despite these benefits anticipated from the reforms for the managers at the decentralised levels, there still remain some issues to be addressed in order to enable the managers fit in with the changes. These issues include: The redefinition of roles and responsibilities of managers with specialisation especially in management and leadership dimensions to enable managers respond to the changes have not been clarified. Only a limited number of managers already existing in the system benefitted from in-service and continuing education programmes aimed at updating the skills and knowledge of managers to cope with the new changes (National In-service Training Policy, 1997).

The continuing change in fiscal and financial policies has affected the employment of health workers in the public sector. This has also affected fund flows to the PHS as donors and other partners have started to demand performance outputs. With the enactment of some laws and the decentralisation of budgets and administrative functions, this has resulted in confusing lines of accountability for District health managers. The implementation of the NHIS has also led to increase in workloads thus creating a lot of pressure on health staff.

With all these taking place, there has not been any re-examination of the role of the existing managers regarding their capability to contribute to quality health care in line with the ideals of the reforms. The development of a reliable information system to support and provide indicators for the planning and management process has not been done. Above all, as the health ministry is a labour intensive one, the management input is very crucial. However, a system has not been put in place for the continuing motivation of managers to retain their interest and dedication to the service. Consequent to the above, it is evident that very little
has been done in preparing managers at the decentralised levels to manage resources including HRM/D. In order to find out whether the managers are competent enough in performing their managerial duties particularly as they relate to HRM/D at the decentralised levels as a result of these omissions, that this study is being conducted.

1.6 Definition and Justification of the problem

According to Martineau and Martinez (1996, p3), “the management of human resources is an essential component of an effective health system and can be the most important factor influencing success or failure of health sector reform.” Therefore, it has been generally recognised that more effective management systems complement or synergise other health systems and organisational goals and help to improve organisational outcomes, and which are sources of sustained HRM-performance link. In the PHS of Ghana however, the component of HRM/D is often neglected in favour of personnel administration. Although the latter is necessary, it is not sufficient in itself to meet the challenges of planning HR especially at the decentralised levels in the context of the reforms as described above. In spite of this, there has been the revelation of human resources and managerial crisis in Africa and especially in the PHS of Ghana in literature, policy documents and WHO as outlined above. Despite the realization of the importance of district health managers in the implementation of the health sector reform ideals in Ghana to complement or synergise other health systems and organisational goals, managerial capacities have been said to be weak. Coupled with this, unfortunately, there is limited empirical evidence documented on these in Africa and particularly in the PHS of Ghana which support such claims. The only limited number of books in relation to HRM in Africa and Ghana are those by Aryee in Kamoche et al. (2004), Debrah in Budhwar (2001) and Arthur et al. (1995). However, Wood (2008), notes that these books gave accounts of the realities, issues and contestations of HRM in Africa and the future directions. Again, none of these was directed at the health sector. Additionally, despite WHO (2007) documenting the widespread health workforce crisis across the African Region particularly in SSA, it has not provided empirical evidence as to how HRM can be made more effective.

As a result of this yawning gap, the thrust of this study is an attempt to bridge this gap in existing literature with the aim of contributing to HRM/D literature in Africa and also pave
the way for understanding management in the African context. Secondly, since most
developed countries are collaborating with developing countries in all aspects including
health service improvement, there is need to adopt a new facet in the study of HRM/D.
Studies need to factor in the perspective of other economies, especially those in Africa.
Specifically, the study aims to evaluate the understanding of HRM/D using a framework
that identifies the context within which they operate regarding the implementation of HR
activities from the perspectives of managers themselves and stakeholders in the PHS. The
framework highlights the issues through the four HR practices of recruitment and selection,
performance management, training and development and rewards management. To be able to
do this, the research objectives and questions to guide this are highlighted next.

1.6.1 Objectives and Research Questions
In order to help address the research problem of managerial effectiveness, objectives and
research questions were formulated to guide the study.

(a) Main Objective of the Study

To explore the understanding and experiences of managerial effectiveness from the
perspectives of managers and staff of the PHS of Ghana of key HRM/D policies and
practices and how these can be made more effective for organisational performance.

(b) Specific Objectives

i. To establish the context of HRM/D within the PHS of Ghana

ii. To explore the understanding of managerial effectiveness by policy makers,
managers and employees of health and some stakeholders

iii. To examine the extent to which this understanding of managerial effectiveness
(knowledge, skills, abilities, attitudes and qualities) are reflected in the current HR
practices within the PHS from the perspectives of managers and employees of
health.

iv. To investigate the factors/processes that have links with the effective management
of HRH in the PHS of Ghana.

v. To recognise gaps and identify key competences and appropriate managerial
behaviours based on the perspectives of managers, policy makers and employees
of Health.
The basis of meeting these objectives is to understand and explain HRM/D in the health sector from the perspectives of managers and stakeholders. It also aims to identify managerial roles/competencies as a way of making HRM/D more effective within the current health sector reforms by this approach.

1.6.2 Research Questions

In order to achieve the objectives of the study, the following research questions are formulated to obtain answers to the research problems.

i. What is the context of HRM/D in the PHS of Ghana?

ii. What understanding do managers and employees have about managerial effectiveness for practice at all levels?

iii. How have HRM/D practices of recruitment, performance management, staff development and rewards been defined and measured in the PHS of Ghana?

iv. How does this understanding/perception coupled with environmental factors affect their managerial roles including the approach to employee resourcing and deployment, capacity development, motivation and appraisal of staff and the performance of the organization?

v. What lessons can be learned from the perspectives of managers and employees and what are the implications for policy, practice and in making management more effective?

1.7 Organisation of the Thesis

To enable readers have a general idea as to what is contained in the thesis in addressing the problem of managerial effectiveness, the thesis is organised into eight (8) chapters.

Chapter One presents the introduction and background of the study. The chapter introduces HRM/D as a concept and an overview to the understanding of the trends in HRM/D globally, then its performance-link in organisations including health. It then proceeds to focus on HRM/D in the developing world and within the health care delivery. Following from this, the contestations of HRM/D are highlighted and literature reviewed along the lines of HRM/D and health sector reforms. The chapter then tapers down to HRM in Ghana, then health sector
reforms and its implications for HRM/D. Based on the arguments, the problem statement is made and justified for the study and consequently, the research objectives and questions are stated. Finally, the chapter describes how the thesis is organised.

Chapter Two presents the analysis of the context of the study which includes the country profile, the health care system including the goals, structure, and organisation of health care and management of HR in the health sector. The chapter also outlines the environmental factors of the study context.

Chapter Three reviews literature in line with the topic. The chapter focuses on literature from empirical perspectives to distinguish between HRM and HRD and their similarities. Next, in the chapter, the key concepts related to the study are defined. Thus, it reviews literature on the various perspectives that underpin management, organisations and HRM, line managers’ involvement in HRM and competency to provide an understanding to the study.

Chapter Four reviews literature on both management and organisational theories in order to build a conceptual framework for the study for the analysis which is relevant for the understanding of HRM/D effectiveness. This chapter takes note of the local context/practice based on the contents of chapters two and three.

Chapter Five presents the research methodology for the study. The chapter highlights the mixed methods research methodology adopted for the study. In addition, the ontological and epistemological issues of the chosen philosophical stance and how this was used to achieve the research objectives are discussed. The research setting, the parameters of the research population, strategies for data collection and data analysis are all discussed in this chapter.

Chapter Six presents the findings of the study from both interviews and survey obtained from managers and stakeholders. The chapter aims to provide evidence from the challenges outlined from interviews held with frontline managers and stakeholders on managerial effectiveness.

Chapter Seven discusses the findings. The chapter aims to make the findings more in-depth for the understanding of managerial effectiveness. It thus highlights and discusses all the challenges in the implementation of HRM/D activities.
Chapter Eight draws conclusions from the findings and gives recommendations, states limitations of the study and implications for further research. Contribution to knowledge, literature and policy input and practice are also provided in this final chapter.
2.1 Introduction and overview

Following from the introductory chapter, which highlighted some of the issues related to HRM/D globally, Africa and Ghana, this chapter further describes the context of the research which is the Public Health sector (PHS) of Ghana. The chapter presents the profile of Ghana which is the study country. This is intended to help readers understand the unique context in which the study has been undertaken so that they can appreciate the findings. Kiggundu, (1991) articulated this uniqueness and states:

“Foreigners interested in designing, implementing and evaluating effective management development programmes must read widely in order to gain an appreciation of this diverse and complex continent, its peoples and social organisations, and the contexts within which organisation and management take place…” (p32).

In line with the above quote, the chapter begins with the description of the country profile which is on the population and population growth, geography, the environmental factors which include the economic, political, legal and socio-cultural contexts. Next the health care system is examined. The overview of the health care system includes the general health status of the population and the disease profile, an overview of the organisation of health service in Ghana, the structure of the Ministry of Health (MOH) and its agencies and the structure at the district level, which is the focus of this study. It also presents the organisational strategy. More importantly the chapter examines how HRH practices are carried out and the gaps in management. Most of the information provided in this chapter is based on publications on Ghana, studies conducted in Ghana and the health sector, official documents/reports and from my own experience as a Deputy Director of the HR Directorate of the GHS.

2.2 Country Profile

Studies have pointed to the fact that environmental and contextual societal factors may act as external influences on HRM (Abdulai, 2002; Scott, 2002 and 1995). Such factors include the laws and regulations (Abdulai, 2002; Heneman, 1983) economic, political and cultural factors (Debrah, 2000; Hofstede, 1980; IDRC, 2010; Kamoche, 2004 and Kiggundu, 1991). Thus, there is the need to outline these contextual aspects.
2.2.1 Background and Geography

Modern Ghana, a former colony of Britain is situated in West Africa in Sub-Saharan Africa (SSA). It was formed from the merger of the British colony of the Gold Coast and the Togoland trust territory in 1874. It is bordered by Togo in the east, Burkina Faso in the north, Cote d’Ivoire in the west and the Atlantic Ocean to the south. Ghana has an approximate landmass of 239,000sq kilometres. A narrow grassy plain stretches inland from the coast, widening in the east. The south and west are covered by dense rain forest. To the north are forested hills, beyond which is dry savannah and open woodland. The Black and White Volta Rivers enter Ghana from Burkina Faso and lead to the largest man-made lake in the world, Lake Volta (CIA World Fact book, 2010, Ghana web, 2010). The climate is tropical; warm and comparatively dry along southeast coast; hot and humid in southwest; hot and dry in the north.

The geography of the country is important to the study as some diseases may be seasonal and or endemic in certain geographical locations due to seasonal variations. For instance upsurge of malaria in the rainy season. For HRM/D, the terrain and climatic condition can also influence the willingness of staff to accept postings to the location.

2.2.2 Population and population growth

The estimated population as of July 2010 has been estimated to stand at 23,887,812 million (CIA, 2010) with a density of 99 people per square kilometre based on the projection of the 2010 National Population census. This compared to the population of Ghana at independence which stood at a little over 6 million has almost quadrupled. Like many developing countries, the population is youthful with 37.2% under age\(^2\) 15, and the population aged 65 and above is about 3.5%. It is assumed that the population will continue to increase at an annual rate of 2.4%. The Ghana Maternal Health Survey (GMHS, 2007) estimated that 52% of total population are females and 48% males. MOH (2010), indicates the estimated population growth trend in Ghana as in table 2.1.

\(^2\) Age structure

0-14 years: 37.2% (male 4,494,633/female 4,394,074)
15-64 years: 59.2% (male 7,065,273/female 7,086,023)
65 years and over: 3.5% (male 389,886/female 457,923) (2010 est.)
The size and age of the population of a nation affect a nation’s key socio-economic issues as these determine the magnitude and type of social infrastructure and services to provide. For instance, countries with young populations (high percentage under age 15) need to invest more in schools, while countries with older populations (high percentage ages 65 and over) need to invest more in the health sector. The age structure can also be used to help predict potential political issues. For example, the rapid growth of a young adult population unable to find employment can lead to unrest (CIA, 2010).

Table 2.1 The Regional breakdown of the population trend of Ghana

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashanti</td>
<td>3,612,950</td>
<td>4,165,447.75</td>
<td>4,689,877.23</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>1,815,408</td>
<td>2,093,022.92</td>
<td>2,356,534.31</td>
</tr>
<tr>
<td>Eastern</td>
<td>2,106,696</td>
<td>2,428,855.12</td>
<td>2,734,647.76</td>
</tr>
<tr>
<td>Central</td>
<td>1,593,823</td>
<td>1,837,552.81</td>
<td>2,068,900.54</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>2,905,726</td>
<td>3,350,073.99</td>
<td>3,771,848</td>
</tr>
<tr>
<td>Northern</td>
<td>1,820,806</td>
<td>2,099,246.39</td>
<td>2,363,541.32</td>
</tr>
<tr>
<td>Upper East</td>
<td>920,089</td>
<td>1,060,790.39</td>
<td>1,194,343.81</td>
</tr>
<tr>
<td>Upper West</td>
<td>576,583</td>
<td>664,754.94</td>
<td>748,447.525</td>
</tr>
<tr>
<td>Volta</td>
<td>1,635,421</td>
<td>1,885,512.04</td>
<td>2,122,897.83</td>
</tr>
<tr>
<td>Western</td>
<td>1,924,577</td>
<td>2,218,886.21</td>
<td>2,498,243.78</td>
</tr>
<tr>
<td>National Total</td>
<td>18,912,079</td>
<td>21,804,142.6</td>
<td>24,549,282.1</td>
</tr>
</tbody>
</table>


2.2.3 Political Context

In Aryee’s (2004) view, management does not exist in a vacuum and highlights the importance of political-economic environment and its effects on HRM, people and health. Loewenson (2000) asserts that the political-economic environment incorporates how different social groups articulate their interests, the way political, economic and administrative authority is exercised; how social groups exercise their rights and obligations and how power is exercised in managing the economic and social resources for health.

Ghana became the first Sub-Saharan country in colonial Africa to gain its independence in 1957. Ghana endured a long series of coups d’états interspersed with democracies since independence and now has a constitutional democracy since 1992 with a parliament as the legislative arm of Government. For administrative purposes, the country is divided into ten Administrative regions comprising 170 districts with 230 constituencies as at 2008. The
District Assemblies (DAs) develop plans and mobilise resources for plans, programmes and strategies for the development of the districts. The political situation is stable, with presidential and legislative elections held every four years. The transition of power between political parties took place without any incident in 2000, 2004 and 2008.

2.2.4 Economic Context

The economy of a country is vital for its developmental agenda and which includes its human resources. Thus, the prevailing economic situation dictates which developmental activities should be given priority or how these economic resources are distributed. Most of the sources\(^3\) which highlighted the Ghanaian economy admit that Ghana’s post-independence economic story has been a difficult one, but over the last 20 years, stability and growth have increasingly taken hold.

Ghana’s economy started to decline due to political crises consequent to frequent change of Governments through coup d’états after independence. In order to revive the economy according to Aryee (2004), the Government together with the World Bank and International Monetary Fund (IMF) implemented the Economic Recovery Programme (ERP) and Structural Adjustment Programme (SAP) in June 1983. In spite of these, the economy did not improve as expected. So, in 2002, Ghana opted for debt relief under the Heavily Indebted Poor Country (HIPC) programme, and also benefits from the Multilateral Debt Relief Initiative that took effect in 2006. Ghana also signed a Millennium Challenge Corporation (MCC) Compact to support the Agricultural sector. Human Resource development, good governance and sound macro-economic management were listed among the thematic priorities under its current Growth and Poverty Reduction Strategy (GPRS), which also provides the framework for development partner assistance along with high prices for gold and cocoa helped sustain GDP growth in 2008 and 2009.

Ghana has a mixed economy consisting of a dominant agricultural sector (small scale peasant farming). The economy thus continues to revolve around agriculture, which accounts for more than a third of GDP and employs more than half (60%) of the work force (WHO-CCS, 2002-2005). Ghana has roughly twice the per capita output of the poorest countries in West Africa. Even so, Ghana remains heavily dependent on international financial and technical

\(^3\) CIA world fact book (2010, 2008); WHO-CCS, (2002-2005); Aryee, 2004
assistance. Gold and cocoa production and individual remittances are major sources of foreign exchange. Oil production is expected to expand in late 2010 or early 2011 (CIA world fact book, 2010).

2.2.5 Socio-cultural Context

Socio-culturally in Ghana, people are socialised into the extended family system, in which Ghanaians are expected to support their kinsmen who expect to receive help from their relationship with relatives. Also, people have been socialised into the beliefs and practices and the culture of respect for elders, status and people in authority. There is also a high degree of subservience to the elderly and authority figures in organisations (Debrah, 2001). Social distance between superiors and subordinates is marked, with a sharp distinction and status difference between management and rank-and-file employees. Workers are expected to do their work and to follow management’s instructions and directives and rarely question or challenge those in authority. This often compromises the integrity and efficiency of managers and affects performance of organisations (Debrah, 2001). The above affirms why the study should take the cultural perspective into consideration when examining HRM practices from the perspectives of employees and other stakeholders.

2.2.6 Legislation

The administrative and legal environment in a country provides a framework within which an organization operates. The administrative context within which the health sector operates is shaped by a unique combination of forces, including policy, legislative, regulatory, and legal frameworks. These include laws such as the labour law, the laws that set up the health sector (Act 525) the decentralisation law (Act 650) and the regulations governing professional bodies and the influence of these on HRM/D need to be examined and understood. It is here pressures from unions and professional bodies impact on the health sector.

2.2.7 General Health Status

The status of health in the country is outlined to highlight the disease burden of the study country as well as populations most affected. This can influence the numbers and types of
HRH needed in the system. From various documents\(^4\), current health indicators are indicated in table 2.2. Within these figures are very large inequalities across geographical areas and socio-economic groups; for example, the U5MR ranges from 62 per 1,000 live births in Greater Accra Region to 171 per 1,000 live births in Northern Region. In addition, 26% of children under-five are stunted, and one in every four children is underweight. The maternal mortality ratio (MMR) for Ghana has been computed at different times by various methods and national estimates vary from 214 to 740 per 100,000 births. The Expanded Programme on Immunisation (EPI) coverage in children (zero to 11 months) for 2001 is as follows: BCG 91.0%, DPT3 76.0% and measles 81.0%. However, there are significant disparities in coverage by region and locality. In nine out of 110 districts, DPT3 coverage is lower than 50%. Antenatal coverage was at 89% in 1998. Overall utilization is higher in the urban than rural areas. There are also regional variations in Ante Natal Care (ANC) with the highest coverage of 96.1% in Ashanti Region, and the lowest coverage of 69.1% in Upper West Region. The average number of antenatal visits made by pregnant women is 2.8, and 44.3% of deliveries are supervised by trained medical personnel.

2.2.8 Disease profile

The epidemiological situation of Ghana is similar to other Sub-Saharan countries, i.e. a predominance of communicable disease conditions, under-nutrition and poor reproductive health with emerging importance of non-communicable diseases such as neoplasm, diabetes and cardiovascular diseases. The major causes of morbidity and mortality are anaemia, respiratory tract infections, hypertensive diseases, malaria, diarrhoea, among other infectious disease (GDHS).

2.3 The healthcare system

The health care system represented by the Ministry of Health (MOH) as the umbrella organisation is the second largest employer after Education in Ghana, with over 60 thousand employees in over 100 careers, in 1000 institutions and health facilities. The MOH is part of the larger civil service with a centralised system of administration. The MOH has the responsibility of direct provision of public health services delivery in the country for promotive, preventive, curative and rehabilitative care to the Ghanaian public. With the

enactment of the law (Act 525 of 1996), to restructure MOH, this function has been ceded to the Ghana Health Service (GHS) and Teaching Hospitals (THs). The four main sectors of the health care system which are the public, private, traditional and other sectors will be discussed under the structure of MOH. MOH currently provides stewardship to the entire health sector (MOH, 2005). The other non-health stakeholders include the Ministries of Education, Local Government and Rural Development (MLG & RD), Environment, Science and Technology and Works and Housing.

Table 2.2 Trend in Health Indicators over a four-year period

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality Rate (per 1000 live births)</td>
<td>77</td>
<td>66</td>
<td>57</td>
<td>64</td>
</tr>
<tr>
<td>Under 5 Mortality Rate (per 1000 live births)</td>
<td>155</td>
<td>119</td>
<td>108</td>
<td>111</td>
</tr>
<tr>
<td>Neonatal Mortality Rate (per 1000 live births)</td>
<td>44</td>
<td>41</td>
<td>30</td>
<td>43</td>
</tr>
<tr>
<td>Post-Neonatal Mortality Rate (per 1000 live births)</td>
<td>33</td>
<td>26</td>
<td>27</td>
<td>21</td>
</tr>
<tr>
<td>Crude Birth Rate (per 1000)</td>
<td>47</td>
<td>44</td>
<td>39</td>
<td>33</td>
</tr>
<tr>
<td>Crude Death Rate (per 1000)</td>
<td>17</td>
<td>12.5</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Life Expectancy at birth (in years)</td>
<td>54</td>
<td>55.7</td>
<td>57</td>
<td>58</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>6.4</td>
<td>5.5</td>
<td>4.6</td>
<td>4.4</td>
</tr>
</tbody>
</table>


MOH therefore, has the responsibility for policy formulation, resource mobilization, regulation of the health services delivery and monitoring and evaluation. The Ministry operates only at the national level and has seven (7) divisions which include the human resources development and its agencies and stakeholders. Next, the structure of MOH is described.

2.3.1 The structure of the Ministry of Health (MOH)

Administratively, the PHS is organised at three levels (National, Regional and District) but functionally, it is at five levels (National, Regional, District, Sub district and Communities). The structure of MOH is shown in Figure 2.1. As in figure 2.1, there are four groups providing health services in Ghana – the Public/government, missions/non-governmental organisations (NGOs), private and traditional practitioners. These are discussed next.

i. Public Sector

Within the public sector, GHS is the major implementing body of the MOH. The GHS is part of the Public Service, but distinct from the Civil Service.
The GHS is organised administratively at three levels – National, Regional and District levels but functionally at five levels – National, Regional, District, Sub district and Community levels. Thus, it is responsible for all services and health institutions at these levels apart from the THs.

**ii. Private Sector**

The private sector includes doctors, nurse practitioners, pharmacists, licensed chemical sellers and midwives. The private sector plays a complementary role to the MOH and GHS in providing health service in the country. The private sector has two categories of providers - the private-for-non-profit and the private for-profit providers.

The private for-non-profit is mainly the mission faith based institutions. Over 45 NGOs and religious bodies are involved in the provision of health care of which the Christian Health Association of Ghana (CHAG) is the largest. It is estimated that approximately 42% of total health services in the country are provided by CHAG’s member institutions (CHAG website,
2010). The CHAG secretariat and the Catholic Health Secretariat serve as co-ordinating bodies for a large number of mission-run health programmes in Ghana. The government and mission work closely together. In many districts, missions are active in the administration of government health services. The government contributes to the budget of the missions by paying their personnel costs.

The private-for-profit comprises the private hospitals, maternity homes and chemical sellers and these provide about 10% of health services.

iv. Traditional Health Practitioners
Traditional medicine practitioners use herbs, spiritual beliefs, animal and mineral substances, or other methods and local wisdom in providing health care (Tabi et al., 2006; WHO, 2001). Four main groups of traditional health practitioners are distinguished: traditional birth attendants, herbalists, spiritualists and fetish priests. It has been estimated that about 75-80% of Ghanaians patronise traditional medicine with approximately one traditional medicine practitioner for every 400 people, compared to one allopathic doctor for every 12,000 people. (WHO, 2001).

v. The statutory Bodies
The statutory or Regulatory bodies are under the authority of the MOH and are the bodies that officially license health workers. The three which are currently active include those of the Nurses and Midwives Council of Ghana (NMC), the Ghana Medical and Dental Council (MDC) and the Pharmacy Council. The fourth which is the Allied Health Council is still in its formation stages.

The NMC, apart from its responsibility for professional and ethical conduct for Nurses and Midwives, has direct authority over the training schools for nurses and midwives as mandated by law (NRCD, 117, 1972). The counterpart medical council, though established around the same period does not have such authorization over the medical schools, which are managed by the Ministry of Education. However, it is responsible for professional and ethical conduct and continuing professional development of doctors and influential on matters pertaining to the training of doctors.
2.3.2 The Organisation of health service

Government advocates the provision of health care services through the four groups of service providers discussed above. The responsibility for ensuring adequate and acceptable standards of performance belongs to the MOH. By the passage of Act 525 (1996), the implementation has been delegated to the agencies of the MOH as outlined above and health service is organised at five levels – National, Regional, District, sub-district and communities.

i. National Level

A GHS Management Executive Group which is accountable to the GHS Council manages the GHS at Headquarters. This group is responsible for policy formulation, monitoring and evaluation. The Regional Directors are part of this group and report directly to the Council. Regional Hospitals are directly managed under the GHS. National executive is organised into nine directorates at headquarters and in all the ten administrative Regions. The second level is organised into 170 District Health Directorates. The GHS is represented at all levels and so its structure and functions at the various levels are outlined as follows.

ii. Regional level

This level is a critical link between the national headquarters and the district level and serves as a buffer in reconciling needs identified by districts with national concerns. Its role is to help translate central policy into district action plan by providing support in the form of guidelines, protocols and procedures, to ensure co-ordination between districts, to monitor district programme implementation and to provide feedback to districts and the national headquarters (Health in Brief document, 1991).

iii. The district level

This is the second level of management in the GHS, and the service is managed by the District Health Management Team (DHMT). The team comprises a core of five team members headed by the Metropolitan, Municipal or District Director of Health Service (MMDDHS). The DHMT has the overall responsibility for operational planning, programme implementation, managing the entire government and non-governmental district health services including management of resources – both human and material and the supervision of the district and sub-district staff throughout the district.
As a result of decentralization and health sector reform, services are integrated as one goes down the hierarchy of health structure from the national to the sub-district.

2.3.3 Structure of Delivery of Services

At the regional level, curative services are delivered at the regional hospitals and public health services by the DHMT as well as the public health division of the regional hospital. The Regional Health Directorate (RHD) provides supervision and management support to the districts and sub-districts within each region (GHS website, 2010).

At the district level, curative services are provided by district hospitals and there are 124 of these hospitals and serve an average population of 100,000–200,000 people in a clearly defined geographical area. The number of beds in a district hospital is usually between 50 and 60 and district hospitals that typically have 50–200 beds serve 100,000–200,000 people. It is the first referral hospital and forms an integral part of the district health system. Public health services are provided by the DHMT and the Public Health unit of the district hospitals. The District Health Directorate (DHD) provides supervision and management support to the sub-districts (Abdullah et al., 2010).

At the sub-district level, both preventive and curative services are provided by the health centres as well as out-reach services to the communities within their catchment areas. Basic preventive and curative services for minor ailments are being addressed at the community and household levels with the introduction of the Community-based Health Planning and Services (CHPS). These frontline nurses referred to as Community Health Officers (CHOs) are accommodated within the community to provide services and refer cases for further management when beyond them. This therefore has HRH implications as zoned communities have between two to three of such staff. The number of functional CHPS zones increased from 409 in 2008 to 868 in 2009\(^5\) (Figure 2.2).

Other ministries either provide or support health care. The Ministry of local government through the District Assemblies (DAs) is responsible for sanitation. The department of social welfare provides rehabilitation services for the physically handicapped whilst the Ministry of Agriculture carry out extension services related to nutrition. The Ministry of education is responsible for the training of some health care workers and also provide health care to the

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\(^5\) Ghana Health Service Annual report (2009)
universities while the ministries of Defence and Interior provide health services to the armed forces and the police respectively (GHS website, 2009).

2.3.4 Current Staffing Situation

Human Resources working in health as already stated in Chapter One include people of many disciplines with a multiplicity of skills. An accurate estimate of health workforce including health professionals in Ghana is extremely difficult, since the only reliable database is the Integrated Payroll and Personnel database (IPPD) and which also takes time to be updated after staff have disengaged. Moreover, the prevalence of health personnel working simultaneously in public and private practices, particular among the medical group, makes it difficult to determine the actual size of the health workforce. However, the MOH/GHS workforce census in 2007 showed significant growth in the numbers of overall staff with about 52,258 health workers. The composition is made up of public, CHAG, private, Islamic mission, quasi and other organizations. From this figure, the MOH employs a total of 42,299 staff made up of staff in GHS, Teaching Hospitals, CHAG, and health training Institutions, regulatory bodies, and headquarters. Details are in Table 2.3 and Figure 2.3 for total numbers and agency distribution respectively.

Figure 2.2 Organisation at the district level adapted from Nyonator (2008)
Table 2.3 Categories of Personnel and their numbers in the PHS

<table>
<thead>
<tr>
<th>Category of staff</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officers</td>
<td>2,026</td>
</tr>
<tr>
<td>Dental Surgeons</td>
<td>31</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1,550</td>
</tr>
<tr>
<td>Expatriate Doctors</td>
<td>200</td>
</tr>
<tr>
<td>Professional Nurses</td>
<td>7,304</td>
</tr>
<tr>
<td>Enrolled Nurses</td>
<td>2,956</td>
</tr>
<tr>
<td>Community Health Nurses</td>
<td>3,246</td>
</tr>
<tr>
<td>Registered Midwives</td>
<td>2,810</td>
</tr>
<tr>
<td>Medical Assistants</td>
<td>430</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>588</td>
</tr>
<tr>
<td>Traditional birth Attendants</td>
<td>367</td>
</tr>
<tr>
<td>Non Clinical and Clinical Support Staff</td>
<td>27,918</td>
</tr>
<tr>
<td>Traditional Practitioners</td>
<td>21,182</td>
</tr>
</tbody>
</table>

The GHS annual report (2009) highlights the professionals-population ratios as per tables 2.4a and 2.4b with the number of doctors increasing from 1,514 in 2006 to 1,676 in 2007. This ranges from 1:5,624 in Greater Accra Region to 1: 67,154 in Northern Region. Greater Accra Region has about 61% of all doctors. The dentist population ratio is 1:639,900. Nurse population ratio is 1:1,230 (this excludes nurses in the two teaching hospitals).

Figure 2.3 Health workforce distribution by Agency: Data Source, MOH (2007)
Table 2.4a: Doctor Population Ratio by Region, 2006 - 2009

<table>
<thead>
<tr>
<th>Region</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASH</td>
<td>11,681</td>
<td>10,667</td>
<td>9,537</td>
<td>8,288</td>
</tr>
<tr>
<td>BAR</td>
<td>25,365</td>
<td>22,479</td>
<td>21,475</td>
<td>16,919</td>
</tr>
<tr>
<td>CR</td>
<td>31,675</td>
<td>29,260</td>
<td>26,140</td>
<td>22,877</td>
</tr>
<tr>
<td>ER</td>
<td>22,019</td>
<td>18,141</td>
<td>17,571</td>
<td>16,132</td>
</tr>
<tr>
<td>GAR</td>
<td>5,624</td>
<td>5,202</td>
<td>4,959</td>
<td>5,103</td>
</tr>
<tr>
<td>NR</td>
<td>67,154</td>
<td>92,046</td>
<td>68,817</td>
<td>50,751</td>
</tr>
<tr>
<td>UER</td>
<td>28,897</td>
<td>30,111</td>
<td>33,475</td>
<td>35,010</td>
</tr>
<tr>
<td>UWR</td>
<td>45,568</td>
<td>43,265</td>
<td>43,988</td>
<td>47,932</td>
</tr>
<tr>
<td>VR</td>
<td>25,430</td>
<td>28,269</td>
<td>27,959</td>
<td>26,538</td>
</tr>
<tr>
<td>WR</td>
<td>32,746</td>
<td>33,794</td>
<td>31,745</td>
<td>33,187</td>
</tr>
<tr>
<td>National</td>
<td>14,732</td>
<td>12,591</td>
<td>12,713</td>
<td>11,929</td>
</tr>
</tbody>
</table>

Source, GHS Annual Report (2009)

Table 2.4b Nurse Population Ratio by Region, 2006-2009

<table>
<thead>
<tr>
<th>Region</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASH</td>
<td>2,136</td>
<td>2,028</td>
<td>1,336</td>
<td>1,173</td>
</tr>
<tr>
<td>BAR</td>
<td>2,036</td>
<td>1,964</td>
<td>1,140</td>
<td>993</td>
</tr>
<tr>
<td>CR</td>
<td>1,577</td>
<td>1,476</td>
<td>895</td>
<td>811</td>
</tr>
<tr>
<td>ER</td>
<td>1,251</td>
<td>1,175</td>
<td>959</td>
<td>832</td>
</tr>
<tr>
<td>GAR</td>
<td>993</td>
<td>979</td>
<td>881</td>
<td>874</td>
</tr>
<tr>
<td>NR</td>
<td>2,126</td>
<td>1,953</td>
<td>1,534</td>
<td>1,367</td>
</tr>
<tr>
<td>UER</td>
<td>1,298</td>
<td>1,132</td>
<td>956</td>
<td>805</td>
</tr>
<tr>
<td>UWR</td>
<td>1,315</td>
<td>1,209</td>
<td>870</td>
<td>750</td>
</tr>
<tr>
<td>VR</td>
<td>1,302</td>
<td>1,266</td>
<td>892</td>
<td>800</td>
</tr>
<tr>
<td>WR</td>
<td>2,368</td>
<td>2,004</td>
<td>1,413</td>
<td>1,213</td>
</tr>
<tr>
<td>National</td>
<td>1,537</td>
<td>1,342</td>
<td>1,079</td>
<td>971</td>
</tr>
</tbody>
</table>

2.4 Current National Health Policies and Proposals

In line with Government policy of vision 2020 of the Constitution, the National Health Policy (NHP, 2007) has been designed within the context of Ghana’s vision of achieving middle income status by 2015. Thus, within the thrust of this policy, health has been placed at the centre of socio-economic development with a clear shift in the role of health towards wealth creation due to the recognition that health is not only a human right issue, but also a key driver of development.

The policy provides broad guidelines for the development of programmes by key stakeholders, namely Government, other Ministries, Departments and Agencies (MDAs), local authorities, such as DAs, the private sector, civil society organizations as well as communities and traditional leaders. It is also intended to guide health-enhancing actions of
individuals, households and communities and corporate entities. The NHP outlines the vision, mission, goals, objectives and principles as follows:

2.4.1 Vision, Mission and Goals

The vision is to create wealth through health and to contribute to the national vision of attaining middle-income status by 2015.

“The mission is to contribute to socio-economic development and wealth creation by promoting health and vitality, ensuring access to quality health, population and nutrition services for all people living in Ghana and promoting the development of a local health industry.”

The ultimate goal of the health sector is to ensure a healthy and productive population that reproduces itself safely.

The objectives of the health policy will be achieved through the development of a combination of policies, standards, programmes and investments that are underpinned by some guiding principles in the policy.

2.4.2 Capacity Development in the Health Sector

The NHP (2007) defines capacity to refer to the stock of capabilities available to the health system for health delivery. It includes a mix of technical, managerial and logistic capacities required to promote, protect and improve health.

The objective of capacity development of human resources will focus on increasing the stock, with equitable distribution and ensuring their efficient utilization.

2.4.3 Policy Measures for HRD (technical and managerial)

The policy defines human resources to include all human capacity involved in developing, providing, managing or supporting curative, preventive, promotive and rehabilitative health, both in-country and externally, who directly or indirectly influence health development. Based on this, the following policy measures were proposed.
2.5 Human Resource Policies and Practices

Human Resources’ policies are based on the Medium Term Health Strategy (MTHS). This was formulated in 1996 in line with the Fourth Republican Constitution and the Labour Law and used as the background document to develop other HRH policies including scheme and conditions of service, the employees’ handbook, disciplinary among others before the New NHP. Most of the issues raised here are based on these manuals, reports from studies in the health sector, policy documents and on my personal views.

2.5.1 Human Resource Planning

A human resource policy is in place and there is an urgent need to finalize the human resources plan. The policy is that persons are employed in the Health sector based on need as defined by service requirement and staffing guidelines approved by the Council. An annual recruitment plan is made to guide the recruitment. Central to this is an analysis of the supply of various health personnel against demand in both the private and public sectors. Such an analysis will also facilitate redistribution of existing staff in favour of the deprived districts. These measures will require enhanced capacity at the regional and district levels for implementation. However, the capacities are weak at these levels.

i. HRH Financing and Budgeting

There has been in recent years an increase in government spending within the health sector but dropped from 13.8% in 2007 to 9.6% in 2008 (III 5-POW, 2008). Budgeting for the plan for the MOH/GHS is based on the standard activity costing procedure using the Medium Term Expenditure Framework (MTEF). HR activities most commonly included in regional budgets are personnel recruitment, salaries, training, promotions, and allowances. Plans are collated from all levels including national and submitted to the budget unit of MOH. These are collated into one budget for the MOH and submitted to Ministry of Finance and Economic Planning (MOFEP). The latter then submits the annual budget to Parliament for approval. When approval is given, funding is then released on quarterly basis to health by MOFEP.

The policy environment on financing the sector by donors and partners is changing gradually with a shift from SWAp “basket funding” to Multi-donor Budget Support (MDBS) and Sector Budget Support (SBS) which aims at long-term development in partnership with
government in conformity with the Paris Declaration. Based on this the government of Ghana has signed a memorandum of understanding with nine development partners.\(^6\)

**ii. Proportion of Government health budget allocated to personnel emoluments**

From the III-5-POW (2008), health staff salaries and other emoluments constitute 40 per cent of the total Health Sector budget for 2008. There has been some variation from year to year over the past three years (range 40-50 per cent).

**2.5.2 Human Resources Training**

MOH proposes to provide adequate training facilities and programmes to encourage and assist its employees in improving their knowledge, attitudes and necessary skills for the services of MOH and employees’ personal development. This is in recognition of the fact that training is essential for sustaining the competencies, morale and quality of the health workforce. This can be done through pre-service and in-service training.

An employee trained by MOH before and or after employment shall be bonded to provide service between one to five years depending on the type and duration of training.

In-service training policy states that newly engaged personnel shall have an induction programme relating to the functions of the MOH. Personnel in the service shall be given periodic in-service training consistent with new developments in the areas of expertise and deficiencies emerging from performance appraisals.

External courses, in which there are foreign exchange implications, the policy is that external training shall be limited to areas where local institutions lack the necessary expertise.

**i. Management and Leadership Development**

There have been steady improvements over time in establishing a systematic preparation of staff for effective management within the service. About 20 senior health staff at a time are sent in June and November of every year for training at the Ghana Institute for Management and Public Administration (GIMPA) dating back to the 1980s. Unfortunately, there are no

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\(^6\) WHO, CCS – 2008-2011
mechanisms to ensure that staff who have been offered appointment or earmarked for appointment are given priority unto these routine and regular programmes.

2.5.3 Recruitment and selection, induction and placement policy and procedures

The policy is that appointment in the Service shall be made through open or closed advertisement and by merit selection among others. This is based on need as defined by service requirement.

2.5.4 Performance management

Performance is managed by making available job descriptions to all new employees, educating them on the goals of the sector, monitoring and supervising their work and giving feedback. Then is the performance appraisal (PA) arrangement that was carried over from the Civil Service to the Sector, which stipulates that at the end of the year, all employees of the service shall be assessed by their immediate superior officers in accordance with the PA guidelines of the MOH. PA forms are required to be filled yearly by all employees in the MOH/GHS. The assessment shall highlight individual training and development needs and recommendation for positive or negative reward as appropriate.

2.5.5 Rewards, compensation and discipline

i. Rewards

The salary payable to any employee from the policy is in accordance with the approved salary structure of the MOH/GHS. There has been a current evaluation of jobs and a new salary scheme implemented in 2006. This generated a lot of discontent among professional groupings as it was not based on performance, experience or qualification but rather on professional lines and so it was further reviewed in 2010.

ii. Promotion policy and procedure

There is a promotion guideline which spells out in detail the objective, eligibility criteria and procedure for promotion. Although the guideline is adhered to in most instances, sometimes the guideline is misinterpreted and often leads to discontent among employees. The policy has not been disseminated enough and most staff are still ignorant about what it entails to gain promotion.
iii. Discipline
There is a disciplinary procedure which states that an employee whose commission or omission brings the name of Service into disrepute shall be sanctioned. For a major or repeated minor offence the employee may be interdicted, suspended and subsequently dismissed after the due process of disciplinary proceedings or reprimanded in the case of minor offence in conformity with the disciplinary code of the Service. In practice, however, the disciplinary procedure is centralised and ineffective.

2.5.6 Career development
Although there is a policy on career development which states that career development shall follow a scheme of service that will enable employees to develop their own careers, it was only in 2008 that the scheme of service document which has been in draft for over ten years has been resubmitted to Council for approval to be utilised officially. For instance, there is no formal approach to the dissemination of the relevant information on education and career development.

2.6 Summary of Challenges in HRM/D in health
The above highlights the following HR challenges. These challenges are the causes of both internal and environmental influences as discussed earlier under the context of the study:

i. HR Planning (HRP):
Planning of HR is centralised and non-existent in the regions and districts. The staffing norm is outdated and does not match the current needs of the sector. HRP has therefore become paramount in the MOH/GHS in the current Health Sector Reforms because of its importance in determining the type and numbers of HR at the right place and right time.

ii. HR Financing
Most often, the budgets submitted for HR plans and activities are further cut and releases can be delayed for more than three to six months.
iii. Recruitment and Selection and Appointments

Due to cultural and political influence, employees appointed lobby to be posted to places not based on needs. This has resulted in over concentration of various categories of staff in some of the localities and especially in the urban areas as against maldistribution in the rural areas. Also, during recruitment, the lobbying and interference can compromise the policy by appointing people due to their connections to people in authority to the detriment of more qualified persons.

iv. Induction and In-service Training

Induction is non-existent in many facilities for new employees. Where this exists, it is not consistent. Other types of in-service training provided for MOH’s workforce such as workshops, remedial courses etc. tended to have no strict adherence to laid down criteria for the selection of personnel for training. Also, training covered only 1% of staff every year. Again training is organised at all levels on an ad hoc basis and along vertical programme lines often driven by donors. On external training, there is first of all, no strict adherence to the laid down criteria for the selection of the personnel for external training. Also the procedure is so cumbersome and most of the time suffers from lack of funds. This makes external training inaccessible to all eligible personnel.

i. Performance Management

In practice appraisals are the only tools used for performance management. Even so, these are not done consistently but done based on Supervisor ratings and used primarily for such personnel decisions as promotions and other incentives. In view of the general absence of systematic planning, performance goals are not set and therefore, performance criteria are vaguely defined. There is no follow up to check if individual employee’s performance objectives have been met or not.

ii. Career path development

There is a policy on career path development and a final draft of scheme of service which has not been approved by the Council and Minister. Although this has not been approved, the current salary structure for the GHS is in line with this scheme. Booklets of the promotion policy have been developed, printed and distributed to the Regions but further dissemination to the lower levels is uncertain.
iii. Dissemination of Information

There is lack of dissemination of information on policies to the lower levels. Cultural orientation coupled with poor remuneration leads to nepotism, corruption and social injustice.

2.7 Conclusion

This chapter highlighted the contextual factors both from literature and from the health sector of Ghana. It can be seen that in order to understand HRM/D in health in Ghana, it is imperative that one understands the environmental context first. As stated by Aryee (2004), it can not be understood without the context as management is not done in the vacuum. For one to also understand managers and the way they manage, one also needs to take Hofstede and Hofstede’s (2005) work which states that the nature of management skills is such that they are culturally specific: a management technique or philosophy that is appropriate in one national culture is not necessarily appropriate in another.
CHAPTER 3: Literature Review

3.1 Introduction
This chapter focuses on empirical evidence from the literature in order to undertake research into what constitutes effective HRM/D as it relates to HRM/D implementation by Metropolitan, Municipal and District Directors of Health Service (MMDDHS), who are the frontline managers (FLM), towards quality health service delivery in Ghana. The focus of the chapter is to differentiate between HRM and HRD to generate evidence on the issues faced in devolving HRM/D to frontline managers and to lay a basis for the development of a conceptual model as described in Chapter Four. As a result of the issues highlighted in the introductory chapter, this chapter reviews relevant literature on effective HRM/D in line with empirical evidence in other organisations including health with a focus on describing the strategic context for devolving human resource responsibilities to FLM. Although the majority of analyses of HRM/D models are not in health organisations, Hyde et al. (2006) admit that they are still particularly relevant to HRM in the NHS.

Thus, the chapter is divided into four sections. First, the chapter focuses on literature on the differences and similarities between HRM and HRD and justification for their merger in the study. Next, selected literature on the definition of the concepts of ME, HRM/DE are reviewed to give an insight to what has been done so far in the area so as to provide an understanding of the phenomenon. Thirdly, literature on the role of FLM and devolved HRM/D functions is reviewed. The last section reviews literature on competence.

3.2 HRM and HRD
These two terms have been viewed by several researchers to be controversial and boundaries difficult to draw. For instance, Watson et al. (2007) quoting other sources assert that HRM and HRD have grown up as distinct fields of study using separate theories and practices. Relationships between line managers mainly practising either HRM and HRD are arguably changing (Gibb, 2003) and becoming more fused, despite continuing debate about the focus of HRM (Budhwar, 2000) and scope of HRD (Garavan et al., 1999). In Watson et al. ’s view, in defining the connections between HRM and HRD, the relationship has been dubbed “ambiguous and elusive”. Historically, the literature on these two areas largely treats HRM
and HRD separately (Ruona and Gibson, 2004). Thus, this section explores the literature for HRM and HRD in turn before the line managers’ responsibility for the two are explored.

Haslinda (2009), states that, in order to examine how HRM and HRD are different, it is pertinent to examine and understand the definitions for HRM and HRD. As the list of definitions are inexhaustible and cannot all be provided in this study, the study only provides definitions from limited perspectives first as a way to establish the differences and similarities. These similarities will then be the justification for the study merging the two into one as human resource management and development (HRM/D).

3.2.1 HRM

Researchers including Beardwell (2007), Boxall and Purcell (2003), Bratton and Gold (2001), Budhwar (2000) Gibb (2003) HRM Guide (2008), Legge (1995), Lundy and Cowling (2003), Maxwell (2008) and Storey (1995) state HRM has been subject to considerable debate in Britain and in the USA where the term originated. Specifically, the HRM Guide (2008) posits that many people find HRM to be a vague and an elusive concept – especially as it appears to have a multiplicity of meanings. Therefore, the guide states that “pinning down an acceptable definition can seem like trying to hit a moving target in a fog”. In the same vein, Storey (1995), noted that the concept is shrouded in managerial hype and its underlying philosophy and character is highly controversial because it lacks precise formulation and agreement as to its significance. Maxwell (2008) also noted the contentious nature of HRM as a subject in industry and academia since its emergence in the UK in the 1980s. Other writers including Boxall and Purcell (2003), Legge (1995) and Lundy and Cowling (2003) in an element of the contention wonder whether there is a separation between the theory and practice of HRM. This confusion reflects the many and different interpretations found in articles and books about HRM. These vary from a short and simple definition to a lengthy and comprehensive description. Whilst some define it to include the development of the individual, others link it to the achievement of an organisation’s objectives. Below are sampled varied definitions from literature reviewed.

HRM according to Bratton and Gold (2007, p7) is;

“a strategic approach to managing employment relations which emphasises that leveraging people’s capabilities is critical to achieving sustainable competitive
advantage, this being achieved through a distinctive set of integrated employment policies, programmes and practices.”

A second definition by WHO (2007), is that;

“HRM can be summed up as the integrated set of roles, functions, decisions, systems and processes in an organization that meets the needs and supports the work performance of employees in order to accomplish the mission, goals and strategies of the organization”.

Armstrong (2006, p3) simply defines HRM as:

“employing people, developing their capacities, utilizing, maintaining and compensating their services in tune with the job and organizational requirement” (p3).

Again, according to Haslinda (2009, p180), HRM is best understood as the “process of managing human talents to achieve organization’s objective”. In the latter’s view, this process of managing human talents includes the process of recruitment and selection, compensation and benefits, labour and industrial relations and also the management of employees’ safety and health in organizations.

A final definition by McCourt and Eldridge (2003, p2) is that “HRM is the way an organisation manages its staff and helps them to develop”.

3.2.2 HRD

The debate about the scope of the HRD concept is similar to HRM (Harris and DeSimone, 1994; Harrison, 1997; Stewart and McGoldrick, 1996 and Torrington and Hall, 1998). Two problems highlighted by Garavan et al. (1999) which are immediately encountered when one starts to survey research and literature on HRD are the definition of research and literature on HRD and that of the boundaries. Consequently, HRD, as a concept, in the latter’s view, is both complex and problematic. Definitions differ according to the perspectives adopted by different writers (Garavan, 1991; Harrison, 1997; Stewart and McGoldrick, 1996). In Garavan’s view, the difficulty in defining HRD is also seen in the way HRD can pursue a wide variety of agendas and serve a wide range of purposes. Accordingly, the latter posit that much of the literature is perspective rather than theoretical/empirical in nature and is written from the perspective of the medium to large scale organisation that possesses the expertise and resources to invest in HRD. Owing to this, they recognise that much disagreement exists
about what constitutes HRD and the common usage of the term leads to the exclusion of important contextual factors.

Due to the confusion in definitional difficulties, Reed and Barrington (1997) admit that there is a general lack of definitional precision resulting in some critics abandoning the search for a unitary definition and instead focusing on sets of dualisms. Generally the definitions emphasise planned learning activities, whilst others put emphasis on the target of the learning process (Stewart, 1999) and others still on a variety of interpretative dimensions of HRD (Lee, 1996) or the menu of strategies that come within the term HRD (Harrison, 1997). Some reviewers discuss the concept in relation to corporate and strategic thinking (Garavan, 1997), while the more traditional discourse is an action oriented one, placing the emphasis on the delivery of learning events (Buckley and Caple, 1995; Reed and Barrington, 1997).

Garavan et al. (1999) agreeing with the latter, postulate that perhaps due to the futility of finding some form of acceptable and suitably comprehensive definition of HRD, commentators such as Stewart and McGoldrick (1996) advocate the identification of sets of dualisms that may help explain what HRD is about. In the latter’s view, such a dualistic perspective is ultimately perhaps more fruitful than attempting neat definitions.

Haslinda (2009), also accenting to these definitional difficulties highlights other numerous definitions of HRD that have been proposed by researchers and writers. These definitions varied from the perspectives of the individual researcher or theorist to those by country. In addition, theorists have even tried to define HRD from a global and international perspective. Indeed, many definitions have been suggested. Desimone, Werner and Harris (2002, p2) define HRD as “a set of systematic and planned activities designed by an organization to provide its members with the opportunities to learn necessary skills to meet current and future job demands”.

However, Garavan et al. (1999) have acknowledged that despite the recent progress in wide ranging research based literature on HRD, HRD as a concept, model, approach discourse or set of practices remains unclear. The latter, however, outlined a number of dimensions among others which emerge from an analysis of the literature as follows:

- HRD is intrinsically related to overall business strategy and competitive advantage.
• HRD is conceptualised as an investment in human resources capability rather than an employment cost.
• HRD is concerned with change at all levels both organisational and personal.
• HRD is concerned with identifying and enhancing the core competencies required at each level to meet its present and future objectives.
• HRD is concerned with organisational and individual learning.

For the purpose of this study, author combines the definitions of McCourt and Eldridge and those of Armstrong, WHO and Haslinda as above. These definitions highlight the idea of helping the individual to develop and also link HRM and HRD to the achievement of an organisation’s objectives. By combining these definitions, the author seeks to merge the HRM and HRD as HRM/D in line with McGoldrick and Stewart (1996). The latter repositioned HRD and described HRD’s function as supplementing HRM rather than supporting. Thus, a parallel pathway also known as the parallel nexus of HRM and HRD was introduced. This is because of their similarity and emphasis on the elements of corporate strategy. The parallel pathway is usefully understood by Fig. 3.1. HRM/D is therefore defined to be the coherent approach to the management of staff in relation to the organisation’s objectives.

3.2.3 Similarities between HRM and HRD and reasons for merging the two concepts for the study.

The difficulty in trying to delineate HRM and HRD functions have been a long standing debate as outlined above and which has been described by Stewart and McGoldrick (1996) as a nexus. However, Harrison (1997) argues that the HRD literature is now “more strategically focused and better integrated with parallel fields of HRM, business strategy and organisational learning”. This indicates how similar the two concepts are when it comes to trying to separate the responsibilities for the two. This therefore emphasises the similarities between the two more their differences. These similarities can be found in the functional areas (Harrison, 1997; Hutchins and Wang, 2008; Lees, 1992; Storey, 1989), models (Wright and McMahan, 1992), competitive advantage arguments (Pfeffer, 1999, Porter, Storey, 1999), organisational contexts and environmental factors (Jackson and Schuler, 1995).
Hutchins and Wang (2008) on similarities between HRM and HRD functional areas, state that learning and performance interventions are also routinely coupled with other HRM responsibilities such as managing emergency compensation. Another functional area is the employment relationship which can be likened to the recruitment and selection function in HRM. The learning process which has been described by Garavan (1999) as the primary focus of HRD is equated to the individual management and staff development using the planned, unplanned, haphazard and accidental processes suggested by the latter for this study.

The models of HRM and HRD are also similar as they both employ organisational/strategic theory, specifically systems thinking and both classical and scientific management theories. Both concepts also have links with economics, sociology, and psychology and are again underpinned by organizational contexts and environmental factors. The functional performance model has a strong focus on the knowledge, skills, and attitudes of individual employees as argued by Harrison (1997), Lees (1992) and Storey (1989). These have been recently highlighted by some reviewers to have such alternative purposes to include the reinforcement and propagation of skills and attitudes valued by top managers. There is also the assumption that HRD is motivational and encourages commitment and retention and therefore represents a form of reward (Lees, 1992), a scenario where HRD provides a safety valve for employee anxieties (Stewart and McGoldrick, 1996) or that HRD represents a major socialisation mechanism available to organisations (Reed and Barrington, 1997). All these can be likened to the competencies of managers and the rewards management in HRM in the study.

Figure 3.1 Parallel pathways of HRM and HRD (Developed from McGoldrick and Stewart, 1996)
From the descriptions and definitions above, the author agrees with the nexus argument between the two terms due to their interwoven nature. Thus, the above have justified why this study has combined the two as HRM/D to look at their effectiveness within the health sector of Ghana. This study thus focuses on the roles of HRD and HRM in recruitment and selection, staff development and performance improvement, providing rewards systems as a way to explaining HRM/D effectiveness and the link of these to providing quality care in the PHS. Therefore the definitions would be taken to include both terms and therefore has the acronym of HRM/D. Having defined and distinguished between HRM and HRD, the next section presents the definition of the remaining concepts of ME, HRM/DE and competence.

3.3 Definition of other concepts

Jackson and Schuler (2003, p51) state that, much of the confusion in organisational research has been because the focal construct has not been clearly defined. For this reason, the definition of terms would be outlined as part of the literature review. The terms defined in this study are management, effectiveness, competence and human resource management/development effectiveness. Owing to these admissions, management and effectiveness are defined separately first and then the two are then defined together in order to move towards a conceptual understanding of ME in this study.

3.3.1 Management

Management has received several definitions from the 1900s to date and as such not all can be highlighted in this study. A few of them spanning the various generations are however, worth examining. First, is the definition by Fayol (1916) who views ‘to manage’ as to consist of the traditional functions to forecast and plan, to organise, to command, to coordinate and to control. Hitt et al. (1979) also describe management to be the integration and coordination of resources in order to move effectively towards desired objectives. Again in 1984, Koont and O’Donnell say managing is an operational process initially best dissected by analysing the managerial functions and these are planning, organising, directing, staffing and leading and controlling. Next, is the definition by Handy (1999, p322) who sums up the new relationship in discussing the role a manager has to grapple with to comprise key variables such as interpersonal, informational and decisional roles.
Then, is the definition by Cole (2004, p4), which links management with organization theory. Management in Cole’s view is no longer but rather seen as the controlling factor in work organizations. Instead it is seen as a function of organizations. Its task therefore is to enable the organization’s purpose to be defined and fulfilled by adapting to change and maintaining a workable balance between the various, and frequently conflicting pressures at work in the organization. Thus, Cole defines management as a “social process which consists of ...planning, controlling, coordinating and motivating”.

This last definition would be adapted as it corresponds with the thinking in this thesis which aims to examine the management function in line with organisational goals and the external and internal factors which influence the management of human resources in the health sector.

3.3.2 Effectiveness

Various authors including Brodie and Bennett (1979), Flanagan and Spurgeon (1996) and Hitt et al. (1979) have either articulated the controversy or differences of views exist over the meaning of effectiveness and its translation into the managerial context. In their view, effectiveness is to signify the relationship between performance and task objectives, between achievement assessed against goals and purposes. A dictionary definition in Brodie and Bennett (1979) is in terms of results or consequences, bringing about effects in relation to a purpose, giving validity to particular activities. Drucker (1974) expressing this in his own special way differentiates between effectiveness and efficiency. In his view, efficiency is doing things right and effectiveness is doing the right thing, “even the most efficient business cannot survive, let alone succeed, if it is efficient in doing the wrong things, that is if it lacks effectiveness. Summing up, the latter concludes that effectiveness is the foundation of success – efficiency is the minimum condition of survival after success has been achieved”.

Renu et al. (2004) state that effectiveness is best seen as something a manager produces from a situation by managing it appropriately, producing the results or meeting the targets in every sphere of the activities of organisations.
For the purpose of this thesis an operational definition of ME based on the contingent nature of ME in line with Flanagan and Spurgeon (1996, p26) and Willcocks (1998, p13) and Renu et al. (2004) is given as:

“Any set of managerial actions believed to be optimal for identifying, stimulating and utilising both the internal and external resources towards sustaining over the long term the effective functioning of the organisation unit for which a manager has some degree of responsibility”.

However, these actions would focus on the management of HRH. Next, the definition and determinants of ME are reviewed.

### 3.3.3 Managerial Effectiveness (ME)

The thinking of writers cited earlier (Flanagan and Spurgeon, 1996; Garavan and McGuire, 2001; Shipper, 2000; van der Velde et al., 1999) who support situational and “contingent” views of management and leadership, state that due to the contingent nature of management, in order to understand ME, one must first attempt to define it. Given the contingent nature of ME noted in literature, they contend that as a variety of definitions exist, an absolute or exclusive definitions are not particularly useful.

Brodie (1979) in an attempt to define ME also agreed with the difficulty with its definition and therefore followed a similar line of defining management which also cannot be reached unless there is an assumption of a theory of organisation which will outline what needs to be done to make that organisation viable and to fulfil its function. In line with this, op cit has defined ME as the relationship between performance and task objectives and between achievement assessed against goals and purposes within the constraints imposed by the manager himself and his position, the organisation and the socio-economic environment.

On more research-based writing on ME, Brodie and Bennett (1979) again offer models of effectiveness based on literature, as a dual function of both organisational and individual characteristics of variables.

Again, the work of Analoui (1998) concerned with the characteristics of ME in terms of HRM/D, suggests attention to be paid by managers to the nature of the complex relationships amongst and between the subsystems of their organisations, and their organisations and other influential external forces in their market. Thus, they argue that managers should understand
that their HRM and HRD policies and procedures should be made contingent upon the circumstances in which they find themselves, often without prior warning.

Also, Willcocks (1998) examines the concept of ME in a NHS hospital Trust utilizing the contingency perspective proposed by Bennett and Brodie (1979) and a contrasting theoretical perspective of political theory. He concluded that in analysing ME, it is necessary to take account of the political configuration of a large organization like an NHS Trust; the differences in power, individual or group interests, values, assumptions and expectations.

Finally, Renu et al. (2004), despite acknowledging the importance of ME for the survival and growth of the organization, still have difficulty in defining ME in concrete terms. In their view, decisions about effectiveness are bound to be situational and contingent upon the definition and perspectives of those making the judgement. Hence they state that based on literature, ME has been studied with three perspectives: Traditional/conventional, organisation level, competency based and the individual level competency based perspectives.

### 3.3.4 Determinants of ME

Earlier studies on ME identified some factors which determined ME. Foxley (1980) in her study identified the factors which contribute to ME and grouped these into four major categories as - personal characteristics of the individual manager, managerial functions, or the managerial process, the components of the organizational environment and the outcomes or results of the managerial process. Foxley however admitted that all factors are interactive as they help to determine either managerial effectiveness or ineffectiveness.

In another study on the personality type of ME, Renu et al. (2004) supported this finding of personality type and the work environment. The two perspectives in their view can be divided further into three perspectives of ME to include the traditional/conventional perspective (the ability to set and achieve goals), organisational level based competency (accounts for both external and internal influences on the organisations) and individual level based competency (to develop transferable generic management skills that are applicable across different circumstances). However, this competency-based perspective on ME has been heavily criticised on the ground of the contingencies and the contexts.
From the arguments reviewed from literature regarding the three perspectives, it is apparent that effectiveness is a multi-determined concept depending on the manager, his position, the organisation and the socio-economic environment. From these reviews, the second perspective as outlined by Renu et al. is adopted for this study as it appears to suit the object of this study.

### 3.3.5 Human Resource Management/Development Effectiveness (HRM/DE)

The definition of HRM/DE for this study is the merger of the definitions for HRM, HRD and Effectiveness. Thus HRM/DE is thus defined in line with Armstrong (2006), Flanagan and Spurgeon (1996), Haslinda (2009), McCourt and Eldridge (2003) and WHO (2007) and summed up by Huselid, Jackson and Schuler (1997) and adapted as;

> “any set of HRM/D policies and practices believed to be optimal for identifying, stimulating and utilising both the internal and external resources as well as to provide members with learning opportunities to update skills towards sustaining over the long term the effective motivation, commitment and performance of staff to meet organisational goals”.

### 3.4 Empirical evidence on HRM/DE in organisations

As stated in Chapter One, there has been a great deal of empirical evidence as to the HRM-performance link. The types of HRM/D practices that make HRM/D effective and lead to organisation performance are expatiated in this chapter. The notion that there is a link between the way people are managed has an impact on performance – either at an individual or an organisational level – has long attracted the interest of both academics and practitioners. Egger et al. (2001) and Filerman (2003) admit that the issue of effective HR managerial behaviours and competencies related to organisational performance is not new to the management literature as already highlighted above and that there is a growing body of empirical evidence to support the assumption that organizational effectiveness is directly tied to ME. Though it was seen in its early days as little more than a welfare function designed to act as an intermediary between managerial and non-managerial staff, HRM/D is now perceived as a key factor for improved organisational performance (Hyde et al. (2006).

### 3.5 Devolution of HRM/D functions and the role of Front Line Managers (FLM)

This section reviews literature on the role of FLM in making devolved HRM/D functions effective within the health sector reforms as discussed in Chapter One. This is to highlight empirical evidence on how FLM have been viewed in performing such roles. In line with the
restructuring of organisations and the devolution of HRM practices to FLM, several researchers have debated the issue since the 1980s. Brewster et al. (2003) and Mayrhofer et al. (2004) note that HRM is not left untouched by these developments and that the move towards assigning more decision making power to line management has its HR facet. Power et al. (2010) opine that FLM assuming an increased involvement in HRM is not a contemporary phenomenon although the practice of devolving HRM responsibilities to line managers has received increased attention in management and HRM literature in recent years (Budwhar, 2000; CIPD, 2006; Hall and Torrington, 1998; Larsen and Brewster, 2003; Renwick, 2000; Watson et al., 2007). Larsen and Brewster (2003) state that within the last decade, the issue of devolving HRM to line management has been the focus of both academics and practitioners in the UK and Europe. Various reasons for this devolution have been cited, including restructuring, downsizing, and an increased need to focus on encouraging employee inputs for improving their competitive edge (Cunningham and Hyman, 1999; Gibb, 2003; Renwick, 2000).

In the health sector of Ghana in particular, research on the devolution of HRM to line management is limited. However, Antwi et al. (2007), having recognised the important role the decentralised level staff can play in the HRM in Ghana, called for the promotion of an integrated approach to organisational learning that would require the development of three inter-related human resource capabilities, including: human capital (knowledge, skills and competencies) as a way for improving core competencies of staff and management in decentralised local governments.

Young et al. (2010), state that many studies have demonstrated the importance of different levels of management within the adoption and integration of HRM in organizations. Mayrhofer et al. (2004) accenting to this assertion, posit that a common theme in much of the management literature and practitioner rhetoric is the replacement of centralised, bureaucratic and hierarchical structures by more flexible, decentralised, project oriented forms where information networks and the culture ‘glue’ are more important than formal rules and regulations. Mayrhofer outlines four aspects which are linked with this as follows: First, is that companies retain only the core competencies within the firm while outsourcing most low value-added activities. Second, FLM are provided with greater autonomy. Hamel and Prahalad (1994, p290) add that FLM are allowed “to design their own jobs, fix their own
processes, and do whatever it takes to satisfy a customer”. Hence, these new organisational forms question the degree to which responsibility between line and staff functions is shared (Mayrhofer, 1999). Third, there is much less emphasis on hierarchies which generally become much flatter. Fourth, formal and informal information networks bind the autonomous units together.

In Mayrhofer et al.’s (2004, p131) view, “middle and lower level managers are important because of their understanding of their employees and employee competence and their potential to impact on employees’ behaviour”. Thornhill and Saunders (1998) agree that these managers play a crucial role in the development of employee commitment through their leadership skills, and their ability to communicate, motivate and manage change. Mayrhofer et al. (2004), admit that this issue is not new as it has been discussed in the literature. Thus, their argue is that line managers play a key role within major areas of HRM like recruitment and selection, retention, development, compensation and lay off. Due to the closeness of line managers to the employees and their first hand insight, responsibility should not be left solely to human resources specialists. Based on this argument, Schuler (1990, p51) state that HR specialists are moving into a role of coordinator and catalyst for HR related activities of line managers – as “management team player(s) working (jointly) with the line manager solving people-related business issues”.

Despite this realisation, Gibb (2000) and Purcell and Hutchinson (2007, p6) argue that the role of FLM in the causal chain between HRM and organisational performance has largely been ignored over the last 15 years because of a reliance on single respondents in multi-employer research projects while Young et al. (2010) noted that many researchers suggest that there are difficulties with the devolution of HR activities. The argument on this difficulty has been tackled by a number of researchers which ranged from lack of competency of line managers (MacNeil, 2003; Renwick, 2003), inconsistency of practices (Currie and Proctor, 2001; McGovern and Stiles, 1997) having negative effects on employees’ commitment (Thornhill and Saunders, 1998) among others.

Consequently, Cunningham and Hyman (1999) postulate two hypotheses for personnel function to be devolved to either an internal or external body. Both views point to the potential or threat to the function. The optimists point to the need for a professional discipline to orchestrate the vast changes in organisational structure and to catalyse the resources
demanded to meet contemporary market conditions, such that a senior personnel specialist confidently predicted that: “today, the personnel function has greater opportunities than ever before” (Allen, 1991 p42). Two assumptions underpin the optimistic hypothesis. The first assumption is that by relegating the routine activities of selection and recruitment, discipline and dismissal, appraisal, counselling, pay level determination, the function will be liberated to concentrate upon strategic activities associated with a personnel transformation to “human resource management” (Hutchinson, 1995; Tyson and Fell, 1986). In their view, by devolving these traditional personnel activities to line managers, contribute to organisational effort through enhancing the capabilities of line managers and by raising staff commitment (Fonda and Rowland, 1995; Gennard and Kelly, 1997). The second assumption developed from this restructuring of personnel activity. A number of research studies indicate that lack of competence of line managers in dealing with devolved personnel matters will help to ensure a continuing organisational presence for personnel specialists.

In line with the optimist hypothesis, Mayrhofer et al. (2004) admit that the assignment of HR activities to line managers’ task portfolio increases their effectiveness. Given that line managers have the most immediate and up to date information about the employees’ competence and represent the company to the employees, providing them with authority and responsibility to cover all or at least many crucial aspects of HR work gives them a greater impact on the employees’ behaviour. Therefore, Kennoy (1990, p7) asserts that modern HRM has two components as follows:

“... the strategic business policy decision-making activity designed to ensure a coherent and integrated approach to the overall management of the organization ... and the generic responsibility of line or general managers for the day-to-day 'people-management' activities” is added.

Thus, both elements should contribute to increasing organisational performance. In particular, Cunningham (1995) states that HRM represents a catalyst for change for the supervisory function as supervisors can become a “minimanager” and may be expected to shoulder additional and extensive responsibilities in employee relations. Again, the latter (1999, p9) highlight the role of line managers as in promoting an “integrative culture of employee management”. Also, Thornhill and Saunders (1998) signal the role of line managers in securing employee commitment to quality, while increased productivity has also been asserted as a basis for devolution of HRM (IRS Employment Review, 1995).
Additionally, a recent Chartered Institute of Personnel and Development (CIPD, 2010) report on the people and performance research found that FLM played a pivotal role in terms of implementing and enacting HR policies and practices. They found that where employees feel positive about their relationship with their FLM they are more likely to have higher levels of job satisfaction, commitment and loyalty which are associated with higher levels of performance or discretionary behaviour. Line managers also play the strongest part in structuring people’s actual experience of doing a job. Another CIPD (2005) report indicates that line managers’ involvement in coaching and guidance, communication and involvement has a positive influence on overall organisational performance.

Additionally, Renwick (2003, p262), notes that inherent in the concept of HRM is a “centre-stage” role for line managers. Renwick (2003), drawing on other researchers’ work, identifies that a partnership approach to HR requires the integration of HR activities into the work of line managers and that a real partnership approach requires a “triad” approach between HR specialists, line managers and employees.

Despite being critical about the use of the “partnership” concept in advancing employee well-being, Renwick (2003), admits that as organisations – particularly those in the service sector – need employees’ input to help achieve human capital advantage, therefore involving line managers in HRM has an organisational value.

Similarly, the involvement of line managers in HRD has also been the subject of academic debate and organisational challenges. In line with the optimist view on HRD. Sluzdziene (2005) argues that the devolution of HRD policies and practices to line managers is one of the key enabling characteristics of the SHRD system. The fundamental assumption is that line managers can drive HRD policies and practices, which are designed to achieve the organization’s strategic objectives through identifying, developing and supporting the appropriate knowledge, skills, commitment, and performance in employees. In her assertion, the processes of learning and working are becoming very much intertwined and on the job learning is stimulated as much as possible. Informal learning is also considered as a very important learning activity. This means the changing view of learning in the context of SHRD has far-reaching implications for line managers who are expected to manage the workspace as a place to fit learning. Since HRD activities are increasingly devolved to operational managers the actual training and development activities are being carried out by
line management and employees, while HRD specialists monitor the quality and provide assistance. Based on Nonaka and Takeuchi (1995), knowledge is created by line managers at the intersection of the vertical and horizontal flows of information within the organization and line managers should be able to identify the knowledge gaps and communication problems. Furthermore, in Slugzdiniene’s view, line managers are a key link in the learning process within organizations, and a channel through which the knowledge is transferred. It is suggested that line managers are in a very powerful position to block or support implementation of HRD strategies and activities.

Gibb (2000) again, postulates that in the UK, the emphasis on the role of line managers in Learning and Development (L&D) at work has for some time been acknowledged as an important aspect of L&D at work. On the positive side, Gibb (2000) suggests that the greater involvement of line managers as developers can provide mutual satisfaction for organisations, for managers and for learners. On his part, greater line manager involvement in L&D is appropriate for both creating and sharing knowledge and creating environments for effective performance. He however, emphasised the need for further reviews and analyses, empirically based to explore both aspects of this important and complex aspect of line managers’ involvement in HRM. Also, Harrison (2002) emphasises the need to include line managers in planning for L&D, and to “hand over primary responsibility to the line”.

While the above represents the positive or optimistic aspect of line manager involvement, the problematic or pessimistic side has also been outlined by some of these authors. The pessimists’ view on the contrary, however, is that owing to personnel’s longstanding weakness as a management function and, indeed, which have been supplemented in recent years by newer threats to its independence or viability, it is claimed that the devolution of responsibility makes personnel’s contribution to business success even more difficult to measure (IRS, 1995, p7). Based on this pessimist’ view, Keenoy (1990) argues:

“If line managers are to be effective in running team briefings and performance related reward systems and if they are to develop more participative managerial styles, they – just as much as workers – will need more not less support from personnel managers” (p7).

Cunningham and Hyman (1999), suggest challenges lie not least in the relationship between line managers and HRM specialists rather “the ability and willingness of line managers to
carry out HR tasks properly” (Renwick and MacNeil, 2002, p407) and line managers’ knowledge of company policies (Bond and Wise, 2003). Whitaker and Marchington (2003) also found tensions between line managers’ general functions and HR responsibilities. For example, they found that HR took second place in relation to other business needs of sales and marketing and finance, and Renwick (2003) found issues around lack of time, inadequacies in ability and distraction from general managerial focus and tensions between HR specialists’ expectations in relation to completion schedules of HR tasks.

In clarifying the role of line managers in HRD, Heraty and Morley (1995) present the difficulties in drawing the line between HR specialists and Line managers’ domain for the activities of identification of training needs, deciding who should be trained and undertaking direct training should fall within. Another issue is that while line managers have been identified as “one of the key stakeholders with the HRD process” (Heraty and Morley, 1995, p31), difficulties in securing line manager acceptance of HRD responsibilities have been evident (Ashton, 1984). Research has identified factors that may enable or inhibit the take-up of line manager responsibility for HRD.

Contributing to the pessimist’s view, Young et al. (2010), add that for example, while operational manager involvement in HR activities is possible, practices vary considerably in the consistency of implementation across the organisation which may distort, and even undermine the contribution of HR practice to organizational effectiveness. Furthering this argument, the latter state that the knowledge and ability of operational managers to take on HR responsibilities is often questioned. Renwick (2003), suggest a lack of understanding of how to enhance the willingness and ability of operational managers to take on responsibility for HR issues. Thornhill and Saunders (1998) found that managers left to inspire, develop and encourage employees without clear strategic direction have a significant negative effect on employees’ commitment, flexibility and quality of work.

Some of the pessimists’ arguments are attributable to the rewards systems in some organisations. For instance, Badawy (1995) argue that when a technically competent front line staff member is rewarded with a promotion to a line manager position, there is a tendency for them to operate in a senior technical, rather than managerial role. This is further aggravated by the lack of human and conceptual skills held by front line staff, for example the absence of the ability or desire to have difficult discussions with subordinates. The end
result of such rewards to front line staff is an overall drop in efficiency, and staff who are promoted beyond their level of competence (Robbins, *et al.*, 2008). Others concluded that in order to prevent the use of promotions to managerial roles as rewards for technical staff, it is necessary to take a look into the reward strategy in use within the organisation (Hartel *et al.*, 2007).

In line with the concept of decentralisation/devolution in most countries, the involvement of line managers in HRM/D has been a subject of debate as above. While some authors are positive about line managers’ involvement or responsibility for HRM/D, others have contrary views. However, to conclude in Gibb’s (2003) opinion, there is a case for seeing the trend as having advantages and disadvantages. This means that there is a case both for seeing greater line management involvement with L&D as both a phenomenon of minimal significance and an important area of change; it depends on the organisation, the context and the broader HRM issues involved in these. There are many factors that determine or influence the behaviour and performance of health-sector managers. These determinants include social, cultural and motivational aspects of inter-human dynamics and organisational behaviour. Thus, Antwi *et al.* (2007), having recognised the important role the decentralised level staff can play in the HRM in Ghana and noting the lack of capacity therefore calls for the improvement of core competencies of staff and management in decentralised local governments.

In order to make this study both practical and feasible, a clear contextual boundary was introduced in that it is concerned specifically with the immediate context surrounding its core concern, which is the consideration related to competency and effectiveness of district level managers in HRM/D and performance. The next section looks at HRM/DE and competences in organisations.

### 3.6 HRM/DE and managerial competence

Competencies, according to Ennis (2008), have become the code words for the human resources and strategic management practices of recruiting, selecting, placing, leading, and training employees and evaluating employee performance about two decades ago. This enthusiasm of organisations to adopt a competency framework in their view has led to its employment of a plethora of uses and purposes often without critically assessing the wider implications. Armstrong (2001) asserts that the reason for the growing literature in this area
is because it is about performance. It is directly concerned with the factors contributing to high levels of individual contribution and therefore organisational effectiveness. Again, this enthusiasm has been justified to be due to the rapid response to change, accompanied by increasing cost-consciousness and the realisation of the need to develop managers which has forced organisations to seek quick fixes (Anatocopoulou and FitzGerald, 1996). On furthering this point, Ramlall (2002), posits that competing in today’s turbulent global economy provides additional challenges to the HR function in creating the expected value to create and sustain competitive advantages. Therefore in his view, to function effectively, HR professionals must master the necessary competencies but however, admits quoting Brockbank, et al. (1999) that mastery of HR knowledge comes from knowing the concepts, language, logic, research, and practices of HR. Furthermore, mastery of abilities comes from being able to apply the knowledge to specific business settings.

3.6.1 Definition of Competence

On the definition of competency, Abraham et al. (2001), Anatocopoulou et al. (1996) and Garavan and McGuire (2001) agree that different academics and practitioners refer to competencies differently. For instance, Abraham et al. state that Prahalad and Hamel (1990) treat competencies of corporations as an entity, while others including Boyatzis (1982), Burgoyne (1989) and Collin (1989) treat competencies of employees. Employees’ core competencies also referred to as personal competencies (Burack et al. 1997; Greengard, 1999; Reagan, 1994). On the other hand, when the competencies of managers are being discussed, the term “managerial competencies” is frequently used (Abraham et al., 2001). Anatocopoulou and FitzGerald on the other hand view the understanding of competency to be divided between the Universalist and context specific researchers whilst Garavan and McGuire suggest that these distinct perspectives may be labelled “traditionalists”, “inventors” and “scientists”. For traditionalists, the use of competencies is based on the behaviour of the most successful managers or employees in the organisation. They view successful job performance in terms of the speed of career advancement. They advocate the use of the characteristics of quickly promoted individuals as the basis for the development of an organisation’s competency model. Inventors focus on predicting what an organisation and its attitudes will be in the future and consider this to be the most effective way of identifying appropriate managerial behaviours. The outcome of the perspective is the creation of competency lists based on imaginary future organisations.
The scientific perspective places emphasis on identifying, measuring and developing behaviours, which will distinguish individuals, who continuously outperform others. This perspective advocates that there are generalisable high performance competencies that appear to distinguish high performance from average performing employees. In the latter’s view, many descriptions of competency do not consider the characteristics of the human agent. In particular, they give little consideration to when competencies are used, how they are used and the moderating influence of personal characteristics on their usage. Sandberg (2000) uses the term “indirect descriptions of competency” to characterise a situation where the typologies advocated reflect the researchers’ own models rather than capturing employee’s notions or models of competence.

Based on the foregoing, it is therefore not surprising that there is a disagreement over the definition of competency similar to other concepts in management discussed earlier. Anatocopuolou et al. (1996) indicate that many definitions and perspectives have emerged over the years. In their view, this lack of clarity in the terminology is further complicated by a diversity of purposes. The latter have also criticised the use of management development quoting Burgoyne (1989, p58). The latter, thus queries;

“…if managerial competencies are simply treated as a tool-kit list, then this raises the question of who is the craft person and who is using the tools and what abilities do they apply to their use?”

They again criticised Fayol’s attempt in the use of Universalist’s standardising of managerial roles to describe the manager’s work and its related work using the four categories of planning, organising, coordinating and controlling. Another criticism which was directed at Dulewicz’s (1989, p58) study (which suggest that firm-specific managerial competencies represent only 30% of the total competencies basket, while the remaining 70% represent general requirements across different organisations) which led the latter to claim that: ‘with more and some unity of purpose, it should be possible to produce a universal model to explain the majority of middle and senior levels’. Supporting their arguments with earlier researches such as those by Stewart (1987, 1979), whose results demonstrated considerable differences in the nature and processes of managerial work in different functions and those of Kotter (1982) (who concluded that there is very low transferability from successful general managers from one organisation to another), she concluded that the fact that many organisations use the same technology to describe a set of managerial characteristics is not a
strong argument for claiming that it is possible to identify a set of universal management competencies.

Garavan and McGuire (2001) also share this view. Citing the epistemological and philosophical aspects, they note that the literature reinforces the general tradition of a positivist, quantitative approach; in particular the dual tendency to assume that there is an objective reality independent of and beyond the human mind and the de-contextualisation of the individual in the competency debate. Work is conceptualised as objective described in precise terms and it exists independently of these employees who accomplish it. Work and worker are essentially independent. In the latter’s view, one alternative, the phenomenological approach, has made only modest impact to date. Despite this modesty, they acknowledge phenomenology does postulate the view that our understanding of competence and competencies cannot ignore the internal organisational context, the role of the employee and their experiences of work. Thus they conclude quoting other sources that the emergence of a postmodernist lens to study competencies has some value. It is argued that postmodernism, by embracing chaos and complexity offers a coherent explanation to the unpredictable, uncertain and uncontrollable nature of the modern business environment. Free from the overarching ideological claims of positivism, it leaves open the possibility that competencies may need to be adjusted to take account of a range of contextual factors and as a result, competency frameworks may differ from one organisation to another.

Despite the plurality of definitional approaches and the use of competency approaches in educational and entrepreneurial arenas, Boon and Van der Klink (2001) suggest that the vagueness surrounding competencies seems not to hinder discourse on the topic. On the contrary, they posit that the strength of the concept lies in its complexity, serving to embrace educational and labour organisations, internal and external organisational experts and management and employee interests at the same time.

In Armstrong’s (2001, p300) view, the concept of competency was first popularised and developed through research by Boyatzis (1982) which established that there was no single factor but rather a range of factors that differentiated successful from less successful managers. This range of factors included personal qualities, motives, experience and behavioural characteristics under various headings. He therefore defined competency as:
“A capacity that exists in a person that leads to a behaviour that meets the job demands within the parameters of the organisational environment and that, in turn, brings about desired results”.

Competence of an individual as defined by Becker, Huselid, and Ulrich (2001) is the knowledge, skills, abilities, or personality characteristics that directly influence one’s performance. Thus the discussion in this study is limited to managerial competencies. Owing to the assertion that there is an increased emphasis on HR competencies as a means to increase HR’s effectiveness, this research study seeks to explore and understand which competencies are needed by MMDDHS for implementing the HRM/D function, determine if there is a relationship between specific competencies and particular responsibilities of MMDDHS; and determine the relationship among education, years of HR experience and competencies. In line with Garavan and McGuire (2001) phenomenologist view of competencies and Thomas and Mabey (1996) and Flanagan and Spurgeon (1996), this study reviews competencies with the lens of context specificity and one that takes into consideration the individual’s knowledge, skills, abilities and personal characteristics as that defined by Becker, Huselid and Ulrich above. The study thus explores managerial competencies from the phenomenological perspectives in line with the Critical Incident Technique (CIT) as by Flanagan and Spurgeon, (1996), Thomson and Mabey, (1996) and New (1996) which involves clarifying the differences between average and superior performers, interviews with the job-holder, supervisor or other relevant person, participants asked to describe particular job incidents, process is repeated a number of times, individuals must describe what behaviours were displayed, who was involved and the outcome. Then a long list is developed and this is further categorised into bad and good behaviours.

3.7 Conclusion
The chapter reviewed literature and empirical evidence on the differences and similarities for HRM/HRD. It also provided definitions for the key terms for the study. Third, empirical evidence on the role of FLM in devolved HRM/D functions was also reviewed. Finally, literature surrounding competence was also reviewed. By so doing, first the chapter provided justification for the merger of HRM/HRD as HRM/D for the study. Second the chapter in defining key terms for the study made it clearer for readers to understand and lastly in
highlighting empirical evidence on the roles of FLM in devolved HRM/D functions further broadened the understanding on how HRM/D functions should be effectively devolved to FLMs. Above all, the chapter laid the foundation for the development of the conceptual framework in Chapter Four.
CHAPTER 4: Building a conceptual framework on managerial effectiveness

4.1 Introduction

Chapter Three reviewed the relevant literature on human resource management/development and managerial effectiveness needed for understanding HRM/D. In addition, the chapter illustrated the importance of aspects of context and context specific measures as well as the importance of FLMs and competence in determining links between HRM/D and organisational performance. As a continuation of Chapter Three, this chapter offers a critique of relevant theories in order to build a conceptual framework for HRM/DE for guiding this study’s research design. With increasing attention to HRM/D within health care organisations all over the world in recent years, most studies conducted into the relationships between HRM/D and performance adopted varying theoretical aspects to develop frameworks for exploring this relationship. Despite this plethora of studies, there has been no consensus for a most preferred aspect. For instance, whilst some authors (Arthur et al., 1995) used HRM bundles to explore the links, Willcocks (2002) used social context of HRM. Wright and McMahan (1992) departed from this and focused solely on strategic HRM research. Yet still, Richardson and Thompson (1999) noted that there were three broad perspectives on the ways that HR practice contributes to business performance:

1) “Best Practice” – a set of HR practices can be identified, that, when implemented, will improve business performance.

2) “Contingency” – business performance will be improved when the best “fit” between business strategy and HR practices is achieved.

3) “Bundles” – specific bundles of HR practices can be identified that will generate higher performance in organisations; the most effective composition of these “bundles” will vary in different organisational contexts.

Due to this lack of consensus, Wright and Boswell (2002) noted the segregated different aspects of the field and called for an integration of both the macro and micro aspects of HRM/D as a unified framework to explore how interactions between them can lay a basis for more profound progress. Way and Johnson (2005) agreeing with the latter, add that the development of a theoretical SHRM framework must incorporate a multiple stakeholder perspective as the absence of a theoretical framework which explicates the primary linkages among organisational strategies, SHRM (HRM policies, practices and systems etc.) and
organisational effectiveness will produce limited insight into the process by which SHRM creates value and enhances organisational effectiveness.

Regarding organisational context of these studies, Buchan (2004), notes that very few of these studies were conducted in the health sector. Although he admits the positive relationship between HR practices and business performance, he contends that these studies focused on private-sector business corporations that cannot readily be applied to a public sector health system. Thus, he cautions that the one sector-specific issue has to be considered when looking at the implications of the current evidence base for HRM practice in the health sector. Again, another difficulty is that whilst health systems have been attempting to decentralise to improve efficiency, they tend to be characterized by a broad range of active stakeholders, a high level of direct and indirect governmental and regulatory intervention, and recurrent “top-down” attempts at reform. Above all, as health is also labour-intensive the proportion of total expenditure on staff is much higher in health than in most manufacturing industries and in many service industries (Buchan 2004).

Based on the above, this chapter sets out with the aim to identify a framework that will integrate the various aspects of HRM including multiple stakeholder perspectives as a means to explore the links between HRM/D and performance of the PHS of Ghana considering the unique characteristics of the sector. These unique characteristics of the latter are similar to what Buchan (2004) highlighted. First, the workforce is large, diverse, and comprises separate professional groupings often represented by powerful professional associations. Second, some have technical skills only meant for the health sector while others such as the administrative and support staff can be redeployed to non health sectors. Also, loyalty of technical staff (doctors, nurses, diagnostic personnel etc.) is to their profession and their patients rather than to their employer.

Thus, to develop this framework for examining the impact of HRM/D, this chapter is in line with Way and Johnson (2005) which and will review literature, integrate and extend several strong theoretical perspectives that address prior shortcomings in the HRM/D. To focus the research, the literature review is on organisational effectiveness issues such as, multiple stakeholder perspectives, horizontal versus vertical linkages. Then theories with relevance to the health sector characteristics are discussed and finally these two are integrated in an attempt to explain the primary linkages of HRM/D and performance in the PHS of Ghana.
4.1.1 Aims of the Chapter

The aims of this chapter are to:

1. Provide a theoretical insight into the effective management/development of human resources given the various conceptual perspectives introduced in Chapter Three.

2. Discuss the theoretical assumptions about the difficulty in identifying factors which directly or indirectly impact on HRM/DE as performed by managers.

3. Give an overview of the strengths and weaknesses of the theoretical perspectives based on empirical works to pave the way for developing a conceptual framework for the study.

4.2 Organisational Effectiveness

Way and Johnson (2005) quoting Meyer and Gupta (1994) state that organisational science research has concluded that organisational effectiveness is multidimensional. Thus, to use research designs that adopt a single or narrow perspective of organisational effectiveness are unlikely to explain or evaluate the primary linkages of SHRM research appropriately. Consequently, the literature that is reviewed for this study emanate from sociology, economics, management, and psychology with a focus on the different aspects of the field of HRM/D in context (Wright and McMahan 1992). These include management and organisational/strategic HRM/D theories. The management theories include the classical, neoclassical - human relations and contingency approaches. Both strategic and non-strategic organization theories are also reviewed. The strategic theories include the behavioural perspective, resource-based view (RBV)/human capital and open systems view. The non-strategic comprise the multiple stakeholder perspective, competency and resource dependence/political/institutional theories. In addition, the chapter reviews six context perspectives that illustrate how context links with individuals and groups behaviours. These include the internal and external environmental factors. Then, a critique of literature is presented as a prelude to the explanation of the conceptual framework for the study.

According to Ferris et al. (1998), the foundation of any field including organisation sciences is sound, theory-driven empirical research with the theoretical underpinnings as precisely specified as possible. However, over the years, researchers in management have been saddled with the confusion of which theories to use as well as how they should be classified. For this reason, the selection of theories for this study had to be considered carefully as suggested by evidence from Mamman and Rees (2007) who, quoting other sources, note that for some time management research has demonstrated that specific organizational attributes such as
strategy, structure and systems impacts on employees’ behaviour and organizational performance are important. Therefore, theories in management and organisation are reviewed.

4.3 Review of research on theoretical perspectives of management and SHRM theories

The search for a conceptual framework for HRM/D is as complex as its definition. The lack of consensus in the definition of the terms also applies to the theory. Hence, there is no consensus on a single theory that governs management and therefore HRM/DE. As an illustration of the above mentioned dilemmas on the role of theory, some writers (Ghoshal 2005, p76 and Schuler and Jackson, 2003, p50) have expressed concerns about the role of theory in HRM research. The former states that “… academic research related to the conduct of business and management has had some very significant and negative influences on the practice of management”. She therefore cautions that nothing is as dangerous as a bad theory and that bad management theories are, at present, destroying good management practices. A second caution is that intensive research in a particular field of research and propaganda thereof does not necessarily mean that the approach is correct. The latter, quoting Dubin (1976), assert that although the primary goals of theorist-researchers and practitioners may differ, a strong theoretical model has great value to both. Practitioners are primarily concerned with the accuracy of prediction of a theoretical model in order to guide their decision making; thus, an accurate theoretical model allows for better decision making in conditions of uncertainty.

With this caution in mind, therefore, the search for a theory to guide decision-making in HRM/D for quality health care, will be done based on the choice of a framework that will explain the links of organisational context and environmental factors to HRM/D and how these can be reviewed to establish the linkages in order to improve the role of the human resource function in the PHS. In order to make an informed choice, a number of research findings adopting different strategies would be highlighted to guide the decision.

The importance of HRM/D in the health sector as described previously demonstrated a significant gap between the rhetoric and actual practice. It is obvious that in the health sector, clerical and ad-hoc approaches to HRM/D take precedence over the strategic one and, as a consequence, people often remain just a potential source of advantage that is not effectively utilised. It may be argued that there are still many ways to achieve long-term human capital
advantage and high performance in developing countries and especially the PHS of Ghana despite this difficulty. However, the ability to do this may lie with the availability of a conceptually based but practical framework. It is in this light that this study has chosen to design a framework to guide the analysis of this situation. However, it must also be recognised that despite the numerous models designed by other HR practitioners and scholars, these general models may not feature the performance links that are specific to the context of the developing world and especially the PHS of Ghana. The challenge therefore has been to develop a framework to suit the specific context of the health sector in a way that makes it practical enough to be tested in describing the strengths and relationships between the key organisational variables and HRM/D practices. Such a framework could then serve both for learning and to strengthen the strategic HRM/D in the sector.

A variety of prior conceptualizations for an integrative view of HRM/DE has been described by a number of researchers including Attwell and Rule, 1984; Barley, 1990; Davis and Taylor, 1986; Hartmann et al., 1986 and Scott, 1981. However, each has focused selectively on some aspects of HRM, at the expense of others, with the result that the current state of knowledge about HRM/DE in organizations is ambiguous and conflicting. Ferris et al. (1998) acknowledge that the foundation of organisational sciences (or any field for that matter) is sound, theory-driven, empirical research with the theoretical underpinnings as precisely specified as possible. However, they also note that research such as that by Bacharach (1989) clearly failed to explain just how HRM affects performance and the effectiveness of organisations while Becker and Huselid (1998) made passing reference to the intermediate linkages on HRM. The conclusion to be drawn is that there has been no systematic effort made to date to clearly specify the mediating processes and how they operate to influence organisation effectiveness within the health sector.

Consequent to the above arguments, the study next reviews literature rooted in the theories of both management and SHRM/organisation and environmental and contextual factors in order to present a conceptual framework for the study. Thus, the following sections review the various theories that will be used as a basis for the development of the framework.

4.3.1 Classical/Scientific Management Theories as explanatory factors to HRM/DE

Most management and organisational theories are applicable in HRM/D. However, HRM/D scholars (Guest, 1987; Legge, 1995b Storey, 1992) have named two theories surrounding
HRM research as hard and soft. The soft-hard dichotomy in HRM exists primarily within normative or prescriptive models. The hard and soft can be likened to the classical and neo-classical theories of management respectively. Guest (1987), in seeking to define HRM, identified the two dimensions, soft-hard and loose-tight. Soft HRM is associated with the human relations movement, the utilisation of individual talents, and McGregor’s (1960) Theory Y perspective on individuals (developmental humanism). Hard HRM focuses on the importance of ‘strategic fit’ and stresses ‘the quantitative, calculative and business-strategic aspects of managing the “headcount resource” in as “rational” a way as for any other factor of production’, as associated with a utilitarian-instrumentalist approach (Legge 1995b; Storey 1992, p29), where human resource policies and practices are closely linked to the strategic objectives of the organisation (external fit), and are coherent among themselves (internal fit) likened to the structural contingency approach. Vertical and horizontal alignments that are distinctive in strategic HRM systems are also found in hard HRM theory as illustrated by Storey (1992) and Guest (1987). These two perspectives on HRM are viewed as conflicting nevertheless, they can be integrated as a model. The approach for this is similar to the contingency theory which seeks to integrate all management theories despite the dichotomy between them. As a result, the methodology of the study combines both quantitative and qualitative methods and is also aligned with the critical realism philosophy. Following from this, the strategic/organisational theories are discussed.

4.3.2 Organisational/SHRM Theories as explanatory factors to HRM/DE

Schuler and Tarique (2007) admit that even though it appears scholars have not yet adopted a common definition of SHRM, most would probably agree that it covers research intended to improve our understanding of the relationship between how organisations manage their human resources and their success in implementing business strategies. They state that SHRM research has evolved to include several streams of theoretical and empirical investigations. An element that differentiates the SHRM approach from earlier approaches in their view is a focus on the system. Also, horizontal alignment among HRM policies and practices is a hallmark of an SHRM system (Schuler and Jackson, 2007 and Schuler et al., 2001).

As discussed at length in the previous chapter, it has been established by researchers and practitioners that effective HRM is linked to performance either at an individual or at organisational level and thus, HRM is now perceived as a key factor for improved
organisational performance. When trying to make HRM more effective, a number of competing theoretical perspectives have to be assessed because they try to provide explanations as to how HRM and its associated competences can be achieved to make HRM more effective to improve performance. Also, how the links operate between different aspects and how any obstacles preventing the conversion of HRM into practice might be overcome. Schuler and Jackson (2003) contend that most reported studies of HRM and performance can be classified within one or other of these categories but that there is still some way from seeing all the possibilities tested. Delery and Doty (1996) on the other hand argue that there are really three main approaches - the strategic contingency approach, the best practice approach and the configurational approaches representing external fit, internal fit and systems theory.

Several organisational theories exist that can be applied to the HRM/D-organisational performance link. However, for this study five key theories that are deemed to help explain the linkage between the HRM/D and health sector performance are reviewed. These theories include systems, the strategic fit including fit as bundles, behavioural, resource based view, resource dependence/institutional/political and the influence of some environmental factors. These were chosen due to the uniqueness of the health sector as described earlier above. Thus, the theories that are chosen will help explain better the linkage among health sector contextual variables and HRM/D functions and health sector performance. This is in line with Buchan (2004), who states that the need for the ‘fit’ between the HRM approach and the organisational characteristics, context and priorities, and the recognition of the so-called ‘bundles’ of linked and coordinated HRM interventions will be more likely to achieve sustained improvements in organisational performance than single or uncoordinated interventions.

From the above classification of theories, various scholars have provided different nomenclatures. However, to focus on the needs of this research, the strategic and non-strategic nomenclature would be used to discuss the theories. The components of these are outlined below under each heading. Thus, the study first reviews the systems theory and the horizontal and vertical linkages after which the other theories and multiple stakeholder approaches are reviewed.
4.4 Strategic theories

The strategic theories include the open systems, behavioural/cybernetic, Resource-based view (RBV).

4.4.1 Systems theory

McNamara defines a system as an interrelated and interdependent set of elements functioning as a whole. In examining the role of HRH, an open systems theory by Mowday (1983) is particularly useful. Mowday applied it to HRM practices and generated alternative strategies for reducing turnover relying on Thompson's (1967) input-throughput-output model of how organisation structure can control behaviour. The use of the systems’ approach in understanding a phenomenon helps in identifying the individual parts and then seeks to understand the nature of their collective interaction to make the whole unique - it is the whole, not the parts alone that counts. Open Systems Theory according to the latter portrays organisations as receiving inputs (material or human resources) from the environment and then transforming (technological and managerial processes) those inputs into some outputs (products or services) and feedback from an outside group or system (reactions from the environment).

Viewing the system as an interrelated and interdependent set of elements functioning as a whole; the study adopts the systems theory to explain the linkages among HRM/D systems, environmental factors and organisational outcomes. The key elements of a typical open system model with its basic interrelated parts are summarized in Figure 4.1

Wright (2010) states that the behavioural perspective is one of the original and more popular theoretical models used in the SHRM literature and which has its roots in contingency theory. The theory as explained focuses on employee behaviour as the mediator between strategy and firm performance. It assumes that the purpose of various employment practices is to elicit and control employee attitudes and behaviours. Also, the specific attitudes and behaviours that will be most effective for organisations differ, depending upon various characteristics of organisations, including the organisational strategy. Thus, in the context of SHRM, Wright notes, these differences in role behaviours required by the organisation’s strategy require different HRM practices to elicit and reinforce those behaviours. Based on the open systems theory, Wright and Snell (1991) likened the systems model to the human resource system for generating HRM strategies. The major focus of the Wright and Snell
model was on the coordination of various HR practices across sub functions (selection, appraisal, compensation, training, etc). They substituted the ‘skills and abilities’ of employees with ‘inputs’ from the environment; employee behaviours with ‘throughput/transformation’ and their satisfaction and performance with ‘outputs’. These authors noted that an open systems’ view of SHRM requires organisations aligning all of the various HR practices toward some strategic end, rather than simply focusing on how one set of practices (e.g., compensation) supports a firm strategy.

**Figure 4.1 Schematic representation of the Open systems model Environment.** *(adapted from Wright and Snell, 1991)*

Thus, the research implications of this theory focus on examining exactly how organisations develop and align HR practices across traditional functional lines. Based on this, Way and Johnson argue that SHRM can have a direct impact on HR outcomes.

Chalofsky and Reinhart (1988, p31) argue that an effective HRD function as a sub-system of an organisation should have a highly trained professional staff; demonstrating close working relationships with line and staff management; and developing a track record of delivering high quality products and/or services. This has been viewed by Antwi *et al.* (2007, p3) to imply the capacity to acquire, utilize, train, develop, retain and displace the needed competencies for the organisation, recognising that “micro and macro level phenomena interact and influence each other”.

87
On the weakness of this model, Walker and Bechet (1991) noted that though this model seems to have some intuitive appeal, due to its assumption that strategies lead to HRM practices that elicit employee role behaviours to bring about some outcomes and consequently benefits to the firm, there is however, no empirical data. For this weakness, the behavioural perspective though important cannot be used in isolation to explain the linkages and so the study combines it with other theories.

On the contingency aspect of the theory, Flinsch-Rodriguez (2008), notes it as a class of behavioural theory. In their view, it is a unique approach to leadership which is about applying management principles and processes as dictated by the unique characteristics of each situation. However, another critical shortcoming as noted by Stern (1995) is the absence of a process theory in contingency explanations concerning uncertainty, and potential disagreement. Thus, the latter suggests that resource-based theory is necessary to fill the gap.

From Way and Johnson (2005), this theory is the most recent of the organisation theories and acknowledges that it is one theory that has strong implications for SHRM. RBV approaches make up the firms’ resources (physical, human and organisational resources) and blend organisational, economic and strategic management (Porter, 1985). The non-substitutability of the firm’s resources refers to how different these resources are across firms.

Although Barney (2001) has debated RBV as to whether it is tautological or a theory, Wright et al. (2001) viewed RBV as the conceptual perspective upon which most SHRM has been based. In addition, some scholars (Lado and Wilson, 1994; Wright, McMahan and McWilliams, 1994) have concluded that SHRM can produce sustainable competitive advantage and enhanced organisational effectiveness.

Human capital theory according to Jackson and Schuler (1995) is a subset of the RBV and has its roots from economics and refers to the productive capabilities of people (skills, experience, and knowledge) that have economic value to organizations because they enable it to be productive and adaptable; thus, people constitute the organisation's human capital.

The weakness of this theory according to Delery and Shaw (2001), Ferris et al. (1998) and McMahan et al. (1999) however, is that, it lacks insight into the process by which (how and why) it enhances organisational effectiveness. Thus, Way and Johnson (2005) conclude that
while the RBV helps identify what is needed for organisational effectiveness, it does not explain how to achieve it. Therefore in isolation, RBV is inadequate in providing explanatory power for the impact of SHRM.

4.4.4 Competence based theory

Lado et al. (1992), proposed a competency-based model for sustainable competitive advantage through HRM. Expanding the RBV approach, the competency-based model addresses managerial, input-based, and transformational and output based organisational competencies as per Figure 4.1.

Competence management, according to Wright and Snell (1991) deals with those things that the organisation does to ensure that the individuals in the organisation have the skills required to execute a given organisational strategy. This recognizes the negotiations with the external labour environment in order to attract, select, retain, and use employees with the necessary knowledge, skills, and abilities for executing the strategic business plan.

4.4.5 The multiple stakeholder perspective

The multiple stakeholder perspective provides a theoretical framework that can enhance the ability to accurately define and measure organisational effectiveness. The underlying theory in integrating a multiple stakeholder perspective in SHRM research is the systems theory. When adopting a multiple stakeholder perspective, the focus is on external and internal stakeholders with common attributes such as customers, government, society, employees, owners, etc. Although all stakeholders have some influence on some outcomes or decisions, the power of a stakeholder (i.e., stakeholder’s influence on an outcome and/or decision) will vary by organization (Ferris et al., 1998; Morrow and Hitt, 2000; Pfeffer and Salancik, 1978 and Truss and Gratton, 1994).

4.4.6 The concepts of vertical and horizontal linkage

In line with the behavioural and contingency theories which call for a fit of HRM to each other and with organisational processes, theoretical perspectives related to ‘fit’ would be outlined. The three theoretical perspectives of ‘fit’ are strategic interaction, fit as contingency or best fit and fit as bundles. These according to Schuler and Jackson (2003), represent the
Some HRM researchers (Huselid, Jackson and Schuler, 1997; Way and Johnson, 2005) contend that although the effective deployment of technical HRM practices (e.g., selection, training, etc.), lay the foundation for a HRM system capable of creating value and enhancing organisational effectiveness, technical HRM alone is unlikely to produce sustainable competitive advantage. Other scholars have put forward that to create value, produce sustainable competitive advantage, and enhance organisational effectiveness, the deployed HRM system must be linked with other organisational resources (Delery, 1998; Delery and Doty, 1996; Huselid et al., 1997). However, the exact conceptualization of such a linkage varies among researchers (Becker and Gerhart, 1996; Chadwick and Cappelli, 1999).

For the most part, scholars believe that the value of SHRM, and the impact of SHRM on organisational effectiveness, will be enhanced when an organization has deployed an HRM system comprised of practices that are consistent with each other and work to elicit those behaviours (outcomes) from the organisation’s human resources, necessary for the achievement of organisational goals and objectives (Schuler and Jackson, 1987; Wright, 1998). Within SHRM research, vertical linkage typically refers to the degree to which SHRM is consistent with other key organizational processes (Delery and Doty, 1996; McMahan et al., 1999), while horizontal linkage typically refers to the degree to which the HRM practices deployed by SHRM elicit congruent behaviours (outcomes) from the organisation’s human resources (McMahan et al., 1999; Wright and Boswell, 2002).

Then is the debate between the Universalists such as Pfeffer (1994) and Osterman (1994) and the contingency theorists. The former argue that greater use of “high performance” practices such as participation and empowerment, incentive pay, employment security, promotion from within, and training and skill development result in higher productivity and profits across organisations. By contrast, contingency theorists note how the consistencies of a number of HRM practices with different strategic positions relate to firm performance.

A third group, configurational theorists have attempted to integrate patterns of SHRM-related practices and test their effects on performance: for example, Delery and Doty (1996). In
adopting the configurational approach to SHRM, Ichniowski et al. (1997) explain that when HRM practices are combined in different forms, the effects on organisational performance are much greater than when practices are explored individually. Due to the difficulty and confusion in finding a theory for HRM, some scholars turned to the non-strategic theories of HRM as explanatory factors. These are discussed next.

4.5 Non-Strategic HRM Theories

These theories which also link HRM with organisational effectiveness were introduced by American organisational theorists – Williamson (1975), Jensen and Mackling (1976), Aldrich and Pfeffer (1976) and Pfeffer and Salancik (1978) among others. They suggested a segregation of those considered as non-strategic to HRM. They include the resource dependency/institutional and political theories.

4.5.1 Resource dependence/power/institutional theories

Wright and McMahan (1992), likening resource dependence theory to institutional theory, state that the former focuses on power relationships within organisations and its constituencies. It assumes that all organisations depend on a flow of valuable resources (e.g. money, technology and skills) into the organisation in order to continue functioning. Therefore the ability to exercise control over any of these valued resources provides an individual or group with an important source of power (Pfeffer 1981). These contrast with RBV and human capital theories. In Jackson and Schuler’s (1995) view, these were developed in the context of understanding large public bureaucracies, where efficiency may not be among the most important goals. In contrast, the RBV/human capital theories were developed in the context of understanding business enterprises, for which issues of efficiency are presumed to be central. These theories were however criticised by Donaldson (1995), who thinks resource dependence theory and institutional theories were just an aspiration for novelty by American organisational theorists.

4.5.2 Political theory

The political theory is also in contrast with the contingency approach. In Willcocks’ (1998) view, this perspective rejects the notion of the organisation being rational and objective in pursuing agreed goals. In the political perspective, no such claim is made for the existence of common uniform goal preferences. Rather, there is a diversity or multiplicity of goals
derived from diverse interests, values and beliefs, and hence the political perspective argues that power becomes an influence over whose goals are favoured. At the organisational level, there is a focus on the structure of power and the ability of powerful groups to ensure their own interests prevail. In Harney and Dundon’s (2007) view, this approach perceives conflict between rival groups or individuals as power struggles, each group representing different interests and being successful (effective) or otherwise by virtue of their relative power in the organisation. Willcocks (1998) in trying to explain how some people come to have access to these resources, while others do not, state alternative wider determinants of power emanating from external sources such as class and ownership.

Having reviewed the necessary theories, the next section looks at the context of organisations as they relate to HRM/DE.

4.6 Organisational contexts

The International Development Research Centre (IDRC, 2010) emphasises that no organisation can exist in a vacuum; each is a set in a particular country and region to which it is inextricably linked. Furthering this assertion, WHO (2005) states that the environment in which public health operates both globally and locally is becoming increasingly complex. As a result, there is the need for efficient management of resources including human.

An examination of both the internal and external environment is an attempt to understand the forces inside and outside the boundaries of the health sector that are helping to shape it. Thus, its inclusion in this study therefore cannot be overemphasised due to the fact that environmental factors appear to play a major role in HRM/D in the research setting.

In studying the context of organisations as an explanation to understanding HRM/D, Daft (1998) identified organisational contextual variables that are possible predictors of HRM practices. These are the external environmental variables which include company size, structure, size, technology, culture, legal and economic while the internal environmental variables comprise the organisation’s strategy, organisation’s resources, its capabilities, competencies, politics and culture.

Ramlall (2002) illustrates these environmental variables in societies which create impact on organisations as in Figure 4.2. This has been adapted to illustrate some of the external
challenges and changes facing the health sector, their linkage to the health sector processes and how these are linked to HRM/D

Organisation

- Organisational Structure
- Technology
- Socio-cultural, Political and Economic issues
- Diverse workforce

HRM

Figure 4.2 Environmental variables influencing role in driving performance (adapted from Ramlall, 2002)

4.6.1 Internal environmental contexts

The internal environment according to Hitt et al. (2003) plays a crucial role in the strategic management process of the organisation. It is a direct reflection of what the organization can do in the event of a business-related exigency. The study therefore examined empirical literature regarding the internal environmental factors and processes in organizations. In this context, the study also examined the issue of managerial competency.

i. Organizational strategies

Organisational strategies define the process or set of processes by which organisational goals and objectives are to be achieved. Organisational strategies are influenced by the feedback of the organisation’s various functions regarding its ability to provide the resources and inputs as well as produce the outcomes necessary for the function to contribute to the attainment of the goals and objectives of the organisation as a whole. Organisational strategies reflect the views of the firm’s leaders and also emerge from an organisation’s culture (Way and Johnson, 2005).

ii. Structure

According to Way and Johnson (2005) quoting Semler (1997), structural alignment relates to the congruency between the goals of different activities (processes) within the organization and how SHRM is designed to elicit the behaviours necessary to meet these goals. There are
two types of alignments – vertical and horizontal. Schuler and Jackson, 1987; Wright, 1998 differentiates between the two alignment as already discussed previously.

4.6.2. External environmental context

The external environments which are forces outside the organisation can provide both facilitating and inhibiting influences on organisational performance. Multiple influences in the immediate or proximal environment from the boundaries within which an organisation is able to function; these influences likewise shape how the organisation defines itself and how it articulates what is good and appropriate to achieve (IDRC, 2010). In the PHS of Ghana, these include the political/economic, socio-cultural, Government/health policies and legal frameworks and health sector reforms to provide an explanation to their linkages to HRH policy implementation. All these are further explored and explained in the framework.

i. Socio-cultural context

The most widely known framework for comparing national cultures is that developed by Hofstede (1980), who identified four dimensions of culture: individualism, masculinity, uncertainty avoidance, and power distance. There has been considerable speculation about the possible implications for HRM of cultural variations along these dimensions but empirical studies seldom include direct measures of both culture and HRM. Thus, Scott (2003), supporting this argument, argues that health systems reform have tended to focus primarily on structural change and despite these structural changes as in the UK, USA and Australia, recent studies show that structural changes alone do not deliver anticipated improvements in quality and performance in health care.

ii. Political/economic context

The ability to exercise control over these valued resources provides an individual or group with an important source of power (Pfeffer, 1981). The latter applied the resource dependence to his study, and hypothesised that much pay allocations are based on power, rather than just performance criteria.
iii. Government policies and health sector reforms

It is important that HRH policies and strategies are aligned to the specific vision of government and health sector reforms to ensure health sector reforms fulfil the legitimate needs of health workers.

iv. Legal environment

The laws and regulations are linked to the institutional theory. According to Jackson and Schuler (1995), research on institutionalization focuses on pressures emanating from the internal context that has been outlined above. Forces in the external environment include those related to the state (e.g. laws and regulations), the professions (e.g. licensure and certification), and other organisations–specially those within the same industrial sector.

4.7 Critique of literature, models and justification of framework

In discussing the available types of conceptual SHRM models, it has been observed that varying models adopted different HR practices; different variables of measurement and varying organisational contexts. First, a common distinction within the HRM literature is that many studies have examined individual practices (e.g. performance management) in isolation of other HR practices. Such research, when conducted by micro researchers often aims at the technological sophistication of a particular HR practice through demonstrating the efficacy of a particular HR technique in isolation from other HR practices (e.g., how highly a structured interview correlates with individual job performance). Within the macro literature such research attempts to demonstrate the organizational impact of a particular practice (e.g., the use of monetary incentives correlates with organizational performance).

Again, Boselie et al. (2001) and Zupan and Kase (2009), noted that most often conceptual SHRM models assume linear relationships between the build of the model. For instance they argue that the model proposed by Becker et al. (1997) suggests that business and strategic initiatives are the basis for designing HRM systems, thus affecting employee skills and motivation as well as job design and work structures. While the author agrees with Zupan and Kase who argue that systems in such models can explain outcomes such as creativity, productivity and discretionary effort that lead to improved organisational performance, these
simple linear models neglect some moderating variables including environmental factors that are key to understanding causality links critical in achieving new understanding.

Finally, one of the criticisms in the SHRM literature by Truss and Gratton (1994) is that conceptual and empirical models are outnumbered by normative models and which can be equated to the classical management model developed by Taylor (1912). Such conceptual SHRM models often remain prescriptive and according to latter are more useful for academic discussions compared to their practical ability to convert models into effective execution.

From the above, Paauwe, (2004, p69) acknowledges that it is evident “we need theoretical models and accompanying research design that take into account the institutional setting and allow reality to emerge and enable us to analyze the underlying processes”. Considering the current state of SHRM in the developing world and the growing need to develop the field in these countries and more particularly in the health sector, SHRM models should have different characteristics. They should be positive and show the different interacting variables that should be considered when constructing models in order to accelerate the development of the SHRM field among managers, HR professionals and academia.

Harris et al. (2007) in their study on HRM and performance in health care organisations also found relationships between a range of HRM practices, policies, systems, and performance. Despite being an important concern for HR professionals, there is little research exploring the link between HRM and performance in the health sector. Rather all the studies in health mentioned in earlier chapters found HRM practices to be associated with patient outcomes such as mortality (West et al., 2002). Yet they yield little information regarding the competencies of managers themselves and therefore managerial effectiveness. Thus, there is the need to rely on studies derived from other environments to guide studies in health as admitted by Hyde et al., (2006).

To date as noted by Buchan (2004), Richardson and Thompson (1999) and Zupan and Kase (2009), many general conceptual SHRM models studying the HR-company performance link have been developed. They have been classified as ‘best practice’ models (Hyde et al., 2006; Pfeffer, 1998; 1994; Purcell, 1999) or high performance working systems (Appelbaum and Batt, 1994; Macky and Boxall, 2007) and ‘best fit’ models (Delery, 1998; Miles and Snow, 1984; Wright and Snell, 1998; Wright and McMahan, 1992; Youndt et al., 1996). Delery and
Doty (1996) further divide the best fit models into those emphasising contingency perspective and on those following a configurational approach. Contingency models are either very narrow and focus on a single contextual variable such as business strategy (Schuler and Jackson, 1987) or a firm’s capital intensity (Richard and Brown Johnson, 2001), or very broad and enter numerous contextual variables into the model (Jackson and Schuler, 1995). In discussing the available types of conceptual SHRM models, Wright and McMahan (1992) suggested a broader contextual approach for HRM model. This was also supported by Brewster (1995) who also suggested likewise for European Transition Economies (ETEs) due to the limited autonomy of a typical European organisation in HR-related issues and the large number of external contingencies. In addition, he argues for improved explanatory power and applicability of contextual models (Brewster, 1999).

In Africa, only limited numbers of models including that of Kamoche (2002) using Guest’s (1987) model of four policy goals - quality, integration, commitment and flexibility and Budhwar (2002) who proposed a framework that would help to evaluate the main reasons for the continued reliance on specific HR practices (i.e., cultural, institutional, or company philosophy) were noted during literature search in English. In health as noted earlier, very limited research has been carried out on the link between HRM and health sector performance. Regarding the health sector of Ghana in particular there has not been any single study which specifies any model.

In line with Paauwe (2004) on the criticism of normative models of HRM the following section presents a conceptual framework which attempts to accommodate the heterogeneity of HRM by detailing the determinants of HRM in the context of the health sector. In search for a framework for this study, the arguments of Ferris et al. (1998) have been noted and therefore this study has tried to review all earlier works incorporating theories of management, motivation, organisation contexts and those on strategic HRM to be able to arrive at a broader framework. Another piece of work that has been utilised is Turner’s (1976) work on the role of social, political, and technical factors on HRM/D. The conceptual framework thus presented in Fig 4.3 makes use of the open systems theory as put forth by Mowday (1983) using the inputs-through-puts-outputs model combined with other perspectives. Hence, the study combines both traditional and progressive HRM practices to explain the competencies needed by managers and their connection with managerial effectiveness as an approach to understanding HRM/D in the PHS of Ghana.
4.8 The framework

The notion of human resources being key to the success of organisations and a lever for HR practitioners continues to dominate research literature (Barney, 1995; Pfeffer, 1994). However, the extent to which such a link has been ‘proved’ to exist in general, and in particular which, specific HRM practices lead to high performance continues to be debated. Therefore in evaluating HRM/DE the issue is to understand how HRM practices impact on performance (Baron, 1999; Purcell et al., 2000), as without such a conceptual foundation any empirically based relationship between HRM practices and employee performance is difficult to achieve. In addressing this issue a conceptual framework is developed.

4.8.1 Reasons for the choice of theories and other variables to develop the framework

i. Systems theory

The aim of a theory to guide the development of a framework for the study is with the view for an integrative theory for HRM. This is because the health sector has a complex system and is labour intensive and thus the need for a theory that can guide the interaction of the sub functions of HR practices in line with other health subsystems and the uniqueness of its human resources. The use of a systems theory thus enables the study to analyse and collate data for all the systems that interact with the HRM/D bundles and health sector strategies. From scholars discussed above, several theoretical and methodological arguments for why a systems approach is preferable within SHRM research had been outlined (e.g Becker and Gerhart 1996, Becker and Huselid, 1998, Delery, 1998 and Delery and Shaw, 2001).

Again, systems theory according to Anaf et al. (2010), has established the reputation of its relevance to health care research. Additonally, Flood and Jackson (1991) and Mikan and Boyce (2002) state that systems theory’s principles are ideally suited to exploring complicated social, organisational and clinical features that are usually inherent in the cases explored by qualitative health care researchers. Thus in line with this assertion, the study found the systems theory useful for the context in which the study is conducted.

ii. Choice of HR practices

Becker and Huselid (1998, p63)) concluded that the SHRM literature has a preference “for a unitary index that contains a set (though not always the same set) of theoretically appropriate
HRM practices derived from prior work”. There appears to be a general consensus among most SHRM researchers that systems of HRM practices, rather than single, isolated practices is the appropriate level of analysis (Delery and Shaw, 2001). Also, Hyde et al. (2006), note that the specific choice of which practices to include depends on the circumstances affecting each organisation, as well as the interplay between HR professionals and line managers. Therefore the choice of practices for this study is based on how these practices add value to the health sector through bringing about human capital advantage. In lieu of this, the framework includes recruitment and selection, performance management, rewards management and staff development. These practices were selected for use due to the context of the study. Some of the reasons for this choice are the shortage of staff in the health sector coupled with regional imbalances as a result of maldistribution and less motivated workforce who are not appropriately trained and not adequately compensated.

4.8.2 The framework as a guide to evaluating HRM/DE

The framework which seeks to examine the interaction between HRM/D activities and the context of the organisation is linked to existing empirical works. Early research studies assumed organisational context to be an objective, external force that would have deterministic impacts on HR management. Later, researchers focused on specific HR activities such as performance management or recruitment and selection to determine their effectiveness and efficiency. Other researchers (Huselid et al., 1995) explored the impact of HRM on firm performance using the behavioural approach and some on the contexts of the organization. Additionally, Wright and McMahan (1992) used the ‘fit’ and Wright and Snell (1998) used the ‘fit’ and flexibility model of HRM functions to organisational goals/strategy to analyse organisational performance. Ferris et al. (1998) with an additional encompassing view included the social contexts but did not specify which HRM practices they used. All these studies are laudable and well researched and have laid a solid foundation for theories in HRM/D.

Based on the above, this study complements most views with additional external environmental factors which were not incorporated in previous studies in order to present a useful framework for understanding the different perspectives regarding how HRM/D has been studied in related organisations. The study thus reconceptualises HRM/DE with a framework that combines the open systems as put forth by Mowday (1983) using the inputs-
through-pus-outputs model with the ‘fit’ model by Wright and McMahan (1992) and the flexibility model by Wright and Snell (1998) on aspects of the organizational context.

The framework has been additionally informed by the organisational and environmental contexts literature of Jackson and Schuler (1995) and strategic literature on HRM by Schuler and Tarique (2007). The purpose of the conceptual framework (Fig 4.3) is an effort to provide a study focussed perspective for explaining the linkages between HRM/D and performance in the health sector. Also, the framework is to assist in illuminating the relationship dynamics among organisational strategy, HRM/D functions, HR managerial roles and environmental factors and how all these are linked to HRM/DE. The framework accommodates the complex interaction of variables based on the context of HRM/D in the PHS of Ghana.

Accordingly, the framework borrows from the works of other scholars such as Renu et al. (2004) on their organisational level competency-based perspective of ME; Wright and Boswell (2002) on disaggregation of HRM; Wright and McMahan (1992) who described the contingency fit and bundles for studying HRM; Wright and Snell (1998) on the flexibility and HR as a practice configuration (Delery and Doty, 1996; Lepak and Snell, 1999). Although significant disagreements exist as to how to combine these practices, Wright and Boswell (2002) state that the shared assumption of multiple, rather than isolated practices should be examined. Based on these, the study adopts the configurational approach (Delery and Doty, 1996) which combines systems theory with internal and external fit.

The framework explores the various HR practices in the context of the organisation and their linkages with HR managerial roles. The model can also be likened to that developed by Wright and McMahan (1992), in which the integration of HRM activities were explored including both vertical and horizontal fits of HRM activities with the organisational goals and among HRM activities respectively. All these are explored in line with the strategic and non-strategic organisational theories. As concluded by Wright and McMahan (1992, p315), “…These models may serve as fertile grounds for broadening our perspectives on HRM in organisations”.

The next section explains the framework using the multiple approaches. As noted by Harney and Dundon (2007), the idea in operationalising the framework is not for prediction but is on
understanding and explaining thereby appreciating the nature of the interactions open systems can explain.

4.9.3 Description and explanation to the framework

Figure 4.3 Conceptual Framework: Green broken arrows represent organisational theories which influence managerial competencies. The blue arrows show the linkages and alignment.

Figure 4.3 with darkened arrows demonstrates the horizontal fit among the practices and their vertical linkage to the health sector strategy. Based on the open systems model of Mowday (1983) the inputs represent the resources needed to implement HR policies to improve practices to achieve organisational goals. These comprise the internal environmental factors within the organisation – (the strategy, policies, resources, capabilities, culture etc.) which support the development of the roles and competencies and the external environment factors (structure, size, legal, politics, economic etc.) are shown as an influence on all variables and are explored to predict the relationship dynamics with managerial behaviours and their linkage to HRM practices. These are placed in the bottom centre and to the bottom right
respectively of the framework. The throughputs represent the managerial competencies and the outputs as performance. The two are placed in the centre of Fig.4.3 and the first one (managerial competencies) by an arrow lead to the outcomes. The outcomes also lead to the achievement of organisation strategy placed vertically above. The RBV/human capital theory which is placed between the internal and external environments is also influenced by the internal factors.

The framework visualises that the implementation of better HRH interventions (inputs and process) is expected to generate outputs in terms of improved HR managerial roles and behaviours, motivation, improved staff retention among others. These in turn result in the outcome of the intervention in terms of measurable improvements with respect to the responsiveness to policy and regulation changes regarding HRM/D practices and/or competence of managers. These outcomes of the intervention will then lead to improved quality health care which contributes to an improved health status. For example through a reduction in morbidity or mortality of target groups maximises health service impacts derived from preventive and clinical developments. This framework aims to envisage the mechanisms on how HRH interventions could influence performance, and assist in identifying assumptions underlying selected HRH interventions. A hypothesis underlying the framework is that the implementation process and the results of these HRH interventions are influenced by the wider socio-economic and political environment as well as other environmental characteristics, which together form the context within which an intervention takes place. This framework is a simplification of the reality. Moreover, outputs and outcomes can influence each other. For instance, improved competencies could lead to increased responsiveness of health workers, or enhanced motivation could lead to improved retention. The framework does not however, seek to identify causal relations between the variables in the figure. The framework is also not showing how interventions are implemented; who should do this and which stakeholders should be involved. These aspects are subject to the findings of the research itself.

4.9.3 Components of the Framework

The components as indicated in Figure 4.3 are organisational strategy, strategic and non-strategic HRM/D components (RBV, behavioural, Resource dependence, external environmental factors (legal, regulations, political, economic, culture, HRM/D policies and
practices (recruitment and selection, performance management, staff development and rewards management) and HRM/D effectiveness.

i. Health sector strategy
The framework begins with the health sector strategy which is located at the top and links to the national HRM/D policies on the left side of the framework. The policies located on the left then link to the four HRM/D activities of recruitment and selection, performance management, rewards management and staff development which are located in the left hand corner of the framework and thus linking these up with the health sector strategy through the national HRM/D policies above. This thus describes the type of alignment the HRH activities have with the health sector strategy/objectives. In the middle are the managerial roles and behaviours that managers exhibit in the implementation of these practices. To the right side of the framework, are the improved managerial roles which if these are managed well result in employees’ behaviours that lead to service outputs and contributes to the organisational strategy.

At the bottom of the framework are the internal organisational variables of resources, culture, politics, and organisational processes etc. which determines how the HRM/D activities are implemented. These also influence the RBV/human capital located to the right bottom of the framework. To the right of these are the external environmental variables which include legal, socio-political, socio-cultural and economic factors. All these have links to the HRM/D in the health sector and thus the framework sought to understand and explain how these are linked. These also influence the implementation of HRM/D activities. The linkages of these are discussed further in the sections following.

ii. Socio-political
Based on the findings of Pfeffer (1981), the framework aimed to clarify to what extent politics and powers within and without the health sector will either pose as an opportunity or threat to HR managerial behaviours. The socio-political factor was explored in line with the resource dependence theory, which assumes that all organisations depend on a flow of valuable resources (money, technology, skills) in order to continue functioning. The political and economic context determines the feasibility of various HRH strategies and the potential to implement them. Thus, how well HRH policies and strategies are implemented depends to
a great extent on the political commitment and economic situation prevailing in Ghana. The framework thus examined this context in order to understand its linkage to HRM/D in the health sector. These can influence the HRH policy implementation if politicians do not view HRM/D as a priority or when there are more urgent emerging national or health issues in which economic resources have to be redirected. Also, the way compensation including salaries of health workers are determined and administered in the PHS of Ghana and their linkage to employee motivation are examined. Additionally, the idea of who wields more power over how these resources are distributed and how that power is acquired are all explored.

iii. Legal Environment

The administrative and legal environment in a country provides a framework within which an organization operates. Understanding the administrative/legal environment is essential to determining if organizational change can take place. The administrative context within which the health sector operates may be shaped by a unique combination of forces, including governmental, legislative, regulatory, and legal frameworks. In evaluating HRM/DE in the context of the PHS of Ghana, laws such as the labour law, the laws that set up the health sector (Act 525) the decentralisation law (Act 650) and the regulations governing professional bodies and the influence of these on HRM/D are examined to determine the extent of influence these laws impinge on the HRM/D activities. It is here pressures from unions and professional bodies impact on the health sector.

4.9.4Alignments in the framework

The vertical structural alignment in the framework refers to the extent to which the goals for key health sector processes harmonise with the HR practices to contribute to the attainment of goals. Vertical structural alignment is achieved when the goals and objectives of the health sector are matching with the HR practices to facilitate each other to realise organisational goals and objectives. Horizontal structural alignment on the other hand is the extent to which the health sector produces behaviours (outcomes) from its human resources that are consistent with the achievement of its goals and objectives. This is achieved when the system of HRM practices deployed by the health sector elicit from its human resources those behaviours necessary for the realisation of organisational goals and objectives.
4.9.5 The framework, a source of integrating HRM/D activities in health

The issue of integration is based on the fact that Wright and McMahan (1992) indicated that HR field has not evolved with great levels of integration across the various functions. Rather each of the functions has evolved in relative isolation from one another, with little coordination across the disciplines. This led to researchers only becoming extremely in-depth at studying the various techniques of particular HR functions that maximise accuracy and effectiveness. Consequently very little research attention has been devoted to understanding the relationship between or among the various HR functions. Since, it is the sum of technical knowledge within each of these functions that are referred to as the field of HRM (Wright and McMahan, 1992), the framework integrated these activities.

Regarding building flexibility into the health sector, the framework adopts that by Wright and Snell (1998) who emphasise the need for employee autonomy and decision-making, decentralisation of authority within the associated restructuring of any rigid organisational administrative systems. Thus, the framework has three main points in focus: the development of adaptable HR systems, the development of human capital with diverse skills and promotion of flexibility in employees’ behaviours.

The framework forms the basis for the design of the research methodology and highlights the enablers (external and internal environmental factors) based on resources, finances, personnel (inputs and conditions) that either influence HRM/D or are needed to improve these competencies/roles, the processes used to obtain results and (throughputs) and the outcomes of performance (output). Since the main aim of HRM/D is for managers to achieve organisational goals and strategies through employee performance, the performance of managers in implementing the four HRM/D activities is aligned with the organisation’s strategy, which should be able to motivate employees for increased productivity. Thus, in evaluating the effectiveness of HRM/D practices (performance management, rewards management and staff development), which are all sources of motivation to employees depending on how they are administered, the main issue of factors that motivate staff are evaluated including how employees are acquired and distributed. As stated by WHO (2000), the relationships between each component within each factor and their individual or cumulative effects on HRH policy implementation are complex and highly interconnected. Many may have indirect effects, and their influence is mediated through other factors and
dynamics. This makes it difficult to isolate the precise impact of any one of the factors on HRH policy implementation.

The use of this framework enables the researcher to present and discuss the changes in and evolutions of sub-themes effectively and to design the research.

4.9 Conclusion

The Chapter sought to examine HRM/DE through the use and integration of multiple management theories, competency and stakeholder theories and the environment as explanatory factors. It was revealed through the literature review that definitions of ME are contentious and that using the context of organisation is important. Also, combining the systems and political theories highlighted the complexity of the health system and how politics and power influence HRM/DE. This goes to support the critical realist philosophy as in the methodology to give credence for using the two theories. Finally, ME in the PHS may be characterized by the management of differences and diversity (Willcocks, 1998).
CHAPTER 5 - Research Methodology

5.1 Introduction

The previous chapter reviewed theories relevant to this study and the development of the conceptual framework to guide the study. The purpose of this chapter is to outline the research methodology (RM) and to demonstrate how the RM can be used to achieve and answer the research objectives and questions respectively. This study is based on the assumption that HRM/DE is influenced by the country’s environmental factors such as socio-economic, cultural and political and legal aspects which make the management of HR in the PHS of Ghana unique. Therefore the study needs a methodology that will be flexible to unravel these.

This chapter therefore describes the Mixed Methods (MM) research methodology which was employed in the study as a way to explaining HRMDE. The description covers the process, approach, methods and tools used to collect data in an effort to answer or explain the research question/problem. The use of MM methodology is in line with Curral and Towler (2003), who mentioned the diversity of quantitative and qualitative methodological approaches in management and organisational research. Three benefits have been outlined by the latter for this diversity among which is the requirement of the heterogeneity of research methods. Heterogeneity is important for the reason that management and organisational research draws on numerous theoretical paradigms, including psychology, anthropology, sociology, economics and political science. A MM methodology allows this heterogeneity which enables the researcher to combine qualitative and quantitative methods to extricate the different meanings to the experience of a phenomenon (Neuman, 2003, p77). As already discussed in Chapter Four, there are many variables, especially in the internal and external environments of an organisation that affect each country’s practice of HRM. As these factors are known to be country or sector specific, MM approach goes well with this study.

The aim and scope of the chapter is to provide an overview of MM research and outline the steps in the use of MM research to answer the research question based on Creswell’s (2003) definition of methodology as the logical sequence of a scientific inquiry.

Fundamental to this aim, the chapter is organised as follows: First, the objectives and the research questions are restated. Then literature on the research design (MM) which covers the
comparison between the quantitative and qualitative approaches is reviewed. By this, the epistemology, practicality of data gathering techniques, reliability and validity measurements are discussed in line with management and organisational studies. Next, the methods which take account of the research set up and the criteria for the selection of regions for the study are stated. The strategies used to collect data, types of sampling used, role of researcher, interviewing techniques and data analysis techniques are outlined. Next, the ethical considerations are stated. Finally, the limitations of the research methodology for the study and conclusion follow. Although these descriptions can be applied in all social science research, for the purpose of this study, the discussion is based on organisation and management research literature.

5.2 Summary of research objectives and questions and methods of investigation

The summary of the research objectives, research questions and methods of investigation can be found in Table 5.1 and the stages of the research process in figure 5.1
Table 5.1 Summary of objectives, questions and methods of investigation developed by author

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Research Question</th>
<th>Focus</th>
<th>Methods and techniques of investigation</th>
<th>Sources of data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To establish the context of HRMD within the Health sector of Ghana</td>
<td>What is the context of HRMD in the Public Health sector of Ghana?</td>
<td>Health sector goals, strategies and their linkage to HRM/D: the model of health service delivery as postulated at the national level</td>
<td>National Document reviews, reports, interviews</td>
<td>GoG constitution, National development policies and legal frameworks, Health policy, MOH/GHS documents, including HRH policy and strategy and Expert reports and studies in HRH</td>
</tr>
<tr>
<td>2. To explore the understanding of managerial effectiveness by policy makers, managers and employees of health and some stakeholders</td>
<td>What understanding do managers and employees have about managerial effectiveness for practice at all levels?</td>
<td>Definitions of terminology: management, HRM, effectiveness and HRM/D effectiveness</td>
<td>Desktop review of books, documents and journals</td>
<td>Interviews with managers, policy makers and other stakeholders. Books on management, HRM and HRD, Organisational behaviour and development Research methods, Journals on decentralisation, HRM/D, managerial effectiveness, competencies</td>
</tr>
<tr>
<td>3. To examine the extent to which this understanding of managerial effectiveness (knowledge, skills, abilities, attitudes and qualities) are reflected in the current HR practices within the health sector from the perspectives of managers and employees of health.</td>
<td>How have HRM practices of recruitment, performance management, staff development and rewards been defined and measured in the public health sector of Ghana?</td>
<td>Managerial roles, skills, behaviours and attitudes in the practice of HRM/D</td>
<td>Interviews and surveys</td>
<td>Managers at the district level, policy makers at the three levels, Regulatory bodies and Association representatives and employees at the regional and district levels Review of HRH policy documents</td>
</tr>
<tr>
<td>To investigate the factors/processes that have links with the effective management of Human Resource for Health in the Public Health sector of Ghana.</td>
<td>How does this understanding/perception coupled with environmental factors affect their managerial roles including the approach to employee resourcing and deployment, capacity development, motivation and appraisal of staff and the performance of the organization?</td>
<td>Examine external and internal environmental factors – cultural, political, economic and stakeholder influences</td>
<td>In-depth individual Interviews, focus group discussion and survey</td>
<td>Managers at district level, policy makers, Regulatory bodies and employees</td>
</tr>
<tr>
<td>To recognise gaps and identify key competences and appropriate managerial behaviours based on the perspectives of managers and employees of Health.</td>
<td>What lessons can be learned from the perspectives of managers and employees and what are the implications for policy, practice and in making management more effective?</td>
<td>Compile core managerial competencies and Opportunities and how these can be used to improve HRM/D policies and practice</td>
<td>In-depth individual Interviews, focus group discussion and survey</td>
<td>Managers at district level, policy makers, Regulatory bodies and employees</td>
</tr>
</tbody>
</table>

Figure: 5.1 presents the planning, implementation and concluding stages of the research. The planning stage involved the literature review from all the sources listed above and definition of the problem. During this stage, the research methodology was identified, research instruments developed and administrative issues (seeking ethical clearance, obtaining
permission through letters to conduct interviews and getting logistics including funding) was sorted out.

The implementation stage includes the sampling, the collection of data by the various methods listed in figure 5.1, data processing and data interpretation. The concluding phase is the presentation of the data, discussion and the conclusions.

5.3 Research Design (RD)

Research design (RD) has been described by Blaikie and Yin (2006, p37 and 1994, p19) respectively as “the logical sequence that connects the empirical data/material to the study’s initial question and ultimately to its conclusions”. Generally, in the view of Trochim and Land (1982), RD refers to the strategy to integrate the different components of the research project in a cohesive and coherent way. Rather than a “cookbook” from which you choose the best recipe, it is a means to structure a research project in order to address a defined set of
questions. Also, Crotty (2004) describes RD as one that shapes our choice and use of particular methods and links them to the desired outcomes.

Relating the design of research to organisational research, Buchanan and Bryman (2007) quoting Cook and Campbell (2001), Cook and Campbell (1979), Campbell, Stanley and Shadish (1966) note that the field of organisational research is changing and is no longer dominated or constrained by positivist (or neopositivist) epistemology and its extended family of primarily quantitative hypothetico-deductive methods. Instead, it has embraced a variety of other research philosophies such as the phenomenological, constructivist, and interpretative, feminist and the positivist perspectives. Currall and Towler (2003), note that despite the fact that most management and organisational researchers have adopted the positivist stance of the natural sciences, nevertheless, an integration of qualitative and quantitative methods maximises the knowledge yield of research.

The study thus adopted MM approach with regard to the purpose, aim and context of the research. The MM design is based on the concurrent triangulation design model as described by Creswell and Clark (2007), but with qualitative method dominating. This strategy according to op cit combines both the qualitative and quantitative methods with one of them used as the dominant method. MM research design in management has been used by Bazeley (2008), Buchanan and Bryman (2007), Modell (2007), Groenewald (2006) and Currall and Towler (2003).

5.3.1 Definition of MM

MM research has been given different nomenclatures and has also been described in various ways by different authors. For instance, MM research has been called the third path by Taylor and Gorard (2004), the third methodological movement (Teddlie and Tashakkori, 2003) and again as the third research community by Teddlie and Tashakkori (2009) due to the relationships that exist within and among the three major groups that are currently doing research in the social and behavioural sciences. Johnson and Owuegbuluzie (2004), however, define MM research as the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts and language into a single study. Other terms (integrating, synthesis, quantitative and qualitative methods, multimethod and multimethodology) are also used for this approach.
From the definition provided by Johnson and Onwuegbuzie (2004) above, table 5.2 gives a summary of MM research to highlight the qualitative and quantitative approaches where the two focus on the same things but use different concepts, paradigms and methods to arrive at similar results and which are then interpreted and combined into one whole or single study.

5.3.2 The Quantitative Approach

Researchers including Teddlie and Tashakkori (2003) assert that quantitative research has been the single method in long use before the 1970s. The view held by some researchers is that quantitative methods are based on the epistemology of objectivism – positivist philosophy and thus it is thought to be objective. For instance, Creswell (2003) state that;

“We quantitative approach is one in which the investigator primarily uses post positivist claims for developing knowledge, reduction to specific variables and hypotheses and questions, use of measurement and observation, and the test of theories. It is thought that in gaining, analysing and interpreting quantitative data, the researcher can remain detached and objective” (p19).

Also, Crotty (2004), views the objectivist view of ‘what it means to know’, understandings and values are considered to be objectified in the people being studied and, that if we go about it the right way, one can discover the objective truth. Similarly, Buchanan and Bryman (2007) quoting Hamel (2000) likened the quantitative method to the normative (positivist) discourse which assumes progressive enlightenment, rationalization and control, with concerns for codification, with establishing causal relations through hypothesis testing, with cumulative evidence, and with nomothetic laws. Creswell and Clark (2007) and Denzin and Lincoln (2000b) share this view and add that quantitative research is inclined to be deductive and normally tests or confirms theory and tends to produce results that can be generalised (Creswell and Clark, 2007). Quantitative methods thus tend to specialise in quantities and are strict in the quantification of observations (data) and on careful control of empirical variables in the sense that numbers come to represent values and levels of theoretical constructs and concepts and the interpretation of the numbers. Quantitative studies stress the measurement and analysis of causal or correlational relationships between variables (Denzin and Lincoln, 2000b).
5.3.3 The Qualitative Approach

Qualitative research on the other hand came into wide use in the early 1970s and introduced the beginning of the interdisciplinary approach (Taylor and Bogdan, 1998). According to Creswell, (2003) a qualitative approach is;

“one in which the inquirer often makes knowledge claims based primarily on constructivist perspectives (i.e. the multiple meanings of individual experiences, meanings socially and historically constructed, with an intent of developing a theory or pattern) or advocacy/participatory perspectives (i.e. political, issue-oriented, collaborative or change oriented) or both” (p18).

In management and organisational research, Currall and Towler (2003) state that typically, qualitative observation identifies the presence or absence of something. The advantage of qualitative methods in the view of Currall and Towler (2003, p12) is that data obtained from either participant observation or interview are rich in detail about interactions among organisational participants. That is qualitative techniques often involve “sustained interaction with the people being studied in their own language and on their own turf”. Second, the qualitative methodologist’s intimate knowledge of organisational history and norms provides an interpretive framework with which to interpret the actions of organisational participants.

Spector, (2005) add that qualitative research, as opposed to quantitative research methods, is that it requires the researcher to become personally immersed in the entire research process, as opposed to being just a detached, objective researcher. It is also based on the inductive approach, and can generate theory whereas quantitative research is based on deductive approach and can test or confirm a theory. Also, the sample size is usually small in the qualitative research. Qualitative researchers are also interested in answering those “why” questions and are not simply carried away by the quantitative answers. The social constructivists argue that meanings are varied and multiple and that research should rely as much as possible on the participants’ views of the situation being studied. However, a disadvantage of qualitative studies is that the results that are produced are less easy to generalise. This has to do with the subjective meanings that individuals attach to their experiences and if the same people were interviewed again, their experiences may differ because these feelings and experiences can change due to circumstances (Neuman, 2000, Lincoln and Guba, 2000).
i. Type of Qualitative method used

In line with the descriptions above and subsequent discussions in section 5.4.3 on choice of methods, the interpretivist method with phenomenology as data collection strategy are the choice of qualitative methodology for the study.

5.3.4 Challenges in the use of MM research

All research approaches have their limitations - so too are MM. Despite the growing interest, some MM researchers (Onwuegbuzie, 2007; Teddlie and Tashakkorri, 2003) still note challenges inquirers face in the use of this method. The former describes these in what they term the six unresolved issues namely: the nomenclature and basic definitions, the utility, the paradigmatic underpinnings, design issues, issues in making inferences in MM research and finally the logistics of conducting MM research. Onwuegbuzie further identified the four crises or challenges that researchers face when undertaking MM research. These are outlined to include the difficulties in; representation - in capturing the lived experience using text in general and words and numbers in particular, in obtaining findings and/or making inferences that are credible, and/or confirmable, integration - the and what he terms politics.

These concerns are genuine and are acknowledged by the investigator. Based on the cautions from researchers already mentioned above about the use of MM, there was careful thought before embarking on the use of MM. Although these unresolved issues and challenges could not be totally eliminated, they were nonetheless kept to the minimum in the study. Aware of the challenges in MM research, the investigator reviewed literature widely during the planning stage and which helped the investigator devise ways to deal with the challenges. First, the literature review enabled the investigator to consider carefully skills needed to be able to integrate methods and philosophies as well as develop questionnaires. As a result, a lot more time was allotted for data collection and transcription so that the massive data could be handled appropriately. Interviews were also planned to last between 45 minutes to over an hour. This was to allow time for clarification to avoid misrepresentation. Again, the analysis stage also had a fair allotment of time with the awareness of the quantum of both textual and numeric data to be analysed as well as the need to integrate the findings into a meaningful outcome.
5.3.5 Rationale for MM Research

Dovona-Ope (2008), states that contextual features and research problems are among some of the important factors that must be considered in making decisions about the most appropriate RD to employ in designing and undertaking doctoral research. As such, there was a careful review of all the factors before MM was chosen for this study. Although this methodology has been highly criticised, it was adopted for the reasons that follow. First, as the study focused on HRM/DE in health in Ghana which is a unique and complex context, MM research design informed by the pragmatic and transformative-emancipatory theoretical positions (Creswell and Plano-Clark 2007; Mertens 2005a; Teddlie and Tashakkorri, 2003) was considered as providing the most appropriate design for this study.

It is the design that enabled the researcher to answer the research questions. Tashakkori and Teddlie (1998) stated that the ultimate goal of any research project is to answer the research questions that were set forth at the project’s beginning. MM are useful if they provide better opportunities for answering the research question. Again, MM research enabled investigator to conduct this study which involved obtaining perspectives from diverse stakeholders and according to Teddlie and Tashakkori (2003), MM provide the opportunity for presenting a greater diversity of divergent views and which made it suitable for this study. Also, another logic underlying the choice of MM was to ensure complementarity of methods since in Creswell et al. (2004), neither quantitative nor qualitative methods are sufficient in themselves to capture the trends and details of the situation but when used in combination, both qualitative and quantitative data yield a more complete analysis, and they complement each other. Giddings et al. (2006) also support the latter’s view when they affirm another dimension of the advantage of MM which can bring value to the research process itself by highlighting the particular shortcomings in each of the methods used and compensating for them.

MM as a methodology was considered for its direct engagement in the complexity encountered by researchers in culturally diverse communities (Creswell and Plano-Clark, 2007; Dovona-Ope, 2008). Thus, it was also considered because of the diverse cultural context within which the study was conducted. It was identified to be useful in elucidating the underlying issues which were important to this study. These were: the need to obtain perspectives from different stakeholders – managers, the managed (living the experiences),
the supervisors and the regulators with an intention of understanding the complexity of the issues and possibly informing policy changes as an outcome of the research.

Also, it is particularly useful in survey, evaluation, and field research (Patton 2002) because it has a broader focus than single method design and gathers more information in different modes about a phenomenon. It can also give insight into complex social phenomena such as managerial effectiveness by producing findings that illuminate that complexity. Thus, the two methods simultaneously accomplished two goals. For instance, quantitative method demonstrated that a particular variable had a predicted relationship with another variable (political and economic environmental factors and organisational processes on recruitment, selection and deployment, promotions etc. in the health sector). This was made known through qualitative research techniques such as document analysis, individual interviews and focus group discussion which answered the exploratory questions about how that predicted relationship actually happens.

This is also supported by Brannen (2006) that while the key research question or questions in a piece of research may be underpinned by realist assumptions, some research questions may be underpinned by interpretivist assumptions, for example concerning how people make sense of their actions. A quantitative researcher may be more concerned with the actions and behaviour of informants while they may also have an interest in informants' meanings, framed in terms of attitudes (Brannen, 2006; Teddlie and Tashakkori, 2003).

Finally, its usefulness as outlined above is such that it was the best design and that answered the research questions of the study and both supervisors supported this approach.

5.4 Philosophical Perspectives

Social and behavioural sciences research have been characterised by pluralism over the past decades. The paradigm–method fit issue in their view relates to how the philosophical paradigms of postpositivism, constructivism and research methods have to fit together. While some (Guba, 1987; Ryan et al., 2002; Smith, 1983), took entrenched positions and viewed mixed methods research as incompatible because certain paradigms and methods could not “fit” together legitimately, others (Crotty, 2004: Greene and Caracelli, 2003; Patton, 1990;
Teddlie and Tashakkorri, 2003) countered this viewpoint by suggesting that different philosophical paradigms and methods were compatible. They argued that the divide between the two methods only occurs at the methods level and not at the epistemology or theoretical levels. These counter arguments led to what has been described as paradigm wars (Smith, 1983).

Crotty (2004), in furthering his argument for the compatibility theorists, notes that paradigms and methods are not inherently linked, and maintains neither are quantitative procedures always objective nor qualitative procedures always subjective. He cited earlier ethnographic researches which were carried out in utterly empiricist, positivist manner and added that quantification is by no means ruled out within non-positivist research as the measure of count is a precious human achievement. Greene and Caracelli (2003) supported this and stated that indeed, the perspective exists today that multiple methods may be used in a single research study to take advantage of the representativeness and generalisability of quantitative findings and the in-depth, contextual nature of qualitative findings. Also, in organisational research, Buchanan and Bryman (2007) admit that the paradigm wars of the 1980s have thus turned to paradigm soup, and organisational research today reflects the paradigm diversity of the social sciences in general. One reason they assigned for this paradigmatic diversity and methodological innovation is that this field is a meeting point for numerous disciplines: psychology; sociology; economics; public policy; human resources among others. Each of these disciplines, and related sub disciplines, brings its own distinct perspectives and traditions.

Brannen (2006) on the debate state that two philosophical traditions have dominated the discussion of MM research strategies: positivism and interpretivism. Qualitative researchers typically locate themselves within an interpretivist tradition, albeit they also often hold realist assumptions about the world and the contextual conditions that shape and embed the perspectives of those they seek to study.

As discussed above, it is important to know the paradigm-method-fit in order to conduct and/or evaluate MM research. For the purpose of this study, the philosophical tradition adopted is a combination of the neo-empiricist stance and constructivist-interpretivist epistemology as by Alvesson and Deetz (2000) and Ponterotto (2005) and post-positivist/critical-realistic (CR) approach as put forth by Sayer (2006). For the former, the
ontological assumption is that reality is subjective and multiple. This orientation is based on the premise that human experience makes sense to those who live in it prior to all interpretation and theorising (Creswell, 2003) and as such it determines what is studied and the methods used to study them. Basing the study on the positivist epistemology, the ontological assumption is that there is objective reality whose understandings and values can be objectified in the people that are studied and when it is done in the right way can discover the objective truth (Crotty, 2004). The methodology also links the philosophy to the research methods that were used. Thus, phenomenology was applied in data collection whose belief is that the researcher cannot detach him/herself from his/her presupposition. By applying phenomenology in data collection, the researcher immersed herself during the interviews with reflexivity which enabled researcher capture relevant data. Next Critical Realism is discussed.

5.4.1 Critical Realism (CR)

Similar to the pragmatist approach outlined above and which has been viewed to be insufficient for addressing MM problems CR rejects the possibility of empirical realism, revolving around the existence of a singular, objective world. CR is a better option to develop a unified approach for validating MM research. Thus, CR constitutes a more cogently articulated philosophical base in this regard (Modell, 2007). Dovona-Ope (2008), quoting Bhaskar (1979) states that CR partly evolved as a critique of the possibilities of such a position, notably visible in the reordering of natural science procedures to the social sciences. More recently, however, it has also been cited as an alternative to the subjectivist turn in management and organization research (Ackroyd and Fleetwood, 2000; Reed, 2005a).

According to Sayer (2006, 2004) and Fleetwood, (2004), CR may thus be seen as a means of elaborating an intermediate position along the objectivist-subjectivist or empiricism-positivism continuum and which forms the third way between the two frequently used to classify social science research and which is in line with the MM. The following sections describe the assumptions of CR philosophy and explain why this perspective suited this type of study.

science that prioritizes ontology over epistemology in the sense that, for critical realists, the way the world is, should guide the way knowledge of it can be obtained. In organizational and management studies CR has been linked to Ackroyd and Fleetwood (2000), Fleetwood and Ackroyd (2004) and Reed (2005).

The ontology of CR according to Sayer (2006), is that, reality exists in three overlapping domains: the empirical – experiences or observed events, the actual – events whether observed or not we can know and observe them and the real – consists of the processes, structures, powers, causal mechanisms that generate events. Another aspect is that social reality is viewed as a socially constructed world, a result of social actors, cognitive resource which has to be interpreted and understood. A realist aims to explain observable phenomena with reference to underlying structures and mechanisms.

CR as argued by Sayer (2004) on causal explanation is that there is more to the world then, than the patterns of events. In his view, events are not predetermined before they happen but depend on contingent conditions, the future is open - things could go in many different ways. The real is therefore a set of structures that have causal powers from which observable events emerge. Such a layered ontology is congenial to a critical structuralist perspective on management, where the observed regularities of organisational behaviour are understood to hide as much as they reveal about the underlying social and psychological causes of domination (Tsoukas, 1994). In effect, it aims to provide a basis for challenging the scientific standing of accounts that naturalize the social world by reporting its manifestations without regard for the underlying structures. Where empiricism and positivism see science as finding patterns among observable facts, critical realism strives to identify the real structures that generate these facts and patterns – structures that are typically not visible to the naked eye (Bhaskar, 1975).

From CR’s ontology and the above arguments, the study adopted it to match the contingency theory which has similar arguments – that events depend on conditions and are not predetermined. This is in line with management decisions which are influenced by the prevailing conditions at the time. It also fits well with the MM research which spans across paradigms.
5.4.2 Choice of methods and Philosophical Assumptions

The choice of MM is based first on CR whose philosophy attempts to fit together the insights provided by qualitative and quantitative research into a workable solution (Johnson et al., 2006). CR’s epistemology as mentioned above is that of a constructivist-interpretivist as by Ponterotto (2005) combined with positivism, phenomenology and discourse analysis focusing on Creswell (2007), Groenwald (2004), Holloway(1994) and Kvale (1996) used for the study. CR has been viewed to provide an alternative to both hopes of a law finding science of society modelled on natural science. Similarly, the theoretical basis for this study is that of open systems which combines contingency theory and which integrates most schools of management thought. It thus links the classical – the equivalent of quantitative and human relations (the qualitative) management theories which can again be associated with the assumptions of empiricism and constructivism respectively as in the mixed methods.
Table 5.2 Summary of MM Research Design

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Qualitative</th>
<th>Quantitative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus</td>
<td>Constructivist/Interpretivist underpinned by Critical Realism philosophy, and retroductive strategy to understand and explain the experiences of respondents about HRM/D implementation in the Public health sector</td>
<td>Use of positivist/objectivist/Empiricism to survey and measure the number of respondents who rate HRM/D activities by managers as effective.</td>
</tr>
<tr>
<td>Data Collection</td>
<td>Use open ended questionnaires to hold long in-depth individual interviews with managers, policy makers and regulators and hold FGDs with employees. Review literature and documents.</td>
<td>Conduct survey with a larger sample of health employees using structured closed ended questionnaires and use data to support qualitative method</td>
</tr>
<tr>
<td>Data Analysis –</td>
<td>Use retroductive strategy and discourse analysis with NVivo7 statistical package to analyse statements into meanings, themes and then description of the experience of HRM/D management practices</td>
<td>Assigning numerical codes. Use of SPSS programme - Descriptive statistical analysis using simple percentages with graphs and charts of independent variables (environmental and contextual factors) and dependent variable(HRM/D functions)</td>
</tr>
<tr>
<td>Product of Study –</td>
<td>Description of the fundamental nature of HRM/D practices</td>
<td>Interpretation of percentages, charts and graphs</td>
</tr>
</tbody>
</table>

Source: Developed by author with reference to Creswell and Clark, 2007

Second reason is that, studies have documented HRM/D effectiveness-organisational performance link. However, there has been the documentation of non-performance in the health sector and which was attributed largely to weak managerial capacity in HRM/D in several policy documents as stated in the introductory chapter. Thus, the study adopted the CR which combines both the post-positivism and positivism paradigms to evaluate the meanings and understanding managers and stakeholders have about HRM/D effectiveness, through their lived experiences. This helped to discover and describe/explain factors that are linked to managerial behaviours and to document these. Since CR seeks to establish the factors which are typically not visible to the naked eye but are real structures that generate
these facts, the qualitative approach is adopted to explore the perspectives of managers and stakeholders of how this relationship actually happened in the health sector of Ghana. By the qualitative approach as in the table 5.2, the study adopted the constructivist-interpretivist ideas as by Guba and Lincoln (1994) which led to the co-construction of knowledge between managers and stakeholders on one hand and the researcher. Such a stance enabled the researcher to discuss the perspectives of all interviewees regarding HRM/DE. This is in line with the constructivists who advocate that knowledge and truth are the result of perspective.

The qualitative method was used as the dominant one because as stated above, the methodology helped the researcher to be involved, observed and was interested in answering the WHY and HOW questions. As this methodology is associated with many different theoretical perspectives as cited by Creswell (2000) and also oriented socially constructed reality and focused on meanings, ideas and practices and took the participants’ point of view seriously without questioning either the wider context of it or the processes that formed it, it was thus the choice for this study.

The choice is further supported by Cummings et al. (1980:39) who see the human situation as consisting of whole systems of experience and action and therefore the need to approach it from a holistic stance. Again since change (policy change and practice of HRM/D with improved environmental factors) is the ultimate concept the study was interested in bringing about, the qualitative methodology as described by the latter, was used through which respondents explored their situation as members of the PHS. Through the in-depth interviews and semi-structured questionnaires a critical review of HRM/DE was done and which led to the identification of multiple environmental and individual factors which influenced HRM/DE. Again this review led to the researcher and researched collating recommendations and devising strategies that could be used to develop plans to change the situation. This is based firmly in the reality of organisation’s members’ experience. This change is also based on the quantitative findings which complemented the qualitative findings. This is supported by Blaikie (2000, p110) and Blaikie (2006, p108), who suggested that in the retroductive strategy, “the strategy begins in the domain of the actual, with observed connections between phenomena, and to explain why such connections occur and the strategies to be developed for appropriate practice”. These served to explain the choice of CR with MM research for this study.
Finally, the researcher picking clues from the arguments explored the best ways of using the methodology to reduce these complexities. While the relationships of variables that predicted ME could be assessed quantitatively; how these relationships happened could not be understood without a qualitative enquiry and thus the choice for the approach. The MM research therefore was better used to explore the views of middle level managers and stakeholders who lived within the organization and experienced the situation. Also, the ontological and epistemological assumptions of the research question which sought to understand and establish these relationships and by using the crossvergence model of appropriate practice and in the particular context by McCourt and Eldridge (2003), thus informed the choice of MM methodology.

The quantitative method was also used to gather information from a larger audience to confirm environmental and contextual factors linked to HRM/D effectiveness and to corroborate or complement the qualitative results.

5.4.3 Phenomenology

As in table 5.2 above, phenomenology was used to guide data collection for the qualitative method whilst the concurrent nested survey strategy described by Creswell (2003) was used to collect the quantitative data. Thus, in line with Moustakas (1994, p34) transcendental phenomenology “the investigator sets aside as much her experiences to take a fresh perspective as if for the first time” the issues of HRM/D practices in the PHS and described as accurately as possible the phenomenon, refraining from any pre-given framework, but remaining true to the facts as phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved (Groenewald (2004). Therefore, in applying phenomenology based on the latter’s assertions, the concern was on the lived experiences of managers themselves and the stakeholders who were involved with HRM/D activities.

Having outlined the research paradigm used, the subsequent section gives details of the next stages of how the research was conducted. It starts with a description of the fieldwork process which again comprises a series of activities - location of the research participants, followed by the sampling and data-gathering methods. Thereafter the data handling methods are outlined.
5.5 Fieldwork process

The process of conducting the fieldwork comprised a series of tasks. These included the identification of accessible and suitable groups of respondents, initiating contacts with these individuals, preparing for the interviews and survey, arranging and carrying out the interviews, and finally recorded interviews into a format that could be used for the analysis.

5.5.1 Selection of Regions and Rationale

As stated in chapter two, Ghana is divided into ten Administrative Regions and 170 districts. The Health sector has Regional and District Health Directorates (RHD/DHD) in all the ten regions and in 130 districts. Two regions - Northern and Greater Accra representing the Northern Savannah and the Coastal belts respectively were purposively sampled. The selected regions had characteristics that made them suitable for a comparative study. They represented the two geographical locations, the North-South divide, urban and rural areas, cultural differences and inequities in social amenities.

Also, the two highlight extreme and insignificant magnitude of health and social issues including HR management. For instance, data on the background on human resource distribution given in chapter two revealed huge disparities between the two regions with the northern region mostly deprived of this resource. The rationale therefore was to find out and compare factors which relate to this trend. The selected districts were based on time, accessibility and logistical reasons. Table 5.3 shows some of the disparities in health indicators where the northern region is much more deprived.

Table 5.3 Some Characteristics of the study regions

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Greater Accra</th>
<th>Northern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land mass</td>
<td>3,245 sq kms</td>
<td>70,384sq.kms</td>
</tr>
<tr>
<td>Population</td>
<td>3,997,879</td>
<td>2,209,100</td>
</tr>
<tr>
<td>Number of districts</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>No. of Health facilities</td>
<td>272</td>
<td>129</td>
</tr>
<tr>
<td>Under-5 mortality Ratio</td>
<td>41/1000</td>
<td>171/1000</td>
</tr>
<tr>
<td>Nurse-population ratio</td>
<td>1:979</td>
<td>1:1868</td>
</tr>
<tr>
<td>Doctor-population Ratio</td>
<td>1:5,202</td>
<td>1:92,046</td>
</tr>
</tbody>
</table>

5.5.2 Role of researcher

The role of the researcher was that described by Moustakas (1994, p34) in transcendental phenomenology where the investigator sets aside as much as possible her experiences to take a
fresh perspective of the phenomenon under examination – a situation “in which everything is perceived freshly, as if for the first time”. Also, the researcher repositioned herself away from the all known analyst to the acknowledged participant (Creswell, 2007 quoting Charmaz). Thus, during the interviews, personal details about researcher were scanty and kept to a minimum to encourage free flow of information. Also owing to the fact that MM research was the choice of this study, in which reflexivity is emphasised, the researcher acted in line with Blaikie (2009, p107) and became the “faithful reporter, the mediator of language, the reflexive partner, the conscientizer and the postmodern “narrative dialogue.”

5.6 Research Parameters

The following research parameters were used

5.6.1 Sampling Techniques for both methods

The main respondents were the MMDDHS. This was determined on the basis that the MMDDHS are the central figures in implementing HR activities at the district level. As a result, it is around the MMDDHS that the socio-cultural and other environmental factors and their dynamics around HRM/D emanate. Skulmoski et al. (2007) quoting several sources (Anderson, Myers, and O’Brien, 1994; Ashton 1986; Bolger and Wright 1994) in their Delphi research, acknowledge that selecting research participants is a critical component of research since it is their expert opinions upon which the output of the research is based. Thus, they outlined four requirements for expertise.

In gathering data for the two methods, purposive random (expert) and (heterogeneity) sampling was used to select participants from the two regions for the qualitative and quantitative methods respectively. Purposive sampling was done in line with the above authors’ views. People were selected not to represent the general population, rather their expert ability to answer the research questions - knowledge and experience with the issues under investigation, capacity and willingness to participate, sufficient time to participate and effective communication skills. The samples included the primary participants – MMDDHS and three groups of respondents - policy makers, representatives of regulatory bodies and employees. This method of sampling is considered by Welman and Kruger (1999) as the

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7 i) knowledge and experience with the issues under investigation; ii) capacity and willingness to participate; iii) sufficient time to participate and, iv) effective communication skills
most important kind of non-probability sampling, to identify the primary participants. This sample was selected based on researcher’s judgement and the purpose of the research (Babbie, 1995; Greig and Taylor, 1999; Schwandt, 1997) in looking for those who “have had experiences relating to the phenomenon to be researched” (Kruger, 1988, p150). This method was therefore used for the managers, policy makers and regulators. Heterogeneity/diversity sampling was used for both employees for the quantitative data and FGDs because researcher wanted to include all opinions or views and was concerned about representing these views proportionately for the various health professionals to get a broad spectrum of ideas. This is because the health sector is made up of diverse professional groupings.

Another reason for the selection of these districts was based on well performing and least performing districts. The selection of such districts was done with the help of the respective RDHS or their representatives and the HR Managers. This informed the inquirer of the qualities or factors that enabled those to either perform well or less in HRM/D and comparisons made and lessons learnt from the two. For instance, the use of indigenous practices by some MMDDHS to motivate staff was identified in the findings and the proposals of the study. The above choice of districts was strongly linked to McClellands’ (1998) remarks that in each job some people perform much more efficiently than others because they use different ways and behaviours to carry it out. Therefore, the best way to identify the competencies that lead to high performance is to observe the most successful workers. So, in defining the competences model for the organisation it is fundamental to find those behaviours that best contribute to the achievement of objectives.

5.6.2 Levels from which participants were selected

The respondents mentioned above were from the four levels of health service delivery – national, tertiary/regional, district and sub district. Policy makers were selected from regional and national levels but mostly from the national since most policy processes originated from the national level. The four stakeholders selected were all from the professional regulatory bodies and associations and they are all based at the national level. All manager-respondents were either from the metropolitan/municipal/district levels. All of them are also based at these levels which are the service implementing points. Employees were selected from all levels but mostly (over 90%) from the sub district and district with the remaining 10% from regional and tertiary levels.
The aim for this multi stakeholder perspective was to get as many perspectives as possible regarding the managerial effectiveness based on HRM indicators outlined below. This is due to the fact that HRM/D is central to the health sector and since the health sector is made up of multiple stakeholders, for any research on HRM to be meaningful; such a research should seek the views of some of these stakeholders in order for the results to be cuddled. Second, this was also to overcome the potential of respondent bias when MMDDHS alone report on the performance of their own HR activities (Wright, 2005). The use of managerial views on HRM, therefore, does not reveal how satisfactorily HRM is achieving the objectives of other relevant constituencies. This strategy is also in line with authors like Geare et al. (2006) who stated that it has more recently been acknowledged by others like Cully, Woodland, O’Reilly and Dix (1999) and Guest (2001, p1094) that the employee voice should be heard and that the argument for taking cognisance of employee voice is compelling because it “…acknowledges the important position of employees as stakeholders in their own right”. This is also seen by Greonowald quoting Arksey and Knight (1999) and Bloor (1997) as a form of ‘data triangulation’ to contrast the data and ‘validate’ the data if it yields similar findings.

The choice of policy makers and employees are thought to be the two important groups and is in line with the above arguments. In the researcher’s perspective, the policy makers appointed these managers and also have advisory roles while the employees experienced the style of management. This choice helped the four groups highlight the kind of competencies that managers should have since the policy-makers were their superiors and gave useful input. They were also able to outline the level of skills managers ought to have. Employees on the other hand appraised their managers since they experienced the managerial behaviours managers exhibited. The fourth group of respondents who were the professional bodies/Associations was also necessary as most negotiations on policies on personnel training and remuneration were under their purview and initiation respectively. This kind of triangulation not only highlighted the same issues from the four different perspectives but also showed how the stakeholders viewed managers. Furthermore, in the view of (Basit, 2003) this strategy proved invaluable in checking the validity and reliability of the data.

Thus, the diverse stakeholder groups evaluated HRM/D differently, and these differences are reflected in the differing objectives pursued. Consequently, in the findings there was a gap between the managers and the employees’ perceived levels of HRM/D related attributes.
Whereas managers stated they were doing well in some HR activities, (e.g. rewards management and training and development) employees and policy makers held contrary views. This made the results of the study to portray diverse views and also gave weight to the competencies generated and more representative of the diverse workforce in health.

5.6.3 Criteria used for selecting well and less performing districts

The selection criterion of well performing and less performing districts was used and this was based on the achievement of HRH indicators as follows: Therefore all MMDDHS/representatives and their employees automatically became participants

- % employee retention per year in district
- % of annual performance appraisals submitted on time
- % of absenteeism of employees per month
- % of employees recognised and rewarded for good performance per year
- Number of new employees provided orientation
- Number of employees sponsored for further training per year
- Number recommended for promotion out of turn for good performance
- Number of days to respond to employee request
- Number of injured employees through work accidents per year
- Number of employee grievances per year
- Level of morale among employees in district (responses, narrations expressions from focus group discussions. The achievement of these indicators will ultimately influence the achievement of health indicators which is a reflection on staff performance.

5.6.4 Sample size

A total of 414 individuals participated in the study for both methods. Details are shown in table 5. 4
Table 5.4 Details of the Sample.

<table>
<thead>
<tr>
<th>Regions</th>
<th>Qualitative Sample</th>
<th>STAKEHOLDERS</th>
<th>FGDs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Managers</td>
<td>Policy makers</td>
<td>Regulatory and Unions representatives</td>
<td></td>
</tr>
<tr>
<td>Northern</td>
<td>10</td>
<td>1</td>
<td>-</td>
<td>41</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>8</td>
<td>1</td>
<td>-</td>
<td>38</td>
</tr>
<tr>
<td>Tertiary</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>National</td>
<td>-</td>
<td>7</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Subtotal</td>
<td>18</td>
<td>11</td>
<td>4</td>
<td>79</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Quantitative Sample - Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>111</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>191</td>
</tr>
<tr>
<td>Subtotal</td>
<td>302</td>
</tr>
<tr>
<td>Grand total</td>
<td>414</td>
</tr>
</tbody>
</table>

Though it was intended to have equal sample numbers of manager-respondents from the two regions, it was however, difficult to gain access to the managers in the Greater Accra region (GAR) and this difficulty led to more managers to be interviewed in the northern region. This notwithstanding, met the requirement as suggested by Boyd (2001) who regards two (2) to ten (10) participants or research subjects as sufficient to reach saturation. Creswell (1998, p65 and 113) also recommends “long interviews with up to 10 people” for a phenomenological study.

Also, the aspect of redundancy of information with no new or similar information received also made the sample to be adequate. Guba and Lincoln (1985, p202) advised that ‘redundancy’ to purposive sampling be terminated ‘when no new information is forthcoming from new sampled units’. By this stage, the study had covered a geographically representative sample of managers and employees.

5.6.5 Biographic Data:

Respondents for both methods were aged between 25 and 58 years and comprised both sexes with a higher proportion being females. Their qualifications ranged from certificates to doctoral degrees with majority in the diploma group. Majority were married and were from diverse professions. Most of the eighteen MMDDHS or their representatives were persons
who had served in the position for at least three years or more. Only two had served less than three years whilst three who had served over four years were still in acting positions.

5.6.6 Data collection strategies in using mixed methods:

From Creswell (2007), there are different models within the mixed methods strategies among which is the concurrent nested strategy used in this study. This strategy has a dominant method that guides the study (Tashakkori and Teddlie 1998). This was chosen for various reasons. First, due to time, inadequate funding and logistical issues, the travel between the United Kingdom and Ghana and between regions more than once was not sustainable. Second was the fact that it was intended to conduct the qualitative which is the main method first and this allowed investigator to administer the structured interview schedule. Data was collected concurrently but separately in the selected districts, tertiary institutions and at the National Headquarters using in-depth face-to-face interviews, focus group discussions and structured interview questionnaires for both methods. This is similar to a strategy used by Basit (2003) in which the study interviewed the key subjects who were adolescent British Muslim girls as well as their teachers and parents as outside influences.

5.6.7 Interview process

Having identified the regions and districts that conformed to the criteria outlined for respondents, letters were obtained from the Director, human resources directorate which introduced the researcher, detailed the purpose and aims of the study and the number, type and calibre of participants required and despatched six weeks prior to the start of fieldwork to the two RDHS. The letter also outlined steps that would be taken to ensure confidentiality and also indicated it was purely on voluntary basis. This was to give the RDHS ample time to inform the directors of the selected districts to be in readiness for the interviews. Researcher then followed up with phone calls after two weeks to ascertain the receipt of the letters. A week to the start of the study, a final phone call was made to inform the directors of the arrival of the researcher and research assistant two days prior to the start of interviews to plan sequence of visits to the districts.

As part of the preparation for the interviews, questionnaires were designed with broad thematic areas. This was with the intent to elicit information from respondents in a reasonably consistent manner. These thematic areas were based on managers’ knowledge
about organisational goals and strategy and their fit with HRM/D activities and managers’ own approach to the implementation of HRM/D activities. These were likely to lead onto the link with environmental factors including political, socio-economic and socio-cultural which influence the management of the staff. More details are given in questionnaires.

5.6.8 Interviewing techniques

i. Qualitative method

For the qualitative method, a suitable evaluative research strategy- phenomenology that restricted the researcher's biases in HRM/D effectiveness was used for data collection. Strauss and Corbin (1998, p11) state that qualitative method is “one way of gathering knowledge about the social world…. can be used to explore substantive area about which little is known to gain novel understandings”. Phenomenology which seeks to gather information of which some may be sensitive combined with the conversation method in which two people talk about a theme of mutual interest (Kvale,1996) were used. The concern of the researcher is focused on the lived experiences of the people involved, or who were involved with the issue that is being researched and would not prescribe techniques (Holloway 1997). Moreover, the postmodern approach has been used by the former to compare the interviewer with the traveller or miner. Similarly, May (2002, p226) likens interview to excavation and construction. Thus, the researcher therefore adopted this method for the study in order to “excavate” issues of particular interest to gain a sense of what might be the priorities of the respondents. Thus, the researcher and research assistant used the conversation style to interact with respondents. By so doing, the objective was to relax respondents and this enabled both sides to delve deep into issues to uncover how HRM/D activities are carried out by managers.

On the specific phenomenon of HRM/DE managers were allowed to self-appraise themselves as to what they understood by managerial effectiveness using unstructured interviews in the qualitative interviews. The central research question was: What is the nature of HRM/D in the PHS of Ghana? However, Geare et al. quoting Bentz and Shapiro (1998) and Kensit (2000, p104) caution that the researcher must allow the data to emerge: “Doing phenomenology” means capturing “rich descriptions of phenomena and their settings”. For
this reason, two examples of the actual research questions that were put to all participants are as follows:

- What is your understanding of HRM/D effectiveness in the areas of recruitment and selection, performance management, rewards management and staff development?
- What are your views about your managers’ effectiveness especially as it relates to HRM/D functions?

5.6.9 Document Analysis

In addition to the in-depth individual interviews and survey for all stakeholders, secondary data was also gathered from documents in the health sector, search from books, journal articles as listed in table 5.5. Silverman (2005) argues that texts and documents are useful sources of data in both qualitative and quantitative research. These documents and guidance from supervisors provided good sources of literature to augment the previous methods. All three sets of questionnaires had similar themes except the questionnaire for managers’ was more detailed.

Table 5.5 Sources and Number of documents Analysed

<table>
<thead>
<tr>
<th>Documents for Content Analysis</th>
<th>Total Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government of Ghana</td>
<td>13</td>
</tr>
<tr>
<td>Ministry of Health/Ghana Health Service</td>
<td>21</td>
</tr>
<tr>
<td>Academic papers and Journals</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
</tr>
</tbody>
</table>

i. Pre-test of questionnaires

Prior to the conduct of the interviews, both instruments were piloted in another region - Upper West region in May of 2009, with some minor adjustments made before the interviews and survey were launched in July of 2009. During this phase, one policymaker, two District managers were interviewed and five employees completed the structured questionnaires. This highlighted ambiguous questions and terms that were difficult to comprehend. From this, the information and lessons learnt from the pre-test were used to fine-tune the individual interview and structured questionnaires. The researcher then reframed or rephrased the
questions for easy comprehension and to remove ambiguities. This is supported by Stewart and Shamdasani (1990, p103) who state;

“there is no substitute for pre-testing…questions regardless of how experienced the researcher…as pre-testing gives opportunity to determine if questions are appropriate and to identify questions that are not easily understood”.

The pre-test also provided responses which were not very different from the actual field work.

ii. The Interview

This section explains how the interviews were conducted. Individual interviews were held for managers, policy makers and representatives of unions and regulatory bodies. Focus group discussions were also conducted for supervisors and frontline workers (referred to as employees). Most manager-respondents, policy-makers and regulators were interviewed in their offices which were comfortable and quiet as they put notices to keep off visitors. The interviews lasted between one hour and about an hour and a half. The interviews began with exchange of pleasantries or familiarisation questions which served as an initial icebreaker to establish rapport. This included self introduction, explanation of the purpose of the interview to respondent and how long the interview would last. The interviewees were also allowed to introduce themselves and clarify issues. Next, issues of confidentiality were discussed and respondents were assured of confidentiality. Before the start of the interviews, the consent of interviewees was sought through the signing of the written consent form. Respondents were also told they could withdraw at any stage of the interview if they did not feel comfortable since it was purely voluntary. They were also assured that no respondent would be judged based on their responses. Permission to record and take notes during the interview was also sought. During these opening interactions, the opinion of respondents were solicited to get them relaxed and involved in the process. This was in line with Kvale (1996), who asserts that the initial responsibility of the moderator is to establish a non-threatening climate where group members feel comfortable to offer their comments and suggestions and to ensure active participation.

The conduct of the interview followed from this and was done in line with McCracken (1988, p38) in which one begins the interview by demonstrating that the interviewer is a “caring, accepting, curious (but not inquisitive) individual who is prepared and eager to listen to virtually any testimony with interest”. Thus, the moderator listened attentively to interviewees and only interrupted to clarify statements. Respondents either probed or asked
the moderator questions. Having created the therapeutic environment, the moderator then proceeded first with some questions to gather biographic data on respondents. This included name, date of birth, marital status, level of operation, nationality, educational background, and years in employment among others. After this, the moderator then moved into the questions related to the topic. In line with Welman and Kruger (1999, p196), the questions were “directed to the participant’s experiences, feelings, beliefs and convictions about the theme in question”. This study entailed asking the participants to reflect on HRM/D implementation and to share their reflection on its value. Data were obtained about how the participants think and feel in the most direct ways (Bentz and Shapiro, 1998, p96). Researcher then focused on “what goes on within” the participants and got the participants to “describe the lived experience in a language as free from the technical language and society as possible”. Further, it was important to keep in mind that the findings may, or may not, illustrate that the practice of HRM/D contributes to the performance of the health sector but to gain an understanding into ‘why’ and ‘how’ and explain. In this regard Bentz and Shapiro (1998, p39) state that “inquiry doesn’t mean looking for answers”.

As the interview progressed, respondents also cross-examined researcher about some of the issues. This supported the description of the interview being a specific form of human interaction in which knowledge evolves through a dialogue (Kvale, 1996). This discussion was quite lengthy as respondents were always very interested in knowing researcher’s views. However, after a while, researcher had to regain control of the process and had to quickly reflect on a previous response with a follow-up question linking to another theme. This enabled the flow of the interview as planned. During the interview, researcher probed to get more detailed answers. Also, follow-up questions were asked to make meanings clearer. Occasionally, investigator read back some responses to interviewees to ensure the exact meanings. This, according to Bailey (1996, p72) the “informal interview is a conscious attempt by the researcher to find out more information about the setting of the person”. The interview is reciprocal: both researcher and research subject are engaged in the dialogue and thus researcher made room for this dialogue to take place. Kvale (1996, p1-2) remarks with regard to data capturing during the qualitative interview that;

“it is literally an inter view, an interchange of views between two persons conversing about a theme of mutual interest,” where researcher attempts to “understand the world from the subjects’ point of view, to unfold meaning of peoples’ experiences”.

134
During the final part of the interview which was related to indicators for managerial effectiveness, the interview followed that of Brodie and Bennett (1979, p20) who used the approach of retranslation of expectation procedure. This involved the respondents in listing the indicators of effectiveness.

‘Memoing’ (Miles and Huberman, 1984, p69) was another important data source in qualitative research that was used in this study during the interviews. This is the researcher’s field notes that were taken of what the researcher hears, sees, experiences and thinks in the course of collecting and reflecting on the process. As it has been observed that researchers are easily absorbed in the data-collection process and may fail to reflect on what is happening it was important that researcher maintained a balance between descriptive notes and reflective notes, such as hunches, impressions, feelings, and so on. Thus, more recording was done with the research assistant taking notes and which were later on reviewed by researcher. Miles and Huberman (1984) emphasize that memos (or field notes) must be dated so that the researcher can later correlate them with the data and so these were dated accordingly.

During the interview and at the end of each interview, respondents were given the chance to clarify any issues or make any additional comments. We both adjudged the interaction to be good and congratulated each other. Lastly, researcher reminded them of the purpose of the interview to confirm their acceptance before parting. Same principle was used for the FGDs but group members were encouraged to contribute and also appreciate everyone’s opinion.

i. The quantitative component

In gathering the quantitative data, the strategy was different. Structured questionnaires were used to obtain the perspectives from mostly employees. While it was not possible to administer the questionnaires to all employees on the same day due to the scattered nature of the health facilities, researcher was fortunate to have the research assistants who were based in the regions/districts who sent them out to employees of the selected regions and districts and in two isolated cases, the managers including HR managers and officers accepted to distribute the questionnaires on my behalf and which were returned between one to two weeks upon distribution.
As a result, the researcher easily reached a target sample of at least 302 respondents out of the 580 questionnaires that were distributed.

All the questions focused on the degree of effectiveness to which they judged managers in carrying out HRM/D activities and environmental factors which were either challenges or opportunities that were available to managers for managers’ performance. This group was also requested to list indicators of managerial effectiveness as the final part of the questionnaire. Below is the explanation of the codes for rating managers’ degree of effectiveness.

5.6.10 Measures and Codes of the Quantitative data and their meanings

For close ended questions on manager’s performance, respondents were to answer whether or not they strongly disagree, disagree, not sure, agree or strongly agree to the statements about the HRM/D implementation effectiveness of managers on the following dimensions: Knowledge of health sector goals, strategies and priorities, and their alignment of these to HRM/D practices, Recruitment, selection and deployment, Performance Management (job descriptions, feedback, recognition), Training and Development (Orientation, Training Needs Assessment, Management Development) and Rewards Management (extrinsic and intrinsic including good and safe working environment).

For each of the listed HRM/D activities, respondents were asked to check one category on a five-point Likert scale with explanations for the choice of rating, where each point was labelled from 1=strongly disagree as the lowest rating to 5= strongly agree as the highest rating. Care was taken to define the meanings of the scales as below since these were likely to be open to different interpretations.

The codes ranged from 1 - 5 as indicated below:
1 – Strongly disagree
2 – Disagree
3 – Not sure
4 – Agree
5 – Strongly agree
i. Interpretation of responses

Strongly disagree: An employee who strongly disagrees to a statement meant that the manager did not perform that activity at all and there was evidence to that.

Disagree: An employee who disagrees to a statement meant that the manager did not perform that activity but there was no evidence to that.

Not Sure: this meant employee could not tell if manager performed that activity or not.

Agree: This meant the manager performed the activity but there was no evidence to show.

Strongly agree: This represented a situation where the manager performed the activity and there was evidence to that.

The first section of the questionnaire was to gather socio-demographic data of respondents such as gender, age, religion, marital status, education among others.

5.7 Reliability and Validity

The issue of reliability and validity in MM research is controversial. While some contend that the use of triangulation in MM research serves to ensure validity, others think otherwise. For instance, Blaikie’s (1991) criticism of triangulation for ensuring validity concerns the licensing of researchers as detached and neutral adjudicators between subjectively held views of reality. Such a position is alien to genuinely interpretive researchers and arguably not one on which a convincing case for triangulation as a means of validation can be built. Supporting this argument, Silverman (1993) critiqued by suggesting that:

“...the major problem with triangulation as a test of validity is that, by counterposing different contexts, it ignores the context-bound and skilful character of social interaction and assumes that members are ‘cultural dopes’” (p158).

On the other hand, Modell (2007) admits a high degree of construct validity has been established and that triangulation may also be used for enhancing internal validity. However, the latter acknowledges that the views of how this may be accomplished vary somewhat in the literature. Some authors (Bryman and Bell 2003; Bryman, 1988; Hammersley, 1996) primarily see triangulation as a useful means of internal validation where dissimilar methods produce converging findings. Under such circumstances, qualitative data may enrich and substantiate causal explanations suggested by statistical co-variations in the same empirical setting. Other authors have ascribed a somewhat wider role to triangulation beyond mere...
corroboration, arguing that it may also shed additional light on and explain unexpected or diverging findings (Brewer and Hunter, 1989; Denzin, 1978; Jick, 1979).

Following from the above arguments, reliability and validity was ensured first of all by the use of the MM which served to ensure two methods complemented for the biases of each method. Modell (2007) argued that the strengths and weaknesses of different methods should ideally cancel each other out such that research yields more valid, or precise, representations of these phenomena. Second, the fact that triangulation was the strategy also served to ensure validity. The purpose of triangulation, as normally conceived in the social sciences, is to enhance the precision of the representation of the same empirical phenomenon by examining it with the aid of different theories, methods, data sources and/or investigators (Bryman, 1988; Denzin, 1978). Again, during the interview process, where interviewer either asked follow-up questions to make meanings clearer or occasionally, read back some responses to interviewees or probed to get more detailed answers and also clarified responses with respondents with respondents also seeking moderator’s views on some of the issues ensured inter rater reliability.

5.8 Analysis of data

As a brief mention, the framework of this study was to use the systems theory of internal and external fit to understand and explain the meanings of changing relationships dynamics among HRM/D practices, health sector strategy and environmental factors which were empirically derived from participants’ interviews. In furtherance of the research methodology, a two-level analysis was conducted in order to better understand the implications of the choice of the MM. In line with this, an analytical framework was adapted from Marquart and Zercher (2000) which makes use of the retroductive strategy for analysing qualitative and quantitative material/data.
The rationale for retroductive strategy analysis is that this framework provides for cross-over tracks analysis of data for both methods. In cross-over tracks analysis, findings from the various methodological strands intertwine and inform each other throughout the study as both approaches follow similar steps of data reduction, transformation, data comparison and integration.

5.8.1 Data processing

As noted by Dey (1993), raw data can be very interesting to look at, yet they do not help the reader to understand the social world under scrutiny, and the way the participants view it, unless such data have been systematically analysed to illuminate an existing situation.

5. 8.1.1 Qualitative material

Discourse analysis was used in this study to process the data. The focus of discourse analysis which has been adopted by constructivist is any form of written or spoken language such as
conversation. Mills (1997) adds that it is possible to view discourse analysis as a method for examining all sorts of sign systems such as visual and behavioural ones, and not only verbal ones since its concern is with the detail of how something is expressed, and what its patterns and hence meanings are. This therefore made it the choice for this study since the main topic of interest is the underlying social structures, which may be played out within the conversation or expressions, signs or text. According to Barker (2003), discourse analysis is a way of understanding social interactions and that the process involves attempting to identify features in the text such as themes (especially those that relate to identities). Also, Fairclough (2003) states that discourse analysis uses codes and that, codes serve to summarise, synthesise and sort many observations made of the data. Thus, it helps to reduce data by the use of Language.

Thus, data was processed using discourse analysis. The processing employed two stages - data processing during and after collection.

**i. Data processing during data collection**

Since May 2009, recorded interviews were transcribed verbatim from the 33 individual interviews and 8 FGDs and compared with the hand recorded notes and memory recall. The aim of this according to Flick (2005) is to represent on paper as accurate as possible the strings of words uttered. This was then subjected to line-by-line scrutiny and issues selectively categorised into the thematic areas and linkages using descriptive phrases for common and main themes. The recordings of the in-depth individual interviews and focus group discussions were selectively transcribed and broken into themes. Episodes related to the thematic areas of the health sector’s goals, objectives and strategies and the four HRM/D practices including the external and internal organisation’s environmental factors were extracted. The number of episodes that appear in the final version of data analysis was gradually reduced as the research became more focused. Next, the material was conceptualised and the product coded into the key themes and appropriate sub-categories. This was edited and compared with field notes and memory recall again to ensure consistency. This was then categorised into themes.

The data processing after data collection for both the material collected using the individual in-depth interviews and the questionnaires which were distributed was in line with the research methodology. The intention was to establish the links between the conceptualisation
of the data analysis methodology of the study elaborated upon in this chapter and its realisation as it took place during and after interviewing. Data was analysed using an analytical framework above.

During this stage, in addition to the steps outlined in the data collection stage, researcher completed the transcription and then analysed and compared with field notes again. At this stage, codes were allocated to the text as in the collection stage. The analytical process involved coding strategies: the process of breaking down the text into distinct units of meaning which are labelled to generate concepts. The categories were on knowledge and skills, managerial capacity on recruitment and selection, performance management, rewards management and staff development with motivation underpinning the four functions and external and internal environmental factors as per the evaluation framework were done. Next, researcher examined some of the 41 transcripts from the interviews to determine the main categories to be used to code the data.

In doing this, the study reviewed recordings from MMDDHS, medical directors, policy makers, regulators and employees’ views on aspects of HRM/D, organizational strategy processes and priority HRM policies relating to recruitment, performance management, staff development and rewards management as well as external and internal environmental factors.

As already stated above, this first section analyzed data and material based on the research objectives. As such, the section begins with the analysis of the respondents’ characteristics. This was then followed by the questions related to the first objective and which included the goals, objectives, priorities and strategies of the organization (health sector), model of health service delivery and the linkage of the HRM processes to these. Next, questions related to the second objective are analyzed and then continued in that order until all the other questions for the remaining objectives are analyzed.

When the categories were viewed to be satisfactory, coding was then done. The material was coded using NVivo7, a software package designed to aid the analyses of qualitative data, which is the most recent version of NUD*IST (Non-numerical Unstructured Data). As the NVivo was already on the computer, a project was created in NVivo, and referred to as “Knowledge in HRM/D Practices”. The interview transcripts, which were in a word format, were saved and these documents were imported into NVivo. Since the researcher already developed the main categories, a list was prepared of these codes (called ‘nodes’ in NVivo). These included definitions, knowledge of health sector goals and HRM/D practices,
perspectives of HRM/D practices, challenges and opportunities. These nodes were the main themes which also had sub categories and each assigned a position on top of the five ‘trees’ that constituted the node listing for the project. These sub categories can also be viewed to be in a hierarchical manner (Creswell and Plano, 2005). The entire document was coded in a similar fashion, using different tree nodes.

Coding or categorizing the data has an important role in analysis. It involves subdividing the data as well as assigning categories. In line with op cit and the framework above, the first step was to reduce the volume of the data from the transcribed interviews by coding into thematic areas in Nvivo 7 programme. These contained the key thematic areas of Human resources’ managerial effectiveness as in the questionnaires used to gather data and as perceived by the participants. This is in line with Miles and Huberman (1994), provisional “start list” of codes which are created prior to fieldwork. That list came from the conceptual framework, list of research questions, problem areas and/or key variables that the researcher brought to the study. Coding material in line with themes of research helped to avoid the inclusion of unrelated material to the research questions. For this reason, the unit of analysis for coding were the sentences that identified with the thematic areas. Codes or categories are tags or labels for allocating units of meaning to the descriptive or inferential information compiled during a study. Codes usually are attached to chunks of varying-sized words, phrases, sentences or whole paragraphs, connected or unconnected to a specific setting. They can take the form of a straightforward category label or a more complex one, for example, a metaphor (Miles and Huberman, 1994). Seidel and Kelle (1995) view the role of coding as noticing relevant phenomena; collecting examples of those phenomena; and analysing those phenomena in order to find commonalities, differences, patterns and structures. Creating categories triggers the construction of a conceptual scheme that suits the data. This scheme helped the researcher to ask questions, to compare across data, to change or drop categories and to make a hierarchical order of them. Gough and Scott (2000) argue that it may be useful to identify two distinct, albeit linked, phases to data coding: one focusing on meanings inside the research context and the other concerned with what may be meaningful to outside audiences.

5.8.1.2 Quantitative data

The quantitative method was used to analyse the completed 302 structured questionnaires returned from employees. Numerical codes were assigned to the various thematic areas and
each questionnaire was entered one after the other until all questionnaires were completed accordingly. This was done with the use of the Statistical Programme for Social Science (SPSS, version 16) in which data was coded and manually inputted with the codes onto the programme. As the researcher was only interested in a broad picture from the quantitative data to complement the qualitative material which is the main method of the study, analysis involved only simple frequency counts on SPSS with cross tabulations and linear regression. This helped to give the relationship between the independent variables (environmental factors and organisational processes) and dependent variables (HRM/D practices). Results were then be interpreted for their significance.

The next stage was the data reduction during which data were run using frequencies and cross tabulations. These were finally transformed into tables, graphs and charts. This then made it easier for interpretation with the graphical representations. The data transformation stage was when the data was drawn into patterns and for this the themes were already outlined in the questionnaires. Such data consisted of respondents’ characteristics and employees’ perspectives/assessment of Managers’ effectiveness. As stated, the thematic areas in this section are the personal data and the context of the organization for both methods of analysis. Although all thematic areas were analysed, however, based on the analytical framework of data reduction, not all thematic areas are presented and discussed from the analysed data. The areas presented and discussed were based on a careful selection of thematic areas that were deemed to have more relevance to the study. Respondents’ characteristics were analysed first and then the context of the organisation.

Having done the coding and data entry, the material was then transformed into summaries for the qualitative and into tables and graphs for quantitative. Then the summaries for the qualitative and the graphs for the quantitative were then triangulated (complemented, corroborated or elaborated Brannen, 2005), discussed and presented in graphs, pie-charts, histograms etc. into meaningful results.

5.8.2 Ethical Issues

Although the research undertaken did not involve any form of invasive medical or laboratory procedures and tests, it was conducted in line with the ethics of research as outlined in the
British Sociological Association (BSA) and other ethical requirements within the Ghana Health Service. The research proposal which had been approved by the University of Manchester was then summarised and submitted to the Ethics committee of the Ghana Health Service (GHS) and approved.

Next, consent was obtained from all participants who participated in the study. Kvale (1996) and Bailey (1996) caution that deception may be counter-productive and that deception might prevent insights, whereas honesty coupled with confidentiality reduces suspicion and promote sincere responses. Based on this, a consent form was developed and informed consent obtained from participants.

Prior to the interview, respondents were briefed on the following below after which informed written consent was sought from the respondents regarding the interview. All respondents including those for the Focus Group Discussions (FGDs) were also told that their participation was on voluntary basis and therefore had the option to withdraw at any stage of the process.

1. Respondents and participants were told that they were participating in a research study conducted by a doctoral student from the University of Manchester and that the results will be part of her thesis which aims to contribute to HRH managerial policy development to improve competencies of line managers within the PHS of Ghana. They were also told to ask any questions or concerns they had about the research, and to feel free to contact the researcher or Faculty Supervisor(s).

2. Regarding confidentiality, interviewees were assured of anonymity and that names would neither be mentioned in any part of the report nor would any presentations be made that point to any interviewee. Also, respondents were told the material obtained would be analysed and used as basis for developing appropriate strategies for effective HRH Management. Finally, they were informed that a copy of the thesis would be retained by the University of Manchester.

At the time of the interview, the purpose of the interview was also explained to respondents as an introduction including the approximate length of time for the interview and consent was sought from the respondent to be recorded prior to the start of interview.
3. Before participants signed the written consent form (as attached as Appendix…) this was explained to them at the beginning of each interview. Other explanations that were repeated to participants to respondents before the interview included amongst others were the purpose of the study and the length of time.

5.9 Conclusion

The ontological and epistemological debates on MM literature have been characterized by considerable polarization. This has been described as the paradigm wars in social science research and which has been reviewed in this chapter. The review highlighted how MM can be used to study managerial effectiveness in the health sector. Quantitative and qualitative approaches as well as the philosophical underpinnings for the two – positivism and interpretivism respectively were compared and contrasted. Positivism (quantitative) is associated with the use of the natural science model of research to investigating social issues, and is thus criticised for its assumption that social life is made up of objective facts that value-free researchers can use statistical methods to measure. Interpretivism (qualitative) on the other hand, is based on the philosophical principle of optimism which maintains the world view is the construction of the mind, and that we can only experience the world through our personal perceptions which are results of our presumptions and beliefs. This was also criticised for its subjectivity measures in research. The MM research was thus seen to be in line with the philosophy of critical realism which has also been viewed by researchers to be the third way of the empiricism and post-positivism debate. Mixed methods research spanning across these paradigms provided a more comprehensive understanding of human resources management practices.

This is especially the case of MM research or triangulation which has a built-in validity and reliability as the triangulation of findings either corroborates or complements each other’s shortcomings. Even where there is divergence, there is always a reason why this happens. By using MM research, the qualitative approach enabled the researcher delve deep into meanings and interpretations assigned to managerial behaviours while the quantitative aspect enabled the researcher cover a much larger sample group to complement the qualitative findings. This therefore enriched the findings of the study. Therefore despite the challenges in the use of MM research, it has been found to be very suitable for this study.
CHAPTER 6: Findings

6.1 Introduction

Chapter 5 on research design outlined and described the methodology used in undertaking the study. It provided the justification for the use of mixed methodology, how the research was undertaken using qualitative and quantitative methods concurrently and the procedure for how data was analysed. This chapter presents in-depth findings from interviews with managers and stakeholders (those who assessed managers). These comprise policymakers, representatives of regulatory bodies and unions and the two sets of employee respondents in the focus group discussions (FGDs) and survey in the public health sector (PHS) regarding their perspectives of Managers’ HRM/D capacities as a way to explain and understand Human Resources’ Management/Development Effectiveness (HRM/DE). The presentation is in chronological order in line with the research questions on the thematic areas of the topic as in the unstructured instrument and the survey questionnaires. The findings are also presented in accordance with the cross over-tracks data analysis framework by Marquart and Zercher (2000) used for data analysis. In cross-over tracks analysis, findings from the various methodological strands intertwine and inform each other throughout the study. Both approaches follow similar steps of data reduction, transformation, data comparison and integration. The intention is to present findings concurrently with the quantitative findings supporting the qualitative. Only the findings are presented in this chapter and therefore any apparent divergent view is explained in the next chapter (seven) which discusses the findings.

The findings are based on interviews involving managers and four groups of respondents referred to as stakeholders who assessed the managers. As referred, the stakeholders comprise policy makers, representatives of regulatory bodies and unions, employee focus group discussants and another group of employees who completed structured survey questionnaires.

A total of 42 interviews comprising 33 individual in-depth interviews and nine (9) FGDs were conducted with a total number of 79 participants. The quantitative component covered 302 employees who completed survey questionnaires. The data therefore was analysed based
on the inductive and emergent themes of the study and which also followed from the research questions of the study. Details of the numbers of respondents for both methods are presented in table 6.1.

Table 6.1 Categories and number of respondents used for the study

<table>
<thead>
<tr>
<th>Regions</th>
<th>Qualitative Sample</th>
<th>Total</th>
<th>Quantitative Sample - Employees</th>
<th>Grand total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Managers</td>
<td>Stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Policy makers</td>
<td>Regulatory and Unions</td>
</tr>
<tr>
<td>Northern</td>
<td>10</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>8</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Tertiary</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>National</td>
<td>-</td>
<td>7</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Subtotal</td>
<td>18</td>
<td>11</td>
<td>4</td>
<td>79</td>
</tr>
</tbody>
</table>

The findings are presented in six sections in line with the research questions and corresponding objectives and the themes in the questionnaires. However, the first section covers the biographic data of all respondents and the second section begins with the first research question. The second section presents results based on the first research question which deals with the health sector objectives, priorities and strategy and the linkage with HRM/D activities and employees’ goals. The third section presents findings in line with the second research question which sought to establish the understanding managers and stakeholders have about the terminology in HRM/D. Then the fourth section presents the findings on the perspectives of HRM/D activities of recruitment and selection, performance management, staff development and rewards management based on the third research question. Each of the four HRM/D activities has sub themes and findings on these will also be presented accordingly. In line with the fourth research question, perspectives on environmental factors which either constrain or enable HRM/D are presented next in the fifth section. The final section presents perspectives on lessons learnt (the challenges and opportunities), which culminated in the collation of contextual managerial competencies in line with the fifth research question.
For clarity, each finding presented intertwine relevant sampled views of managers and most of the four groups of respondents by sampled statements for the qualitative approach and supported with either tables or figures or statements from the quantitative respondents. Some expressions and mannerisms are quoted verbatim to denote the respondents’ emotions or mood. Respondents represented in the findings are identified simply as male manager or female manager from Northern region or Greater Accra region. However, these will be given acronyms. The following acronyms apply:

Male manager from Northern region: MMNR
Male manager from Greater Accra region: MMGAR
Female manager from Northern region: FMNR
Female manager from Greater Accra region: FMGAR
Male policy maker from Northern Region: MPMNR
Female policy maker from Northern Region: FPMNR
Male policy maker from Greater Accra Region: MPGAR
Female policy maker from Greater Accra Region: FPMGAR
Focus Group Discussants, Northern Region: FGDNR
Focus Group Discussants, Northern Region: FGDGAR

The findings are presented in chronological order as already indicated above. Before then, a general overview of response rates and regional distribution of respondents is presented.

6.1.1 Response rate and regional distribution

For the qualitative method, a total of 42 interviews were conducted, 18 of which were with individual managers, 11 with policy makers and nine (9) FGDs comprising 79 participants held. The quantitative on the other hand had 302 questionnaires returned out of 580 questionnaires distributed. This represents a total response rate of 52%. Of this number, majority 63.2% were from the Greater Accra region (GAR). Details of regional breakdown of employee participants are shown in table 6.2.
Table 6.2 Regional distribution of Focus Group Discussants and Survey

<table>
<thead>
<tr>
<th>Respondents (Qualitative)</th>
<th>Regions</th>
<th>Frequency</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Region</td>
<td>59</td>
<td>74.6</td>
<td></td>
</tr>
<tr>
<td>Greater Accra Region</td>
<td>20</td>
<td>25.4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

| Quantitative              | Northern Region            | 111       | 36.8       |
|                           | Greater Accra Region       | 191       | 63.2       |
| Total                     | 302                        | 100.0     |

### 6.2 Socio-demographics of Respondents

For personal data, the areas that were analysed and presented in this section include age, gender, current position, number of years in organisation, qualification and professional background. The reasons for selecting these variables are discussed in chapter 7.

#### 6.2.1 Age

As per Fig. 6.1 below, the results are presented for the different groups of respondents. Regarding the ages of the 18 managers interviewed, only one, representing 5% was below age 40 whilst majority – 56% were aged between 43 and 49 and 39% were aged between 51 and 59 years.

Majority - 90.9% of policy makers were aged between 51 and 58 years and only one was below 50 years. The ages of the representatives of the regulatory bodies and unions were similar to those of the policy makers with all four representatives aged above 50 years.

Whilst two respondents, did not indicate their ages, majority - 34% of survey respondents (employees) were in the age bracket of 31-40 years with another 28.5% aged between 20 and 30 years, then 18.5% were between 41-50 years whilst the remaining 12.6% were aged between 51 and 55 and the last 5.6% were over 55 years. The ages for the FGDs employees were also similar to the latter. However, six (6) of the respondents did not indicate their ages. From the number who indicated their ages, majority - 38.7% were in the age bracket of 31-40, another 28.8% aged between 20 and 30 years whilst 15% were between 41 and 50 years, another 11% were aged between 51 and 55 and the remaining 8% were over 55 years.
6.2.2 Gender

Generally, there was a higher (55%) representation of females at the managerial level than males although gender distribution differed between the regions. The Northern region recorded 70% males whilst the Greater Accra region recorded 10% males. Policy makers’ on the other hand were predominantly males (10) with only one being a female. Regulatory bodies and unions’ participants had three males with one female participant. Of the 79 FGD participants, only 36.7% were males and the majority 63.3% were females. There was a similar trend for the survey respondents as shown in Fig. 6.2 which shows most employee respondents - 53.3% were female with the remaining 46.7% male. Details are in fig 6.2.
6.2.3 Number of years in organisation

Most managers (15) had been with the organisation for over 20 years, two for 15 years and only one had been with the organisation for six years. In their current positions, majority (10) again had worked in their current positions for over five years, three had worked for three years and the remaining five have been in acting positions for over three years.

Eight policy makers had been with the PHS for over 25 years, two for 20 years and only one for fifteen years. Regarding their current positions, six had worked in managerial positions for more than 10 years but had occupied the current position between less than a year to seven years. Only four had been in this position for more than seven years.

All the four Regulatory and Unions participants had worked with the organisation for more than 20 years and three had occupied the current positions for more than 5 years with one in the current post for over 12 years.
Figure 6.3 Number of years worked in the public health sector

Figure 6.3 shows the number of years worked with the organisation for the quantitative data and FGDs. Majority - 46.4% survey respondents had worked for the organisation for less than one to five years (0-5 years). Another 19.9% worked between 6-10 years whilst 7% and 9% worked between 11-15 and 16-20 years respectively. Twelve percent worked for between 20-25 years and only 3.3% worked between 26 and over 30 years. The focus group discussants show a similar trend. Majority (29) had served less than a year to five years, another 28 less than 10 years whilst only two served over 30 years.

6.2.4 Qualifications of respondents

Findings on educational qualifications among participants in the qualitative data, which comprised the managers, policy makers, regulatory and professional Associations and FGDs, revealed that majority of managers – 14 had master’s degrees; three had diplomas and only one held a PhD. Among the policy makers, nine (9) out of the eleven persons interviewed had Masters Degrees, one (1) had a fellowship whilst the remaining one had a PhD. The four (4) regulatory and professional respondents all held masters degrees. For the quantitative data 98.3% indicated their highest qualification whilst 1.7% did not. Of this number who indicated their highest qualification, majority – 49.0%, had diplomas, the second largest 32.1% were those with certificates. Another 12.6% of this number had bachelor degrees, whilst 4.3% had masters degrees and only 0.3% had any another qualification. Details are as per Fig. 6.4.
Generally, there were no significant differences between the two groups of employee respondents for the survey and the FGDs for the qualitative data in terms of qualifications, age and gender. They had similar qualifications and which differed from those of the policy makers, regulators and managers. Most participants held diplomas, whilst most managers, policy makers and regulators held masters degrees. However, analyses between regions on educational qualification show differences between respondents. The qualitative method shows most managers (7) in the Greater Accra region were doctors whilst those in the northern region had more (six) nurses as managers. Table 6.3 below for the survey and FGDs findings indicates more health professionals (diplomas) in the Greater Accra region and more assistant health professionals (certificate) in the northern region.

Figure 6.4 Highest education of respondents. (Numbers on top of bars are the number of respondents)
Table 6.3 Qualifications of survey and FGD respondents’ regional distribution

<table>
<thead>
<tr>
<th>Regions</th>
<th>Qualifications</th>
<th>Survey respondents</th>
<th>Focus Group Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>certificate</td>
<td>diploma</td>
</tr>
<tr>
<td>Northern Region</td>
<td></td>
<td>58</td>
<td>41</td>
</tr>
<tr>
<td>Greater Accra Region</td>
<td></td>
<td>39</td>
<td>108</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>97</strong></td>
<td><strong>148</strong></td>
</tr>
</tbody>
</table>

6.2.5 Current positions of survey and FGDs respondents (employees)

Regarding the current positions of respondents, all (100%) indicated their current positions. Most respondents - 96% in the survey were in the employee category (which differentiated those not in any management or leadership positions). They were mostly middle level employees. This was similar to those in the FGDs in which 93% were also middle level employees with the remaining five in sub district headship positions. This is in line with the intention of the researcher’s objective of getting employees to evaluate their managers as a way of complementing the in-depth individual interviews provided by their managers at the district level. The few who were in headship positions such as the sub district heads are deemed to be employees as well but who have been delegated duties of supervision by managers and so all these were considered to subordinate employees.

6.2.6 Professional background of Respondents

On professional affiliations, all 18 managers, all four representatives of regulatory bodies and unions and majority (nine) of the policymakers had a medical/health related background whilst only 2 had a management or some other background. Although all managers had health related backgrounds, majority 11 were doctors, six were nurses and the remaining one was a technical officer. However, regional analysis showed most managers from the northern region were mostly (6) nurses whilst those in the greater Accra region were mostly (7) doctors. The policy makers showed a similar trend. Of the 11 policy makers interviewed, only three were non-doctors whilst the remaining eight were doctors. The regulatory and
Association respondents interviewed, however had equal numbers from both the medical and nursing professions.

FGD respondents and those who completed the structured questionnaires show varied backgrounds. Out of the 79 FGD respondents, two did not indicate their professional backgrounds and only 18 were made up of HR officers, storekeepers, accounts officers administrative staff and other non-clinical staff. The remaining 59 had health professional backgrounds such as pharmacy, disease control officers and laboratory technicians whilst majority (34) were nurses. Almost half (131) of the survey respondents had clinical backgrounds, 75 had administrative and HR background and the remaining 96 had other non-clinical background.

Figure 6.5 shows professional backgrounds of the two groups of employee respondents.

![Primary job responsibility](image)

**Figure 6.5 Primary job responsibilities of respondents**

The findings for the second section are presented next. As stated earlier, the findings are presented in line with the research questions, objectives and the retroductive and emergent thematic areas of the topic. Since participants were assured that no mention of their names would be made anywhere in the write-up, and for which consent was obtained, quotations from respondents are only identified with the gender and region of the respondent.
6.3 Section Two

This section presents findings on four HRM/D practices used in the study and the emergent themes. They are presented in line with the research questions and sampled relevant views of some of the respondents are provided for each finding to the questions posed.

6.3.1 Research Question 1: What is the context (situation) of HRM/D in the PHS?

The objective was to establish the context of HRM/D within the Health sector of Ghana. To achieve this objective, questions were posed to find out the knowledge managers held about the health sector goals, and strategies and the linkage of HRM/D processes to these within the sector. The study also sought managers’ knowledge on the model of health care delivery as postulated at the national level and whether what they operated at the district level was in line with what has been postulated at the national level. These same questions were adapted for the stakeholders for them to assess the managers as indicated in the introductory section.

i. Managers’ knowledge of Health Sector goal and strategies

Q.1 Please state in your own words what the health sector goal is

The ultimate goal of the health sector is client focused but experienced particularly harsh pressures within the health sector reforms due to the economic downturn in the 1980s. This led to massive brain drain in the 1990s to 2003 when this started to decline. Therefore, a strategic approach to HRM/D requires an organisation to focus on identifying and solving fundamental human capital issues and aligning HR initiatives with organizational strategies and performance goals. Provision of quality care is a systemic issue and therefore has interdependent linkages with clients and employees to optimize health services. Hence, the study evaluated the knowledge of this linkage of HRM/D activities with health sector goals from managers. Managers were thus asked to outline what the goal of the health sector was whilst stakeholders were asked to evaluate managers’ knowledge about the health sector goals.

Although all managers attempted to outline the goal of the PHS, only seven could appropriately state the goal. Majority either described the motto, mission, priorities or strategies of the sector. Most policy makers - nine agreed that managers were not knowledgeable. Please find below some sampled responses from all groups of respondents.
“The Ministry of Health is to ensure that ... to give health services to people living in Ghana no matter their tribe, political status, or their race...” (FMNR).

“I know that the health sector goal is emmm helping Ghana to become a middle income country because they said if people are healthy, definitely they will work to produce and so the poverty level will be reduced too and to errr to reduce what do you call it... help contributing to Ghana attaining middle income country” (MM GAR).

“The health sector goals? Yes they are struggling. Unfortunately, overwhelmingly a greater percentage of the people I am dealing with are not trained specifically for the positions they occupy” (MPMNR).

“Some of them are okay but for some, if I had control I will not allow them to work as such because they don’t know anything” (MPTL).

Regulators, Association representatives and however, had different views from policy makers but similar with those of the FGDs. They noted that ideally managers should know but were not sure if all managers knew the goal of the health sector.

“In my view, they should know but I am not sure if all managers will know the health sector goal because the calibre of some of the managers is not the best...” (Female representative of unions).

“I think they do not know, they won’t be working to achieve organisational goals there but we have never...” (FGDGAR).

Whereas most (11) managers could not appropriately articulate the goal of the health sector, and policy makers also said managers did not know, majority 78% of employees on the other hand, either agreed (47.4%) or strongly agreed (30.8%) that managers were knowledgeable about the health sector goal as per table 6.5. However, when further requested to provide reasons for their ratings, only 19 out of the 301 who rated their managers, provided reasons whilst majority 282 did not assign any reason for their ratings. Some of the reasons they gave included those listed below table 6.4 and most of which are not related to knowledge of the sector’s goal.
Table 6.4 Showing Survey respondents’ ratings about Managers understanding

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<tbody>
<tr>
<td>Valid</td>
<td>strongly disagree</td>
<td>2</td>
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<tr>
<td></td>
<td>disagree</td>
<td>27</td>
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<td></td>
<td>not sure</td>
<td>36</td>
<td>11.9</td>
<td>12.0</td>
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<tr>
<td>Agree</td>
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<td>143</td>
<td>47.4</td>
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<td></td>
<td>strongly agree</td>
<td>93</td>
<td>30.8</td>
<td>30.9</td>
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<td>99.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>System</td>
<td>1</td>
<td>.3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>302</td>
<td>100.0</td>
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1. According to directives
2. Attends to situations
3. Conducts meetings regularly concerning code of ethics
4. Developed mission statement inline with his mission
5. Directs and teach staff of what to do
6. Employees are distributed using norms to ensure adequacy in achieving goals
7. Ensures quality nursing care delivery to clients
8. Ensures staff are mobilised to work towards achieving goals of health sector
9. Has been involved in health for a longer number of years
10. Should reflect in the work environment
11. Active involvement in policy formulation activities
12. By rendering due respect to her subordinates
13. She is punctual to work and encourages
14. She supports in terms of need
15. Staff are awarded for their performance
16. Staff are not at see of new development or goals
17. Targets are set towards attainment of goals
18. Subordinates to work hard
15. Staff are informed about any new development
18. Works according to activities and plans
19 Yearly budgets

ii. Managers’ knowledge about HRM/D policies and the linkage between these and PHS strategy.

The PHS has a workforce of nearly 52 000 employees in all ten regions distributed in all its institutions and facilities. The restructuring of the PHS to become more efficient and
effective is still being pursued to provide quality care. The PHS works in partnership internally as well as externally with donors, partners, NGOs, DAs and communities. Its HR goal is to enable employees to access the sector’s pool of knowledge to enable them deliver quality health care to its clients. This means an HR strategy with a strong focus on flexibility and requisite skills both acquired and internally developed. Therefore integrated HR activities of recruitment and selection, staff development and performance management and rewards management are considered by the PHS as crucial elements of the PHS strategy. Thus, the study sought to evaluate the knowledge of managers on the health sector strategy and the degree of linkage of this strategy to HRM/D activities.

iii. Managers’ knowledge about strategy/priorities in the health sector

Question 2: Having told us about the goal of the health sector, what are some of the policy priorities regarding health care delivery?

The same trend was observed as in the first question where managers mixed up the goal, mission with the priorities and below are some sampled responses.

“Oh yah. I have mentioned some already, our mission is to provide quality health service and to reach out to everybody resident in Ghana. And then the priorities...health problems are there but the priorities in Ghana today, we would say that our priority now is maternal and child health ...to reduce maternal and child health and control of infectious diseases. ...And then errr to improve life styles…” (MMNR).

“We want to prevent disease, we want to err...errr... tackle clinical care component, and we want to tackle communicable diseases. If you look at things from the beginning we were more of looking at communicable diseases but now with people adopting Western life styles more of the non communicable diseases are coming up which we need to also tackle and so that is another area that we are looking at. I don’t know if I have answered your question well” (MMNR).

“Heiiti.! ...The main objective of the health sector is to make sure that all persons living in Ghana are provided with quality health services, to ensure that all remain healthy” (MMGAR).

Some policy makers (6) and FGDs shared similar views. Whereas policy makers were of the view that managers might know the priorities but not in detail but contended that it was not just the matter of managers knowing them but their ability to work in line with these priorities, FGDs equated the achievement of technical work such as immunization coverage as managers’ knowledge of the sector’s priorities. Comments from the two groups are stated as follows:
“Managers might just simply know them in passing. It is not just reciting them but then showing actions which means that you know. What is the incentive of knowing or not knowing them? That is not here or there. But then there are small small disjointed visions and missions which cancel each other out and in the long run, one is not able to locate the mission”(MPMCL).

“We think managers know the priorities because they are able to do the immunizations and other activities as planned…we have not heard complaints about managers from above” (FGDGAR).

Most employees surveyed (172) strongly disagreed and disagreed that managers were knowledgeable about the priorities while 36 were not sure. Only a third of employees agreed that managers were knowledgeable with none strongly agreeing.

<table>
<thead>
<tr>
<th>Table 6.5 Managers know health priorities</th>
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<td>Missing</td>
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<tr>
<td>Total</td>
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</tbody>
</table>

iv. Managers’ Knowledge about HRM/D policies and their linkage to health sector goals

As to whether managers know about HRM/D policies and their linkage to health sector goal, all managers were generally knowledgeable about linkage between health sector strategy and HRM/D policies. However, majority (14 out of 18) were of the view that this linkage was only on paper and not practically supported. Regulators and Association representatives also agreed with the managers’ statement that the two were not linked but that policies should be flexible for adaptation at the local level.

“Well I think that the intention is very clear, it is very loud but practically it doesn’t work” (MMNR).

When quizzed further he said:
Well there are so many reasons but let me just give you this simple scenario. ...We want to address Millennium Development Goals (MDGs) 4 and 5. Now we have a situation where the entire district we have only 8 midwives serving 162 communities. Out of the 8 midwives, 4 are in the hospital, and then in the course of training you realise that for the whole of this year no midwife has passed out from training. All that we have more general practitioners will pass out. How does that address the MDGs? - fall apart, I mean is clear, ...so we are not looking at really addressing the shortages but rather doing more fire fighting, so for me there is no linkage at all.

“For instance when we are doing postings, we may post three staff to a certain place that really if you go by population; they should get just one staff. But you know what is happening there is far maybe one person cannot cope with that sort of thing and so you manage your staff like that” (FMGAR).

Although most policy makers (8) agreed with managers on the non-linkage of HRM/D policy implementation and health sector strategy, they blamed this non-linkage on the lack of monitoring from the central level to ensure these were linked.

“I think people should be sent back to school. School is not just the subject, surgery or nursing but how to apply these to managing people...The policies are there but there is no system to in place to monitor to ensure that these are implemented in line with what has been formulated and so people use their own understanding and these are disjointed” (MPMNR).

Whereas most managers, policy makers and regulators thought that HR policies were strategically linked only sector on paper, and emphasised that these two were not practically linked, only one FGDs felt otherwise and when quizzed further the responses provided did not support their views. Below are some sampled comments.

“I don’t think that it is in line. ... When drawing a policy, it should be flexible so that managers can adapt it at the district level, if I say policies are not linked to what is practical at the local level, it is because these do not match the reality on the ground and I feel managers should be allowed to adapt policies to suit the local situation. For example if you talk about the staffing norm. Is it realistic? The number of accident cases for a district hospital, if it is situated on a highway where there are a lot of road traffic accidents, this will not work” (FAR).

“Yes. It is in line” (All FGDs NR).

When quizzed to explain how these were linked they continued as follows:

“We go for home visits. And that one we meet them right in their houses and right in the situation. Sometimes when we go for school health services, you meet tutors and you meet the children. So what a mother will hide from you, during school health services, you are able to get it right from the children because the child will not be able to skip certain trickish questions you throw to the mother but you will get the right information you need from the child... And as much as the nutritional background is concerned, we also assess what the children are eating” (FGDNR).
iv. Managers’ Knowledge about Model of health care delivery as postulated at the National level and its linkage to the operations at the district level:

The question was to establish how much knowledge managers had about national health policies regarding organisation of service delivery for the various levels.

**Question 3:** Do you think the way you provide services at the district level is in line with the health service delivery model as postulated?

Most managers (15) stated they knew the way services were postulated at the national level and to be organised and delivered at the district level. However, three of them could not describe the model. Five managers also stated they did not strictly operate according to the model as postulated but used their management judgement. This was neither confirmed nor disagreed by policy makers. FGDs and surveyed respondents were not requested to respond to this question and thus their views are not captured. Some of the sampled comments are stated below.

“I’m not sure...but if you look at the policy under the CHPS concept, it stipulates the various levels where you have the district with a hospital, a sub-district with a health centre and then the community level with the CHPS being the basic and I think it works perfectly because the levels are somehow joined together so that if something could not be done at some level, it is then transferred or referred to a different level then from the district to the regional level” (MMGAR).

“Yes we have guidelines but so to say- these guidelines and policy documents – sometimes you don’t have to follow each word. If you have a district hospital that is not performing as expected, you don’t need to have 2 doctors there if one doctor can do the job. If you have a health centre and you feel that the catchment population is small and you need just a nurse, you don’t need to over staff but if you use these guidelines to see or even use the workload you can even go against the policy/guidelines in that you would have more work than expected within that frame work. These are the management judgments we use” (MMNR).

“... It is very difficult but I’ll expect the manager at the district level in addition to the technical areas, you know the technical areas, I expect the manager, if you take the public health side: you must be conversant with what we want; clinical care he must be also conversant too. He shouldn’t be one sided. He should be knowledgeable. He should know what ministry of health wants to achieve” (MPMNR).

“Due to lack of induction, many tend to learn as they do the job and because there are no clear-cut guidelines for them, others are just whipped into line” (FPMCL).
i. Managers’ knowledge about MMDDHS Responsibilities.

The knowledge about their responsibilities is very important for managers’ performance to be measured. Thus the study sought to evaluate this knowledge to ascertain the scope of responsibility for HRM/D.

Question 1: Can you please outline your main responsibilities as the MMDDHS?

Regarding their responsibilities all (100%) managers outlined some of their main responsibilities. However, the management of HRH was conspicuously left out in most (15) of the responses and two of the responses are given below. Policy makers however, indicated that managers were responsible for the management of all health resources in the district including the health staff assigned to the district.

“...My main responsibilities include the plans. Planning and budgeting for the health sector, coordination of health activities in the district between private and public sector. Also kind of monitor and supervise the activities of health in the district. I do procurement. And... I also conduct operational surveys which will help us make informed decisions about out health sector here” (FMNR).

“To put it concisely, you manage, to develop, manage and report on the district health issues. Guide and if I say manage I mean manage in the broader sense of managing something, coordinating, guiding and all those things directing and all” (FMGAR).

“Then when we come to the management position, we want the person to have the competencies we need to manage the district – to be responsive to the needs of the staff; should have that sort of interaction and should not be a dictator, should be able to supervise and ensure that targets and the indicators of the service are achieved...” (MPMCL).

“...Indeed the DDHS being a technical person responds to all disease conditions and the threat to diseases confronting the district ...to ensure that health issues are articulated. Now when you look at what the DDHS is to do from this perspective means that disease prevention and control is the key area of concentration. Even though redefined the DDHS position to include other management systems this is not really well functioning because the disease part is taking the better of the DDHS” (MPMCL).

6.4 Section Three

This section sets out to evaluate managerial effectiveness of implementation of the four HRM/D practices by managers from managers’ own perspectives and stakeholders. The
Evaluation was based on the following research question.

6.4.1 Research Question 2: What understanding do managers and stakeholders have about HR management/development effectiveness?

The objective of this question was to explore the understanding of HRM/D effectiveness by managers, policy makers, and employees of health and some stakeholders. The question intended to assess managers’ knowledge on the four HRM/D practices used for the study and how this understanding influences the implementation of these practices. In order to answer this research question, questions were again framed along the lines of knowledge and understanding managers and stakeholders had on key terms that are related to the topic under investigation. These terms are management, human resources’ management/development, effectiveness, human resources’ managerial effectiveness and competencies.

i. Knowledge and understanding of key terms

The study viewed it imperative to find out how much knowledge managers at the decentralised levels had about Management, HRM/D and effectiveness. Based on this, questions were formulated to find out how much knowledge or understanding managers had on the terms below. For most of the questions in this section, both FGD and survey employees were not requested to answer since their role was to assess managers based on their experience with managers’ HRM/D skills.

a. Management

Question 1 Please, can you tell us what your understanding of the term ‘management’ is? Below are some summarised responses.

Most managers (16) including two groups of the stakeholders understood management as the traditional function of planning, organising, controlling and directing. The following were some of the sampled responses provided for the understanding of the term from the four groups of respondents.

"Management errrr generally is err ... errr... organising, prioritizing, controlling, monitoring of ... it can be resources that you have to manage organise, control for effective use, it can be human, it can be material and you can... and that it can also apply to your programmes and plans because if you don’t manage them it doesn’t work and so that is a broad definition of management.” (MM NR).
“Well, management will come under administration – administration is going through daily routine or agreed standards of managing things. Management, depending on the situation how you go round not to temper so much with the administrative procedures but to be able to do things not the routine way but do things to achieve the organisational goals” (FMGAR).

“Management, in my opinion, I see it as the traditional function of planning, organising, and controlling and ...” (MPMGAR).

b. Human Resources’ Management/Development

Question. 2 Now that you have given your understanding of management, can you please explain to us what you understand by the term ‘Human Resources Management and Development’?

On the understanding of HRM/D, whereas four managers understood the term to acquire staff and to enable them obtain the needed skills to perform, majority (12) stated the term was broad but included recruitment and identifying competencies and working with them as a team to achieve organisational goals. Policy makers on the other hand understood it to mean recruiting the right calibre of people and developing such people to deliver service. Sampled responses from respondents are stated below.

“That is to have the workforce under you and then you have to build them up by training or organising in-service training for them to be able to perform the duties that they are supposed to perform” (FMNR).

“My understanding of HRM looks very broad, but one is to be able to bring together the individual who you need to work as a team to achieve the objective or the purpose for which you have been assembled: that will include identifying the competency level of the skills identifying their weaknesses and try to blend them and see how you can achieve your target with minimum number of people you have” (MMGAR).

“Errrrrrrr. HRM, you will be looking at who you are working with, and involving everybody in...in... in the work. If you say... you are talking about HRM, who do you have and what are doing and what role does the person play and how comfortable is the person and what knowledge does the person have and then errr how do you resolve conflicts in her in working together and then how do you recognize the person and let the person have the role and know exactly what to do and you can then... because you are the manager” (MMNR).

“What I understand by human resource management is planning, and then planning for, recruiting the right cadre of staff, the right mix that is needed to deliver service in a particular health facility in terms of the work or system and making sure the people are the right mix and whilst they are there making sure that they get the necessary in-service training and constantly upgrade their skills so that they are up to standard at
*all times. ... Having an interest - keeping an eye on their progression and their professional development...” (MPMGAR).*

c. Effectiveness

**Question. 3:** In your view, what does the word ‘effectiveness’ imply?

Whereas most managers (12) understood effectiveness to mean capability, outcome, productivity and achieving results, most policy makers (7) understood it to mean achievement of goals; proper planning and strategies put in place, while some (2) related it to capability and others (2) related it to achieving results. Again, employees and regulators were not requested to answer this question. Examples are as follows:

“To my knowledge, the person is very capable of doing or handling things” (MPMGAR),

“Oohh...Effectiveness, you are looking at errrr...what you put in and what your results are. If your inputs are giving you the desired results, then you think that it is effective” (MMNR).

“Effective is... errrrr... the desired or the best way possible or the expected outcome. You have done well; you have done it the way it is expected” (MMNR).

“Making good use of the little resources to come out with the best of productivity” (MMGAR).

“Effective means the goals have been achieved, proper planning has been done. Strategies have been put in place in order to make sure that the goals are by all means achieved without any excuses. Without saying it was by chance” (MPM GAR).

d. Human Resources Management and Development Effectiveness (HRM/DE)

On the definition of HRM/D effectiveness, respondents gave a variety of attributes. From most managers’ (10) perspectives, HRM/DE is understood to mean involving employees, developing staff and working as a team whilst policy makers perceive it as the ability to achieve results and the knowledge and ability to combine resources to achieve results among others. Below are the different representations.

“I’ll say to be able to effectively handle the HR that is under you so that they will be knowledgeable for them to carry out their duties. And they will be very cordial with the manager too so that they will be able to work happily together...err HRM (laughs, laughs and laughs)” (FMNR).
“Hmm if you talk about HRM/D effectiveness I believe that as a manager, I should be able to ...(pause) normally... you set your targets for the year. I should be able to move along with everybody towards that direction. Yes I should get everybody on board and you can do this by making them aware of the goals you set for them” (FM NR).

“HRM/DE has to do with managing human and other resources available” (FM NR).

“An effective manager is the one who is able to combine all the resources that he or she has to be able to achieve his/her desired results” (MPMCL).

6.5 Section Four

This section is to present findings on research question four which evaluated the skills of the four HRM/D activities used for the study.

Research Question 3. How have HRM practices of recruitment and selection, performance management, staff development and rewards management been defined and measured in the public health sector of Ghana?

The objective was to examine the extent to which this understanding of HRM/D effectiveness (knowledge, skills, abilities, attitudes and qualities) by managers are reflected in the implementation of the four selected HR practices within the health sector by MMDDHS from the perspectives of managers and stakeholders of health.

6.5.1 Perspectives on Recruitment and Selection

Recruitment and selection was one of the four HRM/D practices that the study used in evaluating managers’ effectiveness in HRM/D implementation. This is due to its important role in helping the PHS to acquire the calibre of employees to work towards achieving organisational goals amidst the shortage and maldistribution of staff. Thus, the study sought the perspectives of respondents regarding this HR function, the level of involvement in staff recruitment and how managers assigned staff to sub districts.

Q.1: What is your general view of recruitment and selection?

From the responses, all managers (100%) stated recruitment and selection function for core staff was not within their purview. They all intimated the function was still centralised and that they were only recipients. Also, all managers expressed dissatisfaction about the way
recruitment and selection was done in the PHS plus interferences during deployment. Some sampled comments are represented below with a female manager from the GAR summing up how the recruitment function is executed to the frustration of managers.

“At this level we don’t do recruitment in the real sense except for the lower level staff, the casuals and so on that we engage. But if we think of recruitment as a generic way of doing things, we receive staff from wherever; staff …may be posted to us without asking us. Or we may request for staff and so it is a way of recruitment. … We have problems where sometimes the staff are posted directly to facilities. We are saying that we’ve been given the mandate to manage this district including the human resources and all. So send us the staff and we know where there are vacancies and we will send them there. But sometimes they are posted directly to a certain sub-districts…” (FMGAR).

“We are not addressing our needs, we are not addressing the challenges that we have got and there is also so much interference in the staff distribution from the political possibly and higher levels, there is so much interference, you will get people posted to an area and they don’t go, if those people have a certain backing they can say they won’t go and they refuse to go and that is it and nobody takes them on and that is it” (MMNR).

All policy makers corroborated this finding. Whereas some managers complained about how some staff were posted from the regions directly to facilities in the districts, some policy makers also complained about the interference from politicians and senior public servants. Whilst a policy maker at the regional level complained about interference from politicians, another policy maker from the central level blamed the interferences to managers’ inability to plan well.

“… I had to make some postings. I posted Mr. A to district Z then I received a call from above which said. “The staff you posted is our man and he has been assisting us; so reverse it!” Meanwhile the district the staff was posted to continuously called to say that the officer had not reported. This year it has happened twice and in fact I re…al…ly felt hurt honestly. This one it was coming straight from… you know…through the Deputy Health Minister. You and I know that if you are a little bit hesitant you may be branded that you are anti Government” (MPMGAR).

“It is a natural thing that will happen –We live in a human world and therefore someone can request a favour and say this is my wife and so I want her in Accra. That one you can consider but that doesn’t mean the system is dysfunctional. … but as managers, if you have plans you should be able to resist and tell them where the vacancies are” (MPMCL).

Q2. What is your involvement in recruitment and selection?
This question was to ascertain whether managers were at all involved in the recruitment process at any stage despite the fact that the function was centralised. Responding to this question, the same sentiments as those for their general views on the recruitment function above were expressed about managers’ involvement in the recruitment process. Two policy makers also expressed some of these opinions of interference as to where staff should be posted. Samples of responses follow from here.

“No. I am not mandated to do so but at least at the managerial level where I don’t have casuals of course I get engaged in recruiting” (MMNR).

“At this level we don’t do recruitment in the real sense ...But if we think of recruitment as a generic way of doing things, we receive staff from wherever, staff may come and approach us and say we want to move here from one region to another or you know they want to find out if there is a vacancy so yes if there is we tell them” (FMGAR).

“For now there are two systems. There are those who come that are already with their letters stating the facility that they should go. Even this morning there was someone here, a letter could come from the region to say that to be posted to this hospital” (MMGAR).

Responding to the question, regulatory representatives on the other hand were more concerned about the welfare of their professionals and here is a sampled comment from one of the regulators.

“In the case of posting to deprived areas, for example, the GMA supports such postings, but with the caveat that certain “essentials”—such as decent accommodation—must be in place for a doctor to be able to function there” (MRep GMA).

Corroborating managers’ and some policy makers frustration about the recruitment function surveyed employees disagreed that managers were able to take decisions appropriately on recruitment based on the reason that the function was centralised. Contrary to these, FGDs however, stated managers were able to take appropriate decisions on recruitment by the way some managers deployed staff in the sub districts. Below are some of the responses.

**Question 3:** How do you assign staff that are posted to your district from the region?

Based on the finding that managers were neither in-charge nor involved in recruitment and selection, the study then sought managers’ views as to how they deployed staff assigned to their districts.
Findings indicated divided opinions on how most managers deployed staff. Whereas six stated they posted staff to areas of need in line with staffing norms, another five stated they posted staff according to their calibre to facilities and have never seen the staffing guideline whilst majority 7 deployed staff in line with managerial judgement.

“Yes we have staffing guidelines but so to say- these guidelines and policy documents – sometimes you don’t have to follow each word. If you have a district hospital that is not performing as expected, you don’t need to have 2 doctors there if one doctor can do the job. ...These are the management judgments we use” (MMNR).

“To a certain extent. Emm the policy on recruitment, well recruitment is a problem because basically you don’t get the sort of staff you need at a particular time so then you are forced to work with staff that you don’t need. Some that you need you don’t have. So if the recruitment policy... “(FMGAR)

Table 6.6 Managers are able to take appropriate decision on recruitment

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Over 200 employees representing over 71% supported the views expressed by managers and policy makers by either strongly disagreeing or disagreeing that managers were able to take appropriate decisions regarding recruitment. From this number only 22 gave reasons for why managers are unable to take appropriate actions in recruitment. These included:

- Recruitment is done at head office
- Although selection and recruitment are not done at this facility, she places posted employees appropriately
- Conduct head counting activities and engage new staff to fill vacant position
- Consultation with sub-district heads staff requirements
- Does that often especially during new recruits
- Due to shortage of male nurses at the facility, she has taken upon herself to recruit national service persons
The focus groups discussants from the northern region on the other hand saw balloting to deploy staff to the sub districts as managers taking appropriate decisions on recruitment. This is what they said about their managers.

- They are very firm about that
- Yes, if they post new community health nurses (CHNs), she won’t just say this one go here she will do some balloting so that you will not say she hates you or she likes you.
- Where you have chosen, that’s where you go.

### 6.5.2 Perspectives on Performance Management (PM)

The second HR activity to be evaluated was PM and which has five themes - the performance management systems itself, provision of job descriptions to employees, giving feedback to employees, recognition of employee’s performance and credibility of the system. This function was evaluated based on its ability to motivate employees to deliver quality health care when applied properly.

To evaluate how well performance is managed at the district level, the following questions were asked.

**Question: 1.** What PM system do you have in the district?/Manager reviews employees’ performance regularly.

All (18) managers interviewed, equated PM to the annual appraisal system. The interviews revealed that although most managers were aware of the annual appraisal system, they did not appraise staff unless an employee was due for promotion, appointment into another position or for an interview for an award. Although representatives of the associations and regulatory bodies were of the view that this should be done regularly as it was linked to their requirements, they were however, not sure if managers appraised staff regularly. This is supported by the statements below from managers and policy makers.

“Ooh it is the official system of appraising people annually. But usually they don’t get appraised till they are going for their promotion interviews. This is the routine so we are trying to see if we can do it routinely but we are not able to achieve this.” (MMGAR).

“We did it at the beginning of the year but to be honest most of the time, it is done when people are going for appointments and promotions and the rest” (MMNR).

“…and then we have these appraisals that ideally should be done annually which we really don’t do until people are going for …” (Female manager, GAR).
This finding was not peculiar to managers alone but policy makers also shared the view.

“For now it is just the appraisal that we use” (MPM CL).

“Staff are not appraised until they are going for promotion. Another reason is that the forms are costly and since management has to provide for all staff, the forms are expensive to procure as the facilities under me do not have internally Generated Funds (IGF)” (MPM TL).

“So far staff performance, they appraise them alright but not frequently as we would wish and it has more or less..... Even though we changed that, it should be on quarterly basis” (MPMNR).

On the other hand, majority of employees (196) as per figure 6.6 agreed that managers appraised their performance regularly.

Figure 6.6 Manager is able to review employee’s performance regularly

i. Job Descriptions

Question 2: What mechanism do you have in place to enable staff posted to your district know their responsibilities?/Managers provide employees with job descriptions.

Regarding the provision of job descriptions to employees managers themselves had divided opinions. Whereas most (11) were not sure if they provided job descriptions, two managers stated that all newly appointed staff had their job descriptions attached to their appointment
letters whilst five said they accessed job descriptions from the website of which one manager described as being too generic.

“As for job descriptions, for my employees, I tried to get some for them and downloaded some from the GHS website but I saw that they were too general for the nurses and other employees” (FM GAR).

Table 6.7 shows majority (165) employees who either strongly disagreed or disagreed or were not sure that managers ensured they had job descriptions. FGD participants on the other hand unanimously agreed that job descriptions were not provided at the district office. The latter cited different ways they got job descriptions. Whereas some stated they obtained the knowledge about their roles and responsibilities during the basic training, others said they understudied senior colleagues, while yet some said job descriptions were posted on the notice boards of facilities they worked.

Table 6.7 Manager ensures employees have job descriptions

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</tr>
<tr>
<td>Total</td>
<td>301</td>
<td>100.0</td>
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“Okay when I came in it was my in-charge who took me through what I am supposed to do so I was told what I am supposed to do” (FGDNR).

Although most policy makers (9) were of the view that managers ought to be proactive in acquiring job descriptions for employees, they were however not sure if job descriptions were provided at the district level. One policy maker at the central level however, indicated that all recent appointments had job descriptions attached to their letters.

“With new recruitments from the central level, job descriptions are supposed to be attached to appointment letters for new employees. However, in cases where these are not provided, I think the managers should be proactive to request for them” (FPMCL).
i. Giving Feedback

Based on the importance of giving feedback which can motivate employees to give off their best, giving feedback on performance was the second theme in PM and the study evaluated perspectives and the following was the question posed to respondents.

**Question 3:** What do managers do with the results of the performance appraisal?/Does your manager provide feedback on performance? If they do, please describe how this is done.

Whilst majority (9) of managers stated they only appraised staff when they were due for promotion, some (4) managers stated they gave feedback with caution especially when it is negative and five said they gave feedback regularly. A policy maker attributed the lack of giving feedback to cultural orientation of managers. Among the FGDs however, there was a bitter argument as to the manner feedback was given to them. They claimed that feedback is only given when something goes wrong and it is often in the form of reprimand. However, good performance attracts no feedback. Below are the perspectives on feedback.

“We rather approach the staff nicely which we do very often and if I see you are not performing by comparing previous performance with this I would not like to sit with you in the office because I don’t want it to look formal. I just pick you, sometimes outside the district to sit at a social spot then we have one-on-one with you and by the close of the day I am able to identify what actually is making the performance to go down... I handle it” (MMNR).

When probed further whether he thinks the employees feel well catered for, this was the response.

“I think that one they can answer but may be I think from the other side what I hear people say. Even when I meet my colleagues they begin to say, hey you! It looks like all our nurses say they want to run to your place, all our workers want to run to your place, so I think they are feeling fine” (MMNR).

“Very regular. In fact you should have been here early. We shall be meeting on Tuesday for everything that we have done for the past month. We come here to discuss it on Tuesday to look at it and then display the records for you to see your performance” (MMGAR).

“...the way it is the Ghanaian culture somebody cannot look at a person’s face and say you are a bad person or you are not doing the right thing and so forth but the way to go around it is to be grouped” (MPMCL).

*When they get close – it is only criticisms – why haven’t you done this? Why haven’t you done that? On several occasions people have been confronted in my presence – they don’t praise you at all – all the time trouble and this has happened to several people including one of our orientation nurses – he’s gone*” (FGDNR).
“When they come and you have done well...Oh nothing at all. Yes but when they come and there is a small problem that alone overlaps all the good things you’ve done” (FGDGAR).

On employees who were not performing well, this was the way another MMDDHS stated he would normally give feedback.

“I also find out why... initially I realise that some wanted to please me more and have favour so they even denied their colleagues access to certain resources so that they won’t be able to perform. So I want to find out why. ...especially you as a leader if you are performing like this, what happened and this one is not performing. There is a midwife who is not performing but the same sub district, the leader is performing well, so I tried to find out why and it was revealed...” (MMNR).

**i. Recognition of employees’ performance**

The recognition of an employee’s performance can either lead to the identification of an employee for either intrinsic or extrinsic reward or recommendation for further training. Thus, this in a way can motivate an employee leading to increase output or good performance.

Question 4: What do you do if an employee was seen to be performing well? /Manager recognises good performance. Please elaborate.

On recognition of employees who are performing well, some managers (8) they will normally recommend such people for further training or give then an award. Another four said because they do not have funds, they will normally congratulate verbally first and at times follow with a citation during the annual get together whilst others (6) stated they will recommend well performing staff for promotion out of turn. However, opinions from FGDs were that managers don’t recognise good performance but are only interested in criticising when one does not perform well.

“We encourage people, we find out if they need further training, in-service training, then we make sure we encourage them or we recommend them to the region” (FMGAR).

“...With my case like this I am here 24 hours I am the midwife here. So 24 hours at times during the night we do consultation especially clients will come you will do delivery. Sick people will come and you can’t ignore them. You still have to attend to them but we all collect the same salary, no any incentives to let you feel that actually as you are in the village you are also wanted” (FGDNR).
Employees on the other hand (as per table 6.8 above) mostly agreed that managers recognised their performance. However, when requested to give reasons for their response, only 22 respondents explained their responses. Below are some of the explanations.

- Acknowledges those who excel in their respective profession
- Always mentions recognised people whenever the need arises
- Annual recognition of staff deemed to be hard working
- Give praises and criticizes when need arises
- Gives awards during end of year
- Has never happened
- Individuals who excel in performance are commended
- Motivation is given – in-service training
- Not done in an open manner therefore looks selective
- Praises those who deserve and rebukes those who also deserve
- Rewards deserving staff
- Yes, but most times wrongly

ii. Credibility of performance management system

The credibility of the PM system can either reinforce positive or negative performance depending on how it is used and how employees perceive its credibility. When used properly, it can lead to positive performance outcomes but when it is perceived not be credible then, it can demotivate employees. Thus, the objective for evaluating its credibility was to determine if it motivated or demotivated employees.
**Question 5:** How would you rate the current PM system? Would you say it is credible?

Since majority of managers stated earlier in the PM system that they did not appraise staff until staff was due for promotion or other awards, most managers still maintained that due to the fact that employees felt hated by managers, if negative appraisal findings were documented, appraisal was not done. Here were some responses from managers and policy makers regarding the credibility of the PM system. The policy makers also agreed with managers’ opinion on the PA but attributed it to cultural reasons where people are socialised to feel bad to relay information to others especially when the information is unpleasant.

“Let me be honest with you – With appraisal, people just think that it is not important but that’s the honest thing I must say. Secondly, the attitude or the conception about appraisal itself is not attractive- because it is seen as a tool... let me see... should I say witch hunt? a tool to punish, control and things. ...at the moment... and people are not very comfortable and supervisors are often not quite comfortable with appraisals. I have seen a lot of appraisals but you see only the nice things are written there all the time. So what is the point that everyday I have to say that this person is doing well when I know that the person every time I think I have to say this person is doing well…” (MMNR).

“...the way it is the Ghanaian culture somebody cannot look at one person’s face and say you are a bad person or you are not doing the right thing and so forth but the way to go around it is to be grouped” (MPMCL).

### 6.5.3 Perspectives on Rewards Management System

Rewards play a very crucial role in motivating employees and which can either increase or decrease performance depending on whether these are well applied or not. Owing to its sensitive nature within the PHS, the study selected rewards management as one of the HR activities to be evaluated.

**Question 1:** What rewards systems are in place or available in your district?

Responding to question on the availability of a reward system, most managers (16) talked mainly about material rewards but added there was no structured reward system with two mentioning other forms of rewards including how they also indigenised the practice in a way. Whereas most (10) policy makers stated there were no streamlined systems from national level for over five years due to lack of resources and funding, they therefore encouraged managers to use either the IGF or more of the non-material rewards, only one felt there were a lot of resources that MMDDHS could mobilise to motivate employees. The following were some of the responses.
“Hmmm! (laughter) reward system? What happens is that in a lot of the facilities, it’s basically at the end of the year. Then there is some kind of bonuses that is allowed by the GHS and which is paid to the staff. The other way we reward the staff is unorthodox but we make sure that if we are planning a training or a workshop for them we make sure we put in a little travelling and transport allowance that they can have to go and so that also motivates them a bit...And then emm...which other reward system...? There is no money so things are really tight. In the past the very remote areas when we are going to them and we had donor funds and all of that, we will get money buy a few things that will make them happy. Like things they can’t get easily and send it to the very very remote parts ...We don’t really have a formal reward system. It is adhoc I must say” (FMGAR).

“That is very interesting...Over the years resources to the district has been dwindling, especially resources that can be used for motivation, funding has become tough ... Already as for money we don’t have .... so I have adopted different methods, one of them is concern for your welfare, as I sit here I know every staff or where he or she lives so in the evening before you realise I have driven to your house. I will come and sit and chart with you... I visited a certain lady and she was not there and the following day the mother came to thank me that she didn’t know I appreciate what the daughter was doing and that alone put the person at a very high place.... a nurse lost the father in the Central region and I went there with a team,... Recently some one who is mentally disturbed bit one of my nurses and the chief and people tried to cover up and when I picked the signal I just drove there in the night... packed her that night and locked everything. The following morning the chief and everybody were here begging...” (MMNR).

“eeeedeeeee! hmm. Normally, when you know that somebody’s performance is outstanding ...you congratulate the fellow. For some, I bought a wax print and call you...and say I have a personal gift for you for the hard work. ...Then the other way too is writing to congratulate if the sub district performs well... or give them a feed back that this time you are the first to submit your returns and complete so keep it up. ... We organise end of year award review and during that time we buy items like fridges, video decks, TVs etc to award them” (FMNR).

“Rewards systems have fizzled out – There are two things, the non material reward and material rewards. Writing letter to congratulate” (MPMCL).

“There are a lot of resources that are coming to the districts... People are just refusing to see the decisions phase” (MPMCL).

i. Employees’ preference for rewards

The preference for awards as in literature in the empirical and theoretical chapters in Hofstede’s (1980) view shows that due to the culture of collectivism of Africans, group rewards are usually preferred to individual rewards. Thus the study evaluated the type of rewards preferred by PHS employees.

Question 2: In your view which rewards do you think employees prefer?
As to which rewards employees prefer, opinions of managers were divided. Whilst majority (7) felt employees preferred material (extrinsic) rewards, others (5) stated intrinsic while some (6) indicated both. Most (58) FGDs employees indicated they preferred both while 21 stressed more on the material rewards. Over half (66%) of surveyed employees preferred individual material rewards whilst 18% were not sure with only 14% preferring group rewards.

“I think the one you congratulate in the midst of their colleagues they appreciate it better than even the material things” (FMNR).

“I think they like both but I think they like the material reward. They consider this much more and understandably so because you know we are all in need of additional resources in the daily living. ...” (FMNR).

“Hmm (smiles) I wouldn’t pick one or the other. I think that both must go together. If you keep commending them with your mouth and your citation and then they have difficulty they don’t see anything. I suspect it will go a certain way” (FMGAR).

“In the area of money a lot of people talk about it...Yes material rewards. A lot of people are interested in material rewards” (MMGAR).

“The management of rewards is not the best as it stands now. We will prefer material rewards such cash, soft drinks, end of year awards and get together” (FGDs NR & GAR).

Table 6.9 Employees’ preference for material rewards

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ii. Involves employees in decision making

Question 3: Please describe how you use employees’ views and suggestions/Do managers involve you in decision-making?
The involvement of employees in decision making makes the employee feels valued and can lead to better service outcomes. Indicating whether managers involved employees in decision making, opinions were divided. Whereas managers stated they involved employees, policy makers and FGDs held contrary views. Here are some of the views perspectives represented.

“...So if we have to make such a decision we sit down at the DHMT and say ok let’s train them in this. You, what will you handle, you too, what will you handle? ...and then we basically get it together and then we roll together” (laughing) (FMGAR.)

“The decision making process here is very much broad based. ... I hardly take any decisions here by myself. If I am given the opportunity I will prefer to confer with my team because it is easier to then move forward with it to implement it, if something has to be implemented. Once in a while we have to decide something on behalf of the team. ...So here we are team members...” (FMNR).

“Hmmmmmmmm Not at all. Apart from those who are part of management. The information comes to us and we just have to take it like that or you leave it” (FGDNR).

“Quite a number of them we find out they don’t relate well with their DCEs... their colleagues in the hospital and even their subordinates and so we find it a big problem with them. Many of them do not hold their staff meetings. We find the dictatorial tendencies amongst them so the relationship is not very good as we expect” (MPMCL).

6.5.4 Perspectives on Staff Development

Employee training especially in health is very crucial in meeting organisational goals due to the sensitive nature of health care delivery. Therefore, the study wanted to get perspectives on this function. The thematic areas covered in this activity are the staff development system available, staff managers’ contribution to staff learning, training needs assessment, management development and credibility of the system.

Question 1: What staff development systems do you have in your district?

In responding to the question, most managers (15) were only concerned about formal education and training. None of the managers mentioned methods for staff learning. This is evidenced by their responses.

“May be my staff will tell you when they came in they put in applications that they wanted to do training in certain areas but I will say no, no that is not where your deficiencies are. So I try to assess people and get their training needs. I sometimes call people and talk to them I tell them their competencies and recommend areas that they are weak so they go get training in that area” (MMNR).
“(Ehe)... we don’t do a formal one and I was saying we don’t have a career development structured thing for people here. If people are developing their careers it’s from their own initiatives. There is no official thing. ...” (FMGAR).

“There are no structures in place. Staff themselves look out for opportunities. Few of them are also called and counselled to develop themselves” (FMGAR).

Regulatory body representative however, states how the regulator prevented the MOH from implementing its training policy.

“NMC’s role is to implement policies on behalf of the MOH, but it has in at least one important instance pushed back on the MOH’s authority in practice and established a measure of autonomy over policies that govern the production, training, and evaluation of nurses and midwives. Currently the NMC is playing a key role in scaling back the number of health assistants (a lower skill-level of nurses)” (MRep, NMC).

Most employees on the other hand, stated they benefitted significantly from workshops related to donor funded training programmes in technical areas even though managers did not assess training needs of staff. However, on formal training all stated managers did not support formal further training of employees.

Question 2: As a manager, in what ways do you contribute to your employees’ learning and development?/Manager supports your learning and development?

Concerning the support managers provide for employees’ learning, managers indicated they encouraged and recommended employees for further training. Beyond that it is the employees themselves who have to initiate and get the requirements for further training. This was similar to employees and FGDs’ opinions. Some employees in the FGDs expressed bitterness about the way managers leave employees’ further development to employees. From figure 6.7 majority over 70% of surveyed employees either strongly disagreed or disagreed that managers provided support for their learning needs.

“We still talk to people informally and tell them why don’t you go and do this course or that course. For instance recently, some staff have gone to do MPH course and it was kind of... we kept on prompting them “why don’t you, why don’t you” but we don’t have any formal system of saying that we are developing people’s career for them. But as for in-service training we pay attention to everybody as they need it” (FMGAR).

“Actually, I have never seen them saying so so and so should go for A or B course because you can never go there when you don’t have the requirements. Maybe they may see the potential but if you don’t have the requirements, they can’t push you so
maybe they can only urge you on to get the requirement and when you come if there is any needed assistance, then they will help you go through” (FGDNR).

Figure 6.7 Manager is able to support staff development needs

“...I met a friend who was in school and was telling me ‘sister, do you know the district they don’t visit us?’ They don’t give us anything but some places their PHNs visit them, they greet them with things but some of us and because of that me if I finish I won’t come back.’ ...” (FGDNR)

“Yes that one happens but if you are here and you want to go to school it is a problem. It is not from the district but it is from the top. Because I know teachers they give them study leave and the rest but Ministry of health if you have to especially we the community health nurses it’s not good at all....” (FGDGAR)

“Any way to me I don’t have anything to tell them because we know what to do and so we don’t have to beg you to do something for us. ...because of these things when they come then off they go. My colleague also wants to leave for a better place. If you are in Accra at least you can attend classes and the rest” (FGDNR)

i. Training Needs Assessment (TNA)

TNA helps to identify people and courses to suit their needs in order to improve their skills. Thus, the study evaluated managers to find out if TNA was done before employees are selected for training.

Question 3: How are you able to select staff for training? Or how do managers select employees for training?
From managers’ own narration of how they select staff for workshops and other donor-funded training programmes, none of them mentioned needs assessment and this is substantiated by both policy makers and employees as below.

“...Sometimes they themselves will come to you and prompt you. When somebody comes to tell you I want to go to school then you ask yourself then what of others...” (MMNR).

“No that has been the problem – identifying people to do it too has been a problem that we have got to tackle because most often some people turn out to be virtually neglected and others turn to be over trained. This is an issue ...but you can’t help it. A group that is usually neglected is the medical assistants. If you take leprosy officers for instance, until they moved fully into the disease control, they were also virtually left out” (MPMNR).

“I think we try to give people the opportunities as they become available. And then we try to share fairly so that not only one person of a certain type...When opportunities come we don’t keep sending one person. We try to look at previous participation and things that will give people the opportunity and make sure that it is more or less going round. ...we try to assess their need not necessarily formally but by their performance we can tell that maybe they are not using partograph ... so we can arrange a training so that they can get a refresher course on that, (ehe )”(FMGAR).

“No. that has been the problem – identifying people to do it too has been a problem that we have got to tackle because most often some people turn out to be virtually neglected and others turn to be over trained” (MPMNR).

“Well if they do they don’t communicate that to us ... In the area of the workshop – when there is any workshop – they will pick you because the workshop is in line with your department but not because they think you need the skill” (FGD, GAR).

**ii. Managers’ Development**

The objective for assessing Managers’ Development was determine whether managers were trained in any form before taking up their positions since managers are at the hub of service delivery and need to be told what their job and the organisation are about. Orientation, especially for new employees is important for the reason that it helps the individual know about his/her responsibilities and about the organisations in order to fit in and be able to perform well.

**Question 4** Were you trained or orientated when you were appointed as a MMDDHS?

Most managers (16) were unanimous that they were neither trained for the job nor in HRM/D nor provided any orientation before assuming their new positions. Only two managers indicated they were given a one-day orientation in their region. They all stated they
benefitted from workshops and meetings to develop their experience. Whereas majority of policy makers (9) admitted that there were some management programmes at GIMPA but which were not patronised of late, one policy maker however, maintained that these programmes were implemented regularly. Employees and regulators were not asked this question since they are not privy to when managers’ appointments and training. Sampled perspectives are presented below.

“No, I was not even given orientation. I remember when I was appointed seven years ago, “...When I was appointed as MDHS and seeing the newly appointed MMDDHS, I sympathize with them... it’s like you grope around until you find your feet.’ It was attending to meetings here and there that one picks up how to manage. ...because you were a technical person and had to perform managerial duties” (FMGAR).

“Generally, when we have workshops and things like that, that’s where I gain my experience from the GHS policies, I have my experience through workshops, trainings and document reviews and also applying my previous knowledge (“PK”)” (MMNR).

“Well you are told what you must do as a district director for example they just tell you that all the resources that are available, you must be prudent in your financial management you are called and told record keeping are very important so these are the basic things that we have been taught...” (MMGAR).

“Well when we were appointed we were given some one day orientation at the regional level” (FMGAR).

“All of them try to go GIMPA for training. The public health actually looks at the disease and the health indicators but for the human resource we have a problem with them” (MPMCL).

“Yeah, we have always had systems...Some have stopped but some are ongoing. For example, DISHOP and the management training in GIMPA...It is a recognised fact that capacity building at the district level is necessary” (MPMCL).

Question 1: May I know if you have any qualification or training in Human Resources’ Management/Development?

Responding to above question, most managers (16) stated they neither had on-the-job training nor any formal training in human resources management in the form of a certificate, diploma or degree. Only two managers indicated they had a module on HRM during their public health training.

“No, not at all” (MMNR).
“No. basically I did a small certificate in administration and management at GIMPA, it is there that I would say I had some knowledge and then my basic study as a … officer there was a component of HRM” (MMGAR).

“Ehmm… I have done the Masters in Public Health and which has some aspect of HRM and I have also done health management and Administration course at GIMPA which has some HRM component too and I did another training too in management of public interventions and which also has some HRM. But of course the theory is different from what is on the ground and I think we have come across a number of human resource issues that errr… you have difficulties” (MMNR).

All policy makers corroborated what managers stated about the four weeks course from GIMPA some managers benefitted from which introduced them to management in general. However, one of the policy makers stated that if he had his own way, some of these managers would not be where they were.

“No. That one we need to put in some training programme for them so what we’ve been doing is to send them GIMPA. All of them try to go there for training. The public health actually looks at the disease and the health indicators but for the human resource we have a problem with them” (MPMCL).

“With the line managers… not only managers if I had control, I will not allow them to work as such” (MPMTL).

Among the FGDs, whereas some equated the masters degree in public health training managers held to the HRM/D training others stated otherwise. However, from table 6.10, 169 of those who completed the questionnaires (employees) either strongly agreed or agreed that their managers had training in HRM/D, whilst 130 were either not sure or strongly disagreed to this assertion. This apparent divergence views are discussed in Chapter Seven. Reasons for agreeing that managers had qualification in HRM included those beneath table 6.10.

“She has a masters’ degree in Public Health” (FGDGAR).

“Yeah…hmmm… I think they have because they are able to manage the district” (FGDNR).
### Table 6.10 Manager has requisite qualification in HRM

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Some of the reasons given for rating

1. Allows unit heads to handle programs under them and control the staff
2. Always briefs staff of new development in health sector
3. Always ensures constant interaction through workers or staff durbars
4. Because he is a team player
5. By delegating employees to be in control of affairs
6. Circulars are always distributed and staff are always informed of new development and goals to be accomplished
7. Holds quarterly review meetings with sub-district heads and program heads
8. Implementation of health programmes
9. Organising workshops, seminar and staff durbar
10. Shares the work among the staff and direct them

Having assessed the knowledge, understanding and skills in the four human resources activities used for the study, the next section examines perceived challenges influencing the HRM/D practices and opportunities available to managers in the implementation of the HRM/D functions and including organisational processes.

### 6.6: Section Five

**Research Question 4.** How does this understanding/perception coupled with environmental factors affect their managerial roles including the approach to recruitment and deployment, capacity development, appraisal of staff and rewards management?

The objective was to investigate the factors/processes that have links with the effective management and development of HRH in the PHS of Ghana. Beyond the knowledge and skills of managers in implementing HRM/D policies, the context within which managers operate also needed to be examined based on the systems theory used for the study. The contextual factors as reviewed in literature in chapter 4 are very important since they have
been found to show links with HRM/D implementation. For this fact, the study evaluated respondents’ perceived challenges in implementing the four HRM/D activities.

Question 1. Do you perceive any challenges in implementing HRM/D activities? Do you think managers encounter any challenges in performing HRM/D functions?

Responding to the above question, managers and stakeholders enumerated numerous factors which confront managers in performing their HRM/D duties. All four groups of respondents were unanimous in their responses. However, whereas managers complained about challenges posed to them by some policy makers, some policy makers also complained about politicians’ interference with their HRM/D duties. From the challenges and opportunities that were enumerated by managers and stakeholders influencing HRM/D activities, these were then categorised into external and internal environmental factors. These comprised unfavourable legislation and policies, lack of resources and logistics including human, manager’s lack of capacity, interference with HRM/D functions from politicians and senior public servants, bottlenecks in accessing funding among others.

6.6.1 Challenges:

i. Legislation and Policies

Most (16) managers complained about constraints posed to them in implementing HRM/D activities by the decentralisation law (PNDCL462) and financial policies (Medium Term Expenditure Framework (MTEF), SBS and others and which was consented to by stakeholders. The decentralisation law according them did not include fiscal decentralisation while the financial policies on yearly submission of budgets with quarterly releases made fund inflows to the district for HRM/D activities difficult. Managers also revealed inappropriate institutional/organisational policies (human resources) and processes such as hiring and firing decisions which are centralised. Also, majority of managers (14) indicated their non-involvement in policy making processes and which often makes the implementation of such policies difficult since at times they claim these policies do not match the reality at the local levels. Please below are brief texts from managers and stakeholders.

“There is no money so things are really tight. ...but beyond that it is not easy with the funds not being available. The policy framework also delays the release of funds.” (FMGAR).
“Then the non-involvement of district directors in policy-making is a big challenge in that policies are formulated at the national level and you have to operationalise them and you have problems at the implementation level and - it’s a big challenge” (MMNR.)

This was however countered by a policymaker who stated that inputs are usually received from some MMDDHS during policy development but admitted however that majority were not involved.

“Yes actually now we talk to them during policy development... but we hope to start a more formalized way of developing policies” (FPMCL).

ii. Lack of Political Commitment/Interference
Regarding political commitment, all (100%) Managers complained about lack of political commitment to health programmes in the districts. To support this, managers cited the non-commitment of District Assemblies’ resources to health programmes with the belief that the health sector has donor support. This was supported by most stakeholders. On political interference in HRM/D activities, the recruitment, deployment and discipline of staff were the activities that had most interference. Below are selected perspectives expressed from managers.

“For all those who just come in, for social issue we are able to manage them because sometimes you need to talk to the person then the problem is solved but for political issue they will not even listen to the situation on the ground but what is to be done must to be done” (MMGAR).

“The challenges are staff deployment into the sub districts. We have instances you know that you need people here and there and when you send them they say they won’t go and they get backing from higher levels. Yes interference from politicians is a big challenge and you have to play your cards well or else you are tagged with a particular “political colour” (FMNR).

“...Policy challenges too are also there that have been formulated and documented but we have to implement them - politically motivated policies- Human resource challenges, attitude of staff – develop from these” (MMNR).

Policy makers, FGD and surveyed employees corroborated this finding and in addition, surveyed employees accused managers of constant consultation with DCEs before taking decisions.
“... So we have actually written it, there is a topic here we made it into a speech for him (Minister of Health) so we want him to give a motivational speech showing the direction that we should be going because normally the politicians when they come they don’t tend to encourage people to do things they rather come in with their own plans” (MPMCL).

“Lack of authority to discipline and therefore managers feel limited in disciplining staff for fear of powers above” (MPMGAR).

“We are talking of fairness here ... she knows the RDHS and she has come here maybe the RDHS may direct that you put her at Nyankpala (an urban area) can the manager say you will take her to ‘overseas?’ (referring to a deprived community where staff use boats to cross rivers to deliver service) No! you can’t do that” (FGD, NR).

Sampled views of surveyed employees

“She sometimes cannot take decisions without consulting the DCE and opinion leaders in the district making it difficult to work independently”

“There is a lot of interference from politicians especially in enforcing policies, unnecessary interference especially on staff movement”.

“The DCE belonged to one community and any problem in the community; they just come and report to him. ...So always they like...always want to have the best forgetting that there are so many communities that form the district and not that community alone. So everything they want it to go to their community” (FGDNR).

iii. Lack of managerial capacity

All managers complained about the lack of capacity in HRM/D and expressed the desire for training in the area. This was confirmed by all policy makers and some employees

- Manager does not have skills in management, communication, human relations and all skills needed by a good leader/manager to be effective
- Manager does not have requisite skills in human resource management
- Manager has no in-depth knowledge on administrative procedures as well as human resource management skills
- Manager is unable to communicate plans with employees, intolerance of other managers, inability to effectively coordinate varying expertise of employees to achieve organisational goals, open display of intolerance of diverse roles of officers (Sampled views of surveyed employees.)

“It is a recognised fact that capacity building at the district level is necessary” (MPMCL).

“Lack of capacity: Not only the way we recruit them but the qualified people are not just there. It is the calibre of people in the system” (MPMCL).
iv. Cultural and extended family systems

Culture is one of the environmental factors that have been viewed in literature in Chapter Two to influence HRM in Ghana. The objective was to get the perspectives of respondents on exactly how this happens in the PHS.

Most managers (13) and policy makers stated that cultural and extended family systems influenced their decision making regarding some HRM/D functions. For instance, the posting of staff and the performance appraisal of staff were cited as examples. Below are excerpts on this.

“In Ghana, our culture doesn’t permit us to apply appraisal very well. So... what we are saying ... the way it is the Ghanaian culture somebody cannot look at one persons face and say you are a bad person or you are not doing the right thing...” (MPMCL).

“...With appraisal, ...the attitude or the conception about appraisal itself is not attractive- because it is seen as a tool errrr...let me see... should I say witch hunt? Nobody is prepared to write any bad thing down like this person is always submitting reports late” (MMNR).

i. Geographical location

The geographical location of one region and some districts were also seen by both managers and policy makers as a challenge. They are not able to attract staff to those areas because of underdevelopment, terrain and remoteness of the area.

“We are not able to attract and people may have the qualification but for them to relinquish their position down south and come; he will prefer to stay where he is and not come. We are not able to attract to the three northern regions, we are no. ...look at the development of the country. It is skewed therefore it’s not favouring some regions and some area” (MPMNR).

“... Some of them are working under very difficult conditions in some of these rural areas. If you went there and saw where they were working you would be surprised at where they are working. ...One of the CHPS zones we are opening now, everybody is like who are you going to put here? Whose daughter are you going to put here? When you send the regional people or people from Accra they say ooops, this place whose daughter will you put here?” (FMGAR).

“Nobody wants to accept posting even to the three northern regions and now if you decide that people should fill forms and make choices where they want to work- we will end up having the three Northern regions and in the whole country most non-attractive places without health staff” (MMNR).

i. Lack of information or use of available information on HRM/D

Most managers (16) complained they did not know about the HRH policies on postings, promotions, further training etc. Another also complained that when she downloaded some
HR policy documents, she observed that the job descriptions for instance were very generic. This was confirmed by the HR manager in one of the regions. Policy makers admitted that information flow was not the best but were also quick to add that managers were not proactive enough to look for information.

“I never knew any such policy, I asked and they told me there is nothing like that. I asked for my own after been here for six years and the director was quiet. You become demotivated and it becomes like there are some elephants and there are some ants. It’s like animal farm” (MMNR).

“Since we received the booklets about a year ago, we have not had funding to organise an orientation for the districts before we distribute” (HRMNR).

“Well I don’t know. From my colleagues not I per se, they say they have written letters to some institutions that if you are a community health nurse they shouldn’t admit you which is very bad” (FGDGAR).

i. Inadequate Resources
Managers complained about inadequate human and financial resources and which are discussed next.

a. Shortage of staff and Low calibre of staff
All managers (100%) complained about shortage of staff to deliver service. However, the most endangered species were midwives who are in an acute shortage. In addition to the shortage, managers also expressed their dissatisfaction about the calibre of health personnel trained.

The excerpts from managers below highlight the magnitude of the problem.

“...Sometimes like I told you right now I need midwives ur...gen...tly. All the midwives are retiring. I need midwives ur...gen...tly for this new CHPS zones we are opening. I can’t find them. They are nowhere to be found....” (FMGAR).

“They are producing number of... Very soon you will have so many health assistants’ personnel and you won’t know precisely what to do with a large number of them. (MMNR).

The complaints by managers about the shortage of staff was upheld by policy makers who stated the shortage was affecting output.

“...is not only what you know but the inputs that support you to do it and the personnel, the human resource available to you to execute your activities and when you go to some districts, there is only one midwife then naturally, some of the sector-wide indicators will suffer when you are talking about maternal deaths and skilled
delivery. If there is only one midwife, how many skilled deliveries can she provide?” (MPMNR).

The shortage has also affected staff and they state how they are overworked in several FGDs.

“... I am here 24 hours I am the only midwife here. At times, during the night we do consultation especially clients will come you will do delivery. Sick people will come and you can’t ignore them. You still have to attend to them but we all collect the same salary, no any incentives to let you feel ...you are also wanted” (FGDNR).

a. Lack of funding and logistics

Managers and stakeholders all stated that often funds are not matched with HRM/D plans and activities. Even when funds are available, the quarterly releases are delayed and make implementation of plans difficult. Brief excerpts from respondents to support this finding.

“Over the years resources to the district have been dwindling, especially resources that can be used for motivation, funding has become tough and so is very difficult... Already as for money we don’t have...” (MMNR).

“Resource in the area of financial resource, that’s an area that we need to look at because if you have the people and you don’t have the funds, you don’t have the transport to go out it, becomes a problem” (MMGAR).

“...There are certain resources they need to help at the grassroots level but when they request they don’t get. Mostly, it is finance, logistics – motorbikes, maintenance of motorbikes, transportation is a problem” (FGDNR).

“Financial support from external sources have dwindled affecting activities of managers in supporting the system” (MPMCL).

Surveyed employees

“Economic factors such as insufficient funds prevents the manager from pushing through the plans of the organisation concerning employee issues,.”

“Lack of resources to carry out planned activities successfully

i. Employee Attitudes

Whilst over half of managers expressed regrets at employees’ attitudes towards work some (six) managers also attributed the negative employees’ attitudes to heavy work loads which stress out employees. However, four policy makers and surveyed group attributed employees’ attitudes to the dictatorial attitudes of some managers.

“... I see to it that I check absenteeism because.... People come in late, people would like to leave early, and people would absent themselves without permission” (MMMGAR).
“Staff attitude is a big problem. ...but when you go further to analyze it, it is because of the stress ...you expect so much from the few you have and that is where the attitudes set in because of the pressure. They cannot continue anymore then you think that it is an attitude being developed” (MMNR).

“Quite a number of managers we find out they don’t relate well with their DCEs, with their other colleagues in the hospital and even their subordinates and so ...we find the dictatorial tendencies amongst them” (MPMCL).

Surveyed employees

- The way he talks sometimes to staff
- Shouting, absence of long-term plans, adhoc approach towards some strategic decisions
- Seems to be in a sole trading firm, has no time for anybody
- Political influence-inability to delegate, socio dictatorialism.
- Attitudinal problem, lack of management skills
- Intolerance of other managers, inability to effectively coordinate varying expertise of employees to achieve organisational goals, open display of intolerance of diverse roles of officers (Sampled views from surveyed employees).

Among the FGDs, heavy workloads and long hours of work stress them out

“We are going to start with AFC and then there is CD4 coming, we are going to start TB test, blood banking” (FGDNR)

“Recently people from NACP came and they were talking about focused antennal care and they wanted us to do PMTC, counselling, testing and all that and I was telling them that it not possible otherwise I will work 24 hours a day no rest I will just be there forever, and they were also trying to put force on me and I did it and that day and at the long run I got tired on the way, and I said the rest of you go home and come back tomorrow and it was the best at all,... every day in and day out they are adding more programs ...the work increases then we are just there”(FGDNR).

i. Deprived areas versus motivation

Motivation of staff who serve in very remote and dangerous areas in districts was another challenge managers expressed concerns about. Although managers recognised the need to motivate such staff, the lack of funding does not enable them to do so. Policy makers as already discussed under rewards management admitted incentives were not available currently but felt managers could mobilise resources and use some of that to motivate employees in deprived areas.

“...how to motivate the staff in the face of scarce resources...some of them are working under very difficult conditions in some of these rural areas. If you went there and saw where they were working you would be surprised at where they are working and the results they are bringing. One of the CHPS zones we are opening now, everybody is like ooops, whose daughter will you put here?” (FMGAR).
“Accommodation...you as the manager, how do you deal with staff accommodation” (MMNR).

Employees in FGDs expressed same sentiments about motivation despite the sacrifice to
serve in remote areas and ‘one man’ stations.

With my case like this I am here 24 hours I am the only midwife here. So 24 hours at times
during the night we do consultation especially clients will come you will do delivery. Sick
people will come and you can’t ignore them. You still have to attend to them but we all
collect the same salary, no any incentives to let you feel that actually as you are in the
village you are also wanted” (FGDNR).

i. Lack of monitoring and supportive supervision from central level
Managers also highlighted lack of supportive supervision through monitoring from central
level as another set back to their performance. Policy makers conceded to this complaint.
Below are excerpts.

“Hmm, that thing is what is lacking. The monitoring bit, most of the time when we do
monitoring, it is actually not organized monitoring. But as we speak now the units go
individually and that is not very effective” (MPMCL).

ii. Competing Programmes with Managers’ time
Another area that managers stated was a challenge were the frequent calls to meetings and
workshops at short notice and which interfered with their plans and does not allow them to
perform their duties effectively.

“Yes any given time you are called for one meeting or the other. The other thing too
is that if you are not very careful you can’t follow any given schedule because of
interferences from above. You have your own programmes before you realise the
national level, regional level come in and say this thing must be done so you have to
stop whatever you are doing and do theirs” (FMGAR).

“We have only one doctor and he is a facilitator for IMCI and so for the next two
weeks he will not be there because he is gone to facilitate because is very important
because we need to be able build the competencies of the middle level personnel to
be able to deliver the services but then management at the senior level should realize
that if you are pulling this doctor there will be a vacuum that will last for two
weeks,” (MMNR).

Policy makers and employees consented to competing programmes with managers’ time and
state the following.

“...from the perspective means that disease prevention and control is the key area of
concentration. ...redefined the DDHS position to include other management systems
this is not really well functioning because the disease part is taking the better of the DDHS” (MPMCL).

6.6.2 Opportunities:

Despite the plethora of challenges, the study also wanted to find out if there were any opportunities at all for managers to overcome or minimise these challenges. Thus, a question was posed to determine if respondents perceived any opportunities.

In response to the above question on any perceived opportunities all managers felt there were avenues to either minimise or overcome the challenges. The same was admitted by stakeholders and below are relevant responses which have been categorised in line with the challenges.

i. Political interference

To deal with political interference some managers stated it was possible to dialogue with politicians while others also believed it might only minimise interference but not eliminate it based on the culture into which people are nurtured makes it difficult.

“It is possible to talk to politicians but is impossible for them to understand because the position is looking at job security right, and if am an MD and am been posted and they have posted constituency chairman’s daughter to your place...” (MPMCL).

ii. Lack of managerial capacity

All managers felt orientation and training in HRM/D could improve their skills. Supporting this, all respondents affirmed that managers’ knowledge could be upgraded either by in-service or formal training in HRM/D and general management including interpersonal skills and communication to be more effective. Sampled responses are as follows.

“We have and there is the need for orientation. People have to change the old ways of doing things otherwise we can’t take them seriously and that will be a catastrophe because if I don’t take you seriously if you tell me stuff it’s like am listening and not listening” (MMNR).

“Like I mentioned earlier this team building and lifting up the spirit of people concerning the job I think it is a major component. You can motivate them if they are not developed they cannot work. You can distribute them if they are not developed they cannot work. So I think that aside distributing and motivating them they need the development to be able to do the best” (MMGAR).

“Managers need to be orientated into their positions; they also need to given some training in HRM/D” (MPMCL).
“Yes the people are there, they can do the work but if they are not helped like the capacity building I keep mentioning. So the opportunity is that we have the people. They are of good quality but probably they don’t have the training or the skills and knowledge so once you are able to put the knowledge and skill in there they can do their best” (MPMGAR).

“Getting the universities to announce the courses – for sandwich programmes to enable managers participate. For example, school of Public Health and Ho University” (MPMCL).

Sampled views from surveyed respondents

- To be trained on interpersonal skills
- To have managerial exposures
- Training on managerial practice, forms of leadership styles and where to implement each, motivation.
- Undertake a course in human resource development
- To acquire formal training on-line
- There should be more exposure to management training
- Self education, other forms of education like short courses, workshops
- Needs at least two years training to become efficient HR manager
- Learn more on issues related to staff performance management practices
- Has no chance, it will be so till his retirement

iii. Inadequate resources

On the subject of inadequate resources, these were classified into finances/material and human resources

a. **Financial and material resources**

All managers (18) acknowledged there were avenues for them to mobilise funds and other resources other than from Government sources to provide accommodation and motivate staff. Policy makers and employees all shared this view. Some suggestions are stated below.

“Accommodation: The opportunity is that the NHIS is implemented and IGF is increasing so the opportunities are there in that you can build houses on your own which can help us solve the problem” (MMNR).

“On resources, the opportunity is that we can run some services with the IGF. Then the opportunity is there again you can motivate staff and reward them because we have the money – we can also provide the tools and the resources to make the work more rewarding for satisfaction. And of course other opportunities are that other NGO’s and other partners are there to support some of these areas” (MMGAR).
“Managers can benefit from resource mobilisation from District Chief Executives (DCEs), communities, NGOs. What managers need is to be more analytical in their thinking” (MPMCL).

b. Human Resources

On the shortage and attitudes of staff, all managers again acknowledged they need to dialogue more with staff to understand issues and based on this understanding, with the available and knowledgeable staff, an internal shifting could be done by redeploying staff to areas of need. Regulators however, added that managers could advertise positions with amenities to attract qualified staff to areas of need. Employees supported this opinion and added that the provision of amenities by managers could be an opportunity to attract employees. Sampled opinions are found below.

“With the staff attitude too there are opportunities such as running several workshops to re-orientate them and now that you are pushing us, the big opportunity is to use the performance appraisal to...” (FMGAR).

“Oh yes for example we don’t have the requisite staff numbers we need, so the issue is that those that we have ...So we look at the various needs and redeploy people. We try to move people from one place to the other we need to involve everybody in the process. We need to overcome these challenges if we can’t overcome them then you don’t qualify to be at that post” (MMNR).

NHIS funds and IGF can be utilised efficiently to improve the system-internal, (Surveyed employees)

iv. Lack of information and Communication

Managers agreed to be more proactive in the search for information through contacts with national level and web searches where this is available. Policy makers also felt they could involve managers more in policy processes and improve information dissemination to managers. Employees on the other hand stated an opportunity was for managers to be trained on communication and interpersonal relationship.

“Use available organisation structure, create enabling environment for effective communication” (MMGAR)

Surveyed employees

- He need to control how he talks to workers
- Regular interaction with staff and meetings with subordinates to iron out problems in the office and work harmoniously
- Needs to be trained on communication skills including interpersonal relations.
- Hold regular meetings
Research Question 5: What lessons can be learned from the perspectives of managers and employees and what are the implications for policy, practice and in making management more effective?

6.7 Perspectives of competencies that makes one an effective manager

In trying to evaluate the HRM/D effectiveness of MMDDHS from the perspectives of managers and stakeholders, it was likely to learn some lessons in the context of the PHS and so the study which was also interested in compiling competencies from the perspectives of respondents used the opportunity to collate these competencies from respondents. This was to enable the study compile contextual managerial competencies for HRM/D in the PHS.

Please refer to Appendix … and table 6.11 for details of the verbatim responses of that respondents outlined as HRM/D competency attributes that managers should possess in the health sector.

6.9 Conclusion

Findings presented in this chapter from both qualitative and quantitative methods generally complemented each other except in few areas where there was divergence. Even where there was divergence as in the regular appraisal of performance and providing feedback reasons further assigned by employees from the quantitative sample did not match ratings and further supported the qualitative findings. Some of the quantitative analyses between the regions on educational qualification and professional background show differences, there were however, no significant differences in formal training in human resources management, age, experience and the intention of respondents to attend future training programmes in human resource management.

In total, 100% of managers, all policy makers and majority of employees stated managers need further management development, suggesting that, managers and stakeholders felt that managers could benefit from further training. As a group, managers recognise they are least competent in all HR management functions. Nonetheless, they did feel relatively more competent in their ability to plan, manage and lead in the technical programmes.

Overall, the results of managerial competencies in the study coupled with comparable findings from the several studies reviewed which helped in the compilation of these competencies, provide credence to the type and range of specific behaviours that managers
operating at these levels need to exhibit (or avoid exhibiting) if they are to be perceived and judged effective by other people in the PHS.
CHAPTER 7: Discussion

7.1 Introduction:
The research set out to evaluate managerial effectiveness of FLMs in the implementation of HRM/D policies at the district level. The study did this by assessing the competencies of FLMs in line with HRM/D functions from the perspectives of managers themselves and stakeholders. In Chapter Six, findings from document analysis, interviews and a survey were presented. A conceptual framework used for the evaluation of the HRM/D practices was in line with the external and internal environmental organisational contexts of the PHS and which included national cultures, and the politico-legal, and socio-economic climate. The aim of this chapter is to discuss and synthesise the findings in line with the study’s main aim and research questions within the context of existing literature. The discussion is designed in line with the main research question which is: What do the findings reveal about the effectiveness of FLMs in the implementation of the four HRM/D activities of recruitment and selection, performance management, rewards management and staff development? The discussion will also state if the empirical findings support the defined problem that justified the conduct of this study.

The discussion is thus organised around the findings presented according to research objectives. First, the significance of some biographic data is discussed and which is then followed by the perspectives on managerial effectiveness. This will begin with the knowledge of managers about the health sector goals, priorities and model of health service delivery and HRM/D policies and their linkage of these to implementation of HRMD activities at the district level. Following from this, managerial competencies, the constraining environmental factors and the opportunities available to managers to become effective implementing HRM/D activities are discussed and conclusion drawn.

7.2 Socio-demographics
Four areas - age, gender, qualifications and position and professional backgrounds of respondents are discussed for socio-demographics due to the important relationship these have with some of the characteristics to HRM/D effectiveness. Before then, the response rate is discussed.
7.2.1. Response rate and regional distribution

The overall response rate of managers (90%) and employees (52%) was encouraging. Owing to the busy schedules that these managers have as highlighted in the findings, the response rate was relatively high. Possible reasons for this response rate may be due to the fact that managers attach some degree of importance to HRM/D as they all expressed the need for management development to better manage HRH. It may also be that the information sent out for the conduct of the research was timely and adequately disseminated to managers. Managers may also be interested in the study due to the fact that investigator was from the central level and reasoned this might be a form of monitoring or dissemination of information on HRM/D. Despite this general high response, there were regional variations. For instance, it was easier to contact managers from the northern region (NR) than those in the Greater Accra region (GAR) and this accounted for lesser numbers (8) of MMDDHS from the GAR being interviewed and three FGDS compared to six in the NR. Conversely, the response rate was higher (191) among employees in the GAR region than in the NR (111). This goes to confirm the distribution disparities of health personnel.

The finding of high response rate by managers is supported by Pillay (2008) who had a similar response rate among hospital managers using self-administered questionnaires. He thus stated that given that response rates in studies of professionals using self-administered questionnaires are generally poor, this may indicate that managers attach a high degree of importance to HRM and the need for management development. The similarity in responses between manager respondents and of policy makers suggests that non response bias was minimal and the sample was therefore representative of all MMDDHS in the PHS of Ghana.

7.2.2 Age

Managers were aged between 40 and 51 years whilst policy makers and regulators’ ages ranged between 50 and 58 years. Whilst this trend pointed to the fact that only those who had served for many years occupied these positions, and thus bringing their experience to bear in policy formulation and managerial roles, the potential danger is that younger professionals who might have competencies to better manage may be excluded from occupying these positions to the detriment of the sector. On the other hand, however, majority of the respondents and interviewees in the employee group who were neither managers nor policy-makers were aged between 20-40 years with a negligible number over 50 years. This indicated a young health population from the two regions. This goes to support the situation analysis in chapter two where it was stated that the increase intake into health training institutions in the early 2000s augmented staff shortages in the country’s health sector to provide service for a longer period of
time. This finding is in line with Akuoko et al. (2008) who acknowledge that age is an essential determinant of labour force participation as human capital investment decisions depend on how long the organisation would benefit from an employee's working life. Therefore the employee groups who form the bulk of the implementers of health services and have a younger age will serve the organisation for a long period.

7.2.3 Gender

From the findings, most policy makers interviewed were males whereas the managers comprised equal numbers. Again, Akuoko et al. (2008) had similar findings in Ghana where all policy makers interviewed except one were males while among managers there were equal numbers of both sexes. This, in the latter’s view quoting Moser (1994) could be attributed to the triple roles of women in the society and the negative perception of women generally in organisations, which states that traditionally a woman is supposed to perform the reproductive, productive and community managing roles.

However, majority 161 (66%) of employees in the mid level were females. When this finding is reviewed by region, majority of MMDDHS in the GAR were females with only male, whereas in the NR, only 3 out of 10 were females. This finding is also consistent with those of Adetutu and Emelike (2010) in a study in Nigeria and again with Akuoko et al. (2008) both of which found female employees to be concentrated at the entry or middle level positions but remained scarce at senior management or board positions in most industries and organisations. This is further supported by some worldwide statistics. For instance, Lantz (2008) found that the American College of Healthcare Executives (ACHE) which conducted surveys in 1990, 1995, 2000, and 2006 on key aspects of male and female executives’ career attainment, suggested that women executives are much more likely than males to be a department head or to fill some other staff position, whereas men are much more likely to be chief executive officer (CEO), chief operating officer (COO), president, or vice president. Among ACHE’s executive members, the proportion of female CEOs changed insignificantly between surveys: 11 percent in 1990; 8 percent in 1995; 11 percent in 2000; and 12 percent in 2006. The majority of female managers in the GAR is also supported by Dussault et al. (2006) which found gender imbalances, according to geographical distribution because women tend to avoid rural and remote areas.
Despite the finding of female dominance among respondents and which also supports the notion that the middle level professionals (especially nurses) of the PHS are mostly females, most top leadership positions are however occupied by males. Clark (2010, p1), also support the above findings and quoting Zahidi of the World Economic Forum (WEF) of women’s leaders stated that, “while a certain set of companies…are indeed leaders in integrating women, the idea that most corporations have become gender balanced or women friendly is still a myth”. Some of the causes for this phenomenon according to the latter, “…lack of role models, general norms and cultural practices and masculine or patriarchal corporate culture.” Although this finding is not peculiar only to the health sector of Ghana or only to Ghana, this calls for the re-examination of gender and professional equity in top management positions.

7.2.4 Positions and Professionalism

On professional lines, all positions were occupied by health professionals. However, whereas most MMDDHS (seven) in the GAR were medical doctors, majority (six) out of the ten in the NR were nurses. This regional breakdown revealed that both regions were at the two extremes of ensuring gender and professional equity in appointment of managers. The professional background of the respondents suggests that most managerial positions and leadership of health management in Ghana are occupied by medical or health related professionals. This contrasts with findings of Pillay (2008), who found a perceptible shift of the management of all hospitals in the public sector of South Africa to be managed by people with commerce or management background with less than five years experience. This finding therefore strengthens the fact that managers in the PHS of Ghana are experienced in the health sector. Although it is understandable, it is also a concern that majority of managers are mostly health professionals who could be directing service delivery or providing expert advice to the young ones to provide quality service. Furthermore, they have not also been trained as professional managers and especially in HRM/D. Again, the fact that policy makers were significantly over 50 years of age, has implications in terms of the natural attrition and the replacement of these managers and on the return on investment from the development of these managers. The future sustainability and stability of the PHS will therefore depend not only on enhancing current management capacity, but also on the development of individuals with management potential as part of a broader career management and succession planning initiative.
Most employee respondents were mostly midlevel operatives and had no headship positions. This is in line with the intention of the researcher’s objective of getting employees to evaluate their managers as a way of complementing the in-depth individual interviews provided by their managers at the district level. The few who were in headship positions such as the sub district heads are deemed employees who have been delegated duties of supervision by managers and so all these were considered to be subordinate employees.

### 7.2.5 Qualifications

Findings revealed most policy makers, regulators and managers held masters or higher degrees whereas majority of employees held diplomas. The similarities among the two groups of employees are not surprising because the two employee groups comprise the junior staff and are at the same level because the entry requirement for midlevel professional training in the PHS is a diploma. For the former group the minimum requirement for one to occupy these positions is a second degree and preferably in public health or management but which all managers held public health degrees and thus the finding was in line with the policy. However, a striking finding was on the qualification or training in HRM/D and which revealed that nearly all managers neither had qualifications nor any training in HRM/D. It was also highlighted that they were not given any orientation before taking up these positions. Thus, they all acknowledged the need for orientation in relation to management in general and not only specific to HRM/D regarding their plethora of responsibilities. These needs are highlighted in the findings chapter.

First, this finding is indicative of the fact that academic attainment is important for one to be able to get into either managerial or policy making positions and thus encourages health staff to aspire to get academic qualifications. However, academic attainment does not necessarily equip a person with managerial competencies. This finding goes to support Filerman (2003), as in chapters One and Three, who contrasts managerial competencies with public health competencies and concludes based on evidence, that it has been shown over and over again that public health competence without a firm foundation of management skills does not produce successful results. Also, Picket (1998), intimated it is necessary to know which critical which apply to specific functions and individuals within the organization. Thus, the knowledge and skills of people must be developed and matched with their current and projected future roles in the organization. Based on this, the idea of the framework bringing
on board managerial competencies and roles as explanatory factors to attaining HR managerial effectiveness is supported.

The above arguments are true with the findings from the study. Although most managers were highly trained academically and all had second degrees and beyond in public health, all managers indicated the need for either training or orientation in management including HRM/D since the training was not tailored towards HRM/D. Even the two managers who indicated they had modules in HRM/D during their training were quick to add that this was not enough for them to be able to perform HRM/D functions. It also appeared that those who had the training more recently were those who had HRM/D modules incorporated in their programmes.

The above, thus calls for the incorporation of basic modules on human resource management and development in the pre-service training of health personnel in Ghana especially nurses and doctors who often find themselves in management positions soon after completion as asserted by Egger et al. (2005).

The effectiveness of management in the Wikipedia-free encyclopaedia (2010) is recognised as one of the determinants of organisational success. Therefore, investment in management development can have a direct economic benefit to the organization. In furthering this assertion, Harper (2009) states that many employees are promoted because they are good at their jobs, but that does not necessarily make them good managers. Managers are responsible for developing their teams, fulfilling company goals, managing budgets and are accountable for their entire department. From this assertion, the importance of management development (MD) can not be over ruled in the health sector where the frontline managers are responsible for health care implementation. To ascertain whether these frontline managers have been trained in HRM since HR forms the backbone of the health sector and their responsibilities include HRM, the next section discusses ME.

7.3 Managerial Effectiveness (ME)

The discussion on ME covers three areas – managers knowledge and understanding of health sector goals, priorities and the linkage of HRM/D policies to these and managers’ knowledge about their responsibilities. Next, the perspectives of managers and stakeholders on the four selected HRM/D practices are discussed and then followed by competencies and then conclusion.
7.3.1 Managers’ knowledge about Organisational Goal, strategies and priorities

Before examining views on human resource activities, it is important to establish whether there is a mutual understanding of the philosophy of the strategic driver of the PHS as it is the foundation of HR activities as asserted in Chapter Three by Bond and Wise (2003) and Heraty and Morley (1995). The findings revealed a general agreement among respondents that managers were not knowledgeable about the organisational goal, priorities and strategy. Due to the lack of knowledge, most managers could not appropriately articulate the goal, strategies and priorities of the health sector. For instance one equated the health sector goal to the motto of the Ghana Health Service (GHS) while some mixed up the priorities with the goal. From a theoretical perspective in the managers’ views, the PHS of Ghana has taken a strategic perspective in devolving HRM/D to line managers. They acknowledge the PHS linking HR activities in the strategic driver of the service quality initiative. Other conditions include the establishment of a human resource directorate at national level with a director in-charge and designated human resource specialists’ roles in all regions to oversee all HR functions in the regions. Managers however, noted that these are not well linked practically.

On the definition of terms managers defined management to be the traditional hierarchical roles of organising, controlling and directing function as from the management books with few managers adding employee welfare. This finding is similar to that by Branine (1996) in China where Chinese managers used only points and methods that were either given in the lectures or copied from textbooks when requested to provide ways managerial problems could be solved with none of them developing his/her own thinking of people-oriented and behavioural issues.

7.3.2 Model of Health service delivery and policies postulated at National level

All managers and employees agreed that service delivery at the district level was in line with the model of health service delivery as postulated at the national level for the district level. Theoretically, most managers indicated HRM/D policies at the national level were good. However, these did not match the implementation at the district level. Since managers admitted that the two were not linked well, managers thus implement HRM/D slightly differently from the national policies. They supported their arguments with the reasons that it
was contingent on the situation and what suited their local area of operation. This finding has been justified and supported by Larsen (2000) who states that within centralisation and decentralised systems, managers can choose to operate differently at their level. He supports his assertion with the fact that HR departments design personnel policies and the work is done by different people whose backgrounds have different orientation. Hence since the policies must function for employees in other parts of the country and whose values and needs are quite different it should be surprising if the company has difficulties in getting its message across. This supports the systems theory used in the conceptual framework which allows for contingency in the management of HRM/D functions.

7.3.3 Alignment of Health sector goals and strategy with HRM/D Activities

The findings revealed weak alignment between policies and implementation. Several reasons were assigned for this non-linkage. First, due to some environmental factors, some of the HR activities could not be performed in line with the policies. These will however be discussed under the four HRM/D activities in subsequent sections in this chapter. The four HRM/D practices too do not feed into each other but are rather implemented in isolation. For instance findings from PA do not feed into staff development and rewards management. This therefore reveals both weak vertical fit between the four practices and organisational strategy and weak horizontal fit among the four practices. Way and Johnson (2005) quoting Legnick-Hall and Legnick-Hall (1988) stress that the degree of vertical structural alignment of organisation’s goals with HRM/D and employees goals, is expected to be greatest when HRM provides feedback and input regarding the ability of SHRM to contribute to the attainment of the goals and objectives of the organization as a whole. Also corroborating this theory adopted in the conceptual framework, Maxwell and Farquharson (2007) quoting Rodriguez and Ordonez de Pablos (2002, p249) and Harris (2005, p681) state that “contemporary practice of HRM in organizations can be gauged by a number of dimensions, notably its links with business effectiveness and business strategy processes, and HR policy priorities”. This finding again confirms what Larsen (2000) said about centralisation and decentralised managers in which managers can choose to operate differently at their level.

These findings however, contradict Way and Johnson (2005) who posit that to enhance organisational effectiveness, the deployed HRM by the organisation must be linked with other organisational resources. It is therefore worrying that managers at the implementation
levels are not conversant with organisational goals and coupled with this also implement
HRM/D activities their own way without recourse to HRM/D policies and sector strategy.
Due to this weak alignment, one wonders how these managers will work towards achieving
the sector’s goals since according to Becker et al. (1996, p781) quoting Baird and
Meshoulam (1988), an examination of HRM across such dimensions is valuable as
“integrative and innovative HR practices with appropriate orchestration, HRM … support
organisational performance”.

Thus, bearing in mind the importance of vertical fit and strategic linkage of HRM/D
strategies to organisational goals as in the framework, this is however, not the case of the
PHS of Ghana. From the findings, it is clear that within the PHS of Ghana, HRM/D is
afforded high-level organisational support at policy making (directorate at central) level. It is
generally recognised by all respondents as contributing to organisational effectiveness when
it centres on organisational needs. It was also mostly agreed that HRM/D was integrated with
health sector strategy processes at both strategic and operational levels. However, managers
interviewed whilst acknowledging this integration, indicated it was on paper but not
practically implemented. Thus, this reveals a gap between the HRM/D’s integration to health
sector goals and strategic planning and implementation processes. This has been recognised
by Kane and Palmer (1995) who noted that crucially, there is often a disparity between the
rhetoric of organisational contribution and reality of organisational treatment of HRM
together with differences in applications of HRM (Boxall and Purcell, 2000). For instance,
managers cited how they lacked HRM/D competencies as most of them were not trained or
orientated on HR functions and left to ‘groped’ around until they found their feet. They also
enumerated instances and issues linked to the various HRM/D functions which made this
impossible to implement. These would however, be discussed subsequently under the
HRM/D functions. Managers also felt they were not involved in HRM/D policy development
and felt that even though HRM/D policies were good there was a gap between policy
development and implementation. This was also supported by policy makers both at regional,
tertiary and national levels who stated that most managers they worked with are not trained
for the job but for the fact that they found themselves in those positions, they are forced to
work with them. This is supported by the finding that most managers in the developing world
lacked capacity in implementing the HRM function (Egger et al., 2005 and Adano, 2003) due
to the lack of management development capacities to take up the HRM functions.
Consistent with this finding about vertical and structural non-alignment, Picket (1998) cited a similar finding in a major survey of global organisations conducted by The Economist Intelligence Unit and which found out that whilst most respondents from the Asia-Pacific area lacked managerial competencies and indicated a need to improve management competencies, they also attributed this to organisation structure and processes as they maintained these do not encourage them to recruit appropriate calibre of staff, appropriately appraise staff and apply sanctions where necessary and therefore called for the need to better utilize corporate strategy to drive change and to strengthen the link between strategic intent and day-to-day implementation.

From these findings, it can be concluded that due to this weak vertical linkage between HRM/D and the health sector goals and HRM/D implementation is unlikely to contribute maximally to the attainment of health sector goals.

7.3.4 Managers’ knowledge about MMDDHS Responsibilities.

Findings on MMDDHS’ responsibilities revealed disinterest of lack of desire by managers in HRM/D activities as most managers did not outline HR management as part of their responsibilities unless they were prompted. However, policy makers, document reviews and employees on the other hand agreed that managers were responsible for the management of all health staff assigned to the district. This finding of line managers being responsible for HRM/D is similar to literature in Chapter Three in which Renwick (2003) identifies that a partnership approach to HR requires the integration of HR activities into the work of line managers. However, the fact that managers do not even remember that HRM/D was their responsibility could be interpreted to mean that HRM/D was not a priority area for managers. This finding is similar to Whitaker and Marchington (2003), as outlined in Chapter Three, who also found tensions between line managers’ general functions and HR responsibilities and HR took second place in relation to other business needs and Renwick (2003) found issues around lack of time, inadequacies in ability and distraction from general managerial focus and tensions between HR specialists’ expectations in relation to completion schedules of HR tasks. This finding supported by most policy makers that the technical aspect (Public health activities) take most of their time can not be far from true that little attention is given to HRM/D. Also Maxwell and Watson (2006), in the same chapter, also found in their study that the two main barriers to most line managers’ involvement in HR initiative are seen as heavy workloads and short-term job pressures.
A job’s functions are listed in the job description. This can help prevent an employer from asking employees to perform duties not listed in the job description, and can also prevent an employee from refusing to do the job he was hired to do. The issue of MMDDHS not remembering to outline HRM/D as one of their responsibilities may be interpreted as a deliberate attempt not to recognise it as one of their responsibilities and this finding raises eyebrows about their attitude.

As per the conceptual framework in Chapter Four and the research questions and objectives, in Chapter One, the next section discusses the findings on knowledge and understanding of the four HRM/D practices used for the study.

**7.4 Managers’ Knowledge and understanding of HRM/D Activities**

The study embarked on evaluating HRM/D effectiveness using bundles of HRM/D practices as discussed in Chapter Four instead of single HRM/D activities. This is within the context of the PHS of Ghana and their strategic fit to organisational goals based on the external and internal environmental variables and how these have implications for HR managerial effectiveness and sector’s performance. These four practices are recruitment and selection, performance management, rewards management and staff development and are discussed next. Even though there are several classifications or groupings of HR activities, the author uses four groups of activities seen as the most strategic and influential in realising the objectives of the health sector.

**7.4.1. Recruitment and Selection**

Findings from all respondents supported by policy documents indicated that the recruitment function of core staff is centralised and therefore not within managers’ purview. All managers pointed to the fact that they were recipients and expressed dissatisfaction at actions of some top management regarding the manner in which core health staff are recruited and sometimes assigned to their districts and which sometimes do not favour their areas of need.

Politics/power, economic and extended family systems were found to influence the recruitment function. This was either by the influence of politicians or kinsmen or for economic reasons. Almost all managers and a policy maker complained about the
interference by people higher up including politicians who make it impossible for staff to be distributed equitably. This often leads to withdrawal of postings to the detriment of deprived districts and embarrassment of managers. Another reason for the interference was the extended family system which made relations of employees in positions of power or the popular ‘whom you know business’ to seek the reposting of their kinsmen to urban areas.

From the above, it is apparent that the centralisation of the recruitment function coupled with the interference with the distribution of staff results in inequities and which consequently does not favour the deprived areas. Managers viewed this policy of recruitment not practically supporting the health sector strategy. This can therefore be regarded as having a weak vertical fit. This finding brings into view the implications of the resource based view (RBV) (human capital) in the framework has for HRM/D effectiveness. With the framework’s inherent systems’ perspective and the RBV of the health sector, it suggests the importance of complementarity of resources to enhance and sustain organisational performance but if the synergy or integration is distorted due to all these interferences then the search for quality health care is illusive. Maxwell and Watson (2006) quoting MacDuffie (1995) support this finding by stressing that one of the distinguishing characteristics of HRM is that it seeks to convert the often divergent array of policies associated with traditional personnel management into a strategically coordinated or ‘integrated’ set of policies and processes that improve organisational performance. They affirmed that where this has been achieved there is empirical evidence that organisational performance can improve. Conversely, when HRM is unable to affirm its integrative ambition, it loses much of its significance as a distinctive approach to people management and becomes old-style personnel management - a collection of incidental techniques without much internal cohesion.

The resource dependence/institutional theory as in the framework also surfaces in the recruitment function where in the findings, a male regulator boldly criticised the MOH’s way of posting doctors to deprived areas and vows to support doctors who refused postings to deprived areas without decent accommodation.

This highlights politics (power) at play regarding the distribution of staff. Willcocks (1998) had a similar finding with his perspective on the political theory established that with the political perspective, organisations are viewed as complex systems of individuals and coalitions, each having its own interests, beliefs, values, preferences, perspectives and
perceptions and these continuously compete with each other for scarce organisational resources. Hence, conflict is inevitable as power, politics and influence are critically important and pertinent facts of organisational life. This links up with the framework which has resource dependence theory as an explanatory factor for HRM/D implementation in the public health sector. Thus, the influence of power as in the findings in which managers and policy makers can be requested to withdraw posting of staff and the Associations also having the power to dictate the conditions under which staff should be posted seriously inhibit the way HRM/D activities are implemented.

Regarding deployment of staff, the finding made public that some staff were posted directly to the district either from central or regional level. In addition, most managers assigned staff to sub districts, without reference to staffing norms or what the needs may be. Whereas some managers stated that they posted staff according to the calibre of staff to sub districts, others made staff ballot for sub districts whilst some managers did not follow all the guidelines for postings as postulated in the recruitment and postings guidelines. This again highlights another weak fit.

The issues related to the recruitment function and deployment of staff are multidimensional and come form central through to the district level. These are combinations of individual background (gender, age, and beliefs), organisational environment including management style, incentives and career structures, education and training processes and broader socio-cultural environments set of economic, political, social and geographical parameters in which the state, governments, social groups and individuals operate as those found by Dussault et al. (2006). From the literature in Chapter Three, the latter found gender imbalances, which influence the geographical distribution because women tend to avoid rural and remote areas and economic, political and social structures which influence geographical distribution.

This finding is critical in health care as this can compromise quality health care. As argued by Dussault et al. (2006), access to good-quality health services is crucial for the improvement of many health outcomes, such as the health Millennium Development Goals (MDGs) and which cannot be achieved if vulnerable populations do not have access to skilled personnel.
i. Recruitment of MMDDHS

The last finding in the recruitment and selection which was not part of the study but which emerged and is worth discussing as it was striking and relevant to the managerial competency argument in this study are the procedures by which the managers themselves are recruited and appointed. The procedure used in recruiting managers does not ensure that they have the capacity to manage the HRM/D function. Managers are recruited based on their public health qualifications and years of service. The advertisement states that among other things that the applicant should be a health professional with a master’s degree in public health or management with a minimum of five years working experience. In addition, the applicant should pass the selection interview. However, there is no reference to core competencies. This procedure seems to support Harper (2009) who intimates that many employees are promoted because they are good at their jobs, but that does not necessarily make them good managers. Managers, according to ibid are responsible for developing their teams, fulfilling company goals, managing budgets and are accountable for their entire department. In line with this, policy makers admitted that the recruitment of personnel into managerial positions does not emphasize competencies and the meeting of targets.

A policy maker countering the weakness of this recruitment procedure affirms that the job of managers should be linked instead to setting targets and managers tasked to meet such specific targets based on which they would be assessed. However, this notwithstanding, the sector must see the need to offer on-the-job training and capacity building programmes that are related to the job and sector objectives but which in his observation unfortunately has also been overlooked. The latter suggestion supports Ramlall (2003) who states that in assessing the effectiveness of recruitment and advertisement sources an organization uses to recruit its employees, it is imperative to relate the actual performance of the incumbent to the advertising and recruitment. As noted earlier, the potential risk of recruiting managers who only hold qualifications is that such managers may not possess competencies to perform the managerial functions expected of them. Therefore, meeting the minimum requirements for appointment into managerial positions in the health sector should not be regarded as full competence for creditable performance as there is little emphasis on management competencies during the selection process.
**7.4.2 Performance Management (PM)**

The findings on PM system demonstrate managers equating this function to only performance appraisal (PA). However, PM is a holistic process bringing together many activities which collectively contribute to the effective management of individuals and teams in order to achieve high levels of organisational performance (Mathauer and Imhoff, 2006). Accordingly, PA on the other hand can be seen as a subset of PM which feeds into the other activities of PM. Other activities include the communication of the organisational mission, vision and objectives, self-assessments, quality improvement teams, performance related payments, benchmarking and awards (Mathauer and Imhoff, 2006). Armstrong and Baron (2005), note that managing performance is a critical focus of HR activity. Well designed strategies to recognise and improve performance and focus individual effort can have a dramatic effect on bottom line results.

Focusing on PA, all respondents acknowledged the appraisal of staff as the duty of frontline managers. This was also supported by the PM policy document and managers’ job descriptions. Managers however, did not value appraising staff which was viewed as cumbersome. Above all, managers claimed they could not apply the appropriate sanctions as they will only incur the wrath of subordinates by documenting adverse findings regarding employees’ performance and which might not be taken serious and acted upon by authorities above. This goes to support Armstrong and Baron (2005) assertion that if PM is delivered badly is a waste of time that will win you no friends. Compton (2005), however, had mixed findings but concluded there are signs that some organisations, especially those utilising the Balanced Scorecard, as the bridge between organisational and individual employee goals, are serious attempts to implement the strategic HRM agenda in their organisations through PM, and it appears likely that these imperatives are likely to grow in the future.

In the PHS of Ghana, as noted in the contextual chapter, PA is an annual requirement which health workers must fulfil. It is also a requirement for promotions and other incentives or awards. PM is the responsibility of line managers with some policy guidance from the HR directorate. Attitudes regarding the relevance of the annual PA can have an impact on one’s promotion. A good assessment is required for a promotion and other awards. For these reasons, the commitment of line managers is vital for the success of the process. Most managers were very honest in stating that they appraised staff only when staff were eligible for promotion or called for screening for any incentive package. One of the reasons they
assigned was the structural inhibitions in which managers are powerless to apply necessary disciplinary sanctions on the appraised (depending on the gravity of the offence) without referring this further up. This, they claimed attracts no action if even they discovered performance detrimental to the sector. This was also supported by the other respondents and the code of disciplinary procedures’ document regarding taking decisions on the discipline of staff. Among several reasons why employees are not appraised is that managers try to avoid employees’ feelings of hatred by managers.

Although the performance appraisal is essentially linked to staff development and rewards and therefore offers an opportunity for the individual and their performance, this has not been linked to the sector’s policies as both manager and managed do not show interest in its application. Apart from highlighting a weak fit, it also portrays lack of integration with other HRM/D functions. This lack of integration also thus point to the function’s loss of its significance and becomes the traditional form of HRM/D practices in the PHS as noted by Maxwell and Watson (2006) quoting Macduffie (1995) under the section on recruitment and selection above.

Larsen’s assertion is also in line with what policy makers stated about how managers are more enthusiastic in performing their technical duties (Public health programmes) to the neglect of HRM/D activities.

**ii. Involve employees in achieving the health sector’s objectives.**

Involvement of employees leads to motivation and commitment to organisational goals as employees feel part of the organisation However, findings showed inconsistencies between managers and policy makers and employees on the other hand. Whereas managers indicated they involved employees in decision-making to achieve the sector’s objectives, employees stated the contrary and policy makers confirmed some dictatorial attitudes by managers. This contrasts with two recent studies cited by Konrad (2006) in which both studies indicated high-involvement of employees in the life insurance industry studies were positively associated with employee morale, employee retention, and firm financial performance. It has confirmed what was outlined about HRM in Ghana in the introductory chapter where the management style is said to be bureaucratic and authoritative and thus threaten employee involvement in decision-making and therefore rendering the practice nonexistent (Aryee (2004) and Debrah, 2001). As noted by Konrad (2006) high involvement of employees in
recent research suggests that high-involvement work practices can develop the positive beliefs and attitudes associated with employee engagement, and that these practices can generate the kinds of discretionary behaviours that lead to enhanced performance. From this point of view, it is evident that performance problems within the PHS will continue to thrive as rightly decried by employees in the findings that there is no point putting in their best when they already know their views are neither taken nor rewards criteria made transparent for good performance. This again brings into view the behavioural view in which the skills would not be utilised to the maximum benefit of the organisation.

iii. Job descriptions
Concerning the availability of job descriptions for staff, findings were contradictory as in the findings with most employees countering that managers’ claim that managers ensured employees had job descriptions. Employees mentioned different ways they obtained their job descriptions. This finding has brought to light a number of issues regarding the availability of job descriptions. First it has highlighted the importance of having a proper mechanism in place within the PHS that is specifically designed in order to ensure that new job descriptions are written when necessary and old and outdated job descriptions are updated as and when required and made available to avoid the use of outdated ones as experienced by some managers in the finding.

This finding is similar to Al-Marwai et al. (2009) who found that job descriptions in spite of its importance, are often overlooked, outdated and under considered. Notwithstanding the documentary evidence and policy makers’ admittance that job descriptions were available, most employees still did not have job descriptions. Job descriptions spell out the roles and responsibilities of employees in line with the organisational goals (Ramlall, 2003). Despite the importance of job descriptions, these are not made available to employees. From the above it is evident that employees can not be held accountable for their poor performance if their job roles have not been clearly delineated for them by managers. Again, this brings the framework into focus suggesting a weak vertical fit.

iv. Feedback and Recognition
As regards feedback and recognition, the findings revealed that both managers and policy makers attributed managers’ inability to provide feedback on performance to cultural orientation of managers who think they cannot say or document negative findings about
junior staff. Feedback according to managers and some policy makers is always positive, even when the subordinate is performing to the contrary. However, minority of employees’ participants countered this and stated that feedback to junior staff respondents was always negative and more of threats and reprimands especially when performance was considered poor. They were of the view that while efforts go unnoticed, mistakes or shortcomings are noticed immediately. On the other hand, some employees felt feedback motivated them whilst for some employees, feedback is not very useful.

This is similar to Akuoko et al. (2008) and Mathauer and Imhoff (2006) findings in Ghana and in Kenya and Benin respectively where the feedback that health workers received from their superiors in the districts surveyed usually centres on specific shortcomings or technical aspects of service provision. It rarely appears to focus on the personal perspective of the health worker herself or himself. Judging from the answers provided, employees feel neglected by their managers and which demoralises them. There are indications from the findings that supervision is done but only negative things are recognised and given as personal feedback practised in some (CHAG) facilities. On the contrary, managers in Government institutions were hesitant in giving feedback to employees when the performance is poor. Despite these shortcomings, majority of employees regard feedback as useful and desirable to the extent that it helps improve personal performance and to update knowledge. Feedback appears particularly important for health workers posted to remote facilities with little contact with other professionals especially when personal needs and concerns are taken seriously, it provides the feeling of being cared for and appreciated.

Feedback is an important performance management process. It provides an opportunity to recognize achievements or to indicate areas for improvement or development. Feedback is always based on evidence and refers to the results, events, critical incidents and significant behaviours that have affected performance in specific ways (Armstrong and Baron, 2005). Regardless of its importance, the findings from PA do not feed into staff development and rewards management. It therefore reveals both weak horizontal and vertical fits. Thus HRM/D activities are implemented in isolation and which does not bring about organisational effectiveness as highlighted in literature review in Chapters Three and Four. This finding again goes to confirm what Larsen (2000) said about centralisation and decentralised managers at that level as noted earlier under recruitment and selection section. Once again the behavioural theory and environmental factors in the framework with weak
vertical fit are called to play as socio-cultural orientation of managers was cited as the main reason for managers not appraising staff regularly as postulated at the national level for fear that staff will call managers derogatory names.

By providing feedback on health workers’ performance assessments, they are motivated to put in their best since they help improve knowledge and skills. Yet this effect is currently limited as most managers shy away from this whilst others reprimand and criticise only. These therefore do not reinforce positive behaviours and goes to support the behavioural theory. From the utterances, some employees only see performance feedback as demotivating due to the way it is done. Although the responses suggest that health workers are performance-oriented, the potential of PM as a motivating instrument has not been fully realised yet. Given the commitment from policy makers, there appears to be hope for the introduction of a performance culture. The responses also suggest that health workers are receptive to performance assessments. All the above thus point to the fact that any initiative to promote a performance culture must take into account cultural values, norms and characteristics. Hence, the suggestion by a policy maker at the central level should be given a critical look and taken on board seriously. This also goes to highlight the need for training and orientation for managers as the way some either do or do not give feedback is appalling.

The divergence in finding between majority of employees on one hand and policy makers and managers on the other about perceived managers’ effectiveness in the implementation of performance appraisal is not surprising judging from what managers said. They do not appraise staff regularly but only when staff are due for promotion etc. and again, only positive ratings are given. The ratings by employees can be likened to the attribution theory as explained by Geare et al. (2006) who state that it is likely that divergent stakeholder groups will evaluate HRM differently, and these differences will reflect the differing objectives being pursued. Consequently, in practice there is a strong likelihood that there will be a gap between the managers’ and the employees’ perceived levels of HRM related attributes. Geare et al. quoting Zammuto (1984) explain that ratings of importance and effectiveness are fundamentally value-based assessments framed on the preferences of a particular constituency. Preferences relate to a particular constituency's objectives, and these preferences are not necessarily stable over time. It is more likely that individual preferences are subject to temporal adjustment, because they have been satisfied or for some other reason. This justifies employees’ positive ratings for managers on performance appraisal because
employees have been satisfied by managers when they are rated positively to the contrary to enable them gain a favour such as promotion. Thus, managers as implementers, and employees as consumers of HRM practice are likely to have divergent needs and expectations from a HRM practice.

7.4.3 Rewards Management

Consequent to the importance of rewards and increase in performance, this study adopted rewards as part of the HR bundles to evaluate how rewards are administered in the health sector. The findings, however, point to most managers associating rewards mainly with financial or extrinsic rewards with few managers mentioning non-financial or intrinsic rewards (indigenised the reward type, and offering praises and citations). Based on this, managers used financial constraints due to erratic funds flow as reasons for their inability to reward staff as a way to motivate and retain staff. Only few managers talked about the non-financial rewards and mostly spelt out citations and welfare issues for staff – attending to staff’s child naming ceremonies, bereavement etc. In respect of reward type, managers concentrated on the end of year individual awards with only a limited number talking about group awards (ward and institutional awards. Rewards system – which is the way the health sector determines employee rewards outcomes (such as pay and compensation systems, pay increases either based on performance or non-performance), all managers simply ignored the rewards systems and which is very key to the survival of most employees in the health sector. It appears managers did not regard this to be part of rewards management simply because the function is centralised.

As opinions were divided among regulators and unions regarding rewards as in the findings, with some pressing performance based – ‘equal pay’ for ‘equal work’ compensation others viewed the compensation scheme in a ‘traditional hierarchical’ manner (NMC) by urging the scheme to be related to the number of years of training required by the job rather than by some impact based assessment, whilst still others viewed compensation to be based on the status – “among equals, some are more equal” (GMDC).

This brings into focus the resource dependence/institutional theory and environmental factors such as the political, economic and cultural elements of the framework where employees are dependent on money from employers to survive and also satisfy extended family needs. The resource dependence theory thus creates competition and provides motivation to perform, as
indicated by some statements in the findings. The political theory also brings in power and the most powerful get better rewards and remuneration as highlighted in the findings in which one representative boasted about the health sector salary increases in 2006 during which one professional group gained the upper hand in negotiations. Rewards were managed again in isolation and thus another weak horizontal and vertical fits and which does not motivate staff to put in their best (behavioural) since it is not linked to performance and the PHS strategy.

Ramlall (2003) quoting Kerr (1975); Lawler (1971) and Vroom, (1964), confirms that these studies have shown that effective rewards systems can significantly increase the motivation of individuals to increase their performance. The rewards system in the health sector has been centrally determined based on professional qualification, annual automatic pay increases and further training. It has not been related to performance. Thus, the way the rewards system is, does not motivate individuals to increase performance since it is centralised and whether one performs or not one is remunerated. This highlights poor legislation and policies of a centralized pay system which does not reward excellence and hard work. This also contributes to managers’ unwillingness to discipline staff. Another dimension is economic in which due to poor economic state with erratic fund in-flows, managers are unable to motivate staff. This notwithstanding, most managers as revealed in the findings have also resorted to only material rewards as if that is the only way to recognise and reward employees. As a consequence, if rewards are viewed in that light then the quality performance is way beyond achieving. Finally, it is laudable to find few of the managers indigenising motivation practices and which is discussed next.

i. Indigenising Rewards practices
A key finding which is laudable and needs mention is the way managers try to indigenise rewards management (reward type) in line with cultural values as a way to motivate and retain staff. This is in line with what Chiang (2005) found in her study and quoting Hofstede (1980a) and Pennings (1993) concludes that understanding reward preferences in the cross cultural context enables organisations to increase motivational potential of reward systems and to optimise their use of limited resources. A male manager from the northern region said even though it was difficult getting adequate resources to reward and motivate staff, he mentions other ways including the attendance of child naming ceremonies of staff and bereavement etc. to show appreciation as ways to recognise and thus motivate employees.
ii. Preference for rewards

As regards which rewards managers perceived to be preferred by employees, there were mixed results and which goes to provide support for both convergence and divergence viewpoints (Chiang, 2005). Some convergence views were presented when managers and employees indicated the preference for intrinsic rewards. For the financial category, individual incentive based rewards was preferred to the group or organisation based rewards. This was also found by Chiang (2005) in a study of four countries. This mixed finding can be related to contextual factors of the organisation and country as a whole as well as the resource dependence theory and is evidenced in the summed up statements from both managers and employees in the findings.

iii. Criteria/Procedure for awards

Furthermore, individual award schemes at the district level, although carried out on the basis of a performance assessment, were considered by staff to be unfair and hence demotivating. This is probably, because the method and criteria of the selection process had not been sufficiently communicated. The finding on the criteria for rewards has been viewed by employees to be biased towards the long service personnel and therefore interpreted to mean that the young and energetic staff should not put in their best at work if they already know they would not be recognised for good performance since this is based on seniority. Managers did not also link performance appraisal system to further training and rewards whilst another finding signified that managers and employees think the public praises and citations and public congratulations appear to have a strong effect on health workers. However, both managers and employees still felt citations alone do not work for long when employees need financial rewards to help augment financial needs.

The findings are directly linked to environmental factors such as economic, cultural, and job security. For instance, employees’ preference for financial rewards and individual performance incentives could be attributed to the environmental pressures including culture, economic and job security. In Ghana where the extended family system is practised, it puts a lot of pressure on workers’ earnings as they have to contribute to the needs of extended family members in addition to those of their immediate/nuclear family. Again for the fact that Ghana does not practise state welfare benefit systems, therefore for economic reasons, employees tend to rely heavily on employers to provide benefits and as such financial benefits are highly regarded. Again, the theory of expectancy as by Vroom (1964), Lawler
and Porter (1971) also provides one possible explanation that a strong and visible link between reward and performance is central. Therefore, the individual preference for individual reward rather than organization or group is thus perceived due to a clear and direct link between personal performance and reward outcome. This has also been found by Chiang (2005) who states that cross cultural studies have suggested that employee reward preferences are culturally bound. Consequently, reward practices need to be tailored to these cultural differences.

Based on the way the rewards system is managed in the PHS, in which the pay system has been centrally determined based on professional qualification, annual automatic pay increases and further training, it has not been related to performance. Thus, a system which is neither based on performance nor on non-performance can be viewed as having the potential of promoting non-performance since it does not reward good performance. It is only at the local level where managers are expected to reward performance through the performance management system and which also has its limitations as highlighted in the section on performance management.

Rewards management is such a sensitive issue in health owing to the diverse professions who often view each other with suspicion because of the conception that some professions (nurses and doctors) are usually favoured more when it comes to remuneration, promotions and other incentives. Even between the two deemed favourites, they also tend to accuse each other. As such, during the job evaluation and salary negotiations in 2006, the health sector was plagued with numerous strike actions from various professional groups due to this perception. As rightly put, in the quote by an association respondent above, compensation of health workers should be reviewed with the aim of tying it to performance to ease distortions in order to forestall industrial peace.

Accordingly, Abdulai (2000) quoting Dresang (1984, p267) observes that “politics is involved in compensation more than in any other dimension of public personnel management”. He contends that this point of view is well exemplified by the Ghanaian situation where compensation is easily the most vexing human resource management issue and concludes by stating that, “compensation in the Ghanaian public sector may be aptly described as the human resource manager's nightmare”. Some of the reasons for this he
alludes to are partly due to lack of concrete and systematic policies and guidelines as well as the tendency to apply ad hoc measures and solutions to chronic compensation problems.

7.4.4 Staff Development

Findings on managers’ involvement in staff development activities showed most managers focusing on formal education and training without any mention of orientation for their staff. They all appeared to be dependent on the donor funded vertical training programmes as in-service for their employees when they stated that staff had a significant level of in-service training. Managers were however, quick to add that formal training was beyond them and depended on the individual employee but could only encourage promising employees to apply for such courses. Learning of some type and form is the primary focus of human resource development (Garavan et al., 1999). However, it is interesting to note the limited knowledge both managers and employees have on the learning process. Staff development is directly linked with HRD as discussed in Chapter Three on the empirical literature review and encompasses all learning whether accidental or planned. Employee training especially in health is very crucial in meeting organisational goals due to the sensitive nature of health service delivery.

The RBV emphasises this need as represented by its human capital pool and capabilities as revealed from the framework. According to Wright et al. (2001), having a well-trained workforce leads to more efficiency and less wasted time and effort which would otherwise cut into the bottom line. Boxall (1998) expanded on this and identified a second task which is to develop employees and teams in such a way as to create an organization capable of learning within and across industry cycles. Successful accomplishment of this task results in the organisational process advantage. In line with Boxall (1998), first, the human capital pool refers to the stock of employee skills that exist within a firm at any given point in time. Accordingly the framework focuses on the need to develop a pool of human capital that has either higher levels of skills that are health sector specific, or achieving a better alignment between the skills represented in the sector and those required by its strategic intent.

This demonstrates that sustained human capital advantage is not just a function of single or isolated components, but rather a combination of human capital elements such as the development of stocks of skills, strategically relevant behaviours, and supporting people
management systems. Having summarized the conceptual development, the next section dwells on empirical research.

McNamara (2010) notes the similarity between the processes of systematic training and PM. The results from implementing the two processes are highly integrated as well. The latter therefore argues that if a supervisor uses sound principles of PM then training and development can be a straightforward activity which almost always contributes to the organization's bottom line. The use of the RBV in the framework is to support this resource for organizational effectiveness. The heterogeneity and non-imitability of HRH for achieving enhanced performance could be achieved if they are trained to possess the relevant competencies that will result in superior performance and ultimately improved outcomes in health service delivery.

Some stakeholders also shared their perspectives on training. The finding where the NMC stated it pushed back on some policies from MOH regarding training goes to support the issue of stakeholder and legislation influence as environmental factors on HRM/D in the framework. For instance the powers that the regulatory bodies exercise when it comes to decisions regarding the professions are incredible. The ability of the NMC to disregard the MOH also stems from the fact that it has a legal backing (NRCD, 117 of 1972), which gives the NMC the mandate to handle the training of nurses and until that is repealed, the implementation of HRM/D policies to suit the PHS’ needs would always almost be a mirage once the NMC does not support the idea.

The next section on managers’ qualifications in HRM/D underscores almost all the ratings employees provided for their managers’ HRM/D effectiveness and which showed a significant correlation between managers’ qualification and knowledge in HRM/D activities. Although this question appeared to have generated divergent views from employees, further scrutiny of reasons assigned was contrary. Divergent in MMR and may call for a re-examination of the framework. However, the views expressed by employees can not be seen in that context as would be explained. This is then referred to as ‘apparent’ (quote author’s) divergent views. Other areas of divergence were the assessment of performance and recognition of employees in which employees contradicted managers and policy makers.

i. Managers have qualifications in HRM/D
The findings on managers’ qualifications in HRM/D had employees countering what managers said. Whereas most managers admitted they did not have any qualifications or structured training in HRM/D, employees on the other hand stated the contrary about their managers. Despite favourable evaluations by employees on qualification/training managers have in HRM/D, most line managers in these 18 districts reported personal skill gaps in these areas. The ratings appear divergent but reasons and explanations provided for the ratings rather complement the managers and policy-makers’ views and are at variance with employees’ own ratings. For instance when requested in questionnaire to list reasons why employees perceive managers to be effective, the few (19) who gave reasons as in the finding chapter were out of the context of HRM/D. Some of the reasons included:

“manager has masters in public health”, “holds first degree and masters”, “her human relation is good”, “and “there is no evidence that policies and programmes are not well implemented”, Allows unit heads to handle programs under them and control the staff, Always briefs staff of new development in health sector, ... Because he is a team player, ...”

However, when same was requested of managerial ineffectiveness, they were quick in stating environmental factors as forces linked to managers’ ineffectiveness. These are listed under the various HRM/D practices as discussed earlier in the chapter.

Thus, possible explanations for this contradiction as revealed in the reasons provided by employees for their ratings are discussed following. These findings raise several concerns. First, it is debatable whether employees understood their ratings or whether they perceived managers to be making significant contribution to line management and organisational objectives. There are also doubts regarding these ratings of managers’ ability in HRM/D if in the same vein some employees state managers’ inability to support employees training and development unable to give feedback, and involve them in decision-making among others as discussed earlier. Second, if little priority is given to the need to develop employee skills, then questions are raised as to whether managers really have the training in managing the HRM/D functions.

Also, the further contradiction from the employees’ ratings about their managers’ qualifications is that the reasons they provided for their ratings did not indicate the type of qualification in HRM/D and therefore did not concur with the ratings.
Also, it is not certain why employees agreed that managers had qualifications in HRM/D. Perhaps, this could be attributed to what has been described by Aryee (1997) as “respect for the elderly/authority” where Ghanaians are socialised not to say bad things about the elderly or superiors or what has been described by Hofstede (1987) as power distance where the relative gap between high and low is wider, making for a society in which people respect the powerful.

ii. Management Development (MD)

The findings, pointed out that managers have not been trained in HRM/D and which was confirmed by policy makers. Employees on the other hand contradicted these views. Although managers thought of MD as a planned process, focusing on a long-term development programme to increase managerial effectiveness, it also incorporates informal and unplanned elements such as learning from day-to-day experience. Armstrong (1986) views MD as a systematic process to ensure that an organisation has the effective managers it requires to meet its present and future needs. It is concerned with improving the performance of existing managers, giving them opportunities for growth and development, and ensuring as far as possible, that management succession with the organisation is provided for. Despite this broad view of MD, only managers who had been in the position for more than six years admitted they only managed to cope with the managerial work based on the meetings and workshops they participated in. Again this brings to light the RBV theory. Both arguments by Wright et al. (2001) and Boxall (1998) as discussed earlier in the section also supports the RBV claim here.

iii. Staff Orientation

Managers indicated they themselves were not orientated when they were appointed and had to ‘grope’ around until they found their feet. For employees however, managers conceded that though this was available, it was on adhoc basis depending on availability of funds. For this reason, most times new recruits miss out on this. The only way that new entrants were consistently orientated was by showing them round the facility and departments and which employees also corroborated.

Though not exactly the same as that found in Baxter’s (2010) study on staff educators, in which as many as 60% of new graduate nurses (NGNs) will be lost from the workforce within their first year of employment due job dissatisfaction inadequate training, lack of
support and “reality shock”, Baxter’s finding does sound a warning bell to the PHS of Ghana. Baxter concluded that one strategy purported in the literature to ensure an effective transition into all clinical areas, is a comprehensive, interactive, meaningful orientation. Like they say first impression are unforgettable, hence the orientation process has to be carefully planned and executed to ensure that the employee ends up knowing all about the company, the company profile and its policies, the target goals, his/her duties as well as the role s/he plays in helping the company achieve its objectives.

The PHS shares this view, and has set up in-service training units at all levels to perform this function. However, as discussed in earlier sections, the policies normally do not match the implementation. Although for economic reasons the health sector might not loose as many employees as found by Baxter, nonetheless, the utterances and statements from employees shed the degree of dissatisfaction and may not help the sector achieve its goals as employees might not be aware of their roles and how these will help achieve the targets and goals. Second, if better opportunities become available to employees, Baxter’s finding may become a reality.

iv. Training Needs Assessment (TNA):

Despite the divided opinions on TNA, findings generally indicated managers not assessing employees’ training needs. This was supported by both policy makers and employees’ views.

Nelson et al. (1995) cited a similar finding for the American Society for Training and Development where organizations conducted a training needs assessment in less than 50% of the time. In their comments, they state that when these studies are taken cumulatively, they present a rather discouraging scenario: the inputs into the training process are often not systematically identified while the outputs of the process are often not systematically evaluated. Nelson et al. (1995, p27) therefore asserted that a great deal of money and effort may be going into programmes that reflect a precarious and ineffective and referred to this as “Random In–Random Out,” approach to training. Another similar finding is by Saari et al. (1988) who in their study found out that only 27% of companies surveyed reported having procedures for determining the training and educational needs of their managers.

The importance of conducting a thorough needs analysis is well accepted in the training literature. A properly conducted needs analysis yields information helpful to the development of instructional objectives and training criteria. Recognising this importance, the PHS in spite
of the fact that regular training is not provided directly by the PHS, there are quite a number of donor funded vertical technical programmes which employees stated they benefitted significantly from even though managers did not assess needs of staff.

Due to the fact that TNA is haphazard in the PHS, it leads to missed out opportunities for some employees. This has created a situation whereby some staff continuously benefit from training programmes whilst others are neglected as highlighted by some policy makers. This further goes to justify the ineffectiveness as indicated by Nelson *et al.* (1995) above.

The findings also explain the influence of external environment of donor funded programmes on HRM/D as an explanatory factor in the framework. This has been recognised in the HRD literature and Garavan *et al.* (1999), contend that generally, the vertical programmes act as triggers from the external environment and by implication any HRD carried out is reactive rather than proactive in nature. In certainty the finding suggests that while the PHS carries out considerable amounts of HRD, it is often disjointed in the sense that many HRD activities are not integrated into the corporate planning process. This primarily occurs because the organisation is reacting piecemeal to outside stimuli (donor driven programmes rather than to factors within the organisation.

Thus, this finding contrasts with the idea of enhanced performance which argues that sustainable human capital advantage can be achieved through continuous investment in HRD at the level of the individual firm. There is evidence to suggest that this may drive some organisations’ HRD investment efforts. Pettigrew *et al.* (1988a and b) argue that while increased competition has prompted many firms to review their training efforts, specific factors may act as the most significant triggers and in the case of the PHS is the donor funded programmes.

v. Support for employees’ training from managers

The findings contradicted each other and employees sounded bitter and felt managers did not provide them with adequate information regarding further training and also felt neglected by managers during training either financially or with supportive visits. This also pointed to the fact that managers did not either make available these guidelines or that employees misinterpreted these policies.
This finding supports the literature on HRD with a focus in adopting a learning organisation perspective which encourages greater individual responsibility for learning (Pettigrew et al., 1988a, b) and facilitating line managers in the creation of a culture and climate of learning (Senge, 1993). However, it was contrary to Tseng and McLean (2008) quoting Hale (1991) who pointed out that HRD professionals support organizational learning in order to establish performance expectations, address higher-level problem-solving skills, and account for societal outcomes. However, from the findings, both managers and employees perceived training and development of employees as managers’ direct responsibility and stating that this was something they actively provide for their staff. This indicates that, from a managerial point of view, it may be unrealistic to assume that development activities are as self-led as the literature would advocate (e.g. McDowall, and Saunders quoting Hall, 1996). Whilst these managers described their role in relation to training as meeting established business needs, this was rarely the case with regard to development. Rather, they considered that their role was to encourage and nurture those employees who were prepared to commit to their own development.

Findings from data are, to some extent, consistent with the literature reviewed earlier in Chapters Two and Three which they confirm training and development are perceived as important. However employees also argued that some activities were not easily distinguished, for instance for further training in which the policies were not provided or made clear and understandable for them to make informed choices. Some employees held the false impression that central level was blocking their further development when training encompasses a formal long-term developmental element. Employees provided additional insights regarding the impact of linking training and development activities, the role of managers in encouraging and supporting individuals’ training and development and the importance of employee motivation as a prerequisite for development success.

From the managers’ perspective, the quest for formal training is entirely the employees’ prerogative and solely dependent on employees’ motivation to develop and their willingness to acquire the requisite entry requirements in line with their current career path. In contrast to training, where the drive came from the organisation, managers considered the drive for development should come from the individual.
These findings are contrary to Cunningham and Hyman’s (1999) optimist assertion (Chapter Three) that line managers assuming some HRM responsibility can positively influence employee commitment and ultimately business performance. Also on HRD, it is also contrary to Nonaka and Takeuchi (1995) that knowledge is created by line managers at the intersection of the vertical and horizontal flows of information within the organization and line managers should be able to identify the knowledge gaps and communication problems. However, the suggestion by Slugzdiniene (2005) based on Nonaka and Takeuchi (1995) assertion above, that line managers are in a very powerful position to block or support implementation of HRD strategies and activities can be equated to the findings.

Generally, environmental factors of legal, extended family system, political and economic and cultural factors and organisational processes were assigned reasons for this blockage in the implementation of HRM/D activities and thus serve as explanatory factors to managerial effectiveness. For instance a couple of these factors did not permit managers to recruit and deploy staff in line with the norms as postulated by the national level. Although the effective implementation of HRM/D practices which is referred to as technical HRM, lay the foundation for a HRM system capable of enhancing organizational effectiveness, technical HRM alone is unlikely to enhance organisational effectiveness.

According to Way and Johnson (2005), organizational goals and objectives set the purpose of the organization whilst organizational strategies define the set of processes by which organizational goals and objectives are to be achieved and thus the HRM/D system need to be matched with organisational goals to optimise organisational effectiveness. However, for the environmental factors such as those outlined above did not permit managers to recruit and deploy staff in line with the norms as postulated by the national level.

Second, for cultural and heavy workloads reasons, staff were not appraised either yearly or twice yearly as postulated at the national level for fear that staff will call managers derogatory names. Managers could not motivate and develop staff due to economic reasons as evidenced in the findings. Consequently, the four HRM/D practices could not feed into each other but were rather implemented in isolation. For instance findings from PA do not feed into staff development and rewards management. These therefore reveal both weak vertical fit between the four practices and organisational strategy and weak horizontal fit among the four practices. As stated by strategic HRM/D researchers in the Chapters Three
and Four, without proper orchestration among HRM practices and integration with organisational goals, organisational performance will not be realised and this then goes to explain the poor health service outcomes in the PHS. In addition, individual managerial factors have partly contributed to this blockade. The issue of lack of desire by managers for HRM/D functions coupled with competing programmes and lack of time are also contributory factors.

7.5 Perspectives of competencies that makes one an effective manager

In trying to evaluate the HRM/D effectiveness of MMDDHS, the study also sought to compile core competencies from the four perspectives to be able to come out with contextual managerial competencies for HRM/D in the health sector. This is consistent with what Lado et al. (1994) observed about the human resource systems. They stated that the RBV suggests that human resource systems can contribute to sustained human capital advantage through facilitating the development of competencies that are firm specific, produce complex social relationships, are embedded in a firm's history and culture, and generate tacit organizational knowledge.

Again, Picket (1998), adds that managerial competencies provide a sound basis for an effective performance management programme. Using the information obtained during the review of competencies required by the job and those possessed by the person performing that job, an integrated process can be introduced linking competencies with the annual performance review programme and the determination of objectives.

Based on the above and the last objective of the study, respondents were requested to list appropriate attributes of an effective manager in the context of the PHS of Ghana. Analysis revealed over a thousand attributes. In line with Flanagan et al. (1996), Hamlin and Sawyer (2007), the over 1,000 attributes listed by respondents, were reviewed and similar ones were merged to reduce the number and then categorised into three broad areas in line with Lado et al. (1992) transformational competencies. Those that were listed once were not included. The condensed list now came to about 35 attributes as per table 7.1. The raw data set for all respondents of the attributes (full list) can be found in Appendix ‘G’.

The condensed list of competencies compiled from perspectives of managers and stakeholders using the CIT are summarised in table 7.1 These have been classified into those
behaviours that promote either innovation and entrepreneurship, or organisational culture or organisational learning.

Table 7.1 Competencies compiled from perspectives of respondents

<table>
<thead>
<tr>
<th>Competencies</th>
<th>innovation and entrepreneurship</th>
<th>organizational culture</th>
<th>organizational learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be a Visionary</td>
<td>Have integrity</td>
<td>Knowledgeable in job area</td>
<td></td>
</tr>
<tr>
<td>Innovative</td>
<td>Have good human relations</td>
<td>Promote development in organisation</td>
<td></td>
</tr>
<tr>
<td>Resourceful</td>
<td>Maintain confidentiality</td>
<td>Recognise and appreciate good performance</td>
<td></td>
</tr>
<tr>
<td>Good organisational skills</td>
<td>Be democratic</td>
<td>Coordinate activities</td>
<td></td>
</tr>
<tr>
<td>Hard working</td>
<td>Be exemplary</td>
<td>Provide supportive supervision</td>
<td></td>
</tr>
<tr>
<td>Be goal/action oriented</td>
<td>Have Good communication skills</td>
<td>Be a role model</td>
<td></td>
</tr>
<tr>
<td>Exude energy and aspiration</td>
<td>Be friendly</td>
<td>Involves employees in decision making</td>
<td></td>
</tr>
<tr>
<td>Respectful</td>
<td>Have empathy</td>
<td>Review performance of employees regularly</td>
<td></td>
</tr>
<tr>
<td>Approachable</td>
<td>Be truthful and honest</td>
<td>Be able to teach employees</td>
<td></td>
</tr>
<tr>
<td>Fair and firm</td>
<td>Show concern for your employees</td>
<td>Be a good team player</td>
<td></td>
</tr>
<tr>
<td>Transparency/openness</td>
<td>Ensure conducive working environment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Author’s in line with Lado et al. (1992)

7.6 Perspectives on Environmental Challenges and Opportunities

Based on the framework which used both external and internal environmental factors and some organisation theories to explain HRM/D activities and research question five, the findings on these are discussed in this section. They are categorised into challenges and opportunities.

7.6.1 Environmental Challenges

As to what managers and stakeholders perceived as challenges facing managers in implementing HRM/D activities, a list of issues cutting across both external and internal environmental factors were highlighted. These challenges are categorised under policies and legislation, political, economic, socio-cultural and others. These findings are not surprising as
earlier African researchers had already stated the uniqueness of HRM/D research in the African continent due to such environmental factors. For instance, Kamoche (2002) in a similar view with Kiggundu (1991, p32), asserts that current research suggests that the challenges of managing people on the African continent are further compounded by environmental uncertainties which impede planning. Other problems include governmental interference, social-cultural factors among others. This section discusses the findings based on these environmental factors to further the understanding of HRM/D effectiveness in the PHS of Ghana.

i. Policies and Legislation
Findings on HRM/D activities revealed conflicting and restrictive regulations which infringe on recruitment and selection, staff development, performance management and rewards management. First, the findings on recruitment and selection highlight a centralised system. This is due to the fact that the decentralisation law and other public sector financial regulation has not decentralised personnel emoluments and recruitment budget for core health staff to enable district directors recruit their own staff.

The finding on the reluctance of MMDDHS to properly appraise staff due to lack of authority to discipline, hire or fire is attributable to the persistent top-down approach. The recruitment and compensation of staff is still centralised. As a result of the failure of the decentralisation law and other public financial regulations which have not decentralised these functions. The finding that DAs are not willing to support the health sector at the district level is also borne out of the conflict between the decentralisation law and Act 525 of 1996, borne out of the former’s ideals versus MOH policies. These do not allow devolution to the districts with lack of clear line of responsibility of MMDDHS respectively. This brings about role confusion at the district level. Again, the finding that NMC is able to push off MOH’s policy on training of staff again borders on another decree (NRCD, 117, 1972) which gave the training mandate of nurses to the NMC and which legal backing, they use to usurp the MOH’s policy on training of health personnel to offset shortages. All these create institutional bottlenecks with huge human resource gaps – gross inadequate numbers of human resources to work with.

Some of the policies on HRM/D do not match the reality on the ground. A case in point is that hiring and firing decisions of staff are centralised. Thus, MMDDHS are handicapped in acquiring the appropriate staff. It also creates difficulties in holding workers accountable for
poor performance and misconduct coupled with a cumbersome individual appraisal system which decisions about discipline can only be taken at the central level.

Funding as in the finding is becoming difficult and erratic. This is due to gradual policy shift on health sector financing from SWAp “basket funding” to Multi-donor Budget Support (MDBS) and Sector Budget Support (SBS) which aims at long-term development in partnership with government in conformity with the Paris Declaration (WHO, CCS:2008-2011). Thus, the Government of Ghana (GOG) currently has to sign a memorandum of understanding with development partners to support the MDBS. In this regard, findings revealed that this makes financing of health programmes lack flexibility in terms of procurement, financial and personnel management as often funds are not matched to HRM/D plans and activities. Even when the funding is approved, the releases are either delayed or severely reduced with consequent non-implementation of most HRM/D activities.

As argued by Garavan et al. (1999), the introduction of new budget management systems, designed to maintain financial control throughout government, is one of the most important elements of fiscal reform with an overall focus on the performance of public service using mechanisms which are designed for monitoring and enforcement of targets in all government departments. Whilst this idea is laudable in the latter’s view, however, in the health sector, over 50% of costs are labour costs, so that demonstrating effectiveness depends largely on attempting to measure the work of health staff and measuring outputs in health care is often difficult.

This finding is in line with the institutional/resource dependence theory of the framework which according to Jackson and Schuler (1995) sees organisations as social entities that seek approval for their performance in socially constructed environments. Forces in the external environment include those related to the state (e.g. laws and regulations), the professions (e.g. licensure and certification), and other organizations.

**ii. Political**

The findings laid out the political bottlenecks in HRM/D functions. First is the interference by politicians in the recruitment and deployment function which results in maldistribution of staff and embarrassment to managers and health policy makers. Secondly, as indicated in the findings, when there is political commitment to HRM/D, then HRM/D will be supported and
therefore policy makers in health and especially HRM/D try to lobby politicians to achieve their targets. This is evidenced by one policy maker they made a speech for the political head (Minister of Health) on a policy issue for him to commit himself and show the direction. The focus on political will however, has been viewed by Reich (2002) to have a number of problems for understanding the process of health policy reform. In the latter’s contention, it personalises policy change and emphasises individual leaders. It suggests that all you need is political will by leaders for policy to change and which in his view is vague. In Reich’s (2002, p138) view, politics is not just the big “P” politics of major politicians, but also little “p” politics of what goes on within and between all sorts of organisations and people. The focus on political will, moreover, tends to ignore the political constraints and the political risks to policy reform. Politics play a key role in HRM/D implementation. As highlighted by the policy maker above, if politicians are not involved, for them to see the need for the programme, they do not take it serious and would not commit funds, but when they are well informed and buy into the idea, then they are prepared to spearhead it to claim success.

Second, findings highlight interference from senior public servants and politicians regarding HRM/D implementation. On recruitment, selection and deployment as well as compensation, applicants with better connections to higher authorities including politicians get employed and deployed to areas of their choice to the detriment of the ‘powerless’ and neglect of the rural and deprived regions. From the findings in the study most of the professionals are based in urban GAR whilst the sub-professionals are deployed to the northern region which is deprived. Again, with compensation, some professionals who are perceived to wield more power are normally rewarded better than the less powerful. This finding is not new and as argued by Pfeffer (1981), that the ability to exercise control over these valued resources provides an individual or group with an important source of power. The latter applied the resource dependence to his study, and hypothesised that much pay allocations are based on power, rather than just performance criteria. For instance in the recent compensation negotiations in the health sector, doctors got better salaries and then the nurses also used their numerical power to get better remuneration. All these influence the motivation of other professional groupings and their work outputs. This again highlights the importance of the political theory as in the framework that politicians are seen as the power house for action.

From the above, HRM/D involves employment, education, local Government, and finance ministries and others. From Reich (2002) and Grindle Thomas’s (1991) arguments, HRH
advocates, in order to be effective instead of basing their arguments on political will, need to become better at politics, learning how to create political incentives for leaders and how to deal with political risk. Reich (2002) quoting Richard Parish to sum up his argument states: “We need to persuade politicians that the risks of not doing something are greater than the risks of doing something different.”

iii. Socio-economic
The findings make public how employees feel demotivated and frustrated when they are not provided any incentives. This goes to justify the resource dependence of the sector as in the framework. The state of the economy of a country and the policies pursued by the government in this regard has implications for HRM/D. In Abdulai’s (2000) view, as in the Chapter Two, the link between the state of the economy and employee welfare can be gleaned from the economic objectives of Ghana. As already explained above, the changing policy (SBS) regarding donor assistance, has already affected HRM/D activities as discussed above under the policies and regulation.

iv. Socio-cultural
The findings illustrated nepotism and ethnic affiliation demonstrated connections to people in authority, politicians and kinsmen by twisting recruitment policies in favour of employees associated with them blurring the implementation of all HRM/D policies. Cronies and relations are usually favoured over competent candidates during recruitment, scholarships awards and promotions. This lends itself to the extended family system into which Ghanaians are socialised. Abdulai (2000) and Debrah (2001) as in Chapter Two, made similar claims that HRM in Ghana is more bureaucratic and administrative in nature as compared to other countries. Again, the objectivity associated with the practice of HRM in the West is largely tainted by certain Ghanaian traditions and socio cultural issues. For instance, on employee involvement in Ghana, there is high power distance with the belief that management knows best and which creates authoritative managers and threatens employee involvement in decision-making.

On rewards however, the findings pointed to the Ghanaian employee’s preference for individualistic rewards which contrasts with Hofstede’s (1983) cultural dimension of collectivism in which he stated employees from Africa prefer group rewards. This may be seen as partly due to the fact that employees need to satisfy extended family needs and which also is in line with the communal nature of the Ghanaian society where people support each
other. This brings into view the issue of crossvergence where HRM/D in Ghana is blended with traditional beliefs and practices. This finding is similar to that found by Anakwe (2002) in Nigeria. She found in a survey of organizations across three major cities that, the human resource practices were a blend of Western or foreign practices and local practices reflecting the significance of the local context. Other areas that were mentioned as challenges include poor/lack of monitoring and supportive supervision from national level and lack of information or lack of use of available information on HRM/D. Policy makers interviewed at central level also conceded to this.

v. Monitoring and evaluation and supportive supervision

As the findings indicate, MMDDHS are not trained on HRM/D and would benefit from supportive visits from central level to explain some of these policies which they have not been involved in developing and are to implement. Monitoring and supportive supervision in Imhoff et al’s (2006) views are that supervision is a formalized HRM instrument to correct shortcomings and to support good practice on the basis of which recommendations are provided to help improve individual and facility performance. Supervision can contribute considerably to health workers’ self-efficacy and workers’ motivation. This is especially crucial as MMDDHS are not trained in HRM/D. Slugzdiniene (2005) as in Chapter Three also adds that since HRD activities are increasingly devolved to operational managers the actual training and development activities are being carried out by line management and employees, then HRD specialists monitor the quality and provide assistance.

To the contrary this aspect of supervision on HRM/D activities is non-existent for MMDDHS from policy makers and is therefore not surprising findings showing that managers’ morale on HRM/D are low. Akuoko et al. (2008) also revealed a similar complaint from Ghanaian workers about poor supervision.

Continuous monitoring and evaluation of HRM/D policy implementation with supportive supervision are important for several purposes – ensuring that HRM/D policies are distributed, understood and rightly interpreted and implemented by managers. Also this helps with the understanding of the changing political and economic environment, assessing emerging health needs and health system issues, and monitoring changes in health personnel supply and distribution. Sudden changes in any of them may indicate a need to modify HRH strategies.
vi. Lack of Information on HRM/D/non-involvement of managers in policy formulation

Information on HRM/D was another finding that both managers and employees complained they did not have access to. In particular, they stated they did not have access to most HR policies to guide their activities and which was confirmed by one of the regional HR managers who cited lack of funding to disseminate policies from central level. An organisation skilled at creating, acquiring, organising, and sharing knowledge is able to adapt its goals and behaviour to reflect new knowledge (Choo, 1996). While relevant and timely information allows managers to make accurate decisions, irrelevant information makes decision making difficult, adds to confusion, and affects the performance of the company. Therefore it is important that managers are aware of what information they require, how to acquire it and how to maximize the use of it in order to utilise the information to their own benefit and that of the organisation. In line with Choo (1996), managers need to use information not only for decision making and making sense of changes and developments in their external environment but also to generate new knowledge which can be applied to design new policies to enhance existing ones and improve organisational processes. In spite of these challenges, the managers and stakeholders did not just see the end of the tunnel, instead they felt they had some opportunities and these are briefly discussed next as opportunities.

On non-involvement in policy formulation, managers felt it was not fair for them to implement policies which they were not privy to and might not be able to interpret appropriately.

7.6.2 Opportunities

Opportunities were again classified into the various thematic areas and environmental factors in the framework.

i. Recruitment and selection

On the issue of inadequate numbers of staff owing to the centralisation of the recruitment process, all participants stated that the effects of shortage of staff can be brought to a minimum with the optimum use of available staff by redeploying staff to areas of need. Thus, managers would face up to the interferences from authorities by engaging politicians, senior
public servants and opinion leaders to see the need for employees to be deployed to every corner in the district. Also, the system on recruitment of managers should be reviewed to place more emphasis on competencies rather than qualifications and years of service. Those already appointed should be given orientation and monitoring and supportive supervision improved.

ii. Performance Management
Regarding performance appraisal another policy maker was of the view that the current individual performance appraisal system could be modified to group appraisal and thus minimising the number of appraisals to be conducted by managers and which is being looked into seriously. Managers also entreat policy makers to take actions on decisions on performance assessments.

iii. Training and Development
Managers all indicated the need to be orientated on their roles and responsibilities of the job and HRM/D activities to make them more responsive. The performance management systems would also be linked to training and development to encourage employees to be interested.

iv. Rewards Management
On rewards management, managers and stakeholders viewed the DAs and NGOs as possible sources for funding to support employee rewards.

v. Monitoring and Supervision
On monitoring and supervision, a policy maker from central level expressed the need and felt it can be done whilst managers were hopeful that MOH would intensify its monitoring systems to ensure that managers have the information on HRM/D policies and are implementing them well.

vi. Lack of information on HRM/D/non-involvement of managers in policy formulation
On lack of information, the opportunity is that policy makers have stated they will ensure managers are part of policy development. Managers have also stated they will be more proactive in seeking information and also make it known to policy makers that they need to be involved in policy formulation since they are the implementers.
7.7 Conclusion:

Evaluating managerial effectiveness from different perspectives is useful because it provides an insight into HRM/D effectiveness as perceived by different stakeholders including the implementers and the consumers. This revealed interesting findings and most of which have been discussed in line with the framework of the study which used environmental factors, organisation processes and organisation theories to evaluate managerial effectiveness. The findings have also been discussed in comparison with other empirical findings and literature. These comparisons indicate in general that, the extent to which most HRM/D practices were applied was similar or dissimilar in relation to contextual and environmental influences. It has been revealed that the way managers perceive managerial effectiveness as implementers versus stakeholders perspectives both as consumers and observers are slightly different. Generally, the findings were similar in three of the HRM/D functions used for the study except for the function of PM and managers’ and aspects of staff development (qualifications in HRM/D, support for training and involvement of staff in decision making) in which opinions differed.

Overall, the general feeling is that managers do not have competencies in HRM/D to effectively implement HRM/D activities at the decentralised levels. If the health sector is to improve upon its health service delivery, managers need to be trained in HRM/D to be able to motivate and retain staff to perform creditably. Beyond training, monitoring and supportive supervision can be initiated to disseminate information of HRM/D and explain policies and procedures on HRM/D.
CHAPTER 8: Conclusions

8.1 Introduction:

The study evaluated HRM/DE from the perspectives of managers and stakeholders. The evaluation utilised an analytical model that explains how HRM/D activities implemented by MMDDHS in the PHS of Ghana can be understood from four different perspectives of respondents from eighteen districts in Ghana. This was in line with organisation contextual variables: organisational strategy and the external and internal environments. The model integrated key aspects of management and organisation theories - systems theory, RBV, political, resource dependence and behavioural theories. In order to achieve the main research objective, the following research questions were addressed.

1. What is the context of HRM/D in the Public Health sector of Ghana?
2. What understanding do managers and employees have about managerial effectiveness for practice at all levels?
3. How have HRM practices of recruitment, performance management, staff development and rewards been defined and measured in the public health sector of Ghana?
4. How does this understanding/perception coupled with environmental factors affect their managerial roles including the approach to employee resourcing and deployment, capacity development, motivation and appraisal of staff and the performance of the organization?
5. What lessons can be learned from the perspectives of managers and employees and what are the implications for policy, practice and in making management more effective?

The research outcome is that these questions are answered and the following provide a summary of conclusions that also highlight emerging issues.

It has been observed from the findings in Chapter Six that managers lacked competence in HRM/D. Emerging themes such as the indigenising of rewards practices, disinterest for HR activities and a strong call for management development were also highlighted. Underscoring this lack of competency is the complex relationship between HRM/D implementation and environmental factors. Due to the complexity and systemic nature of managing human resources in the health sector, the study developed a conceptual framework in Chapter Four.
building on organisation and management theories which adequately explained the linkage between HRM/D activities, environmental factors and the approach to understanding such a complexity. This is consistent with Branine and Pollard (2010) who state that understanding management principles in the context of culture could help to develop a more appropriate type of management best practice while still benefiting from the transfer of relevant Western management techniques and Western technology.

Findings are consistent with the predictions of the resource-based, behavioural, institutional/resource dependence, political and cultural perspectives as explanatory factors to ineffective HRM/D. In conducting the study, a series of processes were undertaken. First both empirical and contextual literature were reviewed to guide the direction of the study. Through a literature review of organisational and management theories, a framework was developed to guide the study design. Next, was the research methodology and the strategies used for data collection and analyses which culminated in the presentation of findings.

This chapter which aims to summarise the findings, draw conclusions and outline areas for further research and policy development and practice is organised as follows: The first section gives highlights of the literature search and research methodology and how these helped to arrive at the findings. The second section summarises the key findings whilst the third and last sections discuss the implications of the findings for future research and for policy input and suggest recommendations and limitations of recommendations respectively.

8.2 Highlights of the review of Literature and Methodology

To arrive at the findings in the study, both contextual and empirical literature were reviewed in line with the topic including competencies required for effective HRM/D. The empirical literature covered areas of HRM/DE and performance in organisations, then HRM/D and health sector performance, the distinction between HRD and HRM and competencies as they relate to HRM/DE. The contextual literature on the other hand included HRM/D and performance in the PHS, health sector reforms and its implications for HRM/D and the environmental context within which this study is undertaken.
The introductory chapter and Chapter Three brought into focus other studies that were undertaken in the area in the global, African and in the study country’s contexts. This helped to explain the concepts and how contextual factors influence HRM/D.

Chapter Three highlighted the context of the study citing literature both in other organisations and from the PHS of Ghana. It was evident from this chapter that there was limited research on HRM/D in the country with none in the PHS. Thus, in order to understand the HRM/D in the PHS of Ghana as evidenced in this chapter, it is imperative that one understands the environmental context first. As stated by Aryee (2004) it cannot be understood without the context as management is not done in the vacuum. Also, to understand managers and the way they manage, there is the need to take Hofstede and Hofstede’s (2005) work which states that the nature of management skills is such that they are culturally specific.

By using MM methodology, the qualitative approach enabled the researcher to delve deep into meanings and interpretations assigned to managerial behaviours while the quantitative aspect enabled the researcher to cover a much larger sample group to complement the qualitative findings. This therefore enriched the findings of the study. Despite the challenges in the use of MM research, it has been found to be very suitable for this study.

8.3 Summary of key findings and conclusions

Findings presented in this chapter from both methods generally complemented each other except in a few areas where there was divergence. Even in the areas (the implementation of recruitment and selection and performance management policies and possession of skills in HRM/D) where there was ‘apparent’ divergence between ratings of employees and managers, reasons further assigned by employees from the quantitative sample did not correspond with ratings. Therefore ratings cannot be deemed to be divergent. Some of the quantitative analyses between the regions on educational qualification and professional background showed differences. There were however, no significant differences in formal training in HRM/D, age, experience and the intention of manager respondents to attend future training programmes in HRM/D. The results point to one key finding and which is lack of managerial competence in performing HRM/D activities. However, this finding was underscored by some factors which are discussed in the following sections.
8.4 Lack of Management Competency in HRM/D Activities

The study evaluated managerial competencies of frontline managers in implementing HRM/D activities. In Chapter Four, competencies were defined as bundles of demonstrated knowledge, skills and abilities and attitudes. Findings in Chapter Six supported the suggestion that lack of managerial competencies constrain effective HRM/D implementation. This was made evident by all managers and supported by policy makers and employees who stated managers need further management development. Managers’ own expression for training not only in HRM/D but management in general suggests that managers felt that they could benefit from further training. As a group, managers perceive themselves as least competent in all HRM/D activities.

Through documentary review and statistical analyses of the two regions, there were no apparent differences between the managers regarding their competencies, education and experience except that managers in GAR were mostly medical doctors. On employees’ skills however, GAR had more highly qualified midlevel professionals than the northern region even though there are no differences in training. Again, staff shortages were more acute in the northern region. From the response rates as in the findings in Chapter Six, GAR had more employees responding to the questionnaires even though the more districts were surveyed in the northern region. The doctor and nurse population ratios as highlighted in Chapter Five were graver in the northern region and which again give credence to this.

The importance of management competence was stressed throughout the discussion. Policy makers appoint managers and are aware of this gap whereas, employees experience HR policies through the way their managers interpret them, and the skill managers bring to the task. Although employees in the quantitative group did not directly indicate managers’ competency problems, responses and ratings from both policy makers and all employees pointed to problems with implementing HR policies on performance management, staff development and rewards management. A further breakdown of these activities included interpersonal relationship, recognition, and supportive supervision, giving of feedback and managing challenges and inconsistencies in performance. The universal opinion as enumerated above is that managers need more training and support if they are to carry out their HR responsibilities effectively.
Although managers lack competencies in HRM/D as per findings, managers are also, however, constrained by various challenges within the context of the PHS from both the internal and external environments factors as indicated in their statements in the findings in Chapter Six.

To conclude therefore, the lack of managerial competencies showed evidence of an association with the inadequacies of health sector reforms processes and other external and internal environmental factors. Some of these key findings include:

- Lack of strategy-HRM/D fit
- Lack of training and orientation for managers in management and HRM/D
- Lack of capacity - competing programmes and heavy technical workloads
- Inappropriate institutional/organisational policies and processes e.g the reform process is still dependent to a large extent, on top-down direction in spite of the fact that decentralisation is one of its key themes – hiring and firing decisions are centralised.
- Lack of managers’ desire for HRM/D activities
- Lack of and erratic flow of funds which are often not matched with HRM/D plans and activities.
- Interference in the performance of HRM/D activities from superiors and politicians
- Lack of political commitment
- Lack of information or use of available information on HRM/D
- Lack of monitoring and supportive supervision from central level
- Conflicting laws and regulations

These constraining factors are discussed next.

8.4.1 Lack of Health sector strategy-HRM/D Fit

Vertical structural alignment is greatest when HRM/D provides feedback and input regarding the ability of HRM/D to contribute to the attainment of the goals and objectives of the organisation as suggested by Wright and McMahan (1992). However, the findings indicated both weak vertical and horizontal fits. This finding therefore does not correspond with the usual rhetoric of the importance of HRM/D in the health sector. This is evidenced by the finding that managers at this level are not involved in policy development and managers on the other hand do not always implement policies in line with what has been postulated at the
central level. Also, HRM/D activities do not feed into each other – horizontal fit. For instance, performance management does not feed into rewards management and staff development.

8.4.2 Lack of training and orientation for managers in management and HRM/D

Training or orientation is essential for sustaining the competencies, morale and quality of the health workforce and which is applicable to managers’ productivity as highlighted in Chapter Three of the literature review. A way this can be done is through in-service training. However, the findings in Chapter Six point to the fact that managers were appointed into positions with little or without any orientation or training in either management or HRM/D. Moreover, the health sector reforms at the start, as highlighted in Chapter One, only concentrated on developing capacity at the central level with little attention paid to the district level despite the fact that implementation of all health policies including HRM/D are at this level.

8.4.3 Top-down approach in policies and processes

From the findings, the reform process is also still dependent to a large extent, on top-down direction in spite of the fact that decentralisation is one of its key themes. On capacity development during the implementation of the health sector reforms in Chapter One, efforts were made to develop capacity at the central level. However, little attention was paid to the challenges at the district level and thus managerial capacity was not developed and yet managers are expected to perform. In line with this top-down approach, recruitment and selection procedures – hiring and firing are centralised, policies are top-down driven without the involvement of MMDDHS. Again, selection for further training and fellowships are also centralised.

8.4.4 Lack of resources – human, finance and logistics to implement HRM/D activities

Shortage of staff was another finding, which made the management of staff more difficult. Although few managers stated they knew about the staffing norm, the shortage and calibre of staff available still made it difficult for them to deploy staff according to the norms. As a consequence, the few that are available are overworked and this often leads to staff developing attitudes to work.
The PHS as indicated in Chapters One and Seven, relies heavily on external donor funding to implement its activities since over 80% of Government of Ghana’s (GOG) funds go into the payment of employees’ salaries. With the policies for accessing donor funding changing, with more stringent measures of linking it to performance, it is becoming more difficult to access these funds as the performance of the health sector is complex to measure and sustainability appears not to be secured. Again, due to the recent increase in salaries of health workers, GOG funds to the health sector for its activities including HRM/D has significantly reduced with lesser funds inflowing.

Due to the erratic funds inflow to the district level, managers are unable to implement HRM/D activities to the maximum. For instance, as in findings in Chapter Six, managers are unable to support employees’ training and provide incentives as a way of recognising hard work to motivate and retain them. Employees therefore perceive the system to be fraught with inequities. All these factors operating together have created a work environment which hardly motivates employees in the PHS. In other words, what is implemented or ignored, per policy instructions imposed from the financial and donor policies has implications for HRM/D. The bottom line is that, whether imposed from donors or Government financial policies, it is the manager that takes full responsibility for the poor HRM/D implementation.

8.4.5 Lack of supportive supervision from central level

As stated in Chapter Seven in the discussion, through an encouraging and supportive attitude, superiors can strengthen their subordinates’ effectiveness and thus promote personal efforts for the achievement of organisational goals. While most managers felt that their immediate superiors are easily reached, the critique by managers, however, focused on lack of monitoring and supportive supervision from the central level to provide information and encouragement on HRM/D. In corroboration, the policy makers at central admitted their failure to provide monitoring and supportive supervisory arrangements to ensure that policies are available to managers and to explain such policies as a way of contributing to strengthening managers’ competencies in HRM/D. Whilst managers criticised policy makers, employees on the other hand were critical of this lack of supportive supervision from managers.
8.4.6 Interference in HRM/D activities from superiors and politicians and lack of political commitment etc.

Politics play a key role in HRM/D implementation. Interference from superiors and politicians as well as lack of political will to HRM/D implementation as in the findings were some of the challenges that constrained managers a great deal. This interference permeates the recruitment, selection and deployment functions, selection for further training and the rewards system. The interference leads to inequitable distribution of personnel and dissatisfaction among staff. The interference often results in the better qualified persons being excluded from further training. This has also led to most professionals to be deployed in urban Greater Accra region with the sub-professionals deployed to the northern region which is deprived.

Regarding rewards and compensation, some professionals who are perceived to wield more power are normally rewarded better than the less powerful. All these are supported by both the institutional and resource dependence theories as per the framework in Chapter Four. This is not new as argued by Pfeffer (1981), that the ability to exercise control over these valued resources provides an individual or group with an important source of power.

8.4.7 Lack of information or use of available information on HRM/D

Lack of information on HRM/D was another finding that both managers and employees complained about. They intimated they did not have access to most HR policies to guide their activities. This was confirmed by some HR managers who failed to disseminate policies from central level on HR due to lack of funds.

8.4.8 Conflicting laws and regulations

Conflicting and restrictive regulations which border on recruitment and selection, staff development, performance management and rewards management were cited to infringe on HRM/D. Examples include the Constitution which clearly states that “No person shall be appointed to a Civil Service post unless he possesses the qualifications approved for entry to that post”. However, findings revealed perceived discrimination in recruitment, selection and deployment practices. Another law is that of the Nurses and Midwives’ Council’s law (NRCD, 117) which gives mandate for the training of nurses and midwives to the NMC.
Meanwhile, MOH also has policies to train to offset the shortages and which the NMC does not support. This has led to several negotiations to resolve the issue and thus leading to a delay in implementing the MOH policy. Thirdly, is the conflict between the decentralisation law (Act 462) and the GHS and THs Act (Act, 565). Whereas the latter talks about a composite DA in which the MMDDHS would be part and answerable to the DCE, the Act 565 states that managers at this level are to report on technical issues to the RDHS and on administrative issues to the DCE. Due to this conflict, managers are unable to delineate technical issues from administrative issues and therefore have decided to owe more allegiance to RDHS. Consequently, DAs are not willing to support health programmes. In spite of these challenges, the managers and stakeholders did see some light at the end of the tunnel on the basis that they recognised some opportunities and these are briefly discussed next.

8.4.9 Lack of managers’ desire for HRM/D Activities

In Nehles et al.’s (2006) view, willingness among FLMs is an essential precondition to successful HRM implementation. However, the finding in which some managers do not even indicate HRM/D as part of their responsibilities as well as assigning the reason of lack of time for HRM/D activities clearly show managers’ disinterest in HRM/D. The disinterest shown by managers can be linked to institutional factors such as centralization of some functions (recruitment and discipline) and which do not favour them in achieving the sector’s objectives. Nehles et al. argue that this low level of enthusiasm can result from a lack of either personal or institutionalized incentives. The fact that FLMs are not always sufficiently willing to take on HR responsibilities or that their motivation to do so is lacking highlights a lack of personal incentives for implementing HR practices.

The above findings do point to some limitations for extended discussion and to suggest for further research as discussed below.

8.5 Limitations of the study and extended discussion and suggestions for further research

The results of this study point to a number of interesting directions for further exploration. First, consistent with past research in other parts of the world, managerial competencies in
relation to HRM/D practices in the health sector, this study confirms the importance of managerial competencies in predicting the overall performance of organizations. Second, even though the overall sample is fairly small, the districts studied in the research demonstrate that managers’ evidence do not indicate any significant variations in the way managers perform HRM/D functions. However, findings expose critical competency gaps. The latter finding suggests that this may be influenced by other organisation contextual variables, including aspects of the health sector environment and strategy as explanatory factors, which are now commented upon.

First, the lack of synergy between HRM/D and organisational strategy and among the various dimensions of HRMD practices is rather striking. For instance, HRM/D policies at strategy level with HRM/D at implementation levels are not linked and thus revealing a weak fit. Also, although some district managers appraised performance of employees, the performance results are neither linked to staff development function nor to rewards except in very few instances (12%). Performance appraisal is also not done on a regular basis as required by the policy level and managers do not ensure employees have job descriptions. These results suggest that in spite of the recent trend by HRM/D researchers to integrate HRM/D activities as bundles as a homogeneous concept, the findings revealed the contrary where managers implement HRM/D activities as separate entities.

Although the findings showed some stakeholder influence on HRM/D policies, this had more of indirect than direct impact on managerial competencies. An illustration of this has to do with the various professional unions and regulatory bodies. Some of these bodies sometimes hijack HRM/D policies because of either the contradictory laws backing their practice and or power they wield in the organisation. Thus, they schew such policies for their professional benefits and not because managers lacked competence. Examples of activities implemented include the compensation system which was reviewed recently (2006) during which the Ghana Medical Association admitted playing a lead role by convincing Government to structure salaries along doctors’ demands. Another case in point is the Nurses and Midwives’ Council who decided which cadre of nurses in training should be scaled down and vice versa. These stakeholders however do not interfere with the HRM/D functions and the management of staff at the decentralised levels except when it borders on professionalism.
Also, is the interference of superiors, politicians and senior public servants in HRM/D implementation at the district level. Managers are not allowed the free hand to deploy staff posted to the districts in line with their needs. First, this leads to inappropriate distribution. Second, there is dissatisfaction among staff who accept postings to the hard-to-reach area with difficult terrain and such staff feel cheated or not liked by managers.

Thus, taken together, the trend of the findings appears to give more support to the resource-based and institutional/political perspectives rather than external stakeholder expectations, as the primary influence on HRM/D practices in the PHS of Ghana (though this was not investigated). Examples include the interference from politicians, and other authorities in HRM/D activities, versus equitable staff distribution, coupled with the erratic nature of the release of funds on the one hand and the expectation of employees to be motivated to provide quality service. Also, is the lack of amenities for staff in deprived areas versus the need for staff to provide service in these areas.

Another area is the non-commitment of politicians to HRM/D activities. For instance most DCEs are not willing to assist managers provide incentives such as accommodation for staff and therefore staff have to commute to and from their areas of work over long distances. This also aggravates the situation of staff not accepting postings to places where they are not assured of decent accommodation. As concisely put by the GMA representative; he would not endorse any doctor posted to any place without the assurance of decent accommodation.

This suggests some further research is necessary to examine further the impact of some variables such as resources, external and internal environmental factors and the perceived value of HRM/D competencies of managers. These variables might be operationalized and measured in future research to improve our understanding of the determinants of HRM/D competencies. In addition, the customer stakeholder perspective which was not part of this investigation could also be considered for inclusion in a further study.

Finally, given the competency gaps of managers in implementing HRM/D practices at the district level in the health sector and the weak integration of HRM/D policies with organisational strategy and implementation, future research is needed to further clarify the relationships between the various HRMD practices and health sector performance. Though
not empirically tested in this study, future research should validate the importance of managerial effectiveness in HRM/D practices relative to quality health sector performance.

In sum, future research should use non-health staff as investigators and a larger, randomly drawn samples from multiple regions to validate the conclusions outlined here. Additionally, longitudinal research can provide a better understanding of the directions of cause and effect among the proposed linkages. Future research should also examine both the organisation contextual variables evaluated in this study as well as the other omitted contextual variables (including technology). On the other hand, the learning from the findings suggests that the use of organisation contextual variables in addition to managerial competencies shows the potential of research in relation to HRM/DE and the performance of the PHS of Ghana.

8.6 Recommendations - Implications for policy and practice

In line with the above findings and conclusions, below are recommendations for improving HRM/D at the district level. These have implications for both policy and practice

8.6.1 Strategic fit of HRM/D

In order that the importance of HRM/D in the PHS is not just a rhetoric, the Government through the policymakers of health should ensure that vertical structural alignment is greatest where HRM/D provides feedback and input regarding the ability of HRM/D to contribute to the attainment of the goals and objectives of the organization as well as horizontal alignment of HRM/D activities. This can be done by ensuring that managers at that level are involved in policy development and supported to implement these policies. For the reasonable fit of HRM/D with organisational strategy, the rhetoric of HRM/D being the backbone of health service should cease and concrete steps taken to ensure HRM/D is given recognition and integrated with health sector strategy. By this, policy makers should ensure that HRM/D issues are given priority. Policymakers should also ensure that HRM/D policies are implemented and not just given lip service which ends at the policy making level. Thus, the budget for HRM/D activities should also be improved and matched with activities. Above all, policy makers should ensure that the implementers of HRM/D activities are adequately trained ad resourced to be able to perform these functions.
8.6.2 Top-down approach in management

As the top-down and bottom-up approaches neither adequately provide for middle managers, it is recommended that policy makers balance top-down improvement planning with local initiatives which involves identifying and supporting the change and assign more active role to MMDDHS as initiators of change in their respective districts. This is in line with Mayrhofer et al. (2004) who call for the replacement of centralised, bureaucratic and hierarchical structures by more flexible, decentralised, project oriented forms. In the latter’s view, the information networks and the culture glue’ in this arrangement are more important than formal rules and regulations which have been management rhetoric. Hence, in the PHS of Ghana, socio-political and economic contexts have heightened the need to place additional emphasis on bottom-up approaches that can ensure MMDDHS’ participation at all stages of policy-making. Emphasis should be placed on the involvement of managers as this can utilize decentralized governance structures in different districts in order to gain support for policies. The top-down element is essential for developing and communicating senior management's overall vision of change and for sustaining high-level support. However, it is essential for involving middle managers as active participants by planning initiatives in their areas of responsibility that need to be consistent with the senior management vision, yet address real issues. Combining bottom-up and top-down strategies enables employees to determine changes in how they work that would turn management's vision into reality, whilst at the same time meeting local operating requirements and employee needs (Ryan et al., 2008). As put by Clemmer (2010) you “think corporately but act locally”.

8.6.3 Recruitment and Selection

Recruitment and distribution of core staff should be done in a way to meet the staffing needs of districts. This function can be devolved with matching budgets to enable every district to meet the minimum staff requirement instead of the current centralised system which does not favour the deprived areas.

8.6.4 Training and Development

Management development: First, it may be more effective to develop managerial competencies for HRM/D practices by providing training than by mandating that the manner by which managers are recruited and appointed, will be capable to manage the HRM/D
function effectively. Also, there are already plans to place HR officers at the district level (as revealed during interviews by policy maker) to be in-charge of the HRM/D activities with the support of MMDDHS. Policy makers have reliably stated that some districts already have such staff. This is laudable and it would be excellent if all districts could be assigned such staff. In addition, the competencies of such staff should be developed and strengthened by way of training in line with HRM/D functions.

Orientation for all categories of staff is key for updating knowledge and skills of staff on the job and therefore the existing in-service training units should be strengthened and supported with adequate funding and logistics to provide the necessary orientation for both newly employed staff and existing ones on regular basis.

The handling of pre-service training for the nursing and midwifery cadres by the NMC should also be critically reviewed in line with the Ministry’s policies to serve the needs of the sector and not to be left to the discretion of the regulatory body. This therefore calls for dialogue with the NMC and where possible a repeal of the law – (NRCD, 117) which mandates the NMC to be responsible for the training of nurses.

8.6.5 Performance management

There is the perception by managers that performance management is just performance appraisal. Managers should be made aware of the importance of other areas of this HRM/D function and encouraged to appropriately manage them to reap the benefits. The management of performance should be holistic and not just the appraisal alone. Managers should be encouraged to communicate the health sector objectives to employees and have in-built reviews of performance to identify staff’s developmental needs and staff for rewards through supportive supervision and feedback systems. There is a general perception that historically, CHAG institutions disciplined their staff better than those in government-owned health institutions and thus were deemed to be more effective in HRM/D practices than those in the government sector. Results from this study regarding the way a CHAG institution provided feedback and supported their staff, however, has given reason for worry as the institution risks the top-down approach with dictatorial tendencies in managing their staff. To increase the level of motivation among CHAG staff, the way managers monitor and give feedback needs a review. Managers need to be trained on human relations to enable managers handle employees in a humane manner. In giving feedback, this should be based on facts and not
subjective opinion and should always be backed up with evidence and examples. The aim of feedback should be to promote the understanding of the individual so that they are aware of the impact of their actions and behaviour. It may require corrective action where the feedback indicates that something has gone wrong. However, wherever possible, feedback should be used positively to reinforce the good and identify opportunities for further positive action.

8.6.6 Rewards Management

It is evident from the findings that extrinsic rewards are dwindling owing to the fact that funds are scarce and erratic. Coupled with this, frontline service delivery personnel are overworked as a result of staff shortages. However, in order to derive positive outcomes in health, policy makers and managers in health need to adapt other ways that can promote a supportive and flexible organisation. This can be done by managers and policy makers instituting awards and incentives that recognise, validate and value outstanding work. This can be done by providing and making information on employee well being available with good and consistent communication flow, clearly defined goals and objectives, and the right incentive and reward among others. Once these are in place then regular monitoring with feedback can go a long way to motivate employees.

The out of turn promotion system and fellowship for those serving in deprived districts should be strengthened and ensured and also extended to staff who are also outstanding in their jobs using transparent criteria such as peer review and appraisal documentation.

Deprived incentive scheme should also be pursued vigorously and instituted. A study on deprivation is recommended to ensure accurate measures of deprivation. This will ensure well demarcated deprived districts in order to avoid a wholesale incentive system that does no good to the service as was done previously.

In the long term, deprived districts can be assisted with the NHIS funds to provide free accommodation or pay a token fee for such and other social amenities to health staff who offer to serve in deprived districts.

8.6.7 Monitoring of HRM/D policies and implementation

The implementation of HRM/D policies should be ensured through regular monitoring and supportive supervision (quarterly) from MOH/GHS central level and more frequently from
RHDs’ levels. The regional HR managers’ knowledge should be updated, involved more with HR decisions at central level and be given that recognition and role and made to provide information and guidance on HRM/D to district level managers on behalf of the HR and RHDs.

8.6.8 Interference in HRM/D activities and lack of political commitment from superiors and politicians etc.

Politicians play a very crucial role in HRM/D if they understand and buy into the idea of any HRM/D policy. Therefore, on the lack of political commitment, it is suggested that policy makers become HRH advocates by becoming better at politics and market HRM/D policies to politicians and convince them to buy into them. Thus, they then take it up as their baby.

In order to minimise if not curtail the interference from politicians and others in HRM/D activities, the onus lies on policy makers to dialogue with such groups to see the advantages for good recruitment practices with equity in deployment since all citizens in every corner of the country deserve quality care. As put by Reich, (2004);

“We need to persuade politicians that the risks of not doing something are greater than the risks of doing something different.”

8.6.9 Conflicting laws and regulations

The discussion chapter expatiated on some of the influences of these laws. Therefore as a matter of necessity, policy makers need to synchronise conflicting legislations or MOH policies. This can be made possible by discussing these laws or policies at health or at interagency meetings. Where this is beyond the PHS, then inter-ministerial dialogue with affected ministries/departments for repeals of such laws should be initiated.

8.6.10 Lack of information or use of available information on HRM/D

The importance of information has been discussed in Chapter Seven. Thus, for managers to have access to this information and reliable one for that matter, policy makers both at central and regional levels should ensure that relevant and timely information are disseminated to managers at this level. This can be done through the MOH/GHS website and where possible information equipment such as computers with networked internet facilities be installed. In areas where this is not possible, regional HR managers should be tasked with the
responsibility of disseminating hard copies of policies and guidelines to all districts in their respective regions. Where policies need to be explained to managers, funding should be made available and timely for this to be done. By instituting regular monitoring (quarterly), these could be verified by central level and necessary action taken.

8.7 Contribution to knowledge and literature

The study has contributed to knowledge in many ways. First, is the fact that it is the first time such a study has been conducted in the PHS of Ghana and which has therefore made inroads in the existing literature and has contributed to HRM/D literature information in Africa particularly Ghana. This served to fill the gap as to the understanding of how the issues of inadequate and inequitably distributed staff, demotivated staff and weak managerial capacities could be tackled as an effort to improve managers’ skills to organise and mobilise resources to achieve health goals. It also paves the way for understanding management in the African context and perspective and specifically in health care settings.

Secondly, the thesis, in an approach to address the research question regarding managerial effectiveness, developed a framework which combined organisational and environmental factors using four HRM/D practices of recruitment and election, performance management, staff development and rewards management often referred to as ‘bundles’ of which most HRM/D researchers have normally used single practices. It has thus proven that the use of bundles can better improve performance if they are horizontally and vertically linked.

Thirdly, the framework used for the study has been robustly tested in the Ghanaian context and proved useful in answering the research question on HRM/DE research. The framework has thus added value on existing models on research utilization because it emphasizes the logic of the context of the research and strategy policy arrangements. The framework will contribute to a better understanding of the impact of HRM/D research in local health policy development, however further operationalisation of the concepts mentioned in the framework remains necessary.

Fourth, the fact that the study employed multiple stakeholders including managers themselves to assess managers has added another dimension to ME evaluation research which hitherto, has been mostly done using single respondents or at most managers and employee respondents. This study has gone beyond the two groups of respondents and
proved that the use of multiple respondents generates rich findings and unveiled what would normally have not been possible if single respondents were used.

Finally, the framework used for analysing HRM/DE has enabled the investigator to develop a crossvergence framework for the African context including the indigenising of HRM;D practices.

8.8 Concluding remarks

From the study, some new lessons have been learnt and new knowledge added and these can be highlighted as: First, the results of the study have appraised the applicability of HR managerial performance (competencies) indicators in the literature with the following gaps/setbacks identified:

- Meeting the minimum requirements for appointment into management positions in the health sector should not be regarded as full competence for creditable performance. However, the sector must see the need to offer on-the-job training and capacity building programmes that are related to the job and sector objectives.
- Both organisational and national contextual factors have a serious influence on HRM/D implementation and should be pursued earnestly to maximise effectiveness in the management and development of people in the sector.

Second is the originality of the study. This is a new study in Ghana where no one has researched into HRM/DE in the PHS of Ghana and thus has added knowledge to the Ghanaian situation. Also, contextual core managerial competencies have been compiled from the perspectives of managers and stakeholders.

Beyond these, the main research conclusions suggest that managerial capacity challenges manifest in three-dimensions as: organisation and policy-related, competency (knowledge, skills, abilities etc) related and performance motivation-related. Confronting these challenges has far reaching implications for policy and HRM/D practice.

8.8.1 Implications for policy

One of the policy issues that emerged is that decentralisation has the potential to improving health service delivery by ensuring close relationships between employees and managers. However, for this to happen, several HRM/D policy actions and interventions are required,
including: establishing functional, well trained managers in HRM/D with good institutional structures at the local levels.

8.8.2 Implications for practice

Regarding the implications for HRM/D practice, it might be useful to focus on the following issues:

(1) Improving the core competencies of management at decentralised levels by promoting an integrated approach to organizational learning. Effective HRM/D policy in the health sector would need the involvement and alignment with the local levels as well as developing the competencies of managers. The competency approach, in essence, suggests that if organisations design learning events to enhance the competencies of employees to perform specific job functions, then they can develop individuals who are competent and do it in a more targeted fashion.

(2) In respect of the implications for improving HRM/D, it might be useful to focus on synchronising the laws and dialoguing with politicians to focus on organisation human resource strategy, including its: (i) Culture – the beliefs, values, norms and management style; (ii) Organisation – the structure, job roles, and reporting lines; (iii) People – the skill levels, staff potential and management capability; and (iv) Human Resources System – the people focused mechanisms which deliver the strategy: communications, training, rewards, career development.

(3) To improve funding and minimise interference and have political commitment to support HRM/D policy and implementation, there is the need to dialogue with politicians for them to value the course and see the risks for them to support.

These recommendations though laudable also have to take into consideration some constraints that might also face both politicians and policy makers. First, is the issue of training for managers. Though this is possible, there is also the issue of attitudes of some managers. As stated by one policy maker in the finding, some of them have dictatorial attitudes and even though they might benefit from the training the attitudinal change, however, cannot be ensured.
As regards political interference, it is possible to dialogue with them to understand and see the risks of interference, but the culture of the extended family system constrains non-interference as Ghanaians are nurtured to help family members and also receive help in return. Also, it is possible to dialogue with politicians to commit themselves to HRM/D issues but politicians also have constraints and limitations which cannot be overruled. For instance, is the issue of politicians (DCEs) supporting managers at the district level with incentives and accommodation packages (funding and logistics). Although the DCEs might be willing to support this idea, there are however, some constraints that should not be overlooked. First, there are several competing interest for funding in the district. Also, the passage of Act 565 does not allow the DCE to take full charge of health services in the district and therefore health allegiance is more to the RDHS than the DA. Coupled with this, the budget for health at the district level is not controlled by the DCE and there is the perception that health has huge funding from donors.

Despite the constraints, an element of sustainability in HRM/D is that although the managers lack competency, they are prepared to be trained to improve and which they have readily expressed. Thus, with this expression coupled with the willingness from health policy makers to strengthen all MMDDHS through education and continuing education, management and leadership programmes there is an opportunity for managers to become more effective to fit in properly with the reforms. In addition, the strengthening of their advocacy roles and synchronising of legislation will further strengthen managerial decision making in HRM/D and gain support from DCEs. Lastly, their involvement in policy development will further strengthen their capacity in HRM/D in policy interpretation and implementation. Above all, good information flow to managers and their ability to lobby to gain support from central level will pave the way for managers to better perform HRM/D functions. Finally, if managers are provided with adequate resources (both material and human) and other health professionals to work as a team, will make them more effective to meet the current challenges.
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APPENDICES

APPENDIX A: Maps showing study districts in Ghana

(a) Northern Region. Black dots represent study areas

(b) Greater Accra Region. Black dots represent study areas
APPENDIX B: CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH

Interviewee’s identification No………………

1. Invitation to participate in the research
You are asked to participate in a research study conducted by Margaret M. Chebere – a Ghana Government sponsored PhD student and Derek Eldridge (Faculty Supervisor) from the school of Environment and Development (SED) at the University of Manchester and Mr. Albert Anisomyansa (Research Assistant) of Initiative Development, Ghana. The results will contribute to the thesis project.

2. Purpose of the study
The purpose of this paper is to evaluate policy makers, line managers and employees’ perspectives, on the roles and competencies of line managers on Human Resources for Health management/Development with the aim of identifying core competencies for line managers for the management of HRH

3. Description of Procedure
If you participate in this study, you will (may) be asked to do the following:
To respond to a guided discussion this will be initiated by the investigator. The questions are in the following areas:
Respondents’ personal details
Respondents’ understanding of some terminology including effectiveness, human resource management and management
Knowledge and skills on health sector objectives
Knowledge and skills on human resource practices – recruitment and selection, training and development, performance management and rewards management.
The interview will take approximately one hour.
4. Confidentiality: Any and all information obtained from you during the study will be confidential. Your privacy will be protected at all times. You will not be identified individually in any way as a result of your participation in this research. The data collected however, may be used as part of publications and papers related to the research topic.

5. Other considerations and questions
Please feel free to ask any questions about anything that seems unclear to you and to consider this research and consent from carefully before you sign. If you have any questions or concerns about the research, please feel free to contact Margaret Chebere on 0244 – 654488 or Derek Eldridge on 0044 – 161 – 306 – 1220

6. Authorization: I have read or listened to the above information and I have decided that I will participate in the project described above. The researcher has explained the study to me and answered my questions. I know what will be asked of me. I understand the purpose of the study. If I don’t participate, there will be no penalty or loss of rights. I can stop participating at any time, even after I have started.
I agree to participate in the study. My signature below also indicates that I have received a copy of this consent form.
Interviewer’s name……………………………………
Interviewer’s signature…………………………………
Participant’s signature……………………………………
APPENDIX C: RESEARCH INSTRUMENTS

**In-depth individual interview schedule for managers**
The interview guide is designed to evaluate the way you perceive the performance of your managerial duties with regards to the implementation of HRM/D activities in your district. It is not a test, so there are no right or wrong answers. Please respond to each item as carefully and as accurately as you can by expressing your understanding, views and meanings you attach to some of the items in the questionnaire as follows.

**SECTION A – Personal details**
Name of Institution/Region/District..........................................
Name of interviewee.................................................................
Age..........................................................................................
Gender...................................................................................
Religion..................................................................................
Marital status..........................................................................
Current position........................................................................
Total number of years been with this organization.............
What is your current job title and/or position?......................
Please briefly describe your main responsibilities:................
Number of years you have been in your current role...........
Highest educational qualification.....................................
How long have you worked in the Region?

**SECTION.B - Competencies in HRM/D**

**Definitions**
What is your understanding or working definition of the following terms:

- **Management Effectiveness**
- **Human Resource Management/Development**
- **Managerial effectiveness and Human Resource Managerial/Development Effectiveness (HRM/DE)**

Does this understanding reflect in any of the HRM/D practices in the organisation and at your level of operation? If yes, please explain exactly how this happens. If no, why is it so?

In your perspective, who is an effective manager? Please describe

How do you learn to become effective?

What qualifications do you have? Probe for the type of qualification or training and how this qualification or training has helped with the manager’s work?
Health sector Goals, objectives and service delivery model and HRH policies

What is your understanding of the goal of the health sector? Probe for the health sector’s objectives, strategy and priorities.

What is the nature of the current health delivery model as postulated?

What is the health delivery model at the district level?

Do you think the model you operate at the district level is in line with the one postulated at National level? If, yes, please describe. If no, please explain why it is so.

Do you know of any HRH policies and practices postulated by the National level? Probe for availability of policy documents and the understanding of HRH policies regarding Recruitment and Selection, Performance and Rewards, Management and Staff development.

Section C: Skills, behaviours and abilities in implementing HRM/D Activities

Health Sector Objectives and linkage to HRM/D activities

Do you think the HRH practices of recruitment and selection, performance management, rewards management and staff development activities are linked to the goals of the health sector? If yes, how are they linked?

Are employee goals and health sector goals aligned? Please probe for the following:

Do you involve employees in achieving the health sector’s objectives? Do you listen to them? Are they consulted? And, if they are consulted, are their opinions taken seriously? Are there regular opportunities for them to give feedback? Do employees feel safe, loyal, valued and taken care of? Or do they feel taken advantage of, dispensable and invisible?

HRH Practices

As you undertake your role, how much does your knowledge and application of HRM/D apply? e.g In implementing HRH policies, what strategies do you use to attain high performance from employees in your district? Probe for specific policies of HRH that have been implemented and the outcomes.

Are you involved in policy development? Please describe your level of involvement

What kind of decisions do you take on HRH matters in your district in line with the four HRH practices – recruitment and selection, performance management, rewards and staff Development: Probe for the following behaviours under the four areas

a. Recruitment and selection
How do you make decisions on recruitment and selection including casuals? How do you deploy staff assigned to your district?

What is your opinion on the process of recruitment?

b. Performance Management,

What is the nature of the current performance management system in your district?

As a manager, how do you approach performance management for your staff to achieve maximum health sector outputs? Probe in line with these behaviours

Provide information on organisational performance and strategies for better service delivery and how the person fits in the overall plan.

Ensuring that job descriptions are available to all employees assigned to you on time and based on employees’ job analyses.

Linking up with national level to update job descriptions on a regular basis to reflect to changing business environment.

Ensuring that every employee is fully aware of his or her role in the organization, which can easily be accomplished in the performance planning phase of the process.

Ensuring harmony and consistency in performance measures across the entire organization and performance standards.

Ensuring that the process and the system are viewed as credible, fair, valid, and reliable. Communicating a vision of excellence for others that motivates them to improve

**How do you make decisions on performance appraisal?**

How do you empower employees to perform better? For instance do you provide employees with job descriptions that give them some autonomy and allow them to find their own solutions or are they given a list of tasks to perform and simply told what to do?

Provide specific feedback about performance of the person, the department, and the organization.

Recognize, reward, and promote people based on their performance. Deal with low and marginal performers so that they either improve or leave.

c. Rewards Management

What rewards are available to employees and how are these rewards managed to improve performance? Probe whether there is any indication in increase or decrease in performance with either intrinsic or extrinsic rewards.

**Intrinsic rewards**

Please explain how you apply intrinsic rewards to employees in your district. Probe for behaviours as follows:

Thank them one-on-one, verbally, in writing, or both.
Give praise often, sincerely, and in a timely manner.
Take the time willingly to meet with and listen to employees as much as they need or want.
Involve employees in decisions, especially when those decisions affect them.
Provide employees a sense of ownership in their work and the work environment
Strives to create a work environment that is open, trusting, and fun.
Helps others see the personal benefits of doing their job well
Encourages others to do their best
Looks for and uses new, creative ways to motivate others
Acknowledges achievements and contributions
Helps others identify their long range plans and goals
Maintains and communicates a positive, yet realistic outlook, in spite of organizational challenges in order to sustain morale

**Extrinsic Rewards**
What extrinsic rewards system is in place in your district for employees? Probe for type of extrinsic rewards such as financial rewards, promotion etc. and how these are administered. Are these extrinsic rewards from National level or they are local initiatives? Does the current rewards system represent and provide incentives that reward behaviours to support the health sector strategy?

**d. Staff development**
Are you involved in staff development activities? If yes, how are employees’ development enhanced? Probe for through off-site or on-the-job training, coaching or action learning – i.e learning before, during and after learning needs? If yes, how do you approach staff development? For instance how do you select priorities? Please probe for critical skills areas.

Have you been trained for the job you are doing? How often do you benefit from staff development programmes?

What do you understand about good practice for staff development? Probe for needs assessment, informal activities such as on the job training, coaching and formal development activities

Which of these policies do you think you implement well? *Probe in line with the four HRM/D practices as above.* If not what do you think are some of the causes for poor implementation? Probe causes in line with managerial knowledge, skills, abilities and behaviours.

Do you have any manager in mind that you think is effective? If yes, please explain why you see this manager to be effective by listing the behaviours of such a manager.

**Perceived obstacles/Opportunities to HRH policy implementation**

Are there any barriers that you encounter in implementing these HRH policies? If yes, what are the major obstacles in implementing HRH policies at district level. Please probe for barriers within and without the organisation.

Are there any opportunities at all for managers to be more effective? Please describe them.

*Please request interviewee to list these challenges and opportunities and state whether they are external or internal.*
How do you anticipate and deal with the effects of internal and external changes? From this understanding, would you say you are effective in your job? If yes or no, please explain why you think so. Probe for any perceived development needs.

**Instrument for policy makers/regulators**

The discussion guide is designed to measure the way you perceive your managers with respect to his or her HR managerial effectiveness. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by expressing your views and meanings you attach to some of the items in the questionnaire.

**Biographic data:**

How would you describe the managerial capacity of district level managers? Please probe for training, qualifications, knowledge, experience and the availability of any policy document detailing the qualifications, experience and competencies of managers at the district level?

In your view, do all the managers at the district level have the requisite training, qualifications, knowledge, experience and managerial skills?

Is there any policy document outlining planned ways managers can learn to become effective? Probe for the availability of documents and how this is done.

**Health sector Goals, objectives and service delivery model and HRH policies**

In your view, do you think managers know the goal of the health sector and work towards achieving it? Probe for the health sector’s objectives, strategy and priorities.

Do you think the way managers implement HRM/D activities are aligned with the goals of the health sector? Please describe.

How effective are managers at the district level in meeting the health sector objectives?

In your view, are managers at this level given autonomy and adequate resources to perform their duties? Please probe in line with any interference, adequacy of human resources, financial resources, material resources and policy guidelines.

Do you think the health delivery model operated at the district level is in line with the postulated one at National level? If, yes, please describe. If no, please explain why it is so.

What are the HRM/D policies postulated by the National level? Probe for availability of policy documents and the understanding of HRH policies regarding Performance Management, Rewards, and Staff development.

Do you involve managers at the district level and employees in policy development to achieve the health sector’s objectives? Do you listen to them? Are they consulted? And, if they are consulted, are their opinions considered? Are there regular opportunities for them to give feedback?

**HRM/D Practices**

How do you ensure that policies are implemented effectively at the lower levels by managers? Probe for a monitoring system, how it is done, how often and actions taken and the availability of a monitoring tool. Probe in line with four HRM/D practices.
a. **Performance Management** What is the nature of the current performance management system? As a policy maker, have you developed a system for performance management to enable staff achieve maximum health sector outputs?

b. **Rewards Management**: What rewards are available to employees and how are these rewards used to improve performance? Probe for whether there is any indication in increase or decrease in performance with either intrinsic or extrinsic rewards.

c. **Staff development**

Are you involved in management development activities – i.e learning before, during and after learning needs? If yes, how do you approach management development? For instance how do you select priorities?

Have managers been trained for the job they are doing? How often do managers benefit from development programmes?

Do you know any effective manager? If yes, please explain why you see this manager to be effective? List the behaviours of such a manager.

**Perceived obstacles/Opportunities to HRH policy implementation**

What are the major challenges that managers encounter in implementing specific HRM/D processes? Probe for list of challenges in line with internal and external environmental factors, political, socio-cultural, work environment etc.

Are there any opportunities at all for managers to be more effective? Please describe them. How do you anticipate and deal with the effects of internal and external changes? If given the chance, which managerial competencies will you target for development?

**Knowledge/Understanding of Terms**

What is your understanding or working definition of the following terms:

Management
Effectiveness
HRM/D
Managerial effectiveness

Do you see this understanding reflected in the implementation of management and HRM/D policies and practices of recruitment and selection, PM, rewards management, and staff development at the district level by managers in the health sector? If yes, please explain exactly how this happens. If no, why is it so?

In your perspective, which competencies would you like your managers to possess? Please describe
FOCUS GROUP DISCUSSION GUIDE
The discussion guide is designed to measure the way you perceive your manager with respect to his or her HR managerial effectiveness. It is not a test, so there are no right or wrong answers. Everyone is encouraged to contribute to the discussion and each of you will have his or her turn to answer each item as carefully and as accurately as you can by expressing your understanding, views and meanings you attach to some of the items in the questionnaire as follows.

Employees’ views about Managers’ Knowledge regarding health Sector Goals
How would you assess the knowledge of your manager regarding objectives of the health sector? Probe for the health sector’s mission goals/objectives,

As employees are your goals and health sector goals aligned? Probe for how these are aligned.

How do you feel about being employees of the health sector? For instance do you feel safe, loyal, valued and taken care of? Or do you feel taken advantage of, dispensable and invisible? Ask them what would improve their loyalty and commitment.

Are you involved in achieving the health sector’s objectives? Probe as follows: Do you feel listened to and heard? Are you consulted? And, if you are consulted, are your opinions taken seriously? Are there regular opportunities for you to receive feedback?

Managerial Skills, behaviours and abilities
How will you describe your managers’ skills in implementing HRM/D functions? Probe in the following areas
Do managers encourage team work?
How do your managers resolve conflict?
Does your manager strive to create a work environment that is open, trusting, and fun?
Do managers encourage new ideas and initiatives?
Do managers involve employees in decisions, especially when those decisions affect employees?
Do your managers provide employees a sense of ownership in their work and the work environment?

Please briefly describe your manager’s relations with you, peers, superiors, stakeholders and community.

HRH Practices
The Context, the process, stakeholders, implementation and issues etc.
Please describe how managers take decisions regarding the following HRH practices of recruitment and selection, performance management. Rewards and staff development programmes?

How would you describe the effectiveness of these decisions regarding the practices?
Probe separately for four HRH practices

a. Recruitment and selection
Please describe what determines recruitment and the processes.
Please give your opinion about the way HRH including casuals are recruited and how managers deploy staff posted to the district.

b. Performance management
Do managers ensure employees have job descriptions?

Provide for specific feedback about performance of the person, the department, and the organization,

Recognize, reward, and promote people based on their performance. Deal with low and marginal performers so that they either improve or leave.

c. Staff development
Do managers support staff learning and development? Do managers involve employees? If yes, do managers undertake any training needs assessment? Do employees know about any policies and what these policies prescribe? Have employees been trained for the jobs they are doing? What qualifications and experience are managers expected to have? Do you know if managers have these qualifications and experience?

d. Rewards Management
Do managers administer rewards effectively? Probe separately for intrinsic and extrinsic rewards. How are these rewards structured throughout the health sector? How would you describe the current pay/rewards system? Probe further in line with the following: What incentives/rewards are in place? How are rewards and incentives administered? Does the current rewards system represent and provide incentives that reward behaviours to support the business strategy? What aspects of HRM/D are important in ensuring that work is of high standard at your level of operation.

In your opinion, what obstacles prevent managers performing to best effect? Probe for obstacles such as external and internal organisational factors e.g. work environment, socio-cultural, political, resources etc.

How can managers overcome these obstacles during the HRM/D decision process?

In your perspective, who is an effective manager? Please describe what you have seen this manager do. Probe in line with managerial behaviours exhibited in dealing with employees.

In your opinion, what obstacles prevent employees from performing to best effect? Probe for obstacles like work environment, rewards, recognition etc.
APPENDIX D: ETHICAL APPROVAL LETTER FROM GHANA HEALTH SERVICE

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

In case of reply the number and date of this letter should be quoted.

My Ref: GHS-ERC 20/5/09
Your Ref: 30

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of this Study Protocol titled:

"Evaluating Managerial Effectiveness from the Perspectives of Managers and Employees of the Health Sector of Ghana: the case of developing core competencies for improving Human Resources for Health Management."

This approval requires that you submit periodic review of the protocol to the Committee and a final full review to the Ethical Review Committee (ERC) on completion of the study. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification of the project must be submitted to the ERC for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are requested to inform the ERC and your ethical review board before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this protocol.

SIGNATURE

MR. ANNOR-JIMAKO
(GHS-ERC VICE CHAIRMAN)

Co: The Director, Research and Development Division, Ghana Health Service, Accra.
GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE
RESEARCH AND DEVELOPMENT DIVISION
P.O BOX MB 190
ADABRAKA POLYCLINIC
OPPOSITE ACCRA PHYCHIATRIC HOSPITAL
CATHEDRAL SQUARE
CASTLE ROAD
hra-ghs.org
Tel: (233) (021) 661109 Fax: (233) (021) 226739

PROTOCOL SUBMISSION REQUIREMENTS

Thirteen sets (bounded) of new protocol must be submitted to the ETHICS REVIEW COMMITTEE at least two months before the proposed commencement date of the research. Each set must include copies of the following:

1. Principal Investigator's Application for submission
2. Cover letter from head of the Principal Investigator's Institution (Institutional Support letter)
3. A letter affirming that the protocol has gone through a scientific review and has been approved. (if applicable)
4. Full Protocol
5. Consent forms
6. Field guide i.e. questionnaire, enrolment forms, tool
7. Curriculum vitae of investigators (CV must not be more than 1 year old)
8. Completed ERC checklist (copy attached)
9. Insurance Cover if it is a Trial Study
10. Letters Participations/Collaborative Institutions
11. Any other relevant document to facilitate the process.

Note: The Ghana Health Service Committee Ethics Review Committee meets on forth Wednesday of every other month (every two months).

Submit Applications to:

Postal Address
The Chairman or Administrator
Ghana Health Service Ethics Review Committee
Health Research Unit
P.O.Box MB 190
Accra- Ghana

Delivery Address
The Chairman or Administrator
Ghana Health Service Ethics Review Committee
Health Research Unit
Adabraka Polyclinic
Opposite Accra Psychiatric Hospital
Cathedral Square – Castle Road

GHS ERC
Protocol Submission Forms-Revised 2009
In case of reply the number and the date of this letter should be quoted

My Ref. No: GHSHRMW
Your Ref. No:…………………

HUMAN RESOURCE DIVISION
GHANA HEALTH SERVICE
PRIVATE MAIL BAG
MINISTRIES
ACCRA

E-mail: mobhrd@afric online.com.gh
Tel: 021661354
Fax: 021 670239/660472

The Regional Director of Health Service
Regional Health Directorate
Ghana Health Service
Greater Accra Region.

18 June 2009

LETTER OF INTRODUCTION – MS. MARGARET M. CHEBERE (PhD STUDENT)

This is to introduce Margaret M. Chebere, who is a staff of the Human Resources’ Development Directorate of the Ghana Health Service. She has been granted study leave to pursue a PhD programme in Development Policy and Management at the University of Manchester, United Kingdom. She is about to conduct her fieldwork in Ghana. Her research topic is ‘An Evaluation of Human Resources managerial effectiveness with the aim of developing (contextual) appropriate competencies from the perspectives of Policy makers, District managers and employees of the health sector of Ghana’.

This would thus require that she administers her research instruments to different categories of health workers as indicated in her topic. Your Region is one of the Regions she has selected to administer her questionnaire in three Districts. Specifically, the instruments would be administered to Regional and District Health managers and some employees at these levels.

It would be appreciated if you could purposely select these districts to include those you deem to be best performing and least performing in the area of Human Resources management.

Date: 14th – 25th September, 2009

We would therefore be grateful if you would offer all the necessary assistance to enable her carry out her research.

Linda Asamoah (Ag. Deputy Director)
For: DIRECTOR, HRDD
In case of reply the number and the date of this letter should be quoted

My Ref. No. GHS/HFDW
Your Ref. No. ..........................

The Regional Director of Health Service
Regional Health Directorate
Ghana Health Service
Northern Region.

LETTER OF INTRODUCTION – MS. MARGARET M. CHEBERE (PHD STUDENT)
This is to introduce Margaret M. Chebere, who is a staff of the Human Resources’ Development Directorate of the Ghana Health Service. She has been granted study leave to pursue a PhD programme in Development Policy and Management at the University of Manchester, United Kingdom. She is about to conduct her fieldwork in Ghana. Her research topic is ‘An Evaluation of Human Resources managerial effectiveness with the aim of developing (contextual) appropriate competencies from the perspectives of Policy makers, District managers and employees of the health sector of Ghana’.

This would thus require that she administers her research instruments to different categories of health workers as indicated in her topic. Your Region is one of the Regions she has selected to administer her questionnaire in three Districts. Specifically, the instruments would be administered to Regional and District Health managers and some employees at these levels.

It would be appreciated if you could purposely select these districts to include those you deem to be best performing and least performing in the area of Human Resources management.

Date: 13th – 21st July, 2009

We would therefore be grateful if you would offer her all the necessary assistance to enable her carry out her research.

Linda Asamoah (Ag. Deputy Director)
For: DIRECTOR, HRDD
### APPENDIX F: LIST OF RESPONDENTS

#### Northern Region

<table>
<thead>
<tr>
<th>No</th>
<th>District</th>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Position</th>
<th>Marital Status</th>
<th>Religion</th>
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<tbody>
<tr>
<td>1</td>
<td>Savelugu Nanton</td>
<td>Margaret Mwini</td>
<td>F</td>
<td>55</td>
<td>Acting District Director</td>
<td>married</td>
<td>C</td>
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<tr>
<td>2</td>
<td>''</td>
<td>Mr. Combian</td>
<td>M</td>
<td></td>
<td>Acting Med Supt.</td>
<td>married</td>
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<td>3</td>
<td>Tamale West Hospital</td>
<td>Dr. Obeng Adjei</td>
<td>M</td>
<td>43</td>
<td>Med. Director</td>
<td>married</td>
<td>Aetheist</td>
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<td>4</td>
<td>Tamale Metro Health Directorate</td>
<td>Dr. John Abenyiri</td>
<td>M</td>
<td>49</td>
<td>District Director</td>
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<td>5</td>
<td>Tolon-Kumbugu</td>
<td>Denicia Agong</td>
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<td>East Mamprusi</td>
<td>Mr. T. Sennor</td>
<td>M</td>
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<td>West Gonja</td>
<td>Dr. Kubio</td>
<td>M</td>
<td>36</td>
<td>District Director/med Supt</td>
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<td>Bole District</td>
<td>Mr.</td>
<td>M</td>
<td></td>
<td>District Director</td>
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<tr>
<td>10</td>
<td>''</td>
<td>Dr. S. Bosomtwi</td>
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<td>43</td>
<td>Medical Director</td>
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#### Greater Accra Region

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<td>Dr. Opata</td>
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<td>Dangme East</td>
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<tr>
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<td>Dr.</td>
<td>F</td>
<td>58</td>
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<td>widow</td>
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<td>Tema Gen Hospital</td>
<td>Mrs. Mamattah.</td>
<td>F</td>
<td></td>
<td>Health Ser..Admin</td>
<td>married</td>
<td>Christian</td>
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<td>Korle-Bu Teach Hospital</td>
<td>Mr. Tony Apedzi</td>
<td>M</td>
<td></td>
<td>Human Res Manager</td>
<td>married</td>
<td>Christian</td>
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#### Policy makers

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<th>Position</th>
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<th>Religion</th>
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<td>1.</td>
<td>MOH. HQ</td>
<td>Mrs. S. Abdulsalaam</td>
<td>F</td>
<td>54</td>
<td>Ag. Chief Director</td>
<td>widowed</td>
<td>moslem</td>
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<tr>
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<td>GHS HQ</td>
<td>Dr. Elias Sory</td>
<td>M</td>
<td>58</td>
<td>Director-General</td>
<td>married</td>
<td>Christian</td>
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<tr>
<td>3.</td>
<td>HRHD Directorate, MOH</td>
<td>Dr. E. Appiah Denkyira</td>
<td>M</td>
<td></td>
<td>Director, HRHD, MOH</td>
<td>married</td>
<td>Christian</td>
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<tr>
<td>4.</td>
<td>HRHD Directorate, MOH</td>
<td>Dr. Kwasi Asabir</td>
<td>M</td>
<td></td>
<td>Dep. Director, HRHD</td>
<td>married</td>
<td>Christian</td>
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<td>5.</td>
<td>Ministry of Health</td>
<td>Dr. Sylvester Anemana</td>
<td>M</td>
<td>58</td>
<td>Ag. Chief Director,</td>
<td>married</td>
<td>Christian</td>
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<td>6.</td>
<td>HRDD Directorate, GHS</td>
<td>Dr. McDamian Dedzo</td>
<td></td>
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<td>Director, HRDD, GHS</td>
<td>married</td>
<td>Christian</td>
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<tr>
<td>7.</td>
<td>PPMED, MOH</td>
<td>Mr. George Dakpalla</td>
<td></td>
<td></td>
<td>Director, PPMED</td>
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<td>Christian</td>
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<tr>
<td>8.</td>
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<td>Mr. Symon Koku</td>
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<td>Christian</td>
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<tr>
<td>9.</td>
<td>PPMED, MOH</td>
<td>Mr. Senaya</td>
<td></td>
<td></td>
<td>Deputy Dir., PPMED</td>
<td>married</td>
<td>Christian</td>
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<td>Regional Health Dir</td>
<td>Dr. Twumasi</td>
<td></td>
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<td>11.</td>
<td>Regional Health Dir</td>
<td>Mr. Yaw Boamah</td>
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**FOCUS GROUP DISCUSSIONS**

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**METRO HELATH DIRECTORATE & TAMELE WEST HOSPITAL**

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**WEST GONJA DHA & HOSPITAL (CHAG)**

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APPENDIX G: CORE COMPETENCIES

“Somebody who knows what he wants and at what time can use available resources to achieve the set objectives and to be effective we need to also be a team player, you need to be able to know when people are performing and when they not understand the reasons for high performance and low performance try to look for solutions as quick as you can as early as possible and an effective leader who will come out with excuses for non performance” (Male manager, NR).

“An effective manager is the manager that pulls his people along and not just leading them but moving and they follow you. They don’t stop and say: ’let him go alone.’ And because you involve everybody they let you go together. That it is not yours but it is for all of you. They believe that it is theirs. Won’t let you with them and make them have a sense of belonging” (Male manager, NR).

“Somebody who knows what he wants and at what time can use available resources to achieve the set objectives and to be effective. He needs to also be a team player, you need to be able to know when people are performing and when they do not understand the reasons for high performance and low performance try to look for solutions as quick as you can as early as possible and an effective leader who will come out with excuses for non performance” (Male manager, NR).

“I also think you should be somebody who should listen. You should be a good listener instead of always or... authorising people about. Because I have learnt a lot from being in this position actually. Yes because nobody knows it all so you have to gather the information from everybody and I said you should be listening more” (Female Manager, NR).

“An effective human resource manager should be the one who has the welfare of the staff at heart and not just the job being done. Because I think it goes beyond just the work that you expect people to do because their welfare which may go into personal development and other areas” (Male manager, GAR).

“He should be friendly, polite, firm example we need you here he make sure that you don’t compromise on excuses example when you have posted one person and excuses makes you change for another person to go. It means you did not plan well”( Female manager, GAR).

“The person should have some small empathy for the staff, know them in person if possible if they are not too many, know a bit about their background, their strengths, their skills strengths as well as their weaknesses generally their inclination to work and know a bit about what their capabilities are apart from being specialist in a certain area all the things they can do and cannot do the person should be able to know this so that when a person is more or less assigning them duties or requiring performance from them knows what to expect and what not to expect and somebody who would be interested in their career, the person should have contact whether direct or indirect and be able to ... I think these are the qualities and also by all means manage them on paper also, their formal management things have to be done for them, letters and recommendations have to be done be able to appraise them”(Female manager, GAR).

“Manager should have in-depth knowledge of his job area, have good human relations, be fair and firm and be objective” (Male policy maker, NR).

“An effective manager should be committed, have knowledge of job area, ability to communicate, easily bring people together, have good human relations, Good organisational skills, be a good leader and be a team player” (Male policy maker, tertiary level).
“Interested in staff performance, approachable, friendly, be interested in staff welfare, provide supportive supervision, be open, be understanding, knowledgeable and skillful, be patient (have big ear and small mouth), good listener, firm, resourceful, transparent and accountable” (FGD, NR).

“Democratic, Firm in carrying out duties, Good human relations, knowledgeable and skilled, punctual to work, abide by rules and regulations, ability to set goals and achieve them within the period, listens to workers, treat patients well and keen observer” (FGD, GAR).

<table>
<thead>
<tr>
<th>Table 6.11 Surveyed Employees (301) list of managerial behaviours/Competencies of an effective manager</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>a listening manager, innovative, resourceful, accountable, provides supportive supervision, cares for the staff</td>
<td>203</td>
<td>67.4</td>
<td>67.4</td>
</tr>
<tr>
<td>ability to solve problems concerning staff, having a listening ear</td>
<td>1</td>
<td>0.3</td>
<td>67.8</td>
</tr>
<tr>
<td>able to plan, organise and control resources to achieve organisational goals, team work aimed at achieving organisational objectives</td>
<td>1</td>
<td>0.3</td>
<td>68.1</td>
</tr>
<tr>
<td>accommodative, team player, good listener, knows how to motivate staff, respect staff, very understanding, knowledgeable</td>
<td>1</td>
<td>0.3</td>
<td>68.4</td>
</tr>
<tr>
<td>approachable, ensures things are done right, smart, neat, descent</td>
<td>1</td>
<td>0.3</td>
<td>68.8</td>
</tr>
<tr>
<td>approachable, friendly</td>
<td>1</td>
<td>0.3</td>
<td>69.1</td>
</tr>
<tr>
<td>approachable, smart, listening ear</td>
<td>1</td>
<td>0.3</td>
<td>69.4</td>
</tr>
<tr>
<td>avoid discrimination, motivate workers, should be sober, humble</td>
<td>1</td>
<td>0.3</td>
<td>69.8</td>
</tr>
<tr>
<td>be punctual, understand the primary aims and objectives of the health sector, must be approachable and ready to listen to his staff</td>
<td>1</td>
<td>0.3</td>
<td>70.1</td>
</tr>
<tr>
<td>bold and serious, very approachable, intelligent and smart, listens to ideas, very industrious and decisive</td>
<td>1</td>
<td>0.3</td>
<td>70.4</td>
</tr>
<tr>
<td>communication skills</td>
<td>1</td>
<td>0.3</td>
<td>70.8</td>
</tr>
<tr>
<td>competent, trustworthy, strict, able to solve conflicts among subordinates</td>
<td>1</td>
<td>0.3</td>
<td>71.1</td>
</tr>
<tr>
<td>concerned with the wellbeing of the employees, supply regular logistics for work, be knowledgeable about the work the employees does</td>
<td>1</td>
<td>0.3</td>
<td>71.4</td>
</tr>
<tr>
<td>consistent, fair and firm in his dealings, sociable</td>
<td>1</td>
<td>0.3</td>
<td>71.8</td>
</tr>
<tr>
<td>decisive, plans, organise, monitor</td>
<td>1</td>
<td>0.3</td>
<td>72.1</td>
</tr>
<tr>
<td>democratic, work conscious, rel-iable</td>
<td>1</td>
<td>0.3</td>
<td>72.4</td>
</tr>
<tr>
<td>effective communication skills</td>
<td>1</td>
<td>0.3</td>
<td>72.8</td>
</tr>
<tr>
<td>effective monitoring and supervision ensure judicious use of resources, appraise staff, commend hard working staff</td>
<td>1</td>
<td>0.3</td>
<td>73.1</td>
</tr>
<tr>
<td>empathy, listening skills, proper choice of words</td>
<td>1</td>
<td>0.3</td>
<td>73.4</td>
</tr>
<tr>
<td>ensures books are daily updated, staff have conducive working environment, report are prepared on time</td>
<td>1</td>
<td>0.3</td>
<td>73.8</td>
</tr>
<tr>
<td>ensures departments functions effectively, understand problems of departments and help solve them, listens to all categories of staff</td>
<td>1</td>
<td>0.3</td>
<td>74.1</td>
</tr>
<tr>
<td>excellent communication skills, one who has a good working relationship with workers, ability to get the workers to appreciate and share in the vision of the organization</td>
<td>1</td>
<td>0.3</td>
<td>74.4</td>
</tr>
<tr>
<td>fair and firm, be accessible to all employees, there should be rewards and sanctions, delegation and getting feedback appropriately</td>
<td>1</td>
<td>0.3</td>
<td>74.8</td>
</tr>
<tr>
<td>firm, trustworthy, good morale, respects subordinates, punctual, good interpersonal relationship</td>
<td>1</td>
<td>0.3</td>
<td>75.1</td>
</tr>
<tr>
<td>firmness, committed, sociable, motivating, proactive, smart, good human relations</td>
<td>1</td>
<td>0.3</td>
<td>75.4</td>
</tr>
<tr>
<td>free to approach, listen to staff, ensure staff improvement</td>
<td>1</td>
<td>0.3</td>
<td>75.7</td>
</tr>
<tr>
<td>friendly, leadership lifestyle</td>
<td>1</td>
<td>0.3</td>
<td>76.1</td>
</tr>
<tr>
<td>friendly, listening ear to all employees, ensures all workers do as required of them</td>
<td>1</td>
<td>0.3</td>
<td>76.4</td>
</tr>
<tr>
<td>307</td>
<td>0.3</td>
<td>76.7</td>
<td></td>
</tr>
<tr>
<td>Rating</td>
<td>Score</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>5.00</td>
<td>1.00</td>
<td>good communication skills, team work, adhering to laid down rules and regulations</td>
<td></td>
</tr>
<tr>
<td>4.75</td>
<td>1.00</td>
<td>good in delegation of duties, encourage employees to display their skills proficiently, facilitative supervision, rewards hard working staff</td>
<td></td>
</tr>
<tr>
<td>4.62</td>
<td>1.00</td>
<td>good interaction with staff, staff meetings, rewarding staff to motivate them</td>
<td></td>
</tr>
<tr>
<td>4.56</td>
<td>1.00</td>
<td>good interpersonal relations, respect for other members of the team, punctuality and hard work</td>
<td></td>
</tr>
<tr>
<td>4.50</td>
<td>1.00</td>
<td>good interpersonal relationship with staff</td>
<td></td>
</tr>
<tr>
<td>4.44</td>
<td>1.00</td>
<td>good moral standards, work approach, good working relationship</td>
<td></td>
</tr>
<tr>
<td>4.25</td>
<td>1.00</td>
<td>good relationship with subordinates, transparency in administration, ensure the welfare of staff, provide enabling environment for staff</td>
<td></td>
</tr>
<tr>
<td>4.20</td>
<td>1.00</td>
<td>good superior-subordinate relationship, punctuality, prompt decision making on issues and prompt action on challenges</td>
<td></td>
</tr>
<tr>
<td>4.16</td>
<td>1.00</td>
<td>good team player, good listener, mentor others, ready to learn from others, good interpersonal relationship</td>
<td></td>
</tr>
<tr>
<td>4.10</td>
<td>1.00</td>
<td>hard working, firm in decision making, good communication skills</td>
<td></td>
</tr>
<tr>
<td>4.06</td>
<td>1.00</td>
<td>hardworking, should be affable, respect other people’s views</td>
<td></td>
</tr>
<tr>
<td>4.00</td>
<td>1.00</td>
<td>he takes decisive decisions, he cares and advises his subordinates</td>
<td></td>
</tr>
<tr>
<td>3.96</td>
<td>1.00</td>
<td>honesty, approachable, trustworthy, skilful, knowledgeable, good planner</td>
<td></td>
</tr>
<tr>
<td>3.92</td>
<td>1.00</td>
<td>humble, shouldn’t discriminate</td>
<td></td>
</tr>
<tr>
<td>3.88</td>
<td>1.00</td>
<td>humble, shouldn’t discriminate, involve employees in decision making, set a goal to achieve, must have the necessary certificate</td>
<td></td>
</tr>
<tr>
<td>3.84</td>
<td>1.00</td>
<td>Inspiring interpersonal behaviour, innovative behaviour, ability to bring all on board in dealing with an issue, ability to manage all skills of employees to achieve organisational goals</td>
<td></td>
</tr>
<tr>
<td>3.80</td>
<td>1.00</td>
<td>interpersonal relation with staff, encourages staff to do the right things, places staff where deem important</td>
<td></td>
</tr>
<tr>
<td>3.75</td>
<td>1.00</td>
<td>interpersonal relationship, good leadership/managerial skills, effective communication skills</td>
<td></td>
</tr>
<tr>
<td>3.71</td>
<td>1.00</td>
<td>involvement in decision making, recognise staff based on performances, ensures conducive work environment of staff, rewards of performance</td>
<td></td>
</tr>
<tr>
<td>3.67</td>
<td>1.00</td>
<td>knows roles that relate to staff development, performance management and involves them in decision making, ensures conducive work environment</td>
<td></td>
</tr>
<tr>
<td>3.62</td>
<td>1.00</td>
<td>leadership examples, punctual, knowledgeable</td>
<td></td>
</tr>
<tr>
<td>3.58</td>
<td>1.00</td>
<td>leadership skills</td>
<td></td>
</tr>
<tr>
<td>3.54</td>
<td>1.00</td>
<td>listening attentively, approachable, team spirit</td>
<td></td>
</tr>
<tr>
<td>3.50</td>
<td>1.00</td>
<td>love for workers, be good communicant to workers</td>
<td></td>
</tr>
<tr>
<td>3.46</td>
<td>1.00</td>
<td>manager’s relation with subordinates, attitude towards work, equipments and vehicles</td>
<td></td>
</tr>
<tr>
<td>3.42</td>
<td>1.00</td>
<td>medical superintendent, health service administrators</td>
<td></td>
</tr>
<tr>
<td>3.38</td>
<td>1.00</td>
<td>mindful of staff development, making sure things are done right, provision of necessary equipment and logistics</td>
<td></td>
</tr>
<tr>
<td>3.34</td>
<td>1.00</td>
<td>more patient with workers, good manager</td>
<td></td>
</tr>
<tr>
<td>3.30</td>
<td>1.00</td>
<td>motivational, tolerant, courageous, hard working</td>
<td></td>
</tr>
<tr>
<td>3.26</td>
<td>1.00</td>
<td>must have excellent communication skills-formal and informal, must possess the capacity to effectively coordinate differing skills, expertise, must be open to all, must not discriminate openly and must be fair to all regardless of tribe, religion</td>
<td></td>
</tr>
<tr>
<td>3.22</td>
<td>1.00</td>
<td>must operate open administration, motivation and good leadership style, participation and involvement, must be fair in his dealings</td>
<td></td>
</tr>
<tr>
<td>3.18</td>
<td>1.00</td>
<td>must set technical guidelines to achieve policy standards, must motivate the staff, must implement approved national policies for health delivery</td>
<td></td>
</tr>
<tr>
<td>3.14</td>
<td>1.00</td>
<td>not discriminate among staff, motivate staff at the end of the year</td>
<td></td>
</tr>
<tr>
<td>3.10</td>
<td>1.00</td>
<td>not known</td>
<td></td>
</tr>
<tr>
<td>3.06</td>
<td>1.00</td>
<td>not quick tempered, not discriminative, provide materials necessary for the job</td>
<td></td>
</tr>
<tr>
<td>3.02</td>
<td>1.00</td>
<td>one who is people-centred, acts on problems/challenges, builds the capacity of the staff through staff development-training, workshop</td>
<td></td>
</tr>
<tr>
<td>2.98</td>
<td>1.00</td>
<td>one who wants to know the problems of employees</td>
<td></td>
</tr>
<tr>
<td>2.94</td>
<td>1.00</td>
<td>openness, fairness, prudent judgement</td>
<td></td>
</tr>
<tr>
<td>2.90</td>
<td>1.00</td>
<td>openness/honest, tactfulness, dependability, friendly, result oriented, timeliness</td>
<td></td>
</tr>
<tr>
<td>2.86</td>
<td>1.00</td>
<td>out-spoken person, fair and firm, respects views</td>
<td></td>
</tr>
<tr>
<td>Comment</td>
<td>Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>polite, accommodative, objective, fairness and firm</td>
<td>91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>possession of basic managerial skills, delegation, regards for other field of study, honesty, diplomacy, accountability, transparency, fairness, trust for the capabilities of others</td>
<td>91.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>principled, honest, understanding</td>
<td>91.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>punctual, efficient</td>
<td>92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>punctual, works well with other staff, check for late comers</td>
<td>92.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>punctuality, seeking welfare of her staff, motivational packages, dedication to work</td>
<td>92.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ready to teach others, involves subordinates in decision making, encourages the low esteem to work hard, assign duties to others</td>
<td>93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>recognises people based on performance, ensures conducive working environment for staff, reviews performance of all workers regularly, works to achieve organisational goals, involves employees in achieving the health sector's objectives</td>
<td>93.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>regular employee performance review, has requisite knowledge in HR management, involves employees in decision affecting them, effective communication with employees</td>
<td>93.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>regular performance reviews, performing very well administratively, having requisite qualifications in human resources management, having good relationship with employees, the ability to tolerate well with everyone</td>
<td>94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>respect and sociable</td>
<td>94.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>respectful and sociable</td>
<td>94.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>respectful, loyal, truthful, sincere, hardworking, employee focus minded, sympathy and empathy</td>
<td>95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>responsible, takes care of employees in decision making</td>
<td>95.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>self confidence, self-motivated, good listener, love for subordinates, visionary, easy-going, public relation skills</td>
<td>95.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>shouldn't discriminate among the staff, motivate workers to enable them work batter, provide materials to enhance work efficiency</td>
<td>96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>smart, outspoken, good communication skills, good HR practices, good knowledge of the job area</td>
<td>96.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sociable</td>
<td>96.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sociable and tolerant</td>
<td>97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sociable, humble, hard working</td>
<td>97.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>strong decision making, better inter-personal relation with subordinates, does not hesitate to punish if necessary</td>
<td>97.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>team leader/player, performance appraisal, staff motivation, involving staff in decision making</td>
<td>98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>team work, goal centred, motivation oriented, approachable, good player</td>
<td>98.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>team work, interpersonal skills</td>
<td>98.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the listening type, approachable type, should be democratic</td>
<td>99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>understanding, work effectively and efficiently, well organised, reliable and patient</td>
<td>99.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>use of effective HR mgt strategies, people centred, ability to turn challenges to opportunities</td>
<td>99.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>visit employees at workplace and enquire their worries concerning the job</td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total**: 301