DIMENSIONS INFLUENCING THE PERFORMANCE OF DHES IN MASHONALAND EAST PROVINCE

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A dissertation submitted in partial fulfilment of the requirements of the requirements of the University of Zimbabwe Master of Business Administration (MBA) Degree programme

THE GRADUATE SCHOOL OF MANAGEMENT

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February 2015

DECLARATION

I, **Martin Mushate**, declare that I am the sole author of this dissertation and that during the period of study I have not been registered for another academic award or qualification, nor has any of the material from this dissertation been submitted wholly or partially for any other award. This dissertation is a result of my own research work, and where other people's research was used, they have been duly acknowledged.

Signature..... Date.....

CANDIDATE

Name.....

SUPERVISOR

Signature..... Date.....

DEDICATION

To my extraordinarily supportive and at all times patient Wife (Judith Chitida); our inspiring children (two sons and a daughter); my mother (Janet Tambudzai Mushate), who gave me life; my inspiring father (Jerry Munyoriwa Takaendesa): with all my love

ACKNOWLEDGEMENTS

May I take this opportunity to express my heartfelt gratitude to my Supervisor, Dr. David Madzikanda, for his unfaltering and steadfast, mentorship support and guidance. SI am grateful for your wise mentorship and fruitful feedback from the stage of formulating the research proposal up until I finished the research. May God bless you for your dedication even when you were called for help at odd times.

May I also take this opportunity to acknowledge the support of the following:

- ◊ My family, for being patient and understanding and providing moral and material support throughout my studies;
- ◊ My lecturers at the Graduate School of Management, University of Zimbabwe, for illuminating my academic world and mentoring me to be a critical thinker;
- ◊ My study group members, for their moral and academic support;
- ◊ Dr. Ruparanganda (Chairman, Department of Sociology), for the unwavering moral and religious support he gave me;
- ◊ The PHSA, Mr. P. Mwazungunya, for his encouragement;
- ◊ My supervisor at work, Dr. M. Muzamhindo, for letting me off work to conduct my research;
- ◊ Acting PMD (Dr. Kuretu), for allowing me an opportunity to interview health workers;
- ◊ Research participants for allowing me to interview them, and;
- ◊ God Almighty, who gave me the life and opportunity to study for a Master of Business Administration (MBA) Degree at the University of Zimbabwe, without whom it would never have materialized. I thank you.

ABSTRACT

The District Health Executives are performing their work below expectation. The objectives of the study were to: find out the role of supervision on the work performance of DHEs; establish the influence of management development on the work performance of DHEs; determine the role of teamwork on the work performance of DHEs; find out how conditions of service impact on the work performance of DHEs; establish the gaps in the literature and conceptualize a framework that explains the work performance of DHEs, all in Mashonaland East Province

The qualitative methodology was used. Research participants (totalling fifteen) from three hospitals and from the Provincial Medical Director (PMD)'s office were selected, using a non - probability sampling method called purposive sampling, to participate in the interview. Participants were selected for their experience of five years and above, and for their willingness to share their opinions, feelings, knowledge and experiences openly and honestly. Semi–structured interview – pretested before collecting data – were used to collect primary data DHE members, PHE members and other key participants. Objectivity was guaranteed creating rapport with participants. Data was transcribed immediately after an interview.

The main research findings were that supervision was done in an authoritarian and reactive way; most DHE members do not have management skills as their professional curricula do not cover management courses; DHEs lack the autonomy to make relevant and contextual decisions; some DHE members have lost the legitimacy to give their subordinates instructions due to untenable relations with their juniors; certain existing arrangements (like administration of disease control programmes, unstable DHEs, unfair treatment of DHE members) militated against teamwork; inadequate remuneration for DHE members, and; failure on the part of supervisors to acknowledge and value the differences in individual salary grades and length of experience, and failure to acknowledge excellent work: all these were identified as dimensions that influence the work performance of DHEs.

DHE members need to undergo management development courses to acquire management knowledge and skills, to be able to supervise effectively, to be professional and earn integrity,

and to acquire team building skills; should be given appropriate autonomy to make local decisions and resources to perform well. Integrity and autonomy need further research.

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.0 INTRODUCTION

This chapter is made up of an introduction, background to the research problem, statement of the problem, aim and objectives of the research, justification of the research, scope of the research and the summary of the chapter.

The work performance of the DHEs is very important in the delivery of health services to the citizens of the country. This is because it is the DHE that presides over the district health system, a cornerstone of the health system in Zimbabwe (Muchekeza, et al., 2012; Government of Zimbabwe, 2001). A system can be thought of as an entity that is made up of interrelated and interdependent parts which together work towards a common objective. According to Vaughan and Morrow (1989), the district health system is an entity which brings together the district hospital, local government, intersectorial coordination, community participation, Government and Non – Governmental Organization collaboration, rural health centres, health programme managers and other health – related organizations and activities.

1.1 BACKGROUND TO THE STUDY

According to Vaugham and Morrow (1989), the district is the most peripheral unit of local government and administration. It has comprehensive powers and responsibilities. Vaugham and Morrow (1989) note that a typical district has a population ranging from 100 000 to 160 000. It is at the district level that work activities that have a direct impact on people are carried out; where bottom–up planning by the community takes place and top–down planning by the central government also takes place. The district health office is found within the district. It is the centre of a network of health activities (which it coordinates), ranging from the village level to the district level (Vaughan and Morrow, 1989).

The district health office is normally run by a district health management team. In Zimbabwe, the district health management team is referred to as the District Health Executive (DHE) (Ministry of Health and Child Welfare, 2001). According to the Ministry of Health and Child

Welfare (MOH, 2001), the DHE directs the operations of the district health system and it (the DHE) is led by the District Medical Officer (DMO). The DHE is made up of the DMO, the District Health Services Administrator (DHSA), the District Nursing Officer (DNO), the District Health Environmental Officer (DEHO), the Pharmacist and the Accountant. This is the standard composition of the DHE. However, the composition may vary from district to district depending on the situation on the ground. Some DHEs co-opt members such as the matron, the laboratory scientist or the rehabilitation technician. Co–option depends on issues to be discussed or situations peculiar to the district.

The DHE has the mandate to make decisions on any issue pertaining to health within the districts it operates in. According to the MOH (2001), the DHE directs the operations of the health delivery system at the district level. Muchekeza, *et al.* (2012) in a study of the performance of DHEs, note that the DHE is responsible for the district health system, which is the cornerstone of the health system in Zimbabwe. The DHE is accountable for the following responsibilities, according to the MOH (2001): supervising and coordinating local health activities (be they public, private or NGOs); drawing up annual health plans, management of health related development and local health budget control; collecting, analysing and making decisions on the basis of health information; management and development of human resources; coordinating the training and supervision of community health workers; provision of logistics for programme implementation, and; supporting national essential health research, among other responsibilities. In a nutshell, the DHE is responsible for any issue pertaining to health such as finance, human resources, health information, logistics and health research.

The DHE fulfils its mandate through a number of activities: carrying out meetings; planning and coordinating activities; monitoring and evaluation of programmes; auditing of financial and management systems, and; implementation of programmes, among other activities.

Carrying out meetings is a very important function of the DHE. Meetings are held as a means of coordinating health activities (Amonoo – Lartson, Ebrahim, Lovel and Ranken, 1989). They are convened to discuss problems that are common to health personnel, to review progress of plans, to plan future work and to resolve conflicts, among other purposes. The DHE is responsible for making sure that major meetings such as DHE meetings, Heads of

Departments meetings, District Health Team meetings are held and that minutes of the meetings are produced and circulated as required by policy. Policy requires that meetings be held twice every month (MOH, 2001). The minutes should be printed and submitted to each DHE member and a copy submitted to the Provincial Medical Director's (PMD) Office.

Planning and coordination, another important function of the DHE, enables the DHE to target and finance important health activities (Jira, Feleke and Mitike, 2004). It is necessary to target specific activities given the fact that budgets allocated to the public health sector are continually getting reduced (Sithole, 2013) and that the budgets should be deployed effectively and efficiently. Planning provides the DHE with direction and a means of measuring progress (or lack of the same) towards targets.

Monitoring and evaluation of health activities, done primarily through support and supervision (National Health Strategy for Zimbabwe (NHSZ) 2009 – 2013; MOH, 2001), is an important function of the DHE. Support and supervision ensures that standard operating procedures (SOPs, standardized ways of carrying out activities) – sometimes referred to as systems – are in place and that they are being followed by the health workers in the process of carrying out their activities. This DHE function ensures that desired results are achieved and that challenges encountered by the health staff members are resolved. The DHE utilizes or should utilize checklists to ensure that support and supervision as an exercise is effective and comprehensive. While the DHE supports and supervises the Rural Health Centre (RHC) staff, the DHE is supervised by the Provincial Health Executive (PHE) (MOH, 2001) and by the DMO (MOH, 2001). During and after support and supervision, discussions are held with staff on problems they are facing and solutions are found and implemented. The DHE writes comments in the management book kept at each RHC as feedback that RHC staff should act on, and also as evidence that support and supervision is offered to the RHC. The same applies to the DHEs. After support and supervision, the PHE writes feedback in the DHE management book.

Auditing is another important function of the DHE, done to ensure that financial and management systems – SOPs – are in place and that they are being followed (Government of Zimbabwe 1, 1984). SOPs assist to ensure that there is good corporate governance – which is

basically ensuring that management are responsible and accountable, and that there is fairness and transparency when transacting on behalf of the government. Among other functions, the DHE also ensures that health programmes such as Extended Programme on Immunization (EPI), Malaria Control, and Opportunistic Infection/ Anti – Retroviral Treatment (OI/ART) are carried out.

The activities carried out by the DHE can and are used for assessing the performance of the DHE. For example, the researcher went through the auditing reports by internal auditors (MOH) and external auditors on the financial and management activities of the DHEs in Mashonaland East. The researcher concluded that the DHEs in Mashonaland East were not doing well in terms of complying with financial and other management systems and standards as is required by government policies (Government of Zimbabwe, 2012; Government of Zimbabwe, 1984). The researcher also noted that for those DHEs in Mashonaland East who submitted their minutes to the PMD's office, they last submitted the minutes in 2012 and that out of those that submitted, the highest number of copies of minutes submitted was 11 out of the required 24. In 2013 only one DHE submitted minutes to the PMD. These observations are consistent with the results of the researches carried out by Kwambana, et al. (2013), and by Mwazungunya (2009) in Mashonaland East; and the one carried out by Muchekeza, *et al.* (2012) in Midlands Province. These researches concluded that DHEs in both provinces were not doing well in terms of work performance (see details in the literature review chapter). In addition to the above, the trainings carried out by the MOH (2011) in conjunction with the Department of Community Medicine, University of Zimbabwe (2011) were an acknowledgement that the decline of some of the health indicators is attributed not only to economic hardship, the Human Immuno–deficiency Virus (HIV), and other causes, but also to the inadequacies in the DHEs management skills. Although Muchekeza, *et al.* (2012) point out that management trainings were carried out starting from 2011, the study by Kwambana, *et al*. (2013); and the number of copies of minutes submitted to PMD's office by DHEs and the audit reports for DHEs in Mashonaland East analyzed by the researcher suggest that the trainings appeared to have been ineffective.

1.2 STATEMENT OF THE PROBLEM

The vision of the Ministry of Health and Child Welfare (MOH) is stated in the National Health Strategy for Zimbabwe (NHSZ 2009-2013, p22): "The Government of Zimbabwe desires to have the highest possible level of health and quality of life for all its citizens, attained through the combined efforts of individuals, communities, organizations and the government, which will allow them to participate fully in the socioeconomic development of the country". To achieve this vision, it is important for the DHEs to perform their work as expected since they preside over the district health system, a cornerstone of the health system in Zimbabwe. However, evidence demonstrates that DHEs are performing below standard. Some of the possible causes as mentioned in some studies may relate to lack of training, lack of resources, lack of knowledge on the functions of DHEs and lack of teamwork.

1.3 AIM AND RESEARCH OBJECTIVES

1.3.1 Aim

The aim of this research is to characterize the work performance of DHEs and find out the key dimensions that influence their work performance in Mashonaland East Province.

1.3.2 Objectives

a) To find out the role of supervision on the work performance of DHEs in Mashonaland East.

b) To establish the influence of management development on the work performance of DHEs in Mashonaland East.

c) To determine the role of teamwork on the work performance of DHEs in Mashonaland East.

d) To find out how conditions of service impact on the work performance of DHEs in Mashonaland East.

e) To establish the gaps in the literature and conceptualize a framework that explains the work performance of DHEs in Mashonaland East.

1.3.3 Research questions

1.3.4 Main research question

How do we characterize the work performance of DHEs and which key dimensions influence their work performance?

1.3.5 Sub questions

a) How does supervision influence the work performance of the DHEs in Mashonaland East Province?

b) How does training affect the work performance of DHEs?

c) How does teamwork influence the work performance of DHEs in Mashonaland East?

d) How do conditions of service influence the work performance of DHEs?

1. 3.6 Research Proposition

P: The DHEs may not be performing their work to higher expectations for a number of reasons including: inadequacy in training; lack of motivation; inadequate supervision; lack of teamwork, and; inadequate resources.

1.4 JUSTIFICATION OF THE STUDY

The DHE presides over the district health system, a cornerstone of the health system in Zimbabwe (Muchekeza et al., 2012). Comprehension of the key dimensions having a bearing on the performance of the DHEs in Mashonaland East Province will enable the authorities to come up with strategies that will enable the DHEs to perform to higher expectations and contribute to the realization of the vision, mission and objectives of the MOH.

1.5 SCOPE OF THE RESEARCH

The aim of this research is to study the dimensions that influence the work performance of DHEs in Mashonaland East Province. At least three health institutions will be covered. Data will also be sought from key informants who are experts on and have substantial experience in issues that have a bearing on the performance of DHEs.

1.6 CHAPTER SUMMARY

This chapter started with an introduction, followed by a background to the problem. The chapter introduced the DHE as the district health management team that runs a district health office, presiding over the health delivery system, the foundation of the health system in Zimbabwe. A description was given of the mandate of the DHE. A statement of the problem was given, as well as the justification and the scope of the study.

CHAPTER TWO: Literature Review

2.1 INTRODUCTION

This study falls within the Human Resources Management discipline which, among other issues, deals with the work performance of human resources. The first section of this chapter will focus on the theoretical literature that is relevant to the identified problem of work performance, that is, theories on work motivation. The second segment of the chapter will focus on work performance literature and how work performance is influenced by some dimensions such as supervision, teamwork, training and conditions of service or work. The last segment will present the conceptual framework, and the chapter will close with a summary. The purpose of literature review is to avoid reinventing the wheel (Jankowicz's 2005; cited in Saunders, et al., 2009), but building on existing knowledge by identifying gaps in literature and bridging the knowledge gap by providing new knowledge through research.

2.2 THEORETICAL REVIEW

The theories that are relevant to work performance are motivation theories. Lucey (1995) defines motivation as the driving force or commitment people have of doing something; in this case, the driving force to perform work. According to Armstrong (2006) the theory of motivation is concerned with why people at work behave in the way they do and studies the process of motivation. Arnold, et al. (1991; cited in Armstrong, 2006) list three components of motivation, namely: direction (what a person is attempting to do), effort (vigorous physical or mental exertion) and persistence (the duration a person keeps on trying something). Armstrong (2006) notes that a needs–based model of the process of motivation proposes that motivation begins when an individual recognizes an unsatisfied need. The person then sets a goal, takes action to achieve the goal and in the process satisfies the need. He further notes that motivation can either be intrinsic (motivation generated from within an individual) or extrinsic (motivation that is induced by doing something to or for the people, such as giving them rewards, praise or promotion). Armstrong (2006) points out that although extrinsic motivation is immediate and powerful in terms of its effect, it has a shorter duration than intrinsic motivation, which is deeper and long – term in terms of effect because it is inherent in individuals.

Armstrong (2006) notes that the most influential motivation theories have been classified as instrumental theory (concerned with rewarding or punishing people so that they behave in a desirable way), content theory (where an individual identifies a need, sets goals and takes action to satisfy the need) and process theory (which concerns itself with the psychological processes that influence motivation). Maslow's hierarchy of needs theory and Herzberg's two – factor theory have been classified as content theories (they both propose that an individual's performance is influenced by basic needs, as noted by Armstrong, 2006 and Lucey, 1995) while the Expectance Theory (Vroom, 1964), the Goal Theory (Latham and Locke, 1979) and the Equity Theory have been categorized as process theories (Armstrong, 2006).

Although Lucey (1995) and Armstrong (2006) note that Herzberg's two – factor theory provides an influential insight into motivation and continues to thrive, the latter has pointed out that the model has been attacked on the basis of its failure to measure the relationship between satisfaction and performance. It has been suggested that the small and specialized sample used in the research did not warrant the wide generalization that the researchers arrived at. However, the theory is easy to understand and seems to be based on the empirical world experiences, which partly explain its continued influence and its huge impact on the job enrichment movement (Armstrong, 2006).

Guest (1992a; cited in Armstrong, 2006) argues that a much more relevant approach to motivation is provided by the process theory, given that Maslow's and Herzberg's theories have been demonstrated by widespread research to be wrong. This point is reinforced by Armstrong (2006) who notes that the process or cognitive (affecting people's perceptions) theory provides a more concrete guide to motivation methods as compared with content theories.

The Expectance theory originated from Vroom's (1964) valency – instrumentality – expectancy (VIE) theory (Armstrong, 2006). According to the theory, in choosing between alternatives with uncertain outcomes, an individual will not only choose an outcome that is preferable, but also one which is most likely to materialize. Therefore, motivation takes place when there is a clearly perceived relationship between performance and outcome. This is why extrinsic motivation works only if there is a clear relationship between effort and reward, whereby the reward is worth the effort. Great effort will be exerted if the reward is both great in value and also if the probability is high that receiving the reward depends on effort.

Goal theory (Latham and Locke, 1979; cited in Armstrong, 2006), proposes that motivation, and consequently performance increase if specific, difficult but accepted goals are set, and when there is feedback on performance. There is need for participation in setting goals on the part of the individual who will implement them. The achievement of the goals is strengthened if there is guidance and advice. Feedback makes the implementer aware of how s/he is fairing and has the effect of maintaining motivation.

Equity theory concerns itself with the perception of people concerning how they are being treated as compared to others. It is a perception of fairness, not equality. Armstrong (2006) notes that equity is about feelings and perceptions concerning the treatment people receive in comparison with others. Equitable treatment motivates people. On the other hand, inequitable treatment leads to de-motivation. Adams (1965; cited in Armstrong, 2006) suggests that there are two forms of equity: distributive equity and procedural equity. Distributive equity is where people consider the fairness of the rewards they get in accordance with their contribution compared with the rewards other people get in accordance with their contribution. If people feel that they are contributing more but are rewarded less than those who are contributing less, then the people feel that there is no fairness. Procedural justice refers to people's perception regarding the fairness with which issues such as performance appraisal, promotion and discipline are conducted.

Guest (2011) points out in his work that considerable progress has been made in research on human resource management (HRM) and performance. This was in spite of the fact that although an association between HRM and performance had been demonstrated, research had not been able to explain the demonstrated link (between HRM and performance) in a convincing way. In the search for the explanation, Guest (1977; cited in Guest, 2011) contended that there is need for a theory that explains the link between

HRM practices and outcomes. Guest (1997) and Becker, et al. (1997; cited in Guest, 2011) argued in favour of an approach that was based on Expectancy Theory as espoused by Vroom (1964; cited in Guest, 2011). A variant of the approach as advocated by Appelbaum, et al. (2000; cited in Guest, 2011) and Purcell and Hutchinson (2007; cited in Guest, 2011) resulted in a model that came to be called the Ability, Motivation and Opportunity (AMO) model.

A different approach, based on Barney's (1991; cited in Guest, 2011) resource – based view (RBV) theory, was developed by Wright, et al. (1994; cited in Guest, 2011) and Lepak and

Snell (1999;2002; cited in Guest, 2011) and focused on investment in human resources that resulted in high performance and competitive advantage. An interesting and most recent development was the adoption of an approach that focused on the role of the worker and the perception and behaviour of the worker in understanding the relationship between HRM and performance. Guest (2011) points out that previous research had neglected the voice and role of the worker, but the realization that the worker's role had been neglected led to the remedying of that neglect. The neglect of the role of the worker had led to the development of a critical view advanced by Cappelli and Neumark (2001; cited in Guest, 2011) and Godard (2004; cited in Guest, 2011) to the effect that any gains in performance from HRM was at the expense of the workers rather than their positive response to it. According to Guest (2011) the focus was on the extent to which it is feasible for HRM to result both in higher performance and improved workers' well – being.

In connection with the link between HRM and performance, Guest (2011) asks very interesting questions. For example, is there one high commitment form of HRM that has a link with high performance? Other than high commitment HRM, are there other ways of managing people at work that lead to high performance?

2.3 EMPIRICAL REVIEW

Various researchers and authorities have written extensively on the concept of performance and the factors that affect it. According to Koopmans, Bernaards, et al. (2011) work performance is an abstract concept and is made up of multiple dimensions.

The dimensions can be operationalized in terms of indicators. Koopmans, et al. (2011) note that there are many definitions of work performance, and argue that the definition that has been widely endorsed is the one by Campbell (1994; cited in Koopmans, et al., 2011: p856): "behaviour or actions that are relevant to the goals of an organization." Koopmans, et al. (2011) contend that any definition of work performance should be in terms of behaviour rather than results. However, they acknowledge the difficulty of distinguishing between behaviour and results and note that other authorities actually define work performance in terms of results. For example, Viswesvaran and Ones (2000: p8) define work performance as "scalable actions, behaviour or outcomes that employees engage in or bring about that are linked with and contribute to organizational goals."

Koopmans, et al. (2011) also distinguish between work performance and work productivity, with the latter meaning input divided by output (Kemppila, et al., 2003:p2; cited in Koopmans, et al., 2011). According to Anitha (2013) performance is outcomes achieved and accomplishments made at work. Other definitions of work performance have been given, for example, by Elger (www.webs1.uidaho.edu/ele/.../Theory%20of%20Performance.pdf*) and by Scholl and Schmidt (2003).* Elger (*www.webs1.uidaho.edu/ele/.../**Theory**%20of%20**Performance**.**pdf***) argues that performance is like a journey, not a destination. He refers to a particular location in the journey as a "level of performance". He considers that effectiveness or quality characterize each level of a performance. For example, as a nurse improves his level of performance, he is able to make a thorough and comprehensive diagnosis of a condition or disease, and to offer a more effective medical prescription. As a manager progresses in his levels of performance, his ability to organize people and resources becomes more effective and the results he gets are of a higher quality.

Scholl and Schmidt's (2003) have come up with a model of determinants of performance made up of four crucial variables: effort (motivation); ability, skills and competences; role perception, and; resources. According to Scholl and Schimdt (2003), level of performance depends on the effort exerted, all things being equal. High performance by an employee depends on the possession of appropriate skills. An employee will meet his/her boss' performance expectation if s/he has a clear idea of what the expectations are. Last but not least, performance will be possible only if the necessary resources are available.

Scholl and Schmidt (2003) refer in their model to concepts that management should concern themselves about, that is, employee membership (attracting and retaining employees in an organization), employee morale or satisfaction (positive evaluation of the organization and work aspect by the employee) resulting from met expectations and confirmation of one's identity (characteristics, values and competences), organizational or employee commitment (which manifests itself through identification with the organization, loyalty and high levels of behaviour that goes beyond required performance on the part of the employee).

Job performance is made up of three elements, which according to Blumberg and Pringle (1982; cited in Perera, G. D., Khatibi, A., Navaratna, and Chinna, K., 2014) are ability variables, motivation variables and environmental variables. Work environment refers to

what is found in the environment like noise level, dust, and leadership and group characteristics of the job; motivation refers to that which drives an employee to carry out the job, and; ability variables are the employee's capacity or capability to do the job. The three variables have the capacity to influence performance, not only that of the individual employee, but also the performance of an organization, or, in this case, the performance of DHEs.

In the Zimbabwean context, there is also some literature on work performance which deals directly with the performance of DHEs. For example, Mwazungunya (2009) carried out a study on support and supervision by DHEs in RHCs in Mashonaland East Province. The study concluded that support and supervision by complete DHEs was non–existent, with only programme heads going out to support their programmes, and consequently only focusing on their programmes. A study carried out by Muchekeza et al (2012) in Midlands Province concluded that the DHEs were below expectation. They used indicators such as the number of meetings held by DHEs, the number of support and

supervision visits to each health centre, the number of District Health Meetings (DHT) held, the number of quarterly reports submitted to the PMD's office, the number of disease surveillance meetings held, and the availability of work plans. These were compared with the expected standards and it was found that the performance of the DHEs fell short of the standards. Kwambana, et al. (2013) carried out a study on the performance of DHEs in Mashonaland East Province using more or less the same indicators. Their conclusions were that DHEs did not perform well in the 2012. The study of DHEs in Midlands attributed the unsatisfactory performance to lack of resources, lack of management training, lack of teamwork, lack of supervision, and lack of motivation. The study by Kwambana, et al. (2013) on the performance of DHEs in Mashonaland East attributed below–standard performance by DHEs to inadequate resources, lack of teamwork, lack of management training, lack of supervision and lack of motivation. These reasons are the same as those found in the study by Muchekeza, et al. (2012).

In going through this literature, issues to do with work performance that keep on recurring are motivation, ability, skills, resources, supervision/ leadership, training, the environment and lack of teamwork. The section that follows (the dimensions influencing performance) takes into account the key dimensions influencing performance (motivation/conditions of service or

work; supervision; training and teamwork, as suggested in the literature above and focuses on them), in an attempt to establish their effect on performance. The sense or connotation in which the term "performance" is being used in this research is that by Viswesvaran and Ones (2000) which is the same as "outcome".

2.4 DIMENSIONS INFLUENCING WORK PERFORMANCE

2.4.1 Supervision

The term "supervision" has been defined in various ways by different authors. Typically, it is the process of overseeing the work of employees–their progress towards the achievement of organizational objectives, and their productivity. Supervision is a management activity. The term "supervision" has been associated with other concepts like management, direction, controlling, and leadership. While supervision deals with

giving people direction (Cole, 1966), management is concerned with planning, organizing, leading and controlling. Chandan (2005) gives a distinction of three levels of management, namely: top, middle and bottom level management, where the higher level of management supervises the level of management immediately below it.

Supervision is associated with the concept of controlling, where controlling is viewed as an important aspect that ensures that actual activities are carried out in terms of the dictates of the original plan (Stoner, et al., 2006). If performance is deviating from the plan, the controlling process is activated in order to bring back the activities in line with the plan. The process of monitoring to ensure conformity of performance with the original plan is the function of support and supervision. The control function works effectively where standards of performance have been set; performance is measured on the basis of the standards, and; the results of performance are compared with the standards. Supervision has also been associated with the concept of leadership. For Carter (2008) there is a close relationship between supervision and leadership, although supervision can be subsumed under leadership.

The USAID (2008:1) define supervision as "the process of guiding, helping and encouraging staff to improve their performance so that they meet the defined standards of their organization" (http://www.initiativesinc.com/resources/publications/docs/SSguidevol1.pdf: accessed on 28 May 2014) Jira, et al. (2004: 58) define supervision as "… a teaching – learning process of ensuring that workers execute the work and spend money as per plan."

Marquez and Kean (2002: 4) define supervision as the "process of directing and supporting staff so that they may effectively perform their duties." They further note that it is a "process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, optimizing the allocation of resources, promoting high standards, teamwork and better two–way communication." [cited in National AIDS Control Programme (NACP) 2010: 8].

The importance of supervision has been noted by various authors (Marquez and Kean, 2002; USAID, 2008; *www.sagepub.com/upm-data/58975_Creaner.**pdf***; Carpenter and Webb, 2012; Hernandez et al., 2014, and others). There is extensive consensus within the international health community that the delivery of basic health services depends in part on supervision, which is a critical part of human resource management (Marquez and Kean, 2002). Health delivery, the provision of health services, is labour–intensive in nature. One way of improving health care and the performance of the health system is the use of supervision (Marquez and Kean, 2002), a means of getting things done, and it is one of the most direct ways of controlling what employees do. However, Marquez and Kean (2002) note that although supervision provides vital support for health service delivery, it has not been possible to achieve the "promise" of supervision given its tendency to place emphasis on inspection, a point which is corroborated by Hernandez, et al. (2014), who point out that supervision is characterized by inspection and fault–finding. Hernandez, et al. (2014) note that non–supportive supervision leads to de-motivation as health workers feel that their efforts go unnoticed while mistakes are pointed out immediately. The tendency to lean towards **inspection** and **controlling** activities in the supervision process may be traced to some definitions of the concept by authorities such as Gillies (1994), whose view of supervision is that it includes inspecting another person's work, evaluating his performance and approving or correcting performance.

An analysis of the development of supervision has led Basavanthappa (2000) to conclude that supervision was originally conceptualized in terms of inspection and finding fault with the supervisees' work performance. Depending on the outcome of the inspection, the supervisee would either be rewarded or punished and the supervisor was viewed as being not responsible for the employee's performance. Hutchins (1994) differentiates supervision from inspection by pointing out that in supervision, the supervisor is partly responsible for the performance of the supervisee, while in inspection s/he is deemed not to be responsible. Hernandez, et al.

(2014) note that an important condition in which supervision as an organizational intervention may contribute to performance, which condition is also in keeping with international recommendations, is that supervision needs to take a supportive approach that fosters quality through the identification and resolution of problems, strengthened relationships and constructive feedback. The researchers cite studies of district–level supervision of health workers which demonstrate that key techniques such as developing partnerships and problem–solving can contribute to increased productivity and health worker motivation, but point out that these techniques were implemented at low levels in the places that they carried out their studies.

Studies that have been carried out by other researchers have further demonstrated the importance and criticality of supervision as an organizational intervention in linking the work of health workers to the health system. For example, Karimi, et al. (2014) studied the extent to which the behaviour of a supervisor is associated with the behaviour of neglecting a job on the part of employees. Job neglect referred to withholding effort, a type of counter-productivity, according to Spector and Fox (cited in Karimi, et al., 2005). Kidwell and Robie (2003; cited in Karimi, et al., 2014) considered job neglect as manifesting in employee behaviour in the form of showing up late for work, avoiding the supervisor, giving less effort and taking more frequent or longer breaks than had been permitted by the supervisor. Job neglect had the effect of having a drain on productivity, and it violated a manager's expectation of a fair day's work.

Karimi, et al.'s (2014) findings demonstrate that both positive and negative behaviour on the part of a supervisor had an effect on the job neglect behaviour by an employee. Tepper (2000; cited in Karimi, et al., 2014) argues that people have a tendency to avoid negative stimuli, and that a bad supervisor can be a negative stimulus in the workplace. Brunetto, Y., Farr–Wharton, R. and Shacklock, K. (2010) have shown the important association between management practices and policies on the one hand and organizational commitment. They studied the supervisor–subordinate workplace relationship and its impact on the morale of nurses in Australia. They found that there was low moral among nurses in the public sector as compared to the private sector. One of the reasons for such a result was that health sector reform in the public sector brought about increased control–based management. Brunetto, et al. (2010) note that there was an emphasis on compliance and obedience as compared to

commitment, authority over participation and also an emphasis on formal rules as compared to the informal rules. The researchers argue that far from viewing the new form of management as best practice from the point of view of employees, health–care management could have mistakenly thought that this new form of management was in keeping with best practice. Brunetto, et al. (2010) emphasized the need for management to review their management style given that nurses reported being entirely dissatisfied with their supervisors. They recommend the need for policy–makers to ensure that mechanisms are put in place to facilitate and support participative supervisor–subordinate relationships and a paradigm shift from the compliance model of supervision to the commitment model of supervision, which happens to be one of the aims of the NHSZ (2009 – 2013).

Basford (2014) studied the impact of supervisor transgressions which included demeaning insults, inconsiderate treatment, disregard of opinion, underprovided recognition, unfair employment decisions, undue demands, false accusations, performance criticisms and undersupplied resources. Several key organizational outcomes such as turnover and psychological withdrawal (Shapiro, et al., 2011; cited in Basford, 2014), job performance (Harris, et al., 2007; cited in Basford, 2014), job satisfaction (Tepper, 2000; cited in Basford, 2014), engagement (Reio and Sanders- Reio, 2011; cited in Basford, 2014), and many others were caused by the negative impact of the above–mentioned supervisor transgressions.

Bisel, et al. (2012) argue that the supervisor–subordinate communication is a working relationship that is unique to and perhaps very defining of the world of work. This relationship – which is power-laden – creates an environment that shapes interactions, expectations, and outcomes. These (interactions, expectations, and outcomes) are both for good and for ill. The researchers note that supervisor–subordinate communication research should focus on how communication behaviours peculiar to supervisor–subordinate relationship shape or are shaped by what they refer to as system–level organizing, rather than on downward communication, or on the dyad level.

Bisel, et al. (2010) explain in their paper that the command structure (for example, organizational charts, organizational policies, reporting relationships, etc.) determines relational contexts that both facilitate and at the same time restrain the interaction between supervisors and their subordinates and also between subordinates and supervisors. The structures have the effect of formalizing the supervisor–subordinate relationship. The context,

as highlighted by Drew and Heritage (1992; cited in Bisel, et al. 2010), becomes very important in shaping institutional interaction. Bisel, et al. (2010) believe that command structures are vital social influence tactics which were created out of the need to coordinate actions with others for the accomplishment of tasks, which however, is a very big achievement. Commands, orders, directions and instructions are routinized and concretized by the communicative attempts, that is, the command structures. This way, actions may be coordinated and super-ordinate goals are accomplished.

When engaged by an organization, employees forfeit the freedom to use their time and effort as they please in exchange for payment, and also in addition, for status, self esteem, and respect as enshrined in the employment contract (Stohl and Cheney, 2001; cited in Bisel, et al., 2010). Emanating from this arrangement, subordinates expect directives from their supervisors. However, at the same time sociologists such as Goffman (1967; cited in Bisel, et al., 2010) and Brown and Levinson (1987; cited in Bisel, 2010) have observed that individuals in society spend a lot of their effort trying to maintain their independence and also helping others maintain independence.

Bisel, et al. (2010) point out that getting another person to take orders is a threatening action because the other person wants to maintain his or her freedom. However, the command structure as explained above takes care of this potential problem of loosing autonomy as the subordinates expect directives from their supervisor. In order to produce an image of authority and to avoid appearing weak, supervisors need to uphold credibility in the presence of subordinates (Gronn, 1983; cited in Bisel, et al., 2010). Campbell (2007; cited in Bisel, et al., 2010) points out that the supervisor, in giving orders to the subordinate, does not have to worry about insulting the public image of the subordinate because of the hierarchical relationship obtaining.

According to Yukl (2006; cited in Bisel, et al., 2010), a subordinate must look credible in front of a supervisor in order to survive and thrive in the place of work. Foolishness and untrustworthiness may lead to negative evaluations by the supervisor, threatening job security and advancement. There is therefore reluctance on the part of the subordinate to disagree with the supervisor lest they give the impression that they are untrustworthy and are failing to show deference to the supervisor. As Goffman (1967) would put it, to be denied deference is to be told that open insurrection has begun, which in itself is a threatening occurrence on the

part of the supervisor. Bisel, et al. (2010) point out that subordinates do not want to offend their supervisors. Offending a supervisor puts one's financial well–being at stake, which is not the same as offending a friend or a family member.

Bisel, et al. (2010) argue that subordinates do not speak out on issues that would damage their images and their relationships with their supervisors, even if the issues are relevant for the survival of an organization. At the same time, Bisel, et al. (2010) are of the view that subordinates have the ability to scan internal deficiencies and external threats which they can communicate to the supervisor who has the authority to take adaptive action for an organization to both survive and thrive. If knowledge and information are communicated freely, an organization would be in a position to learn about its environment for it to adapt and survive. Schein (1993; cited in Bisel, et al., 2010: 138) explains that "organizational effectiveness is therefore increasingly dependent on valid communication across subculture boundaries … Dialogue is … at the root of all effective group action."

The literature on supervision shows that supervision, as part of human resource management, is an institutional intervention which provides critical support for work performance. The concept has been defined in various ways by different authors and researchers. In the early stages of the development of the concept, scholars appear to associate it with inspection and fault finding (Rue, et al., 2003; Basavanthappa, 2000, and; Gillies, 1994). On the other hand, recent and current views on supervision understand the concept in a different but important way. The recent and current views of the concept put emphasis on the supportive approach to supervision (Marquez and Kean, 2002; Jira, et al., 2004; USAID, 2008; NACP, 2010, and; Hernandez, et al., 2014). The supportive approach encourages the strengthening of relationships, identification and resolution of problems and the provision of constructive feedback. Various authorities have made various contributions concerning what good supervision is and should be like.

For example, Carpenter and Webb (2012) point out that good supervision considers assisting the supervisee with the task, establishing a positive relationship with the supervisee, and providing the supervisee with social and emotional support. Jira, et al. (2008) note that a good supervisor coaches his/her subordinates on many aspects of the job, including setting appropriate goals, coming up with action plans and the timeframes. USAID (2008) notes that

good supervision recognizes that the only way to improve the performance of subordinates in the long term is to encourage them to want to perform well as well as the guidance to perform well.

2.4.2 Research Gap

Hernandez, et al. (2014) point out that further research is required of the supervisors' interpretation of their part in the supervision process and the manner in which their managerial style is generated in order to pin down aspects that can be fortified in order to foster implementation of more supportive supervision.

2.4.3 Training

Training has been defined in a number of ways by different authorities. According to Vukovic and Miglic (2006, cited in Dermol and Cater, 2013), training is a "systematic development of competencies needed by employees to perform their work." Goldstein (1986: p837; cited in Rahman, et al., 2013) has defined training as "the systematic acquisition of skills, rules, concepts or attitudes that result in improved performance." There are a number of other definitions for training.

Many authors, for example, Rahman, et al. (2013); Lancaster, et al. (2013); Bhatti, et al. (2013), and; Dermol and Cater (2013), agree that training is important because it provides the skills, abilities, knowledge and attitudes that are necessary for an employee to discharge his or her duties satisfactorily. Dermol and Cater (2013) note that training is not simply aimed at plugging the gap of missing knowledge, but also to update, revise and systematize the knowledge, skills, abilities and habits of workers. Training is not only related to the current situation, in which the requirement for training may be triggered by the need for workers to gain new skills, abilities, etc, to make new products or deliver new services that meet new demands both by clients and changing environments, but it is also meant to meet future needs of the employees and the company.

Rahman et al. (2013), Dermol and Cater (2013), Hitt, et al. (2001; cited in Rahman, et al., 2013), and Bhatti, et al. (2013); Kalargyrou and Woods, (2011), and Sail and Alavi 2011) all agree that although it enables employees to gain knowledge, skills, abilities and attitudes to improve their performance and that of the organization, training per se does not guarantee improved performance; that training in itself is strongly linked to the acquisition of

information and its interpretation, and is not linked to the occurrence of cognitive and behavioural changes in a company; and that knowledge gained through training must be effectively transferred in order for an organization to gain the full benefits of training. Rahman and Bennet (2013, cited in Rahman, et al. (2013) note that practitioners have reported failure to reap the full benefits of training given that employees who were trained failed to transfer the knowledge they gained through training to their workplace. Bhatti, et al. (2013), citing several researches, are also in agreement that there is much evidence to the effect that although training takes place, training transfer would not have taken place. Mackay (2009, cited in Bhatti, et al., 2013) notes that organizations are not getting the results that they expect from training employees. So, there is general consensus among researchers and authorities (Bhatti, et al., 2013; Dermol and Cater, 2013; Lancaster, et al., 2013; Rahman et al, 2013, and; Pineda–Herrero, et al., 2011) that training alone is not sufficient for effective training to be said to have taken place, and as Bhatti, et al. (2013) point out, training transfer– a concept that has gained considerable attention among training professionals and researchers–is, among other elements, an important aspect of the training effectiveness criteria.

Hilton, et al. (1997, cited in Bhatti, et al., 2013: p 275) have defined the term "training transfer" as "the degree to which trainees apply to their job the knowledge, skills, behaviour and attitudes they gained in training." Broad and Newstrom (2001: p6, cited in Yaw, 2008) define training transfer as the degree to which trainees apply to their jobs the knowledge, skills and attitudes they gained in training." Baldwin and Ford (1988, cited in Pineda–Herrero, et al. (2011: p316) consider transfer of training as "the application of knowledge, skills, and attitudes learned during training to the workplace and the subsequent maintenance of these over a period of time." Transfer of training, following the above definitions, means making productive use of the knowledge gained through training at the place, or implementing the acquired skills at the place of work.

The focus on training transfer has been from different perspectives. From one perspective, training transfer has been viewed as one element of evaluating training effectiveness. This is true when one considers the models for the evaluation of training developed by several authors, such as Kirkpatrick (2005, cited in Pineda–Herrero, et al., 2011), Pineda (2002, cited in Pineda–Herrero, et al., 2011), and Swanson (1996, cited in Pineda–Herrero, et al., 2011), whose models are frequently used for the evaluation of training (Pineda–Herrero, et al.,

2011). Other authors, coming from a different perspective, have considered training transfer in terms of what factors determine it, instead of coming up with models that evaluate the results (Ford, 1988; Thayer and Teachout, 1995; Noe, 1996; Holton, 2006; Lim and Johnson, 2002; Nijman, et al., 2006; and Burke and Hutchins, 2008; all cited in Pineda–Herrero, et al., 2011) and their work is of special interest, according to Pineda–Herrero, et al. (2011). Pineda–Herrero, et al. (2011) note that the contributions of these authors are important because they permit us to comprehend the mechanisms that facilitate or hold back the transfer of training, and make it possible for us to develop strategies for optimizing training transfer. They conclude in their study that the key elements in the transfer of training are working conditions together with support to the process of knowledge application, a conclusion supported by Dermol and Cater (2013), who suggest that conditions of training transfer are created through a combination of training, supervisor support and organizational incentives.

Training cannot produce results unless continuously supported by management, who should also be involved in it. Dermol and Cater (2013), argue that cognitive and behavioural changes are encouraged by supervisor and organizational incentives, not by training itself. Contrary to the indication by Arthur, et al. (2003, cited in Dermol and Cater, 2013), that training based mainly on a combination of lectures, audio–visual methods, self–conducted learning, programmed learning and discussions (as the best combination of training) leads to positive impact on behaviour, Dermol and Cater (2013) argue that their research concludes that cognitive and behavioural changes (and resulting from these, company performance) are not linked to the quality of training, but mainly to supervisor support and organizational incentives. Possible examples of organizational support incentives or supervisor support were given as career goals, career opportunities, and reward and evaluation systems. Dermol and Cater (2013) conclude in their study that peer support did not appear to play an important role, probably because of the applied sampling method they used.

Lancaster, et al. (2013) note that in general, training transfer literature has focussed on the characteristics of the trainee, training design and the work environment. Blume, et al. (2010, cited in Lancaster, et al., 2013) give the most important characteristics of a trainee that have a bearing on training transfer as cognitive ability, motivation and personality. For instance, trainees with a high self confidence are more motivated to transfer training than their counterparts who have low self confidence. Opportunities to practice, varied training techniques, objectives and methods constitute the factor of training design. Lim and Morris

(2006, cited in Lancaster, et al., 2013) report that the alignment between training content and job function influences the degree of transfer of training. This means that a good training design should ensure that training content and job function are well aligned. Martin (2010) notes that a training programme that is properly designed and well delivered contributes in a major way to the transfer of training, as compared, of course, with one that is otherwise not properly designed and delivered.

Lancaster, et al. (2013) argue that the factors under work environment are the most difficult and least understood in enabling training transfer. Cromwell and Kolb (2004, cited in Lancaster, et al., 2013) give the factors as supervisor support, transfer climate and opportunities. Pineda–Herrero, et al. (2011) note that the key elements in the transfer of training are working conditions and support to the process of application. Supervisor support refers to the extent to which the supervisor is supportive in terms of encouraging, reinforcing and creating opportunities for the trainee to practice new behaviour (Birdi, 1997; cited in Lancaster, et al., 2013). By being supportive, supervisors signal the extent to which they value training. Martin (2010) notes that the attitude and behaviour of the supervisor of the trained employee is of particular importance in facilitating or hindering the transfer of learning and the application of skill. A supervisor who does not support the trained employee actually undermines the transfer of training. Lancaster, et al. (2013) point out that support by the supervisor in transferring training has been widely supported by other studies (Birdi, et al., 1997; Burke and Hutchins, 2007; Martin, 2010, Dermol and

Cater, 2013). According to Martin (2010), a supportive work environment also manifests itself through the manner in which both work is designed and skill application is rewarded. Martin (2010) considers peer support as another important aspect of the work environment. Peer support encourages training transfer by enhancing employees' feelings of self–confidence, providing them with feedback and also by coaching (Dermol and Cameron, 2013). Gilpin–Jackson and Bushe (2007, cited in Martin, 2010) argue that peer support may actually play a more important role in transferring training than supervisor support. Networking and idea sharing about skill application enhances skill transfer (Hawley and Barnard, 2005, cited in Martin, 2010). Bhatti, et al. (2013) supports Martin (2010) in considering that social support, in the form of peer support, plays an important part in training transfer.

There is general consensus among researchers and authors that training, although it is important because it equips workers with knowledge, skills, attitudes and behaviours that enable them to perform their duties satisfactorily, it is not sufficient on its own. There is need for the knowledge gained to be transferred to the workplace. The question is: what factors determine transfer of training? Several factors have been identified as having an influence on the transfer of training, for example, trainee characteristics, work environment and training design. Other factors cited are volume and quality of training, intrinsic rewards (which promote the retention of knowledge and it subsequent transfer at the workplace), the trainer (possessing knowledge, and being able to impart the knowledge in a way that encourages retention, technological skills, people skills, creativity, effectiveness in communication, humour and self–confidence), and content of training, which should be similar to the job tasks (boosting the self – confidence of the trainee). Some researchers argue that peer support is more important than supervisor support, while others are of the opinion that supervisor support is more important.

While some authorities place emphasis on the importance of trainee characteristics, training design and working environment as being necessary for application of knowledge to take place, other authors believe that effective training enables application of knowledge at the workplace (Arthur, et al., 2003; cited in Dermol and Cater, 2013); still others think that an expressive and organized lecture enhances recall by the participants, and this in turn facilitates transfer of training (Tower and Dipboye, 2001; cited in Ghosh, et al., 2012). Ghosh, et al. (2012) believe that effective training takes place when a trainer possesses good knowledge of the subject matter, coupled with good use of the teaching aids. In addition, interpersonal skills of the trainer are important to complement good knowledge of the subject as well as good use of teaching aids.

2.4.4 Research Gap

Dermol and Cater's (2013) study is limited to investigating only the most important training transfer factors discussed in literature. They acknowledge the existence of other training transfer factors (especially those related to the characteristics of trainees and training design.

2.4.5 Teamwork

Teamwork was identified in literature as one of the factors influencing the performance of

DHEs (Kwambana, et al., 2013; Muchekeza, et al., 2012). Different researchers and authorities have defined the term "teamwork" in different ways. Xyrichis and Ream (2008, cited in Olupeliyawa, et al., 2009) propose that teamwork in healthcare is a process that is dynamic. The process involves two or more healthcare professionals whose backgrounds and skills are complementary and who share common health goals. The health professionals carry out patient care activities through exercising concerted physical and mental effort. Baker, et al. (2005b, cited in Olupeliyawa, et al., 2009: p63) define teamwork as the "performance of two or more individuals, with specific roles, performing specific tasks, and interacting or coordinating to achieve a common goal or outcome." Ezziane, et al. (2012) view teamwork as the ability that a group possesses of working together. Olupeliyawa, et al., (2009) note that in these definitions, it is highlighted that teamwork requires healthcare professionals from different backgrounds who have complementary skills. The professionals must communicate, coordinate and collaborate in order to be able to perform interdependent tasks. Valentine, et al. (2011) give a somewhat different definition of the term "teamwork". Their definition, derived from organizational theorists, is that teamwork is the "quality of task–related and social interactions between team members" (Hoegl, 2006, cited in Valentine, et al., 2011).

Three aspects of the definition of teamwork worth highlighting are (a) interactions between individuals versus the quality of their collective activities; (b) teamwork depends both on task–related interactions and social interactions, and; (c) interactions occur between members of a team. Valentine, et al. (2011) note that teamwork can be assessed whenever health professionals, on the basis of the given definition, work interdependently for a goal which they share responsibly. The assessment becomes possible whether the professionals are organized into a team formally or informally. It is therefore possible to assess teamwork in the following contexts: within care delivery teams; project teams; management teams and other groups of professionals who work together to deliver special kind of clinical care such as intensive care unit staff. Given the above definition, an appropriate description of teamwork is, according to Valentine, et al. (2011), "the quality of the task–related and social interactions between interdependent workers."

There is a general consensus among researchers and authorities that teamwork is necessary and significant for the optimal performance of an organization. West and Lyubovnikova (2013) note that an accumulating body of evidence suggests a positive association between effective teamwork in healthcare and a number of outcomes such as reduced medical errors

(Manser, 2009; cited in West and Lyubovnikova, 2013), reduced stress (Cater and West, 1999; cited in West and Lyubovnikova, 2013), low absenteeism (Abualrub, et al., 2012; cited in West and Lyubovnikova, 2013) and increased patient safety (Firth–Cozens, 2001; cited in West and Lyubovnikova, 2013). Quality of teamwork in healthcare has also been demonstrated, in other studies, to have a relationship with reduced rates of hospitalization (Sommers et al., 2000; cited in West and Lyubovnikova, 2013), greater patient satisfaction (West, et al., 2011; cited in West and Lyubovnikova, 2013), and patient mortality in hospitals (West, et al., 2012; cited in West and Lyubovnikova, 2013).

Olupeliyawa, et al. (2009) enumerate the same benefits of effective teamwork as stated above and conclude that given the stated evidence, successful practice as a healthcare professional depends on successful teamwork, which is becoming increasingly emphasized because it results in quality care and reduced medical errors.

Berlin (2014), citing Katzenback and Smith (2003), points out that teamwork was introduced to improve workflow, to reduce the establishment of boundaries and to increase cooperation between health professionals. Health and medical care professionalization had resulted in the creation of boundaries and fragmentation of activities and the introduction of teamwork had the effect of integrating the various health professions. Ezzaine, et al. (2012) agree with West and Lyubovnikova (2013) that a growing body of evidence illustrates that teamwork has a high impact on the quality of care that is provided by health care institutions. Ezziane, et al. (2012) argue that teamwork, the ability of individuals to work collectively and in collaboration, although commonly undervalued, is a strategy that can be used to improve health care quality.

In support of the importance of teamwork, Longo, et al. (2005; cited in Goh, et al. 2013), argue that attempts to improve patient safety through the use of regulations, new reporting systems and measures, and information technology and malpractice systems, had a limited impact and were less satisfactory. These measures were introduced based on a wrong focus. Goh, et al. (2013) argue that the focus, instead, should be on those organizational factors that have an effect on patient safety, such as the patient safety culture, organizational learning and flexible organizational structures such as a collaborative teamwork environment with less emphasis on hierarchy.

Different researchers and authorities have looked at various factors that have a bearing on

effective teamwork. Ezziane, et al. (2012) have emphasized the importance of such factors as the ability to deal effectively with conflict, comprehensive decision–making and effective communication. The general consensus among researchers is that the ability to handle conflict successfully is significant in developing a successful team (Morita and Burns, 2014; Goh, et al., 2013; Ezziane, et al., 2012, and; Olupeliyawa, et al., 2011). Authorities and researchers also agree on the importance of the following in building an effective team: effective communication (Berlin, 2014; Morita and Burns, 2014; Goh, et al., 2013; Riley, et al., 2011, and; Olupeliyawa, et al., 2009), and decision – making (Ezziane, et al., 2012). Ezziane, et al. (2012) advise clinical leaders to cultivate independent thought and promote feedback on decisions from all team members. This would promote multi–disciplinary team decisions and at the same time eliminate work related hierarchies. Ezziane, et al. (2012) note that after a team has been built, members should be trained to ensure that the team performs effectively.

Ezziane, et al. (2012) point out that leadership is important for the development of an effective team. According to them, leaders should value management, teamwork, and leadership and communication skills as important disciplines. They also note that followership is as important as leadership. They argue that effective followership encourages flattened hierarchy. They also argue that a good follower thinks independently and critically, but they are loyal to their leader and organization.

Other researchers have considered other factors that lead to effective teamwork. For example, Berlin (2014) refers to "common incentives" that make possible for individuals to work for the common good, for example, shared responsibilities, long–term approach and the appreciation to be part of a healthcare team. Berlin (2014) also notes that successful teamwork needs autonomy (a point West and Lyubovnikova, 2013; and Tanco, et al., 2011 also take note of), trust and cooperation to be developed. Valentine, et al. (2011) point out that although there are problems that militate against teamwork, researchers and practitioners continue to have interest in research on teamwork.

Most authors agree that teamwork is important for the optimum performance of an organization. The researchers go on to make several other points on which they concur. For example, effective teams are autonomous. Hierarchy is not conducive to effective teamwork. Some of the important factors to build a team are effective conflict resolution; good leadership; and good communication.

Researchers and practitioners have failed to arrive at a common definition of teamwork, which makes the measurement of the concept difficult (Valentine, et al., 2011). Some researchers focus on team processes (Honts, et al., 2012) while others put emphasis on team structure (Morita and Burns, 2014; Crawford and Lepine, 2013, and; Honts, et al., 2012).

2.4.3 i) **Research Gap**

Future research needs to explore many effective ingredients of teamwork and any link between teamwork and improved value of care (Ezziane, et al., 2012). Also, future research needs to focus on how teamwork might be improved by particular types of training, and assessing the effectiveness and influence of team skills training on optimizing multidisciplinary interdependence in the health care environment (Fitzgerald and Davidson, 2008; cited in Ezziane, et al., 2012). Future research should not only focus on effective collaboration within teams, but also between teams (Bleakley, 2013, cited in West and Lyubovnikova, 2013).

2.4.6 Conditions of service

One of the main elements of the health system is human resources. For the health system to perform well, human resources not only have to be available, but they need to be motivated and retained. Extant literature on the motivation and retention of health workers in health institutions demonstrates the importance of a number of factors that together actually constitute what are called "conditions of service or work" and have a bearing on the motivation and retention of the same. For Herzberg (Armstrong, 2006; Lucey, 1995), conditions of service/ work are classified as hygiene factors. If conditions of service/ work are provided for, they would simply remove dissatisfaction and will not motivate job holders.

2.4.7 Financial or Economic factors

Economic factors have widely been cited as one of the most important factors that have a direct bearing on the motivation to work and the retention of health workers in the health system. For example, in the context in which Mutizwa–Mangiza (1998) was writing, remuneration was reported as the single most important factor influencing the behaviour of the health worker. During that time the economic environment was so harsh that the health worker was finding it difficult to use his/her salary to meet the basic needs for survival. She argued that even if the basic needs were met, financial rewards would continue to be an

important factor affecting the behaviour of most health workers. This was supported by a motivational survey that was carried out in 1991 which concluded that 74% of health workers believed that their salaries were poor (Mutizwa–Mangiza, 1998).

Songstad, et al. (2011), Adzei and Atinga (2012), George, et al. (2013) and Iipinge, et al. (2006) all echo the point observed by Mutizwa–Mangiza (1998) that economic factors play a very important role in influencing the behaviour of health workers. George, et al. (2013) concluded in their study of the reasons why South African health workers migrated from the public health sector to the private health sector, as well as to developed countries, that economic factors were some of the most important factors influencing the migration of health workers, particularly in the period between 2002 and 2006. In South Africa, according to George, et al. (2013), the introduction of the Occupation Specific Dispensation (OSD) policy resulted in the reduction of losses of health personnel in the public Health Sector because the policy corrected large differences in salaries between the public sector and the private sector. Although a gap still existed, it had been narrowed considerably, and that differences in salaries no longer accounted for migration. Iipinge, et al. (2006) also reported after their study of health workers in Namibia that financial issues came up as very important in affecting the behaviour of health workers. Some nurses, for instance, resigned from their jobs in order to raise, through claiming their pensions, some funds to meet personal obligations like paying for school fees and outstanding debts. The nurses also resigned from their jobs to claim their pensions believing that the government would fail to pay the pensions. According to the same researchers, salaries for health personnel in the private health sector were better, especially for the doctors. While some authorities believe that pay plays a very important role in the motivation and retention of health workers (Mutizwa – Mangiza, 1998; Adzei and Atinga, 2012; George, et al., 2013), other authorities think that health workers do not accord benefits in general that significance (Rad and Moraes, 2009; Waal and Jansen, 2013). So there is general consensus among the researchers that economic factors in the form of salaries or wages, and other rewards play a very important part in the motivation and retention of health workers.

2.4.8 Non – financial or economic factors

Several non–financial factors are also cited by researchers as having an important influence on the motivation and retention of health workers. In other words, the argument is that financial incentives are basic but not sufficient to motivate and retain health workers.

2.4.9 Human Resources Management Issues

a) **Career movement**

In a study carried out by Iipinge, et al. (2006), career movement was reported as one of the important factors influencing the motivation and retention of health workers. The Namibian study demonstrates that lack of or limited career movement forces health workers to leave. If a person reaches the maximum of the pay structure, or a person stays in a position for years without movement, then this creates conditions for leaving the job. Lack of or limited career movement has also been cited as a problem in Zimbabwe (Mutizwa – Mangiza, 1998; Awases et al., 2004, cited in Iipinge, et al., 2006). Reforms introduced in Namibia forced junior doctors to spend many years in that position after internship. Martineau, et al. (1996, cited in Iipinge, et al., 2006) points out that while there were multi–level career structures both for doctors and nurses, there were little or none for other cadres like health inspectors and health technicians.

b) **Career development and Promotion opportunities**

Iipinge, et al. (2006) notes that participants who participated in the research, for example doctors, agreed that there was no staff development opportunities. Mutizwa–Mangiza (1998) picks up this point in a different context, and mentions that when the Zimbabwean government decided to decentralize the functions of the Ministry of Health to local authorities, health workers felt that there would be no opportunities for career development and training. Rad and Moraes (2009) make the same point as Iipinge, et al. (2006) and Mutizwa – Mangiza (1998) that career development is important to health workers. They further note that career development increases job satisfaction, but that it should be done carefully to ensure fairness.

Most authorities believe that promotion opportunities play a significant part in the motivation and retention of health workers. For example, Adzei and Atinga (2013) found out that health workers place a lot of importance on promotion opportunities and that availability of promotion opportunities has the effect of motivating them. This is the case because promotion is associated with higher salaries. Songstad et al. (2013), Iipinge, et al. (2006) and Mutizwa –Mangiza (1998) make the same point that health workers value the availability of promotion opportunities which partly accounts for their (health workers) motivation and retention.

c) **Recognition**

Recognition of employees was also regarded as important since it contributed to their motivation. Adzei and Atinga (2012), Songstad et al. (2011), Rad and De Moraes (2009), and Iipinge et al. (2006) all acknowledge the significance of recognizing the effort of employees. Iipinge et al. (2006) note that nurses felt that management failed to give recognition or appreciation of a good job done or further studies leading to their de–motivation.

d) **Communication and interpersonal relationships**

Adzei and Atinga (2012) and Iipinge et al. (2006) make the point that good interpersonal relationships are important in creating a conducive environment for working, suggesting

that many health workers leave their place of work due to personal conflict with colleagues and/or managers. In the same vein, Kotter (1996; cited in Adzei and Atinga (2012) emphasizes the importance of using motivation rather than authority to make people work. The point of lack of good communication is reiterated in the NHSZ (2009 -2010), in which it is pointed out that throughout the health system there are cries of the need for better communication and support. The strategy document then points out that there is need for the development of new communication approaches, such as the need for full worker participation. Rad and Moraes (2009) make reference, albeit in passing, to the same point, about the importance of open communication in the management of health workers.

e) **Management support and motivation**

Extant literature on management support demonstrates a positive and strong correlation between management support and motivation. Iipinge et al. (2006) found in their study that there was a general perception in Namibia that there was no management support or motivation from those in authority. Adzei and Atinga (2012) note that health managers with adequate supportive and leadership skills have a higher likelihood of inducing a high level of motivation in their employees.

Some researchers are of the opinion that rewards increase motivation, which in turn improves performance. Examples of those who think that incentives are important for improving motivation are George et al. (2013), Adzei and Atinga (2012), Songstad et al. (2011), Iipinge

et al. (2006) and Mutizwa–Mangiza (1998). Adzei and Atinga (2012) argue that financial rewards are probably the most important strategy for motivation. While acknowledging the importance of financial incentives, Mutizwa–Mangiza (1998) notes that other factors which normally have an effect on motivation, such as job security, advancement opportunities, supervision, recognition, and training opportunities will not be activated until remuneration is perceived to be satisfactory. According to Mutizwa–Mangiza (1998), money is important because health worker's behaviour is underpinned by pre–industrial cultural values like valuing kinship. Her argument has been supported by Chiang and Birtch (2012), who found in their study that cultural values mediate between rewards and motivation.

Waal and Jansen (2013) found that use of bonuses and other types of reward systems does not lead to a positive or negative effect on organization performance. The explanation given was that reward systems are classified as a hygiene factor. This point is supported by Werner, Kolstad, Stuart, and Polsky (2011)), as well as by Mullen, Frank, and Rosenthal (2010). Waal and Jansen (2013), deduce that there is consensus among academics, both theoretically and empirically, about reward systems and long–term success. Rynes, Gerhart, and Parks (2005) also reached the same conclusion. LaBelle (2005) gives support to the conclusions above. He explains that while failure to have an appropriate reward system leads to trouble (in the form of opposition from employees), performance is not going to improve when it (the reward system) is put in place. In other words, giving rewards does not necessarily lead to improved performance. This point is consistent with Herzberg's (Armstrong, 2006; Lucey, 1995) two factor theory explained above.

f) **Research Gap**

A qualitative study is required to expose the many intricate views of health workers relating to issues of motivation and retention, since quantitative studies do not sufficiently provide reasons for causal relationships (Adzei and Atinga, 2012). Tsai and Wang (2005), Rad and De Moraes (2009), Chiang and Birtch (2011), Adzei and Atinga (2012), Doef (2012), and George et al. (2013) all used the quantitative methodological approach.

Table 2.3: Research gaps identified in literature

Dimension	Gap
Supervision	Hernandez, et al. (2014) point out that further research is required of the supervisors' interpretation of their part in the supervision process and the manner in which their managerial style is generated in order to pin down aspects that can be fortified in order to foster implementation of more supportive supervision.
Training	Dermol and Cater's (2013) study is limited to investigating only the most important training transfer factors discussed in literature. They acknowledge the existence of other training transfer factors (especially those related to the characteristics of trainees and training design).
Teamwork	Future research needs to explore many effective ingredients of teamwork and any link between teamwork and improved value of care (Ezziane, et al., 2012). Future research should not only focus on effective collaboration within teams, but also between teams (Bleakley, 2013, cited in West and Lyubovnikova, 2013).
Conditions of work	A qualitative study is required to expose the many intricate views of health workers relating to issues of motivation and retention, since quantitative studies do not sufficiently provide reasons for causal relationships (Adzei and Atinga, 2012). Tsai and Wang (2005), Rad and De Moraes (2009), Chiang and Birtch (2011), Adzei and Atinga (2012), Van der Doef, et al. (2012), and George, et al. (2013), all used the quantitative methodological approach.

2.5 CONCEPTUAL FRAMEWORK

A conceptual framework is a model or theory that one develops which one subsequently tests using data from the field (Saunders, et al., 2009). It consists of independent and dependent variables, where the independent variables have a causal relationship with the dependent variables (Mouton and Marais, 1990). In the conceptual framework below, factors such as supervision, training, teamwork, conditions of service and employee engagement affect the work performance of public health workers. Note that in this research, employee engagement will not be researched on due to time constraints.

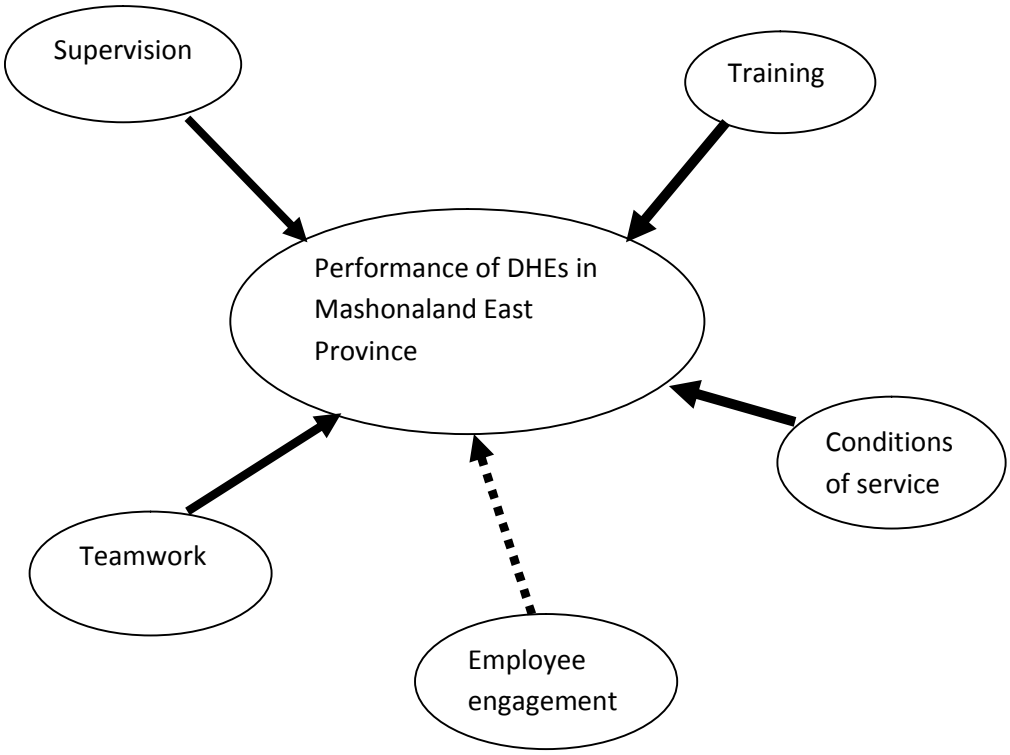

Figure 2.1 Conceptual Framework on the key dimensions influencing the work performance of DHEs in Mashonaland East Province

Source: Constructed by the researcher

2.6 SUMMARY OF CHAPTER

This chapter started with the definition of work performance models. It discussed the models on work performance and then went on to discuss the issues that are perceived to influence the work performance of public health workers. Knowledge gaps were identified that are going to form the basis of this research.

CHAPTER THREE: Research Methodology

3.0 Introduction

In this chapter the research methodology that was used will be presented. The statement of the problem, the study objectives, the research questions and the research propositions will be restated. This chapter will also discuss the research philosophy, the research approach, research strategy, research choice and the unit of analysis. The methods that will be used for collecting data from the targeted population as well as for analysis of the data after it has been collected will be discussed. Ethical considerations will also be discussed in this chapter.

3.1 Restatement of the problem and research objectives

The vision of the Ministry of Health and Child Welfare (MOH) is stated in the National Health Strategy for Zimbabwe (NHSZ 2009-2013, p22): "The Government of Zimbabwe desires to have the highest possible level of health and quality of life for all its citizens, attained through the combined efforts of individuals, communities, organizations and the government, which will allow them to participate fully in the socioeconomic development of the country". To achieve this vision, it is important for the DHEs, as the cornerstone of the district health delivery, to perform their work as expected. However, evidence demonstrates that DHEs are performing below standard. Some of the possible causes as mentioned in some studies relate to lack of training, lack of resources, lack of knowledge on the functions of DHEs and lack of teamwork.

3.2.1 Aim and Research Objectives

3.2.2 Aim

The aim of this research is to examine the dimensions influencing the work performance of DHEs in Mashonaland East Province.

3.2.3 Research questions

3.2.4 Main research question

How do we characterize the work performance of DHEs and which key dimensions influence their work performance?

3.2.5 Sub questions

a) How does supervision influence the work performance of the DHEs in Mashonaland

East Province?

b) How does management development have an effect on the work performance of DHEs?

c) How does teamwork influence the work performance of DHEs in Mashonaland East?

d) How do conditions of service influence the work performance of DHEs?

3. 2.6 Research Propositions

P: The DHEs may not be performing their work to higher expectations for a number of reasons including: inadequacy in training; lack of motivation; inadequate supervision; lack of teamwork, and; inadequate resources.

3.3 RESEARCH PHILOSOPHY

In this study, the interpretivist philosophy was adopted. The philosophy views a social actor as interpreting his/her everyday social role, as informed by the meaning that the actor gives to the role (Saunders, et al., 2009). The interpretivist perspective has its origin in the intellectual traditions of phenomenology and symbolic interactionism (Saunders, et al., 2009). Phenomenology concerns itself with the sense that human beings make of the world. The phenomenologist views human behaviour as a product of how people interpret their world. The attempt on the phenomenologist's part is to see things from the participant's point of view.

Symbolic interactionism as a theoretical perspective contends that human beings do not simply react to a stimulus (Saunders, et al., 2009; Mouton and Marais, 1990). They interpret and define the stimulus first, and then react in accordance with the meaning they give to the stimulus. In terms of behaviour, social actors interpret and define each other's actions, give meaning to the actions and then react in terms of that meaning. Symbolic interactionism also considers that behaviour can only be comprehended when considered in its whole context (Mouton and Marais, 1990). The term "definition of the situation" would not only mean taking the situation as it exists, but also as it seems to exist (Timasheff and Theodorson, 1976: p170, cited in Mouton and Marais, 1990).

Saunders, et al. (2009) note that the interpretivist philosophy is, arguably, highly appropriate when carrying out business and management research, for example, in the field of human

resources management and others like marketing and organizational theory. Other authorities like Adzei and Atinga (2012), Pineda–Herrero, et al. (2011), Hernandez, et al. (2014), for example, concur with Saunders, et al. (2009) that the qualitative approach (which includes the interpretivist approach) is appropriate for carrying out research when one needs to understand or identify the reasons for relationships which are established through the use of quantitative approaches. The qualitative approach basically contends that social reality is created by social actors out of the meaning they give to the actions of others. As noted by Mouton and Marais (1990), the quantitative researchers tend to impose a system on a phenomenon while the qualitative researchers' approach is to let the phenomenon "speak" for itself. In other words, qualitative researchers are interested in the phenomenon revealing itself and the researcher recording it.

The main reason the interpretive philosophy was chosen was the need to understand research participants' views, opinions and perceptions on how dimensions like training, supervision, teamwork, conditions of service and others influenced their work performance. This was important because participants' views, opinions and perceptions are closer to social reality as compared to answers researchers get from participants when the researchers have imposed their system on the phenomenon under study.

3.4 RESEARCH APPROACH

The aim of this research was to characterize the work performance of DHEs and find out the key dimensions that influence their work performance in Mashonaland East Province.

As has been stated above, the qualitative approach (compatible with the interpretivist philosophy) was used in gathering research data. The qualitative approach dealt with participants' views, opinions, perceptions and beliefs. The participants' views were collected and analyzed and, on the basis of the evidence which the views provided, conclusions were then be drawn. In other words, the inductive approach was used in which participants' opinions, beliefs, and views were used as empirical evidence to arrive at general conclusions (Saunders, et al., 2009; Mouton and Marais, 1990). Saunders, et al. (2009) and Mouton and Marais (1990) point out that an inductive approach ends with a theory or at least an interpretation, whereas a deductive approach ends with testing of theory.

In using the inductive approach to carry out research, the main threat to inferential validity is whether a conclusion follows from the available evidence, in terms of whether the evidence itself is both relevant and adequate (Mouton and Marais, 1990). Mouton and Marais (1990)

note that it is fairly easy to determine whether the supporting evidence to a conclusion is pertinent, but it is quite difficult to establish whether sufficient evidence has been collected for lending support to a particular point of view or conclusion. Wright (1982; cited in Mouton and Marais, 1990) suggests that the best approach is for the researcher to regularly ask himself or herself whether, on the basis of the available evidence, an alternative conclusion could not have been arrived at. The inductive approach will be used because the aim of the research is to establish views, opinions and beliefs of participants concerning the problem (phenomenon) to be researched on, while the deductive approach is about testing theory using the facts that would have been collected (Saunders, et al., 2009).

3.5 RESEARCH STRATEGY

Saunders, et al. (2009) point out the need for a clear research strategy when carrying out research. According to Mouton and Marais (1990), a researcher can carry out a research because of its greater contextual interest, where phenomena or events are studied because of their intrinsic interest. When a researcher employees this general strategy, there are specific strategies for carrying out the research that go with this general strategy. For example, ethnography, phenomenology, case study, or grounded theory, can be used to study phenomena situated in their context. On the other hand, a representative sample of phenomena or events may be studied with the aim of generalizing the findings to the population of the phenomena from which the sample was drawn (Mouton and Marais, 1990). This general strategy employs such specific strategies for carrying out the research as experiments and surveys. According to Saunders, et al. (2009) no research strategy is superior to another. What is important is to consider the strategy that is suitable for dealing with a particular problem.

In this research the strategy of case study was used, as explained by Saunders, et al. (2009). The researcher visited at three district hospitals and the PMD where data was collected on the dimensions influencing the performance of DHEs. Also as Yin (2003) and Saunders, et al. (2009) point out, the case study was found to be when considering phenomena under study that engender the “why?” but also the “what?” and “how?” questions. Yin (2003) also points

out that the case study is relevant when the investigator has no control over events. In this case, the researcher did not have control over the way DHEs conduct their affairs in district hospitals.

3.6 RESEARCH CHOICE

For this study, the research choice was a mono–method qualitative choice. This was because only semi–structured interviews were utilized as the method for collecting data. The method was useful because it enabled the researcher to collect data on the dimensions influenced the performance of DHEs. The semi–structured interviews assisted in acquiring an in–depth comprehension of the work performance of DHEs as it allowed the researcher to be closer to reality as compared with a method like administering questionnaires.

3.7 UNIT OF ANALYSIS

Mouton and Marais (1990) note that following a decision on the broader area of investigation, it is important for the researcher to decide the unit of analysis, that is, what it is that is going to be investigated. A unit of analysis can be an individual, a group, an organization, social artefacts, or aspects of these. In this study, both the individual and the group will be studied as units of analysis. Mouton and Marais (1990) note that individuals can be studied then the data collected is aggregated for the group, community or population concerned. However, in order to draw inferences from an individual to a group, authorities (such as Saunders, et al., 2009; Yin, 2003; Mouton and Marais, 1990) note that the individuals studied should be representative of the group, community or population from which they are drawn.

The main units of analysis included in the study were DHE members of selected hospitals. Data was also collected from experts on specific issues, such as the Provincial Health Services Administrator, the Provincial Nursing Officer, and the Provincial Environmental Health Officer. A threat to validity that was guarded against here was what Mouton and Marais (1990) call the "the ecological fallacy" where a researcher, having studied individuals arrives at conclusions about groups instead of the individuals.

3.8 DATA COLLECTION

i) Data Types

This research made use of primary data. Primary data is new data that is collected by the researcher for the purpose of solving the research problem. (Saunders, et al., 2009). Sources of primary data that were used in this research were DHEs and other participants, as indicated

above, who were knowledgeable about the issues investigated. This data was collected during semi– structured interviews.

ii) Data collection instruments

There are a number of data collection instruments, such as interviews, questionnaires, focus group discussions and observations (Creswell, 2007; cited in Saunders, et al., 2009; Yin, 2003, and; Mouton and Marais, 1990). Semi–structured interviews were used in this research. The decision of using semi–structured interviews was in keeping with the aim of the research to explore the reasons for the performance of the DHE. The semi–structured interview, as a qualitative approach data collection technique aimed to come up with in–depth description of issues, to be interpretive and to understand phenomena. Objectivity was increased by building rapport with research participants.

iii) Semi–structured interviews

According to Saunders, et al. (2009) a semi–structured interview is a type of interview in which the researcher will have a list of themes and questions to be covered during the interview. Data was collected both by using an audio–recording instrument for recording conversations and by taking notes (Saunders, et al., 2009). To ensure that the same questions were asked in the same way, the researcher prepared the themes and the questions that were discussed before–hand. Tashakkori and Teddlie (1998; cited in Saunders, et al., 2009) point out that semi–structured interviews may be used to explore and explain themes that emerge from previous questionnaires. Semi–structured interviews allow flexibility. Extant literature on the performance of DHE members indicated some themes that came out of the quantitative studies that had been carried out earlier on. It is these themes that were explored and explained through the use of semi–structured interviews. Research participants responded to interview questions in terms of their knowledge, beliefs, opinions and views as was expected in a qualitative research.

iv) Pretesting the Interview Guide

The interview guide consisted of themes and questions. The interview guide was pretested

before being used in collecting data from respondents. The purpose of pilot testing was to pin down any problems and to correct them before going out to collect data using the interview guide (Creswell, 2007; cited in Turner, 2010). The pilot test was conducted with respondents

who were similar with the respondents who participated in the research. The other purpose of the pre–test was to find out if the questions asked made sense to the respondents and if the responses were easy for the researcher to record (Saunders, et al., 2009). This way the validity and reliability of the data from the respondents was assured (Saunders, et al., 2009). In the case of the qualitative approach, Saunders, et al.(2009) refer to validity as the extent to which the researcher is able to have access to the participant's knowledge and experience and is able to understand the sense in which the respondent couches his or her terms. Concerning reliability, Saunders, at el. (2009) contend that the data obtained from qualitative data collection techniques is not meant to be replicable because they reflect reality at the time the data was collected. Marshall and Rossman (1999; cited in Saunders, et al.,2009) contend that replicating qualitative research is unrealistic without undermining the strength of this kind of research, a point which researchers using qualitative research are advised to stress.

v) Number of interviews

Laforest (2009) points out a number of guidelines for determining the number of interviews that can be carried out. First, if data has been collected using qualitative or quantitative data source, semi – structured interviews may be used for purposes of supplementing the already available data, in which case few interviews would be carried out. Second, semi – structured interviews may be used to captured a range of views that would not have been captured by other methods. Thirdly, if the time and resources available are inadequate, then a few interviews can be carried out. Last but not least, the collection of data from respondents should come to an end once what is referred to as data saturation has been achieved, that is, if no new insights are provided by additional interviews. In this interview, however, 15 respondents were interviewed by the researcher. Due to time and resource constraints, 15 respondents were interviewed.

vi) Sampling techniques

Probability and non–probability sampling methods are used for selecting respondents who will participate in a research. In this research, non–probability sampling was used. Saunders, et al. (2009) note that non–probability methods are used with a specific purpose in mind.

Saunders, et al. (2009) and Kothari (2004) point out that in non – probability sampling, there is no likelihood that any member of the population from which a sample is drawn has an equal chance of being included in the sample. Items for the sample are therefore chosen

deliberately by the researcher. In this study, purposive sampling, where the researcher uses his/her judgement to include certain respondents in the sample, was used. In other words, "appropriate" respondents were selected in the sense that they were qualified to provide the most useful and credible information to the researcher (Creswell, 2007; cited in Turner, 2010), and they were willing to share their opinions, views, knowledge and experiences openly and honestly (Creswell, 2007; cited in Turner, 2010).

vii) Procedure for selection of district hospitals

DHEs work from hospitals. Three hospitals were purposively selected. Firstly, hospitals that were selected were those that had DHE members with a working experience of at least five years. At least five years because the DHE member had had enough experience to understand the dimensions influencing the performance of DHE in his or her health district.

viii) Procedure for selecting DHEs

The DHEs who had five years and above working experience were purposively chosen to participate in the research. Information about the length of experience was obtained at the PMD's office. The PHE was requested to assist the researcher to select respondents who were able to openly and honestly share information.

ix) Procedure for selecting key participants

The key participants were the experts who had extensive knowledge about the DHEs and how they performed. These were the research participants who were targeted as the key participants.

x) Data Analysis and Presentation techniques

The content analysis technique was used to analyze data. Content analysis can be viewed as a set of procedures that are used for structuring and analyzing written material (United States of America, 1989). During the process of interviewing respondents, data was tape–recorded, after which it was immediately transcribed. The researcher read through the transcribed interviews and identified patterns or codes, which themselves (patterns and codes) were

consistent with research questions (http://www.utexas.edu/academic/diia/assessment/iar/resources/quicktips/quicktip_7-32.pdf). However, data were also identified that were inconsistent with research questions. Coding

was also done for these patterns. The researcher decided which patterns were considered. These patterns are called "coding categories" (http://www.utexas.edu/academic/diia/assessment/iar/resources/quicktips/quicktip_7-32.pdf). Each category was given a name and a definition. For a code to be classified under say category X, it had specific characteristics that allowed it to be classified in that category.

Coding categories are the foundation of content analysis (United States of America, 1989). The researcher made sure that coding categories were exhaustive, mutually exclusive and independent so that relevant material was classified within one category and that there was no overlapping of codes. Scales, groupings, tables and matrices are numerous ways of presenting categories. The researcher presented the categories in table form (see appendix section)

The researcher used content analysis to summarize data for analysis. The researcher looked for patterns, trends and relationships in the summarized data. The researcher used the summarized data to test the propositions that were made earlier on. The researcher compared data from various sources. On the basis of this analysis, the researcher then drew conclusions. The researcher used the manual method to do the analysis and inferences. These inferences were used as answers to the questions and objectives posed earlier on.

xi) Validation and Reliability

Validity refers to the extent to which a measuring instrument actually measures that which it is intended to measure (Saunders, et al., 2009). Reliability refers to the accuracy of the measuring instrument. To the extent that the instrument is not accurate, it cannot be reliable. The researcher was aware of the factors that would negatively influence validity and reliability and worked to eliminate them. For example, Mouton and Marais (1990) make the point that research design should be understood as a plan that is made and structured to maximize validity.

The researcher took a number of measures to ensure that data were valid and reliable. The researcher ensured that the identity of participants was protected, which was a minimum requirement for establishing greater validity (Mouton and Marais, 1990). The researcher

made an attempt to create the best possible interpersonal relationship or rapport with the participants. A pilot test was carried out using the interview guide to pin down any flaws and these were corrected (Turner, 2010; Saunders, et al., 2009; Mouton and Marais, 1990). The researcher was also part of the measuring instrument (Saunders, et al., 2009) and he guarded

against any biases that could have originated from what Mouton and Marais (1990) refer to as researcher orientations (prejudices, beliefs, expectations and opinions of the researcher).

xii) Reflexivity

Reflexivity was used as a means of reflecting on the values and beliefs of the researcher. This was meant to help the researcher to lay bare his beliefs and values so that at the he would be aware of these to guard against the possibility of them (values and beliefs) interfering with the validity and reliability of the research outcome. The researcher made use of a diary for recording what was happening as well as what was passing through his heard. This helped him to guard against his biases and assumptions.

3.9 ETHICAL CONSIDERATIONS

The researcher complied with ethical requirements that should bind a researcher throughout the research, right from the beginning of the research to the end of the same. The researcher complied with the ethical considerations that are enumerated below.

a) The researcher was aware of the fact that people have the right to decide whether or not to participate in a research and that right was respected. Even if people decide to participate, they have the right to withdraw at any moment. People have the right not to discuss certain questions and their refusal will not bear any consequences.

b) In carrying out the research, the researcher did not do anything to harm, embarrass or prejudice the respondents in any way (Saunders, et al., 2009).

c) The respondents' identities were not divulged in any way. The researcher made sure that any responses were not linked with specific respondents.

d) The researcher respected the privacy of the respondent.

e) The respondents' informed consent was sought before they participated in the research.

f) The researcher asked for permission from relevant authorities to carry out the research.

3.10 LIMITATIONS TO THE STUDY

The inferences arrived at after analyzing the interview data was not generalized because the respondents were not selected using probability sampling. Also, 15 cases were analyzed and this number of cases could not enable the researcher to comfortably generalize the results of the research.

The PMD granted the permission to carry out the research after the researcher had written an application for permission to carry out the research (see application letter by the researcher as well as the letter written by the PMD granting permission to carry out the research in the appendix section). Before the researcher went into the field he carried out a pre – test of the interview guide. The items that needed correction were corrected.

3.11 CHAPTER SUMMARY

The research methodology chapter started with a recap of the statement of the problem, research aim and research questions. The chapter discussed the philosophy to be used as the interpretivist philosophy. The inductive approach was used. The strategy used in the research was taken as the case study strategy. The chapter highlighted that the mono–method qualitative choice was preferred. The data collecting instrument was pointed out as the semi–structured interview. The chapter highlighted that the type of data to be collected was primary data. It was pointed out that reflexivity as a method was used to record the researcher's actions, beliefs, assumptions, values and emotional reactions during the research process. Reflexivity was used to assist in removing bias, increase transparency as well as increase validity and reliability of the research.

It was noted in this chapter that the interview guide was pilot tested before being used to collect data, which assisted in picking up any problems, wand they were rectified. The procedure for selecting respondents, purposive sampling, was explained in the chapter. The method to be used for data analysis was pointed out as content analysis. Ethical issues considered were enumerated in this chapter. Limitations to the study were also pointed out.

CHAPTER FOUR: DATA ANALYSIS AND DISCUSSION

4.0 INTRODUCTION

The aim of this chapter is to present and discuss the empirical evidence gathered from the interviews (primary sources of data) with the research participants and from documents (secondary sources of data) like records of minutes submitted to the Provincial Medical Director (PMD)'s office by DHEs, audit reports, and support and supervision reports on District Health Executives (DHEs) by the Provincial Health Executive (PHE). The theme of the research project is dimensions influencing the work performance of DHEs in Mashonaland East Province.

A total of fifteen (15) respondents were interviewed and these were drawn from three hospitals and from the PMD's office. To get a balanced view on the dimensions influencing the work performance of DHEs, three DHE members were drawn from each of three hospitals in the province and were interviewed. Four PHE members were drawn from the PMD's office and interviewed. Two respondents from two non– governmental organizations (NGOs) attached to the PMD's office, who oversee some programmes [such as Prevention of Mother to Child Transmission (PMTCT) programme and the Health Transition Fund (HTF) programme] in the province and work closely with DHEs were also interviewed. In fact the last two respondents were DHE members before they left to join their respective organizations

4.2 FINDINGS

1. **How do you explain the concept of "supervision"?**

This question was asked to find out the respondents' perception of the concept of supervision. This information was corroborated with respondents' educational backgrounds. Generally, the majority of respondents explained supervision in terms of checking, following up, monitoring or directing, of the work done by a supervisee. The apparent justification for explaining supervision in these terms was that the supervisor was accountable for the outcome of the work done by the subordinate, hence the need to check, monitor, direct or follow up the work. Any mistakes were thought to bounce on the supervisor, the person who

is accountable. The point of view that supervision consists of checking, directing, monitoring or following up a subordinate's work leans towards controlling.

A few respondents explained supervision in terms of it being supportive. These few respondents noted that supervision would bring the best results if it was supportive of the supervisee. For example, one respondent noted that as supervisors they were not there to watch over people doing their work, policing them, but that they wanted to support people carry out their day to day activities, giving them a helping hand through provision of resources and through creating an enabling environment for the subordinates to exploit opportunities in their environments and excel.

An analysis of the differences in views appeared to emanate from the differences in the educational backgrounds of the respondents. Most DHE members and some PHE members did not undergo training in management courses. Their curricula do not include management courses. It was therefore apparent that they were not well versed with the basic tenets of supervision such as the support aspect.

2. **Given what you have said, may I have your opinion about the supervisor's knowledge, vis – a – vis that of the person s/he intends to supervise?**

This question was meant to establish if it was really important for a supervisor to have more knowledge than the person s/he was supposed to supervise. The general consensus was that the supervisor needed to have more knowledge and experience than the supervisee. One respondent put it rather emphatically, saying that there was need for a steep knowledge gradient between the supervisor and supervisee. The logic, according to the respondents, in having a supervisor who was superior in terms of knowledge, experience and competence than the supervisee was that the supervisor, if s/he was to be effective and help the supervisee improve performance, had to play the role of coaching, mentoring, and advising the subordinate. Besides, a supervisor in that position (of being knowledgeable, experienced and competent) would naturally earn the respect of the subordinate.

One respondent from senior management contented that the DHEs comprised people with different technical skills and that they had experience but in their areas of speciality. For example the District Nursing Officer (DNO) supervised the nurse, the District Medical Officer (DMO) had experience in medicine, the District Health Services Administrator (DHSA) in management, the District Environmental Health Officer in environmental health

and so on. Another respondent, from the DHE level, thought that the DMO, an overall supervisor of the DHE members, did not have to know every discipline such as management, accounting, or environmental health. He contented that just an appreciation of these disciplines was adequate.

An examination of audit reports revealed that DHE members, particularly the DMOs who are overall supervisors at district level, were not well versed with certain disciplines such as accounting or management in general. A number of reports for the districts (including the ones under study) showed that the districts had problems with, for example, their accounting systems, their procurement systems, their human resource management systems and other areas. For example, with regard to the accounting system, a number of audit reports showed that the auditors expected DMOs, as overall supervisors, to be aware of what was going on at institutions in terms of accounting records. In one such report, an auditor pointed out that there were no records at one of the hospitals under study, in terms of income and expenditure, that is, the cashbook. This meant that the DMOs were expected to have knowledge of the accounting system, among other things, in order to be able to supervise the accountant, which none of them has.

One of the reasons why accountants at some of the hospitals were not producing work that was above board, besides not being supervised supportively, was that some of them were not properly qualified themselves, with some being accounting assistants working as accountants on an acting basis. The provincial Accountants only come for DHE supervision twice a year together with other PHE members as they lack resources (fuels and vehicles) to come for the visits say once (one day) in every quarter, which in itself is also not adequate. Given that the DMOs are not knowledgeable of the accounting system, the auditors always picked up the anomalies. The DMOs were not in a position to be mentors, or coaches in this instance, although they are competent in their medical discipline. Over and above this, other DHE members other than qualified accountants are not able to comprehend accounting reports, for example, because they do not have accounting knowledge, and yet one of the mandates of the DHEs is to make financial decisions in connection with running the district's health portfolio.

3. How relevant is supportive supervision to DHE work performance?

The general consensus, among most DHE members, was that supportive supervision is a

beneficial organizational intervention, at least in theory, intended to bring about benefits such as equipping the DHE (with resources) for better performance; improving knowledge and skills of DHEs; strengthening systems and service delivery. However, in practice, supportive supervision was not well regarded, with the majority of DHE members viewing it as being authoritative.

Another respondent noted that the DHEs required regular visits from the PHE and that the visits should be supportive supervision, not theirs (PHE) which they did which she termed "***shumbavision***". The idea of "***shumbavision***" that was mentioned showed how extreme the control element appeared to get, going to the extent of instilling fear in the subordinates. The term "***shumbavision***" can be divided into "***shumba***" and "***vision***". The "***shumba***" part of the term refers to a carnivorous wild animal which survives by feeding on other animals. The fear engendered by the PHE during supportive supervision was equated to the fear associated with the presence of a lion. This response was given by a senior member of a DHE at one of the hospitals, who has worked for the ministry for twenty five (25) years.

Another respondent observed, rather angrily, that the supervisors (PHE) kept on shouting at people when they came for supportive supervision as if they did not know that he (and other health workers) were now adults; and that they did not recognize that people were working hard with minimum resources.

A senior respondent from the PHE category of respondents contented that supportive supervision had almost become irrelevant as it had been fragmented along diseases control programmes like Tuberculosis (TB), Extended Programme on Immunization (EPI) and malaria control for example. Besides ring – fencing resources associated with the programme by the programme heads, leading to the fragmentation of the DHEs, supportive supervision was irrelevant in the sense that it did not give real technical and comprehensive support to the supervisee, because the supervisors only visited the RHC or district hospital for a few hours instead of a number of days to in order to understand subordinates' needs and problems. The general consensus was that supportive supervision, in practice, was authoritarian in approach, irrelevant and inadequate.

4. **Focusing on the DHEs, how does the supervisor interpret the role that s/he should take during the process of supervision?**

5. **Focusing on the DHEs, how does a supervisor's management style get generated**

during the supervision process?

Questions four (4) and five (5) were asked to find out how supervisors deduced the roles they took and the management styles they adopted in the supervision process with a view to pinning down aspects that could be reinforced in order to promote the implementation of more supportive supervision. Almost all respondents from the DHE category and the PHE category who were interviewed agreed that the manner in which the supervisor perceived the situation was the basis on which s/he both interpreted the role to take during supportive supervision, and decided which management style to use. By situation the respondents meant for example, anything found on the ground and the extent to which it was in conformity with goals and expectations of the PHE. The basis of management style appeared to be influenced by what the supervisor saw on the ground and to which s/he reacted.

Three respondents said that the role taken up by the supervisor and the management style adopted depended on the individual subordinate's behaviour. One respondent said for example, the role was influenced by the response of the supervisee. She said that one needed to change attitude according to how subordinates received the supervisor.

A very interesting response from one respondent, an overall DHE supervisor at district level, was that management style was inborn and was constant. He pointed out that people told him that he was consistent in his management style. He said that there was no need for him to change because he was coping well.

The first thing to note is the reactive nature of the management style on the part of the respondents, particularly the PHE members who were interviewed. It would seem that the respondents did not plan their visits, but simply visited a district hospital for support and supervision on the spur of the moment. What this meant was that the supervisors were not really ready to carry out supportive supervision because they simply reacted to what was on the ground, instead of doing a comprehensive situation analysis and root cause analysis, and knowing the issues before hand in order to come to grips with the real problems and bottlenecks that were being encountered by subordinates, as was suggested by one senior DHE member.

Other things to take note of were the views that the supervisor's role and management style depended on how the subordinate received the supervisor, that is, the supervisee's response to

the supervisor's arrival at the work station; and that management style was inborn. These views seem to confirm the fact that most DHE members and PHE members do not have management knowledge and skills but that they are qualified and have experience in their technical fields.

6. **How do you explain the concept of management development?**

This question was meant to find out respondents understanding of the concept of management development. The general understanding among respondents was that it is the acquisitions of skills by managers, such as DHEs.

7. **Looking at the DHEs how has management development or lack thereof influenced work performance of DHEs?**

This question aimed at finding out in respondents' view if lack of management development had any influence on the work performance of DHE members. There was general concurrence among respondents that management (DHEs) did not undergo management development and therefore lacked important skills needed to manage efficiently and effectively, rendering DHE members to a large extent non – functional in terms of running the health affairs of the district. For example, most respondents noted that management was indecisive, was unable to supervise work done by some subordinates, made bad decisions and was unable to handle management decisions. These DHE members also acknowledged the importance of availability of resources to carry out work.

However, some respondents (two) contented that lack of management development (necessary for equipping DHEs with management skills) did not influence the work performance of DHEs, but that resources were more important. If resources were available DHEs would perform better.

Besides the example on lack of accounting knowledge given in question two earlier on, DHE members were for instance, not knowledgeable about human resources issues, and yet interestingly, they had human resources that they supervised in their departments and some of them actually set on boards of investigation for disciplining subordinates if they (subordinates) had been involved in acts of misconduct. The outcome of sitting on boards of investigation without adequate knowledge of the human resources procedures (which

knowledge is gained when one undergoes a management course) caused blunders which have led to a rise in the number of appeal cases against misconduct determinations as noted in the records at the PMD's office.

8. **In terms of management development, may I have your opinion on whether or not DHEs need management development in order to improve their work performance?**

This question was a follow up of question 7 to establish if really management development was necessary so as to improve the work performance of DHEs. There was a general concurrence among respondents that DHEs needed management development in order to acquire management skills which was observed to be very important in order to improve work performance. A senior PHE member noted that there was need to achieve a steep knowledge gradient particularly for the DMOs so that they would not only be able to manage and supervise effectively and efficiently, but also to earn some respect from fellow DHE members. In support of this, a respondent added that over and above ensuring that DHEs underwent management development, there was first of all the need to create stable DHEs. Then management development would follow. This was after it had been observed that DHE membership was very unstable, with many actors, a state of affairs that also influenced DHE work performance negatively.

However, three respondents, one a PHE member, and two others in the DHE contented that resources were equally important, besides acquisition of management skills and knowledge. One PHE member pointed out that some DHE members did not value management as a discipline and their behaviour caused them to lose integrity. He noted that these DHE members in question spent most of their time with subordinates and they impregnated junior female staff members, putting the DHEs into disrepute.

9. **Who should be involved in the selection of management development course content and why?**

This question helped in establishing who was responsible for coming up with the curriculum for management development. Most respondents thought that this was the responsibility of the PHE and the national level. A few respondents stressed the importance of including input from DHEs. The responsibility of developing a curriculum for management development had

a bearing on the scope and range of the management development courses developed and the content validity. DHE input is important because they are aware of their knowledge gaps and the weaknesses that need to be addressed.

So the question of content validity arose: did the management development curricula developed really address the relevant knowledge gaps? In terms of range and scope it appeared that the curricula were not adequate. For example, respondents thought that the time taken to cover the content – usually up to five days – was far much inadequate, which further gave rise to the question of whether management as a disciple was appreciated. A few respondents thought that management as a discipline was not given the importance that it deserved. These cadres (four) were mainly cadres with a management background, and a few two with a medical/ nursing background, plus a management qualification. Normally, management development courses were supposed to take a minimum of one year in order to cover all the content that was relevant.

10. **Suppose that DHEs have undergone management development; how can the application of the acquired knowledge, skills and abilities be maximized at the place of work?**

The general consensus among the research participants from the three hospitals was that DHEs do not have the autonomy to make decisions, which would allow them the flexibility to plan taking their different environments into account, and to plan for the time to implement their operational plans. The DHE, for example, cannot make decisions on how much money to use on which item, the workshops to attend and not to attend (and emanating from this, control over time) or the substantive disciplining of staff.

One respondent, from the PHE category, also noted that the DHEs could not make substantive decisions in the course of running the affairs of the district. He gave the example of government funds that were given to a district in the form of votes, for instance, X funds for medicines and sundries, and Y funds for water. If funds for medicines and sundries had been exhausted, the DHEs could not make a decision of transferring funds from vote Y to buy medicines and sundries, even if they would have undergone management development. This would be despite the fact that medicines would be out stock in the pharmacy. He suggested that an enabling environment was therefore needed. This observation was confirmed by the existence of budget estimates booklets up to the year 2013. In all the booklets, in the preface, it was clearly indicated that if there was need to over funds from one

vote to another, the need was to be communicated to the Accounting Officer giving him valid reasons why it was necessary to move the funds so that he could authorise or not authorise as the case would be (MoHCC, 2013).

Concerning the disciplining of staff members, the disciplinary authority, who is the DMO at district level, only has the authority to cause investigations to be made in the event of a suspected act of misconduct by a staff member, and to give recommendations as to the penalty the staff member should be given, if found guilty after an investigation by other DHE members appointed for the purpose by the former (DMO). This has the effect of prolonging determination of cases as the verdict is procedurally determined by the PMD for junior staff and the Permanent Secretary for senior staff, resulting in demoralization and despondency among staff members.

Two PHE members and two DHE members suggested, in addition, that resources were necessary to implement what had been learnt. Others noted that it would only be possible to transfer knowledge and skills at the work place if the DHE members were motivated to work. Still, other DHE members observed the need for DHEs to have adequate time for planning and implementing what they would have learnt. This suggestion linked up with the need for autonomy which would allow them to manage their time effectively. One respondent observed that once the DHEs had been empowered, no outsiders (PHE or Head Office officials) were expected to interfere with their (DHE) plans and priorities so as to allow them the opportunity to manage their priorities and their time effectively.

11. Let us move on to the concept of teamwork. How do you explain teamwork?

Respondents, generally, thought that teamwork means working as one unit, or as a family.

12. How relevant is teamwork to the work performance of DHEs?

This question was meant to find out from respondents the importance of teamwork to DHE work performance. There was general consensus among respondents across the board that teamwork, in theory, brought about valuable outcomes by aligning the efforts of all team members, by ensuring that tasks were shared by team members and by (the DHE) working as a system. There was also general agreement that lack of teamwork did not bring about

achievement of any objectives. In this regard, it was noted that what was constraining performance in some districts was lack of teamwork, where people were pulling in different directions and where people were even actively trying to downplay each other or to make sure that others did not achieve what they were supposed to achieve as long as they were not the ones who were in charge or were involved.

However, although respondents believed that teamwork would bring about positive outcomes, they also indicated that teamwork was not developed among the DHEs. There were some dimensions that came up which indicated that conditions were not ripe for teamwork to be successful.

The disease control programmes, for example, that were mentioned by a senior PHE member, were said to have completely fragmented the DHE members. The disease control programmes include EPI, TB, and malaria control, among others. The respondent contented that programme heads had a tendency to ring –fence resources that would have been allocated for a particular disease control programme. The programme heads visited clinics for a day by themselves, leaving out other DHE members. They did not have time to discuss technical issues. They did not concentrate on the process of health care. This behaviour was tantamount to monopolizing resources at the expense of others. The respondents themselves had suggested that members were not to let the individual interest prevail over the common interest. If other members of the DHE felt that they were not benefiting, the team spirit would not prevail.

Another PHE member pointed out that the DHEs were not stable. The instability was said to be due to the fact that a large proportion of the members were actors – they were not substantive incumbents. What this meant was that a member would be in the DHE one day and out on the other, resulting in the instability. Members would not have the time to be with others so as to get used to each other. The instability, according the senior PHE member, was also due to some of the young DMOs who were appointed to run districts, who were said to be very experimental, quite raw and also thought that they were now in charge and that they knew everything, which was not necessarily the case. This case was exacerbated by the fact that the young doctors in question did not have management qualifications, as pointed out earlier on.

Some respondents both from the DHE category and PHE category believed that some DHE members were wayward and the leader probably needed to understand them in order to handle them in the most appropriate way. Some of the DHE members were described as having bad attitudes and could not fit in well with other DHE members. An typical example was one hospital where two respondents coincidentally complained that there was no teamwork, because their colleagues were free to do whatever they wanted without apparently being reprimanded.

The treatment that DHE members got from the PHE members was probably a very important issue. About six respondents pointed out the importance of the manner in which DHE members were treated by their PHE counterparts. Of note here was the reprimanding of DHE members in public, which undermined their (DHE) authority.

All the above dimensions mentioned have not helped in building a cohesive DHE team successfully. There appear to be varying levels of cooperation among DHE members, at least in the hospitals that were part of this study.

13. May you explain the role team leaders can play to make the DHEs more collaborative?

The question was meant to find out from respondents how team leaders could promote

collaboration among DHE members. The general consensus among the respondents was that the team leaders were expected to take up the coordination function by uniting team members, by facilitating and encouraging teamwork and by aligning team members' efforts. For example, eight (8) respondents stressed the importance of holding regular meetings as a means of communicating where the DHE members would plan, and discuss issues, problems and the way forward regarding health care delivery. Although DHEs were not holding regular meetings as expected policy wise, the need existed for enhancing communication

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For example, eight (8) respondents stressed the importance of holding regular meetings as a means of communicating where the DHE members would plan, and discuss issues, problems and the way forward regarding health care delivery. Although DHEs were not holding regular meetings as expected policy wise, the need existed for enhancing communication, which extant literature emphasises as being vital for promoting teamwork (Ezziane, et al., 2012).

Eight (8) respondents emphasized the need for the team leader to create an enabling environment in which each DHE member would be able to realize their full potential in whatever they did, getting support from a leader who would not unnecessarily direct or constrain people. Most respondents agreed that the team leader also needed to encourage openness among team members to make them feel close to each other, thereby promoting the team spirit. The team leader's role was also to acknowledge good performance by team members.

There was general concurrence that the leader should unite DHE members by effectively resolving conflicts, treating each member fairly, following up on assigned tasks and requesting for feedback, giving subordinates support and creating feelings of openness and of belonging and of rallying members by use of a vision. Also generally agreed among respondents was the need for the leader to encourage teamwork by giving tasks that only the team, not the individual, could carry out; and rewarding team effort as compared to individual effort, but at the same time recognizing individual effort.

14. **May you explain the role team members can play to ensure that DHEs become more collaborative?**

The general consensus among respondents was that they expected team members to be respectful of each other and their qualifications, to be cooperative, to be supportive of the leader, to be confident, being trustworthy, being an action person, to assist team members lagging behind, and know their roles. In other words, the team member was expected to be helpful, encouraging, being honest, dependable and accountable. Basically, the team member was expected to play a supportive role.

15. **In your opinion, are there other ways or means of ensuring that DHE are more collaborative other than the role of team leaders or the role of team members?**

On this question some members repeated what they had said in question fourteen (14) above, like the team leader aligning team members' efforts; being impartial in dealing with each team member, and; being respectful. However, a new idea – motivational trips, also called retreats – came up, which respondents (eight) emphasized was not supposed to be viewed as part of routine work, such as the Provincial Health Team (PHT) meeting which the PHE, DHEs from districts, and invited stakeholders attended ideally once every quarter, but was in reality convened sometimes once or twice a year due to financial constraints. The respondents meant that retreats were intended for each DHE team, where a DHE team would retreat to a place away from the work place, such as a hotel say for a week or so. Respondents concurred in general that retreats had the effect of stimulating cohesiveness among team members.

Four respondents, one PHE member and three DHE members thought that respecting each other was important to make DHEs more collaborative. However, as noted above, there was need for working on the conditions explained above in order to also improve on DHE collaboration.

16. **How can team skills training optimize interdisciplinary interdependency in the health care environment?**

Respondents were expected to describe how interdisciplinary interdependency could best be achieved by team skills training. Fourteen (14) respondents, five (5) of them PHE members

including an employee of an NGO attached to the PMD's office, and nine (9) DHE members pointed out that team skills training enabled DHE members to understand a colleague's role in achieving an objective and how that role relates to his or her own role. Each DHE member would know what his/her colleague's role was and how that role related to his/ her own role. In the health delivery system, those who had not trained in medicine would understand the needs of a patient and those not trained in management would understand issues of efficient utilization of resources and also adherence to procedures and regulations that they might not necessarily actually know about. Team skills training was meant to emphasize the complementarity of different roles in the health care delivery system.

There were, however, conditions in place mentioned above, that were militating against teamwork; such conditions as the manner of implementing disease control programmes; instability of DHEs; waywardness of some members of the DHEs; and the treatment of DHE

members. These were expected to be addressed so that enabling conditions would be put in place to build successful teams.

17. How do you explain the concept of conditions service or work?

This question was meant to find out what respondents understood by the term "conditions of service". Most respondents thought that the term meant the environment in which one works including the compensation that one gets. Some respondents (six) touched on the issues of recognition, brain drain and favouritism. The concepts of motivation in general and recognition in particular came up in the next question in a rather strong way.

In this study, a recurrent response was that the government should provide the DHE members with affordable loans that would be payable in small instalments so that the DHE members can construct or buy houses, buy vehicles and be able to send their children to school. A house, a vehicle and sending children to school appear to be the things that were at the hearts of most respondents. Suggesting that the government should provide them with loans probably was an acknowledgement on the part of the health workers that the government cannot afford salary increments.

Also recurrent was the concept of recognition. Most respondents felt that their efforts were not being recognized. There were three aspects of recognition that came up in the interviews in connection with the idea of recognition. One was about the grading system. The argument was that there was need for a fair grading system for managers that was in keeping qualifications. There was need to have properly laid down qualifications. Another line of argument was that people should be given remuneration that is commensurate with their responsibility. There was need for reasonable gaps between people in different grades so that the concept of recognition was acknowledged. If for example the monetary gap between two consecutive grades was one dollar, this did not motivate the incumbent in the higher grade. The position should reflect monetary value.

Another form of recognition was when an individual may have more years of experience than others. Their salary was expected to be higher than that of the members who had less years of experience. Better remuneration was also a factor in improving DHE work performance. A third form of recognition was when one excelled at work; they were supposed to be given a token of appreciation.

The issue of substantial gaps between salary steps in a salary structure became a topical one towards the end of the hyperinflationary period when the Zimbabwean dollar was discarded by the state. When government started paying it employees in foreign currency, there was a time when everyone across the board was paid US$ 100 as a salary. This went on for some time until a proper structure was put in place to acknowledge differences in qualifications and work experience. However, the differences in salary between adjacent salary steps have apparently remained very small, which appears to have remained a bone of contention.

On checking the differences between salary grades of DHE members, the differences were apparently significant, but that could be accounted for not only by qualifications, but also by the differences in years of experience as well as the responsibilities of the incumbent of a post. As can be seen, this issue has a bearing on teamwork as well. If one DHE member feels that someone is unfairly compensated in comparison with him or her, then the spirit of teamwork has the potential of being negatively affected.

18. How have conditions of service or work influenced the work performance of DHEs?

A general consensus among the respondents was that conditions of work had affected the work performance of the DHE members negatively. Firstly, conditions of service resulted in brain drain, which occurred not only among health works in general, but also among DHE members. The categories of professionals mostly affected among the DHE members were doctors (who normally become the leaders of DHE teams) and pharmacists.

According to a senior PHE member, the absence of some DHE members from the hospital resulted in some problems such as a leadership handicap, lack of vision as well as the issue with the logistics of medical supply chain where pharmacists were concerned. Also the deployment of doctors to district hospitals, after a long time, most of whom were young, experimental and quite raw, and thought that they were in charge and were knowledgeable caused the destabilization of the health delivery system, a problem that needed to be managed a lot.

However, nine (9) respondents were quick to point out that resources for doing work were not available, and that this had a major influence on how one performed their work. For example, a sizable number of respondents noted that there were no adequate human resources to do work following a freeze on employment by the government. There were inadequate funds to purchase medicines, and sundries like syringes, gloves and x–ray films. There were no funds to buy fuel, for example, to carry out support and supervision in the rural health centres. One respondent observed that they (DHE members) were expected to perform and yet resources were not available. Another respondent pointed out that lack of resources led to problems such burnout among the DHE members. There was therefore general consensus that DHE work performance was influenced by poor working conditions, which led not only to brain drain, but also lack of resources to use.

Another respondent observed that the donor funds that health workers were receiving as allowances caused controversy in some districts if they were not distributed well. The funds had to be distributed well so that people would not feel that they had been disadvantaged. If people felt that they had been disadvantaged they resisted.

19. How can conditions of service be improved to motivate DHEs in carrying out their work?

On this question, a recurrent response was that the government should provide the DHE members with affordable loans that would be payable in small instalments so that the DHE members can construct or buy houses, buy vehicles and be able to send their children to school. This response came from virtually all respondents. A house, a vehicle and sending children to school appeared to be the things that were at the hearts of most respondents. Suggesting that the government should provide them with loans probably was an acknowledgement on the part of the respondents that the government could not afford salary increments.

Ten (10) respondents concurred on the expectation that the government should provide them with loans to enable them to buy or construct houses, to buy vehicles and to send their children to school which appeared to be the three things that the DHE members prioritized.

Airtime, fuel and money for entertainment were mentioned in passing. The issues of retreats and peer reviews were mentioned by a few respondents.

Also recurrent was the concept of recognition. Most (eight DHE members interviewed) respondents felt that their efforts were not being recognized. Two PHE members also mentioned the importance of recognition. There were three aspects of recognition that came up in the interviews in connection with the idea of recognition. One was about the grading system. The argument was that there was need for a fair grading system for managers that was in keeping with qualifications. There was need to have properly laid down qualifications. Another line of argument was that people should be given remuneration that is commensurate with their responsibility. There was need for reasonable gaps between people in different grades so that the concept of recognition was acknowledged. If for example the monetary gap between two consecutive grades was one dollar, this did not motivate the incumbent in the higher grade. The position was expected to reflect monetary value.

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The issue of substantial gaps between salary steps in a salary structure became a topical one towards the end of the hyperinflationary period when the Zimbabwean dollar was discarded by the state. When government started paying its employees in foreign currency, there was a time when everyone across the board was paid US$ 100 as a salary. This went on for some time until a proper structure was put in place to acknowledge differences in qualifications and work experience. However, the differences in salary between adjacent salary steps have apparently remained very small, which appears to have remained a bone of contention.

On checking the differences between salary grades of DHE members as shown on the recent payslips, including that of January 2015, the differences were apparently significant, but that could be accounted for not only by qualifications, but also by the differences in years of experience as well as the responsibilities of the incumbent of a post. The difference between

the lowest paid and the highest paid DHE members was US$ 65, considering salaries only. For grades in between the differences between adjacent grades were US$ 28, US$ 12 and US$ 24. Other differences were accounted for by different allowances or a cadre not being entitled to an allowance. For example, a post classified as higher or more important was paid greater allowances in the form of transport allowance. Those DHE members who have a nursing background are paid a uniform allowance while others (DHE) are not paid. Doctors and pharmacy technicians (who have replaced pharmacists) are paid an on – call allowance while other DHE members are not paid.

So if is a DHE member and but is not a doctor or a nurse or a pharmacy technician, thenone is not entitled to the allowances as explained above. As can be seen, this issue has a bearing on teamwork as well. If one DHE member felt that someone was unfairly compensated in comparison with him or her, then the spirit of teamwork has the potential of being negatively affected.

20. Do you think there are other dimensions that we have not touched but still have a bearing on the performance of DHEs?

Most of the things that were mentioned on this question had been mentioned already in response to other questions above. For example, making resources available, recognition, adequate compensation, and autonomy. However, there was an interesting idea which ten (10) respondents believed was very important. This was the idea of integrity. The idea was that a manager would only be able to give instructions to subordinates if s/he had integrity. A manager who did not have integrity would have lost the legitimacy to successfully give instructions to subordinates.

In connection with integrity, it was observed by respondents (eight DHE members and two PHE members) that one issue which was rampant across many districts was DHE male members getting involved in sexual relations with junior staff. These relations dis–empowered them and they resulted in serious anarchy and chaos in institutions where people now had no moral ground or lost their legitimacy to give instructions or to manage the place. This was pointed out to be a serious issue that occurred even at PHE or at national level. A district could suffer poor performance because the managers would have lost the legitimacy to give instructions. This idea came up in various forms. Other respondents suggested that managers, although they were supposed to create rapport with their subordinates, were not supposed to be too close to their subordinates otherwise they would end up failing to

discipline the subordinates in question because of the close bond. Eight (8) DHE members and two PHE members concurred in general about the issue of integrity.

4.3 Summary of chapter

This chapter drew attention to the dimensions that DHE members and PHE members thought had in influence on the work performance of DHEs. Examples were the authoritarian, reactive nature of supervision; unfavourable conditions for building cohesive teams, lack of management knowledge and skills, and autonomy in DHE members; lack of integrity in some DHE members; and lack of motivation, in particular recognition, among DHE members; and lack of resources (for example, vehicles, fuel, human resources, funds, equipment, stationery). If these issues were addressed, it was hopped that this would result in the optimization of DHE work performance.

CHAPTER FIVE: CONCLUSIONS & RECOMMENDATIONS

5.0 INTRODUCTION

In this final chapter, the conclusions drawn from the study will be presented. Recommendation that need to be adopted by the DHEs that were studied, by other similar DHEs, as well as by the Ministry of Health and Child Care (MoHCC) will be made in order to optimize the work performance of DHEs.

5.1 CONCLUSIONS

The findings show whilst the PHE carries out supervision on the DHEs, some DHE members have management qualifications, some DHE members are cooperative, and the conditions of service have not yet deteriorated to the level of the conditions that prevailed in 2007 to 2008, some measures can be put in place to optimize the work performance of DHE members.

5.1.1 FINDING AN APPROPRIATE SUPERVISORY APPROACH

This research has established that supervision of DHE members, at least for those that participated in the research, is characterized by an authoritarian, reactive approach. Extant literature advocates supportive supervision (Hernandez et al., 2014), a condition that optimizes work performance. Findings indicate that this condition, supportive supervision is not complied with by supervisors. As a result of current supervision orientation in subordinates do not feel free with the in the presence of the supervisor, performance is not at the standard expected.

The above supervisory approach, is compounded by the fact that most supervisors (including DHE members themselves) have qualifications in technical disciplines. As has been explained above, the optimum condition for performance is not created.

5.1.2 BUILDING MANAGEMENT CAPACITY

A significant finding, which is related to the above, is that most DHE members and most PHE members have qualifications in their technical fields only, that is, medical discipline, pharmaceutical discipline, nursing discipline and environmental discipline. In their fields of study, they do not do courses that specialize in management. The irony is that some of them, with specific reference to doctors, and in some circumstances nurses, end up being the overall supervisors of other DHE members. Besides, these cadres supervise staff and activities in their own departments

5.1.3 ACHIEVING AUTONOMY

An interesting finding is that DHE members cannot take substantive decisions in their districts. The PHE, and sometimes the national head quarters always make decision on behalf the DHEs. For a decision to be made, the DHE members have to consult the PHE members.. The best decisions are the ones that are taken after thorough consideration of the situation. The solutions to the problems in the districts should be shouldered by DHE members and yet they do not have the authority to make decisions for the local areas.

In the current economic environment for example, there are no national budgets from the Government of Zimbabwe. People who go out on business used to claim travel and subsistence (T&S) allowances meant for their upkeep when carrying out work on behalf of the government. The only other source of money that people can use to claim for their T&S is the Health Services Fund (HSF). However, PMD through PHE ruled out money from HSF being used for payment of this purpose. The sources of funds for HSF are hospital fess, donor funds and inspection fees. The DHE, led by the DMO cannot use the HSF for the purpose of paying HSF.

However, health workers who go away from the station end up using their own money to buy food. This has demoralized health workers including the DHE members, but the DHE members cannot do anything about it.

5.2.4 INCREASING MOTIVATION

An important finding is that DHE members are not being properly motivated. Another issue related to motivation established in this research was that of recognition. People want to be recognized for their effort, for the number of years that they have worked, and when they excel and do exceptional work. In general, failure to motivate people demotivates them as gathered from this research. On the other hand, if people are motivated, their work performance can be optimized.

5.1.5 BUILDING A COHESIVE TEAM

The findings in this research show that there are conditions in place that do not promote the team spirit. An example is the fragmentation of the DHE members that has been occasioned by the running of disease control programmes. Heads of the programmes have developed a tendency to ring – fence the resources that come with the programmes for their own benefit.

The issue of salaries is another finding that some DHE members are not happy with the amount of money which they receive for their salary, in comparison with their colleagues. A team that is not united will not achieve objectives.

5.1.6 Mobilizing resources

This research established that DHEs were complaining about unavailability of resources (Human resources; fuel, funds, vehicles and so on). Unavailability of resources led directly to non – performance on the part of DHEs. This in turn led to burnout. Apparently government institutions cannot recruit new people into their organization because of the government freeze on employment. The prevailing environment does not allow government institutions to get enough fuel because there are no funds. So the issue of unavailability of resources remains intractable.

Lack of resources such as fuel and vehicles will make it impossible for DHEs to do support and supervision in clinics. Lack of human resources means some work will not be carried out, again causing burnout among the few staff members available. And yet at times the PHE seems to think that people can just perform.

5.1.7 INTEGRITY

An interesting discovery in this research was that some DHE members, particularly males, were in the habit of having sexual relations with their junior female counterparts. The result was that the DHE members in question lost their integrity and legitimacy to give instructions to their juniors. In effect it means that the junior employees withhold their labour. This brings DHE members into disrepute. Incidentally, a lot of chaos visits theses organizations. The end result is that the performance of the DHEs in question is compromised.

5.2 TESTING THE PROPOSITION

The proposition was that the DHEs may not be performing their work to higher expectations for a number of reasons including: inadequacy in training; lack of motivation; inadequate supervision; lack of teamwork, and; inadequate resources.

This proposition was largely supported by the findings of the research. For example, some DHE members lack adequate training in the sense that they do not have management training. They only have their professional training. DHE members are not well motivated to do their work, with some emphasis maybe on lack of recognition. DHE members do not receive adequate supervision, which is attributable to lack of resources (vehicles, fuel, for example). there is lack of teamwork because of prevailing conditions on the ground as explained elsewhere in this research. Also it is noted that resources are inadequate.

Because of the above, the research proposal was largely accepted.

5.3 Recommendations

Based on the findings above, the following recommendations are made:

5.3.1 Policy Recommendations

There is need to ensure that DHE members, as a matter of policy, should acquire management qualifications in order to improve both the efficiency and effectiveness of the health delivery system;

- There is need to ensure that DHE members, as a matter of policy, acquire management qualifications in order to improve both the efficiency and effectiveness of the health delivery system. Related to this, DHE members will learn formally about the tenets of supervision that will give them the most appropriate supervisory orientation. Acquisition of management skills is hoped to improve DHE work performance, and to improve the integrity of DHE members.

- There is need for Ministry of Health and Child Care to decentralize to give DHEs the autonomy to make local decisions effectively by taking into account each district's unique environment and to facilitate the DHEs to do the following**:** allocate resources effectively and efficiently; plan for effective utilization of time (for example, time for planning and for implementing their operational plans), and enable them to discipline staff substantively and timeously;

5.3.2 Management recommendations

- Ministry of Health and Child Care should improve the working conditions of health workers in general and the DHEs in particular in order not only to retain staff, but also to improve their performance. One way of doing this is to provide them (DHEs) with loans (payable in small affordable instalments) to enable them to buy/ construct houses, buy personal vehicles, and send their children to school.

- The PHE should improve on the frequency of supportive supervision; and take into account the need for a paradigm shift from supervision based on controlling the health worker to supervision based on the commitment of the health worker, and;

The PMD, through the Ministry of Health and Child welfare, should allocate adequate resources to districts to enable DHEs to perform at optimal level and to avoid the problem of burnout. The DHEs should be given not only adequate resources, but also the autonomy to decide how much resources should be channelled to which programme or vote. This will enable DHEs to allocate resources effectively and efficiently, and to remove the tendency to ring – fence resources for private benefit (resulting in fragmentation of DHEs);

- The MoHCC, through the PMD, should allocate adequate resources to districts to enable DHEs to perform at optimal levels and to avoid the problem burnout. The DHE members should be given not only adequate resources, but also the autonomy to decide how much resources should be allocated to which programme or vote; this will enable DHE members to allocate resources effectively and efficiently,; and to remove the tendency to ring – fence resources for private benefit;
- There is need for a job evaluation exercise to regularize salary structures.

- There is need for DHEs to be trained so that they respect their integrity.

5.5 Contribution to knowledge

Any research aims at producing and adding new knowledge. This research's contribution to knowledge has been to discover such dimensions as:

- integrity in influencing work performance.;

It is hoped that taking into account this factor will assist in improving work performance of DHEs

5.6 Limitations of study

Some of the limitations this researcher cam across were ;

- The qualitative methodology was used for carrying out the research. The research participants were selected using non – probability sampling, that is, purposive sampling to be precise. Given that the sample that was selected was not a representative sample; the results emanating from the study cannot be generalized

- The qualitative methodology was used. As a researcher on is also part of the instrument for collecting data. the researcher might have introduced bias in the data

5.7 Areas for future researcher

On the basis of the findings of this research the following are two areas of research which need to be researched further:

- The concept of integrity is one of the concepts that came up during the study. The research participants were concerned that had some DHE members had lost legitimacy to give instructions to their subordinates due to untenable relations (such as being intimate) with their junior staff. Further research needs to be carried out to establish the level and extent of loss of integrity and legitimacy.
- The other area for future study is the level of autonomy that need to be given to DHE when they are doing their

REFERENCES

-Adzei, F. A., Atinga, R. A. (2012) 'Motivation and Retention of health workers in Ghana's hospitals. Addressing the critical issues', *Journal of Health Organization and Management*. 26 (4), 467 – 485.

- Arber, A (2005) 'Reflexivity: A Challenge for the Researcher as Practitioner? Negotiating Access.' (http://www.nova.edu/ssss/QR/QR13-4/ortlipp.pdf : accessed on 16 July 2014)

-Amonoo – Lartson, R., Ebrahim, G.J., Lovel, H.J. and Ranken, J.P. (1989) District Health Care: Challenges for Planning, Organization and Evaluation in Developing Countries. Basingstoke and London Macmillan Education Limited

-Armstrong, M. (2006) A Handbook of Human Resources Management Practice. 10TH Edition. London and Philadelphia. Kegan Page.

-Analyzing Qualitative Data (http://www.utexas.edu/academic/diia/assessment/iar/resources/quicktips/quicktip_7- 32.pdf : accessed on 4 June 2014)

-Basford, T. E. (2014) 'Supervisor transgressions: a thematic analysis', *Journal of Leadership and Organizational Development* 35 (1), 79 –97 Emerald Group Publishing Limited

-Basavanthappa, B. T. (2000) Nursing Administration. Jaypee Brothers Medical Publishers P/P, New Delhi, India

-Berlin, J. M. (2014) 'Common incentives for teamwork–the unspoken contract's significance', *Team Performance Management* 20 (½), 65–80

-Bhatti, M. A., Battour, M. M., Sundram, V. P. K. and Othman, A. A. (2013) 'European Journal of Training and Development', 37 (3), 273 – 297

-Bhatti, M. A. and Kaur, S. (2010) 'The Role of Individual Training and Training Design Factors on Training Transfer', *Journal of European Industrial Training* 34 (7), 656–672

-Bisel, R. S., Messersmith, A. S., and Kelley, K. M. (2012) 'Supervisor–Subordinate Communication: Hierachical Mum Effect Meets Organizational

Learning', *Journal of business communication* 49 (2), 128 – 147

-Brunetto, Y., Farr–Wharton, R. and Shacklock, K. (2010) 'The impact of supervisor – subordinate relationships on morale: implications for public and private sector nurses' commitment', *Human Resources Management Journal*, 20 (2),

-Carpenter, J., Webb, C., Bostock, L. and Coomber, C. (2012) Effective supervision in social work and social care. Social Care Institute for Excellence www.scie.org.uk/publications/breifings (accessed on 1 May 2014)

-Carter, M. (2008) Basic Overview of Supervision http://www.managementhelp.org/supervise/supervise.htm (Accessed on 28 May 2014)

-Chandan, J. S. (2005) Management Theory and Practice. Vikas Publishing House Pvt Ltd.

-Chiang, F. F T., Birtch, T. A. (2012) 'The Performance Implications of Financial and Non–Financial Rewards: An Asian Nordic Comparison', *Journal of Management Studies*. 49, 538–570.

-Crawford, E. R. and Lepine, J. A. 'A configural theory of team processes: accounting for the structure of taskwork and teamwork', *Academy of Management Review*. 38 (1), 32 – 48.

-Cole, G. A. (1996) Management Theory and Practice, Continuum. London, UK.

-Day, S. (2012) 'A Reflexive Lens: Exploring Dilemmas of Qualitative Methodology through the Concept of Reflexivity', *Qualitative Sociology Review* 8 (1) 60-85(http://www.qualitativesociologyreview.org/ENG/Volume21/QSR_8_1_Day.pdf: accessed 16 July 2014).

-Department of Community Medicine and University of Zimbabwe (2011) District Health Executive Trainings. Harare. Unpublished.

- Dermol, V. and Cater, T. (2013) 'The influence of training and training transfer factors on organizational learning and performance', *Personnel Review* 42 (3), 324 – 348

-Doef, M. V. D., Mbazzi, F. B. and Verhoeven, C. (2012) 'Job conditions, job

satisfaction, somatic complains and burnout among East African nurses. Nurse health well–being', *Journal of Clinical Nursing*, 21, 1763–1775.

-Elger 'The Theory of Performance'

http://www.webs1.uidaho.edu/ele/scholars/Results/Workshops /Facilitators _Institute/Theory%20of%20Performance.pdf: (Accessed on 5 June 2014).

-Ezziane, Z., Maruthappu, M., Gawn, L., Thompson, E. A., Athanasiou, T. and Warren, O. J. (2012) 'New Perspectives. Building Effective Clinical Teams in Health Care', *Journal of Health Organization and Management* 26 (4), 428–436.

- George, G., Atujuna, M. and Gow, J. (2013) Migration of South African workers the extent to which financial considerations influence internal flows and external movements. Health Economics and HIV and AIDS Research Division (HEARD) South Africa. BioMedical Central Health Services Research 2013, 13.

-Gilles, G. E. (1994) Nursing Management: A System Approach. W. B. Saunders Company, Philadelphia.

-Ghosh, P., Satyawadi. R., Joshi, J. P., Ranjan, R. and Singh, P. (2012) 'Towards more effective training programmes: a study of trainer attributes', *Journal of Industrial and Commercial Training* 44 (4), 194 – 202

-Goffman, E. (1967) The Nature of Deference and Demeanour. National Institute of Mental Health, Bethesda, Maryland.

-Goh, S. C., Chan, C. and Kuziemsky, C. (2013) 'Teamwork, organizational learning, patient safety and job outcomes', *International Journal of Health Care Quality Assurance.* 26 (5) 420–432.

-Government of Zimbabwe (1984) Accounting Procedures Manual. Zimbabwe. Government Printers

-Government of Zimbabwe (2012) Public Finance Management Act Chapter 22:19, Government Printers. Zimbabwe

-Hernandez, A. R., Hurtig, A., Dahlblom, K. and Sebastian, M. S. (2014) More than a

checklist: a realist evaluation of supervision of mid – level health workers in rural Guatemala. BioMed Central Health Services Research 2014. http://urn.kb.sec/resolve?urn=urn:nbn:se:umu:diva-87000 (accessed on 28 May 2014)

-Honts, C., Prewett, M., Rahael, J. and Grossenbacher, M. (2012) 'The importance of team processes for different team types', *Team Performance Management* 18 (5/6), 312–327

-Hutchins, G (1994) Taking Care of Business. Oliver Wight Publications Inc. USA. Portland, Maine: Stenhouse Publishers. (http://www.utexas.edu/academic/diia/assessment/iar/how_to/interpreting_data/interviews/evaluation.php: accessed on 4 June 2014))

-Iipinge, S.N., Hofnie, K., Westhuizen, L.V.D., and Pendukeni, M. (2006) Perceptions of Health Workers about conditions of service: A Namibian case study. Regional Network for Equity in Health in Southern Africa (EQUINET). EQUINET DISCUSSION PAPER 35. With support from SIDA (Sweden).

-Jira, C., Feleke, A. and Mitike, G. (2004) Health Planning and Management for Health Extension Workers In Collaboration with the Ethiopia Public Health Training Initiative, The Cater Centre. (http://www.cartercenter.org/resources/pdfs/health/ephti/library/lecture_notes/health_extension_trainees/LN_HEW_hlth_plng_final.pdf: accessed on 28 May 2014)

-Kalargyrou, V. and Woods, R. H. (2011) 'Wanted: training competencies for the twenty – first century', *International Journal of Contemporary Hospitality Management* 23 (3), 361 – 376

-Karimi, l., Gilbreath, B., Kim, T. and Grawitch, M. J. (2014) 'Come rain or come sunshine: supervisor behaviour and employee job neglect', *Journal of Leadership and Organizational Development* 35 (3) 210 – 225

-Kothari, C.R. (2004) Research Methodology: Methods and Techniques. Second Revised Edition. New Delhi. New Age International (P) Limited, Publishers.

-Koopmans, L., Bernaards, C. M., Hildebrandt, V. H., Schaufeli, W. B., Vet, H. C. W. D. and Beet, A. J. V. D. (2011) 'Conceptual Frameworks of Individual Work Performance : A Systematic Review', *Journal of Occupational and Environmental Medicine* 53 (8), 856 – 866.

-Kwambana, L., Zizhou, S.T. and Tshimanga, M. (2013) Performance of District Health

Executives in Mashonaland East Province. University of Zimbabwe. Unpublished Masters Dissertation.

LaBelle, J.E. (2005) 'The Paradox of Safety Hopes and Rewards', *Professional Safety* 50 (12), 37-42.

-Laforest, J. (2009) Guide to Organizing Semi – Structured Interviews with Key Informants. Charting a Course to Safe Living, Vol. 11 htpp://www.crpspc.qc.ca/default _an.asp?fichier=outils_diagnostic_an.htm (accessed on 4June 2014).

-Lambert, C., Jomeen, J. and McSherry, W. (2010) 'Reflexivity: A Review of the Literature in the Context of Midwifery Research', *British Journal Of Midwifery* 18(5) 321 – 326

-Lancaster, S., Milia, L. D. and Cameron, R. (2013) 'Supervisor behaviours that facilitate training transfer', *Journal of Workplace Learning* 25 (1), 6 – 22

-Lucey, T. (1995) Management Information Systems. 7th Edition DP Publications Alpine Place London

-Martin, H. J. (2010) 'Improving training impact through effective follow–up: techniques and their application', *Journal of Management Development* 29 (6), 520 – 534

-Marquez, L. and Kean, L. (2002) Making Supervision Supportive and Sustainable: New Approaches to Old Problems. Maximizing Access and Quality Paper No. 4 Supplement to Population Reports, Volume XXX, No. 4. Management and Leadership Program of Management Sciences for Health. Johns Hopkins Centre for Communication Programs. (https://www.k4health.org/sites/default/files/maqpaperonsupervision_0.pdf: Accessed 28 May 2014)

-Ministry of Health Child Welfare (2001) Organizations and Functions. "Working for Equity and Quality". Office of the Secretary of Health.

-Morita, P.P. and Burns, C. M. (2014) 'Trust tokens in team development', *Team Performance Management* 20 (1/2), 39-64

-Mouton, J. and Marais, H. C. (1990) Basic Concepts in the Methodology of the Social Sciences. HSRC Series in Methodology. South Africa.

-Muchekeza, M., Chimusoro, A. and Gombe, T. N. (2012) 'District Health Executives in Midlands Province, Zimbabwe: are they performing as expected?'

BioMedicalCentral The Open Access Publisher. BMC Health Services Research http://www.biomedicalcentral.com/1472-6963/12/335 (accessed on 25 May 2014).

-Mullen, K.J., Frank, R.G. and Rosenthal, M.B. (2010) 'Can you get what you pay for? Pay-for performance and the quality of healthcare providers', *RAND Journal of Economics*, 41 (1), 64-91.

-Mutizwa-Mangiza, D. (1998) The Impact of Health Sector Reform on Public Sector Health Worker Motivation in Zimbabwe. Major Applied Research 5, Working Paper 4. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc. www.phrproject.com. (accessed on 15 May 2014)

-Mwazungunya, P. (2009) Support and Supervision by District Health Executives: A Case Study of Mashonaland East Province. National University of Science and Technology/ZIPAM. Unpublished Dissertation.

-National AIDS Control Programme (2010) A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services The United Republic of Tanzania Ministry of Health Social Welfare (http://www.jica.go.jp/project/tanzania/001/materials/pdf/common_03_01.pdf: Accessed 28 May 2014)

-Olukoga, A., Bachmann, M., Harris, G., Olukoga, T. and Oluwadiya, K. (2010) 'Analysis of the perception of institutional function for health sector reform in Nigeria', *Journal of International* 2 150 – 155

-Olupeliyawa, A. M., Hughes, C., Chinthaka D. Balasooriya, C. D. (2009) 'A review of the literature on teamwork competencies in healthcare practice and training: Implications for undergraduate medical education', *South East Asian Journal of Medical Education* 3 (2), 61 – 72

-Ortlipp, M. (2008) 'Keeping and Using Reflective Journals in the Qualitative Research Process', *The Qualitative Report* 13(4) 695 – 705 http://www.nova.edu/ssss/QR/QR13-4/ortlipp.pdf :accessed on 16 July 2014)

-Pineda–Herrero, P., Belvis, E., Moreno, V., Duran – Bellonch, M. M. and Ucar, X. (2011) 'Evaluation of training in effectiveness in the Spanish Health sector', *Journal of Workplace Learning* 23 (5), 315 – 330

-Perera, G. D., Khatibi, A., Navaratna, and Chinna, K. (2014) 'Job Satisfaction and Job Performance among factory employees in apparel factory', *Asian Journal of Management Sciences and Education* 3 (1) 96 – 104

-Rad, A. M. M. and Moraes, A. D. (2009) 'Factors affecting employees' job satisfaction in the public hospitals: Implications for recruitment and retention', *Journal of General Management.* 34 (4) Summer 2009.

-Rahman, A. A., Imm Ng, S., Samabsivan, M. and Wong, F. (2013) 'Training and organizational effectiveness: moderating role of knowledge management process', *European Journal of Training and Development* 37 (5), 472 – 488

-Rynes, S.L., Gerhart, B. and Parks, L. (2005) 'Personnel Psychology: Performance Evaluation and Pay for Performance', *Annual Review of Psychology* 56 (1), 571-600.

-Riley, W., Lownik, E., Parrotta, C., Miller RN, K. and Davis, Stan (2011) 'Creating High Reliability Teams in Healthcare through in *situ* Simulation Training', *Journal of Administrative Sciences* 1 14 – 31 www.mdpi.com/journal/admsci (accessed 15 April 2014)

-Sail, R. M. and Alavi, K. (2010) 'Social skills and social values training for future k–workers', *Journal European Industrial Training* 34 (3), 226 – 258

-Saunders, M., Lewis, P. and Thornhill, A. (2009) Research Methods for Business Students. Fifth Edition. E. T. Prentice Hall. Pearson Education. England.

-Scholl, R. W and Schmidt, C. T. (2003) Individual Performance: The Performance Model http://www.uri.edu/research/lrc/scholl/webnotes/Performance.htm Accessed on 5 June 2014)

-Sithole, A. (2013) 'Results Based Financing in Zimbabwe: Any Changes in the Health Delivery System?', *Journal of Social Welfare and Human Rights* 1 (1), 36–46

-Songstad, N. G., Rekdal, O. B., Massay, A. D., and Blystad, A. (2011) 'Perceived unfairness in working conditions: The case of public health services in Tanzania', *BioMedCentral Health Services Research*. 2011. 11.34 Centre for International Health. Norway

-Stoner, J. A. F., Freeman, R. and Gilbert, Jr. D. (2006) Strategic Management: Concepts and Cases. Tata McGraw Hill Publishing Company, New Dehli, India.

-Tanco, M., Jaca, C., Viles, E., Mateo, R. and Santos, J. (2011) 'Healthcare teamwork best practices: lessons for industry', *The TQM Journal* 23 (6), 20 598 – 610

-The National Health Strategy for Zimbabwe (2009-2013) Equity and Quality in Health: A People's Right. Ministry of Health and Child Welfare. Harare, Zimbabwe.

The National Child Survival Strategy for Zimbabwe 2010 – 2015 UNICERF World Health Organization

-Tsai, k. and Wang, J. (2005) 'Benefits offer no advantage on firm productivity? A empirical examination', *Personnel Review*. 34 (4), 393 – 405.

-Turner, D. W. (2010) 'Qualitative Interview Design: A Practical Guide for Novice Investigators', *The Qualitative Report* 15 (3) 754 – 760. htpp://www.nova.edu/ssss/QR/15-3/qid.pdf (Accessed on 4 June 2014).

-United States of America (1989) Content Analysis: A Methodology for Structuring and Analyzing Written Material. General Accounting Office. Transfer Paper 10. 1.3: (www.archive.gao.gov/d48t13/138426.pdf : accessed on 4 June, 2014).

-USAID (2008) Guidelines for the Supportive Supervision in the Health Sector Ethiopia (http://www.initiativesinc.com/resources/publications/docs/SSguidevol1.pdf: accessed 28 May 2014)

-Valentine, M. A., Nembhard, I. M. and Edmondson, A. C. (2011) 'Measuring Teamwork in Health Care Settings: A Review of Survey Instruments', Working Paper 11 – 116 Harvard Business School

-Vaughan, J. P. and Morrow, R. H. (Eds)(1989) Manual of Epidemiology for District Health Management. London School of Hygiene and Tropical Medicine. World Health Organization.

-Viswesvaran, C. and Ones, D. S. (2000) 'Perspectives on Models of Job Performance', *International Journal of Select Assessment* pp. 216 – 226.

-Waal, A. D. and Jansen, P (2013) 'The Bonus as Hygiene Factor: The Role of Reward Systems in the High Performance Organization', *Evidence – Based HRM: A Global Forum for Empirical Scholarship.* 1 (1), 41 – 59

-Watt, D. (2007) 'On Becoming a Qualitative Researcher: The Value of Reflexivity', *The Qualitative Report* 12(1) 82 – 101. (http://www.nova.edu/ssss/QR/QR12-1/watt.pdf: accessed 16 July 2014)

-Werner, R. M., Kolstad, J.T., Stuart, E.A. and Polsky, D. (2011) 'The effect of pay-for-performance in hospitals: lessons for quality improvement', *Health Affairs*,

30 (4), 690-698.

-West, M. A. and Lyubovnikova, J. (2013) 'Illusions of team working in health care', *Journal of Health Organization and Management* 27 (1), 134 – 142

-Yaw, D. C. (2008) 'Tools of transfer', *Journal of Industrial and Commercial Training* 40 (3), 152 – 155

-Yin, R. K. (2003) Case Study Research : Design and Methods. Third Edition. Applied Social Research Series. Volume 5 SAGE Publications London

APPENDIX ONE INTERVIEW GUIDE QUESTIONS

Research Topic:

Dimensions influencing the performance of DHEs in Mashonaland East Province

1. How do you explain the concept of "supervision"?
2. Given what you have said, may I have your opinion about the supervisor's knowledge, vis – a – vis that of the person s/he intends to supervise?
3. How relevant is supportive supervision to DHE work performance?
4. Focusing on the DHEs, how does the supervisor interpret the role that s/he should take during the process of supervision?
5. Focusing on the DHEs, how does a supervisor's management style get generated during the supervision process?
6. How do you explain the concept of management development?
7. Looking at the DHEs, how has management development or lack thereof influenced work performance of DHEs?
8. In terms of management development, may I have your opinion on whether or not DHEs need management development in order to improve their work performance?
9. Who should be involved in the selection of management development course content and why?
10. Suppose that DHEs have undergone management development; how can the application of the acquired knowledge, skills and abilities be maximized at the place of work?
11. Let us move on to the concept of teamwork. How do you explain teamwork?
12. How relevant is teamwork to the work performance of DHEs?
13. May you explain the role the team leaders can play to make the DHEs more collaborative?
14. May you explain the role team members can play to ensure that DHEs become more collaborative?
15. In your opinion, are there other ways or means of ensuring that DHE members are more collaborative other than the role of team leaders or the role of team members?

16. How can team skills training optimize interdisciplinary interdependency in the health care environment?

17. How do you explain the concept of conditions of service or work?
18. How have conditions of service or work influenced the work performance of DHEs?
19. How can conditions of service be improved to motivate DHEs in carrying out their work?
20. Do you think there are other dimensions that we have not touched on but still have a bearing on the performance of DHEs?

APPENDIX TWO Codes, Categories and Themes

Code	Category	Theme
Follow up of work; Controlling duty execution; Checking on work; Monitoring work;	Controlling behaviour	Supervisory behaviour
Supportive behaviour	Supportive behaviour	
More knowledge; More knowledge and experience; more experience	Superior professional status	
Brings results; brings beneficial results; helps to adapt; capacitates DHEs; ; helps achieve mandate	Beneficial organizational intervention	
Fragments health care delivery; unbeneficial	Compromising service delivery	
Subordinate receptiveness ; Situation interpretation; understanding Subordinate behaviour; Supervision purpose; stop shumbavision;	Situation perception	
Subordinate's attitude; Cadre's expertise, knowledge and experience; Effect of issues on supervisor; Effect on supervisor of how duties are carried out; Situation interpretation; Subordinate's cooperation; Subordinate's reaction;	Situation perception	
Code	**Category**	**Theme**
Acquiring skills	Skills acquisition	Management capacity
Indecisive; Unable to check on work; Unable to coordinate; Unable to coordinate; Unable to resolve problems; Unable to coordinate; Bad decision making; Unable to handle management issues; Unable to coordinate;	Non-functional Management	
Uprightness; legitimacy; role model;	Integrity	
improve performance; Acquire skill; Achieve knowledge gradient; be respected Achieve knowledge gradient; be respected; know roles; management decision; no experience; No skills; Motivate them; no skills	Capacity building	

Code	Category	Theme
no room for decision making; No decision making power; PHE prescriptive; no decision making room	Non autonomous position	Management capacity
Avail resources; resources provision; Provide resources; provide tools of trade;	Resource constraint	
Code	**Category**	**Theme**
Task sharing; Align effort; Non achievement;	Valuable outcomes	
Bring members together; acknowledge good performance; Facilitate teamwork; Encourages teamwork; Aligns members' effort; Coordinates team effort	Coordination function	Cohesiveness
Cooperative; Supportive; Effective; helpful; Dependable; Encouraging; Openness; supportive; Accountable	Supportive behaviour	
Respect; complementary role learning; Task sharing; Team skills acquisition; Complementing each other;	Team building	
Code	**Category**	**Theme**
Work environment; compensation; Employment aspects; fairness;		Motivation
Brain drain; moonlighting; leadership gap; supplementing income; frustration; despondency; demoralization: performance failure; system instability	Service conditions effect	
Non commensurate compensation; distinguishing posts; appreciated? Unfair grading system; no length of service acknowledgement; no acknowledgement for excelling at work ; use of company vehicles; private disciplining of senior staff; small salary gap	Recognition	
No vehicles; no syringes; no human resources; no funds ; no stationery; no fuel; no drugs	Resource constraint	

Code	Category	Theme
Loans; recognition; avail resources; professional and career opportunities; retreats; competitive compensation;	Improve conditions	Motivation

APPENDIX THREE Profiles of Research Participants

Case	Professional	Age	Sex	Experience (in years)	Station /hospital
R1	Nursing	49	F	20	Station 1
R2	Environmental Health	36	M	8	Station 1
R3	Medicine	50	M	25	Station 2
R4	Administration	48	M	25	Station 2
R5	Nursing	59	F	25	Station 1
R6	Environmental Health	34	F	7	Station 3
R7	Environmental Health	57	M	26	Station 2
R8	Administration	38	F	6	Station 3
R9	Nursing	40	M	15	Station 3
R10	Administration	38	M	6	Station 4
R11	Accounting	39	M	11	Station 4
R12	Administration	51	M	25	Station 2
R13	Nursing	56	F	27	Station 2
R14	Medicine	38	M	8	Station 4
R15	Nursing	59	F	30	Station 2