AN ANALYSIS OF LEADERSHIP PRACTICES AND THEIR INFLUENCE ON PROVIDERS AND SERVICE DELIVERY IN LUSAKA PROVINCE-ZAMBIA

BY

REGINA M. MULENGA (SR.)

A dissertation submitted in partial fulfilment of the requirements for the award of the degree of Master of Public Health in Health Policy and Management

THE UNIVERSITY OF ZAMBIA

LUSAKA

NOVEMEBR, 2017

DECLARATION

I, **Sr.Regina Mulenga** declare that this dissertation submitted to the University of Zambia as partial fulfilment of the award of the degree of Master of Public Health (Health Policy and Management) is my own work and has not been submitted either wholly or in part for another degree to this University or any other or Institute of Higher Education.

Signed (Candidate)…… **Date…….**

COPYRIGHT

CERTIFICATE OF COMPLETION OF DISSERTATION

The undersigned certify that they have read the dissertation and are satisfied that it is the original work of the author under whose name it is being presented.

Signed (Principal Supervisor): …… **Date: ……**

Dr. Selestine Nzala

School of Public Health

Signed (Co-Supervisor): …… **Date: ……**

Dr. Wilbroad Mutale

School of Public Health

Signed (Dean of School): …… **Date: ……**

Prof. Charles Michelo

School of Public Health

CERTIFICATE OF APPROVAL

This dissertation by **Sr.Regina M Mulenga** is approved as a partial fulfilment for the requirements for the award of the degree of Masters in Public Health (MPH) by the University of Zambia.

Examiner: 1 ……..... Signature..... Date……..

(Mr. Allan Mbewe)

Examiner: 2 ……..... Signature..... Date……..

(Dr. Likwa Nyondo)

Examiner: 3 ……..... Signature..... Date……..

(Mrs Juliet Musabula)

Head of Department-Health Policy and Management

Name……..... Signature..... Date……..

ABSTRACT

In an evolving health care environment, hospitals need managers with high levels of technical and professional expertise who do not only concentrate on patient care, but also go further to demonstrate good leadership practices. In Zambia, the health sector's mission is "to provide equity of access to cost-effective quality health services as close to the family as possible". Only competent leadership can drive such an agenda. This study, conducted in selected 1st level Lusaka hospitals aimed at establishing the existing common leadership practices and their influence on healthcare providers and service delivery.

The study used a two-phase cross sectional concurrent, mixed method design, to examine leadership practices through 12 health system managers and 30 healthcare providers. Quantitative data was obtained using a Multifactor Leadership Questionnaire (MLQ) and analysed using Statistical Package for Social Sciences Version 20 (SPSS 20). Qualitative data was obtained using in-depth interviews, focus group discussion, participant observation and document review. Quantitative analysis used averages and Pearson Chi-square tests to assess the interaction between Transformation, Transaction and Laissez-faire as independent variables and extra effort, effectiveness, motivation, satisfaction as dependent variables. The P- value of 5% was used to determine the significance. Qualitative data analysis was done by first transcribing audio-recorded interviews and grouping them into data sets (matrixes) where emerging themes were categorised manually. Qualitative data was used to build on the quantitative data to make conclusions and interpretations by providing prominent explanations.

The common leadership practices preferred and perceived or experienced was the transformational leadership followed by transactional leadership while laissez-faire was rare type. The significant *p-value* of *0.001* demonstrated this. These practices were explained as networking, interpersonal relationship, human/material resources management, monitoring and evaluation, dictatorial tendencies and overworking of employees. Furthermore, the above practices were seen to have strong influence on healthcare providers through enhanced confidence, motivation for hard work and compromised quality of care. The resultant impact on service delivery was high quality performance as well as poor performance.
Conclusion: The Ministry of Health policy makers should focus their attention on planning and implementing ongoing leadership and management trainings strategies that would strengthen the prevailing transformational and transactional leadership styles. This will help to strengthen health systems in leadership and governance, human resources for health and service delivery.
The recommendation is that a similar study be done to compare the impact of leadership styles between government and private or mission hospitals.

Key words: Transformational Leadership, Transactional Leadership, Laissez-faire Leadership, and Leadership Practices.

DEDICATION

I would like to dedicate this dissertation to my late dad John Mulenga who moulded me into a courageous person with a great sense of dedication and commitment to hard work.

In addition, I would like to dedicate this dissertation to my mum Mariana Mulubwa for a solid Christian catholic faith that has helped me live as a catholic nun for the past 26 years.

Lastly, I would like to dedicate this dissertation to my religious sisters- the Servants of Mary, my brothers and sisters, cousins, nephews, nieces and friends close to my heart. They have always expressed love and willingness to help me in every way possible without hesitation whenever I needed their help to complete this challenge.

ACKNOWLEDGEMENT

First of all, I would like to acknowledge the Almighty God for giving me the grace not to be afraid to challenge myself with courage to achieve the goals of developing this dissertation with strength and wisdom needed.

Secondly I would like to thank the following people for their invaluable support in coming up with this research project.

Dr.Nzala Selestine my principle supervisor for providing me with detailed guidance and specific feedback in a timely manner. To the Co-Supervisor Dr.Mutale Wilbroad for assisting me with the guidance I needed and by offering himself with passion in this study.

Mrs Grace Sikolongo for providing me specific area of focus and assisting me with the editing process. You were very encouraging and gave me hope. To Mr. Mulabanya M and Mr Israel N for helping me with methodology, despite your busy schedule your flexibility and support will not be forgotten.

The former Lusaka PMO Dr.K.Malama, DMOs(Lusaka, Rufunsa, Chongwe and Chirundu Districts),Hospital in charges (Mtendere mission hospital, Chongwe District hospital, Chipata 1st level hospital, St.Luke's Mission Hospital, MKP Hospital and St.John's Medical center and all my participants without them this study would not have taken place.

To all Public Health faculty members, my religious family, class mates, family members, friends and not forgetting Sr.Matilda Mubanga for taking up my duties during my study period. I am so grateful to be surrounded by such wonderful people.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF APPENDICES

ABBREVIATIONS

CHAZ	Churches Health Association of Zambia
CIDA	Canadian International Development Agency
CSO	Central Statistical Office
DMO	District Medical Office
HSS	Health System Strengthening
LPHO	Lusaka Provincial Health Office
MOH	Ministry of Health
MoNP	Ministry of National Development and Planning
MLQ	Multifactor Leadership Questionnaire
PMO	Provincial Medical Office
SPSS	Statistical Package for Social Sciences
USAID	United States Agency for International Development
UK	United Kingdom
USA	United States of America
WHO	World Health Organization

DEFINITION OF TERMS

Achievement oriented leader-refers to a leader who sets challenging goals and expects followers to perform at highest level

Active management-by-exception occurs when leaders constantly monitor their workers performance, keep track of their mistakes and immediately takes action

Autocratic- refers to a leader who displays authoritarian leadership style, tells the followers what to do and how to do it

Contingent reward provides others with rewards in exchange for their effort

Democratic- refers to the leader who encourages and assists discussion and group decision making-; human relations and team work is the focus

Effectiveness in this context refers to the ability of obtaining desired results of the hospital as well as meeting the needs of clients

Extra effort refers to doing more than what is required and being motivated to achieve success

Healthcare sector – refers to an entity mandated to provide healthcare services to the general public

Health system – consist of all organizations, people and actions whose primary intent is to promote, restore or maintain health

Health system building blocks- refers to the way in which WHO has organized the health system into six (6) functioning units that includes, leadership & governance, health financing, service delivery, human resources for health, health information system and medical product, vaccines & technology.

Health system strengthening- refers to improving the six (6) health system building blocks and managing their interaction in ways that achieve more equitable and sustainable improvement across health services and health outcome

Healthcare provider- refers to persons who provides the healthcare services professionally

Healthcare services-these are health services provided by the healthcare providers with the aim of preventing, alleviating, healing illnesses in persons e.g. nursing care, laboratory services, radiation services etc

Healthcare worker- refers to persons working in different sections within a healthcare facility

Hospital Administrator – refers to the health care worker charged with the responsibility of ensuring that all health care services and non health care services are provided effectively and efficiently by all healthcare workers

Influence - refers to the effects that the hospital administrators and matron's leadership styles will have.

Idealised attributes explain the degree that leaders are able to instil pride in their followers for being associated with the group

Idealised behaviour explain the extent to which leaders establish trust among their followers in order to build a shared mission and vision within the group

Inspirational motivation indicates the extent that leaders are able to communicate a shared vision, establish commitment from their followers in achieving the goals set forth by the organisation

Intellectual stimulation is where leaders involve followers in decision making process and encourage them to find creative solutions to problems

Individualised consideration describe the degree to which the leaders are able to develop new leaders by providing support and encouragement to their followers

Job satisfaction is the feeling and attitude of people towards their job

Laissez-faire – refers to a leadership style where a leader avoids interference, making decision and let events take their own course

Leadership - is defined here as the process of leading a group and influencing that group to accomplish its goals

Leader- is someone who can influence others and who has managerial authority

Leadership Practices-are different habitual actions, behaviours or performance undertaken by a leader to influence others accomplish organization goals

Matron-refers to the person charged with the responsibility of ensuring that patients receive maximum nursing care services

Passive management-by-exception occurs when leaders fail to monitor their workers performance and do not interfere until the problem becomes serious

Practice: refers to actions or what really happens

1st level hospital- also called 'District Hospital' refers to a health facility that offers outpatient and inpatients health services requiring regular monitoring and intervention by the medical doctor

Servant leadership- is servant first that brings natural feeling that one want to serve first and is guided by a set of principles that enriches the lives of individuals

Situational leadership- suggest leaders adapt their style to follower's development or maturity, based on how ready and willing the follower is to perform required task

Transformational-refers to a leader who motivates followers to perform to their full potential over time by influencing a change in perceptions and by providing a sense of direction for the benefit of the organization

Transaction- refers to a leadership style where a leader predefine objectives and goals and uses rewards, punishment to motivate subordinates

CHAPTER ONE

INTRODUCTION

1.1 Background

The health care sector has experienced significant and rapid changes and hospital leaders have had to respond to new technology, new organisational goals and new challenges (Abdelhalfiz et. al, 2015; WHO, 2012).In this evolving and challenging environment, health care organizations must ensure high levels of technical and professional expertise. At the same time, they must develop the leadership capacity needed to adapt and succeed in the future (Centre for Creative Leadership; CCL, 2011). Health care industries are known to be poorly managed in many countries across the globe. There is plenty of evidence that research practice gap exists in health care policy and management and the problem of overuse, underuse and misuse can be seen in the way health care organizations are managed and health care services delivered (Walshe and Rundall, 2001). This gap can be filled in through interventions which this study can recommend.

In the UK for example, there have been growing strategies in leadership in healthcare system at National level. In the 1980s there was an introduction of general management to the UK National Health System followed by an internal market for health care in 1990.The aim was to provide the opportunity for managers to work differently and to create personal space for leadership (Goodwin, 2001)

In the USA, the American Hospital Association (AHA) has been set to focus on identifying and exploring key issues affecting the health care delivery system. This could be why a study was conducted in 2014 in Chicago, USA by the Health Research & Educational Trust to assess leadership effects on health care systems (CCL, 2011). Furthermore, the Centre for Creative Leadership (CCL) in the USA analyzed a sample of 34,899 leadership-effectiveness evaluations taken between 2000 and 2009. One of the key findings was that the top priority for leadership development in the health care sector was to improve the ability to lead employees (Centre for creative leadership-White paper, 2011)

South Africa identified leadership as a necessary element of a strong health system that needs nurturing and sustaining because a leader who can work strategically within his/her complex environment and develop a right-based health system that promotes health equity is an important asset. In 2010, South Africa adopted a health management competence assessment as an important first step in this effort (Gilson & Daire, 2011).
Recognizing the close link between good governance and health system strengthening, the Rwandan Ministry of Health identified the need for an independent review of the state of health governance in Rwanda in 2010.The U.S. Agency for International Development in Rwanda (USAID/Rwanda, 2010) designed and implemented a health governance assessment. The goals of the assessment were to document successes, identify persisting challenges, and recommend ways by which health governance in Rwanda could be further strengthened Rwandan Ministry of Health (MINISANTE, 2010).

In Zambia, the strengthening of transparency and governance in the health sector has been identified and the government of Republic of Zambia through the Ministry of Health (MoH) has developed a five year Governance & Management Capacity Strengthening Plan. This is to be used by all stakeholders to strengthen systems, structures, managerial and governance in Zambia's health sector (MoH, 2012).
The Lusaka Provincial Health Office's (LPHO) core functions are to provide Leadership, Coordination, Supervision and technical support to the Districts, Hospitals, Training Institutions and other levels in the Province. To this effect they identified leadership weaknesses in the management of healthcare services in the province and they recommended priority intervention of orienting 144 health facilities in charges and their deputies in leadership and management skills (LPMO, 2016).

In order to improve leadership in the health sector, the Zambian government through the Ministry of Health engaged tertiary institutions involved in training health personnel to include management and leadership courses as part of the training programme e.g. UNZA Schools of Public health and Nursing Sciences, General Nursing Council and Professional Council of Zambia (MoH, 2012).

They have also introduced health care services administration courses in the health sector as a discipline and persons managing health institutions must possess relevant qualifications e.g. hospital administrators must possess a first degree qualification in any health discipline (MoH, 2012). In addition, the Ministry of Health (MoH) have developed management and leadership capacity building plan for senior and middle level managers in the sector (MoH, 2012).

All these efforts in various countries including Zambia show that leadership is a critical element in the success of a healthcare system. The efforts so far pointed out in different countries to improve health care through leadership need to be strengthened in Zambia through research. True to (Walshe & Rundall, 2001) claim that research gaps exist on health care management, there has been little study in Zambia on health system transformation through research on health care leadership in hospitals which is coming out clearly as a critical determining factor in effective healthcare system. Therefore, its inadequacies need to be addressed and hence this study whose purpose is stated below:

1.2 Purpose of the study

The study aimed at establishing the common leadership practices and the influence they exert on healthcare providers and service delivery in hospitals.

1.3 Statement of the problem

Many countries including Zambia face problems of providing quality leadership and governance in health care delivery services (Goodwin, 2001, MINISANTE, 2010, MoH, 2012). Evidence shows a positive relationship between leadership indices and measures of health performance and output (Islam, 2007, Mutale et.al. 2017). It is disheartening to note that evidence based knowledge in management seems to have made little progress in health care in comparison to clinical care. No wonder managerial decisions are made on negotiation and consensus and these usually lead to compromise (Walshe & Rundall, 2001).

The Zambian health facilities face challenges that have resulted in negative perception by the staff and the public in the area of health care service delivery. There is shortage of staff, staff short in relevant skills, poor work culture, deployment of staff in positions in which they do not hold expertise, poor incentives, lack of transparency and limited promotion chances. In addition, staff exhibit frustrations, lack of motivation, absenteeism, tardiness and increased staff turnover (MoH, 2012). According to the quality of service delivery survey by MoH,(2008) the findings revealed that staff absenteeism scored 27% and tiredness scored 43%, low skilled staff scored between 24-31%, staff vacancy in hospitals was 41%, low staff morale was 42% and 43% reported dissatisfaction. The survey also noted high rates of staff turnover especially in rural areas that accounted for 10% as 'incoming' and 21.5% as 'outgoing' compared to urban areas accounting for 9.4% 'incoming' and 9.8% 'outgoing'. These rates of staff movement in and out of health facilities were noted as serious and where due for many reasons that included 'institutional memory' and capacity strengthening. The Ministry of Health also articulated the above challenges embedded in poor work culture and ethics as compounded by system and collective leadership failure (MoH, 2012). All these have resulted in poor service delivery in many Zambian hospitals that people long for. Sarcasm and negligence from healthcare workers is a complaint of the day from the public (Daily Mail newspaper, 2015 and The Mast newspaper, 2017). In some instances beating up of nurses has been reported (Lombe et. al.2007; Daily National Newspaper, 2016).This concern is big as it has been registered even by those in high government profiles. For example during the 19 hours ZNBC news on 9th October 2017, the first lady Ester Lungu hailed the need for the medical personnel to develop good work culture, have compassion and respect for the patients so that they can receive quality health care services.

Furthermore, the international agencies (EU, CIDA, WHO, GLOBAL FUND, WORLD BANK) in 2009 revealed serious financial irregularities in the health sector and this led to withdrew of MoH status as Principle Recipient (PR) for global funds. This was attributed to leadership and governance gaps in the Ministry of Health, (2012).

It is for the challenges stated above that the researcher intends to identify and analyze common leadership practices in 1st level hospitals to ascertain whether they have influence on healthcare providers and on service delivery in Lusaka Province.

1.4 Justification

The World Health Organization (WHO) has recommended the use of 6 health system building blocks (Leadership and governance, Health workforce, Information system, Medical products, vaccines and technologies, Health financing and Service delivery) for evaluating and strengthening health systems and improving health outcome. Leadership is one of the building blocks which is said to support the other 5 building blocks for Health System Strengthening (HSS) and it is believed to pull together the health system (Health system 20/20, 2012). It is clear that leadership is top on the agenda a sign that it is crucial. Then it cannot be doubted why leadership practices and influence on providers and service delivery need to be identified for improvement in healthcare provider's commitment, motivation and effective service delivery. During the past several years, health care organizations have been focusing on primary areas, one of which is identifying capability gaps and involving the executive team to address them (Health Research & Educational Trust, 2014).

The Ministry of Health noted like any other developing country that leaders in health facilities were trained health personnel who are often promoted to managerial position based on clinical expertise alone (MoH,2010). No wonder in 2012, the Ministry of Health engaged statutory institutions involved in the training of health personnel such as the General Nursing Council of Zambia, Health Professional Council of Zambia and the tertiary schools like the school of Medicine to include management and leadership skills training as part of the programme. The health sector also developed a governance and management capacity strengthening plan to help improve service delivery. They have also been calls to strengthen leadership in the health sector through in-service training programmes Mutale et.al. (2017).

In 2016, the Lusaka Provincial Health Office identified leadership weaknesses in the management of health care services and recommended the priority intervention of orienting 144 health facilities in charges in leadership and management skills (LPHO, 2016).

Very few studies have been conducted in Zambia to establish the common leadership practices in health facilities such as hospitals and ascertain whether they have any influences on healthcare providers and service delivery as evidenced from the literature reviewed. Therefore, the importance of this study cannot be doubted. The findings can be used as a basis to promote the needed commitment, motivation and dedication towards achieving improved health care delivery services. Health systems will improve because one crucial building block within which they function will improve. Policy makers will make informed decisions on areas needing policy guidelines in leadership and effectiveness of health care providers and improved service delivery in hospitals. The interventions that will be recommended if embarked on will enhance improved leadership, promote provider's motivation and commitment thereby improves service delivery in hospitals. This study will also add value to the body of knowledge in health care leadership and service delivery.

1.5 Research question

What are the common leadership practices and how do they influence healthcare providers and service delivery in 1st level hospitals of Lusaka Province?

1.6 Research objectives

1.6.1 General objective

To establish the common leadership practices and how they influence healthcare providers and impact on service delivery in 1st level hospitals of Lusaka Province.

1.6.2 Specific objectives

i. To identify common leadership practices in the 1st level hospitals of Lusaka Province.

ii. To determine the influence of the identified common leadership practices on health care providers in 1st level hospitals of Lusaka Province

iii. To ascertain ways in which the identified leadership practices affect the delivery of health care services in 1st level hospitals of Lusaka Province.

CHAPTER TWO

LITERATURE REVIEW

2.1 General concept of leadership and leadership practices

Leadership is described in many different ways. Koontz (2010) defines it as the ability of a manager to induce subordinates to work with confidence and zeal. Sanford (1973) observes that without leadership, organizations are nothing but masses of individuals. He notes that leadership is the means through which the leader guides the behaviour of other people towards goal accomplishment. The interpersonal influence is experienced through communication and more generally through behaviour.

Armstrong (2002) defines leadership as the process of influencing and supporting others to work enthusiastically towards achieving the objectives. The same has been defined by Huber (2013) that leadership is the process of influencing people to accomplish goals. In an organization leadership enriches and transforms the potentials into reality and the ultimate act that identifies and develops channels.

The definitions above all show that leadership has influence on employees and their performance. It is also clear that this influence is also exerted through communicative and behavioural practices. Then, it is necessary to establish the specific practices that do the influencing and also the type of influence that the practices lead to in organizations such as hospitals.

2.2 Studies done on leadership influences

Studies have been carried out to determine how leadership practices can influence employees for better organizational outcome. Many studies concluded that effective leadership is associated with better and more ethical performance (Kreitner, 1995). Job satisfaction, which is affected by leadership practices, is also found to be positively related to patient satisfaction (Morana, 1987).The use of leadership practices may be an important indirect contributor to health care delivery outcomes. The more the leadership is effective, the better the level of satisfaction among nurses. These also influence the

satisfaction levels among the patients, thereby improving the results of the health organization (Schreuder et. al., 2011). In a study done in Iran in 1997 to investigate the factors that facilitate quality nursing care-giving, the most critical theme that emerged from the interviews of seven nurses was `leadership'. Good leadership was found to make a difference in the effectiveness of the care delivery system (Frank et al. 1997). It is believed that nurse managers are the organizers who facilitate outstanding performances in the delivery of nursing care. In so doing, nurse mangers must be supportive and at the same time, have `faith in their people'. Supporting the findings is the study done by Chiok, (2001) in Singapore and Mohammad et al., (2011) in Jordan who found that transformational leadership was positively related to job satisfaction, as was empowerment.

2.3 Health care services

Health care services entail furnishing of medicine, medical or surgical treatment, nursing care, diagnosis (laboratory and radiation services) dental services, optometric services, complementary services whether or not contingent upon sickness or personal injury. It includes all other services and goods with the aim of preventing, alleviating, healing illnesses, physical disability or injuries in persons.

(Oregon legislature, 2013) http://www.oregonlaws.org/glossary/definition/health care services Management through effective leadership is therefore, an essential component of the health workforce to drive the health care services. Good management exhibited by leaders is essential for quality service delivery and achieving desired health outcomes.

(WHO, 2007) http://www.who.int/management/strengthen/en/ .

The desired health outcome is access, quality and responsiveness care as direct results of health care services while effectiveness, efficiency, satisfaction can be considered as attributes to achieving best health outcome by a well performing health worker (van Olmen et al. 2012).

2.4 Leadership styles

Leadership styles are different combinations of task and relationship behaviours used to influence others to accomplish goals (Huber, 2013).

2.4.1 Transformational Leadership

This is the style of leadership in which the leader uses his influencing power and enthusiasm to motivate his followers to work for the benefit of the organization. Here, the leader seeks the requirement for change in the existing organization culture, gives a vision to his subordinates, incorporates mission and implement the change with the dedication of his followers (Robbins & coulter, 2014).

In transformational leadership, the leader acts as a role model and as a motivator who offers vision, excitement, encouragement, morale and satisfaction to the followers. The leader inspires his people to increase their abilities and capabilities, build up self confidence and promotes innovation in the whole organization (Abdelhalfiz et al.,2015b). The better the level of satisfaction among nurses also influences the satisfaction levels among the patients Schreuder et al., (2011). The study done by Abdelhalfiz et al., (2015) in Saudi Arabia showed the highest score received by the transformational style of leadership than transactional and lasseiz-faire style of leadership. According to Abdelhalfiz et al. (2015), citing Avolio and Bass (2004), a transformational leader is an inspirational leader who promotes encouragement and inspiration among the followers by inculcating a meaning in the assigned work while transactional leaders cater for followers' immediate self-interest by providing rewards to inspire them.

2.4.2 Transactional Leadership

A leadership style whereby the objectives and goals are predefined and the leader use rewards and punishment to motivate his followers. Transactional leaders display behaviour associated with constructive and corrective transaction. The constructive style is labelled; 'reward achievement' (contingent reward) and the corrective style is labelled; 'monitors mistakes' (management by exception either active or passive) Bass

& Avolio, (2000) and Bass & Avolio, (2015). Prize and penalties are the two major tools used by the leader to inspire his subordinates i.e. if an employee achieves the target within stipulated time, he is given initiative for his work, whereas if the task is not completed within the required time then he will be penalized for the same (Abdelhafiz et al. 2015).The study done in Amman by Abdel hafiz et al., (2015) showed some positive relationship between transactional leadership styles with respect to job satisfaction.

Ramey, (2002) in her study in Appalachian state noted that staff nurses working in hospitals perceived transactional leadership style to negatively influence job satisfaction. The findings supported registered staff nurses working in hospitals in this Appalachian state who significantly preferred the transformational leadership style over the transactional leadership style. Whereas transformational leaders uplift morale, motivation and morals of their followers, transactional leaders cater to their followers' immediate self-interest (Bass, 1999)

2.4.3 Laissez-faire

A laissez-faire leader lacks direct supervision of employees and fails to provide regular feedback to those under his supervision. This leadership style hinders the production of employees needing supervision. The laissez-faire style produces no leadership or supervision efforts from managers, which can lead to poor production, lack of control and increasing costs (Nyberg, 2005).

Doci, (2015) described this type of leadership as the passive end of leadership spectrum in which lack of leadership lies. This type of management style is characterized by avoidance of taking leadership responsibilities, decisions and actions even in dare circumstances. The Laissez-faire manager exercises little control over his group, leaving them to sort out their roles and tackle their work, without participating in this process himself. In general, this approach leaves the team floundering with little direction or motivation. A study done by Abdelhalfiz, (2015) in Saudi Arabia reviewed a negative relation between laissez-faire style of leadership and job satisfaction. Similar findings were drawn from a study done in Iran by Ghorbanian, (2011) whose findings indicated

no significant relationship between the laissez-faire management style and job satisfaction compared to transformational and transactional style of leadership. In addition laissez-faire fails to inspire their employees as transformational leaders do and they do not rely on the contractual agreements for performance that are included in transactional leaderships. Since there are no shared goals in place, there is also a lack of recognition of performance.

2.4.4 Autocratic leadership (Directive)

Autocratic (dictatorial) leadership style is embedded in leaders having full organizational power and authority of decision making in their hands without sharing it with their subordinates (Al-Ababneh, 2013).Managers make decisions alone without the input of others and possess total authority and impose their will on employees and no one challenges their decisions. This type of leadership can damage the organization irreparably by forcing their followers to execute strategies and services in a very narrow way, based upon a subjective idea of what success looks like (Ojokuku, 2012). Commitment, creativity and innovation are typically eliminated by autocratic leadership which is promoted in transformational leadership style.

In a study done by Ramey, (2002) staff nurses lack satisfaction with autocratic leadership in hospital settings. In a similar study done in Tehran's hospitals in Iran with the aim of determining managers' leadership style from staffs' viewpoints and its relationship with hospital indicators. The study showed that 13.7% of staff stated that their managers' authoritative leadership style was exploitative-authoritative, 56.1% benevolent-authoritative that reduced their performance (Amerioum & Mahmoudi, 2011). Some situations however may call for urgent action and in these cases an autocratic style of leadership may be best. In a study done in the bank industry in Nigeria revealed that autocratic style of leadership have positive effect on organizational performance with ($r = 0.016$ $df = 53$; $P<.001$) which indicate that autocratic style of leadership induce employees in Nigeria banking industry to perform as expected (Ojokuku,2012).

2.4.5 Democratic (Participative)

Democratic style of leadership as described by Robbins & Coulter, (2014) is a leader who involved employees in decision making, delegated authority and used feedback as an opportunity for coaching employees.

The democratic leadership style or participative leadership values the input of team members and peers, but the responsibility of making the final decision rests with the participative leader. Participative leadership boosts employee morale because employees make contributions to the decision-making process. The participative leadership style focuses on team support, autonomy, motivation, commitment, and team member development, job satisfaction, employee performance and group cohesion which autocratic leaders do not (Deshpande and Hills, 2011).

Participative leadership styles in healthcare were found to improve the organizational efficiency which is reduced in autocratic leadership as evidenced in the study done in Iran (Amerioum and Mahmoudi, 2011). Similar conclusions were drawn in the study done in USA by Deshpande and Hill, (2011).

2.4.6 Situational Leadership

Leadership manifest itself as behaviour related to task and behaviour related to relationship with the group. Situational leadership style suggests that there is no ‘one size fits all’ approach to leadership. The situation will guide the leadership and this is influenced by various conditions that are present (Hersey and Blanchard, 1988).

Ability and willingness are an interacting influence system and the significance change in one will affect the whole. Ability is the knowledge, experience and skill an individual or group brings to a particular task or activity. Willingness is the extent to which an individual or group has the confidence, commitment and motivation to accomplish a specific task (Hersey et.al., 1996).

A leader must identify the ability and willingness levels in their followers before applying the leadership style of directing, coaching, supporting and delegating as discussed in other styles above.

2.4.7 Servant hood Leadership

This focuses primarily on the growth and well being of the people and the communities to which they belong. The servants-leader shares power and puts the needs of others first, helps people develop and perform as highly as possible (Centre for Servant Leadership, 2016).

Servant-leadership influences individuals and groups to better achievement in an organisation thus providing greater creative opportunity for its people and raises capacity to serve and increase performance in an institution (Greenleaf, 1996).
A servant-leader primary motivation and purpose is to encourage greatness in others while organisational success is the indirect derived outcome. It nurtures participatory empowering environment and further encourages talent of followers thus influencing a more effective motivated workforce and ultimately a more successful organisation (Greenleaf, 1996).

This study then will be modelled by the postulates of path-goal theory such as the application of leadership styles by Hospital Administrators and Nursing Officers and its influence on employees who in the case of this study are doctors, nurses, clinical officers, laboratory technologist, pharmacy technologists, radiographers and effects on service delivery.

2.5 Multifactor Leadership Questionnaire-MLQ (Form 5X)

MLQ adopted by Bass in 1985 is the instrument used to measure leadership in aspects of transformational, transactional and laissez-faire leadership styles as well as three outcome of leadership: extra efforts, effectiveness and satisfaction (Bass & Avolio, 2000).

The MLQ -5X classifies transformational leadership into five components: idealized attributes, idealized behaviour, inspirational motivational, intellectual stimulation and individualized consideration.
The MLQ-5X also includes three scale of transactional leadership: contingent reward, active management-by-exception and passive management-by-exception (Bass & Avolio, 2000).

The MLQ-5X further describes the laissez-faire type leadership which is similar to passive management-by-exception.
Lastly, the three outcomes of leadership explained in the MLQ-5X is to measure the success of the group: extra effort, effectiveness and satisfaction. Outcome of leadership as explained by Bass & Avolio have the influence on the success of subordinates and organization.

Extra effort is defined as the wish of followers to strive for superior performance or doing more than what is required and being motivated to achieve success (Bass & Avolio 2000). Bass, (1985) states that subordinates of transformation leaders are more likely to put forth extra effort in comparison to transactional leaders. Supporting this statement is the study done by Ramey, (2002) who noted that going beyond self-interests for the good of the group were important characteristics of transformational leaders.

Efficiency refers to obtaining the best possible value for the resources used or using the least resources to obtain a certain outcome (Health system 20/20, 2012). Health care leaders can make the most efficient use of their resources especially human resource by embracing good leadership practices in order to obtain good health outcome. This is because health workforce is central to achieving health and organizational objectives (Bass & Avolio, 2000 and WHO, 2000). This is also supported by Ramey, (2002) who in her study concluded that instilling pride in individuals and going beyond self-interests for the good of the group were important characteristics of effective leaders which is associated with transformational leaders.

Satisfaction with leadership generates satisfaction in followers. The leader is warm, nurturing, open and honest with good interpersonal and social skills capable of developing feelings of satisfaction in their followers Bass and Avolio, (2000) and Deshpande and Hill, (2011). Satisfaction of followers is said to improve performance of organization (Amerioum and Mahmoudi, 2011). Ghorbanian et. al. (2011) in their conclusion indicated that job satisfaction was important in health care delivery services especially in medical emergencies and recommended that health sector policy makers should provide the ground work for implementing the transformational leadership style to enhance job satisfaction thereby improve service delivery. This is supported by the study done by Nyberg et. al. (2005) who argued that the end result of transformational leadership is empowering others to take more initiative in they work, inspiring them to be more committed and building their self-confidence.

2.6 Long-term outcomes on Service Delivery

Better-performing teams contribute to better organizational performance, which translates into improved health services (Lemay and Ellis, 2008). Employees extra effort, effectiveness (efficient) and satisfaction are said to influence service delivery positively (Schreuder et al. 2011 Abdelhafiz et al.2015b). The similar conclusion was given by Deshpande and Hill, (2011) in the study of two sister hospitals in the US that transformation leadership style which is said to instil these characteristics in employees is the best style to utilize to improve processes within the organization as well as increase employee performance and the quality and safety of care for patients. This is because it builds collaborative relationships in order to engage in the sharing of knowledge and improving processes to ensure that patients are receiving the highest quality of care.

Studies have shown a negative correlation of employee job satisfaction, performance, low organization production and the laissez-faire leadership styles (Abdelhalfiz, 2015, Ghorbanian et al. 2011 Doci, 2015).

2.7 Theoretical framework

The theoretical basis of this study is the path-goal theory, also known as the path- goal theory of leader effectiveness or path-goal model developed by Robert House in 1971 and revised in 1996.The theory states that leaders' behaviour is contingent to the satisfaction, motivation, and performance of his or her subordinates. The theory was inspired by the work of Martin G. Evans (1970) in which the leadership behaviour and followers perception's of the degree to which following particular behaviour (path) will lead to particular outcome (goal) Robbins and Coulter, (2014).The path-goal theory assumes that leaders are flexible and that they can change their style as situation requires. The intervening variables include age of the leader, education qualifications, training, environment and follower's characteristics.

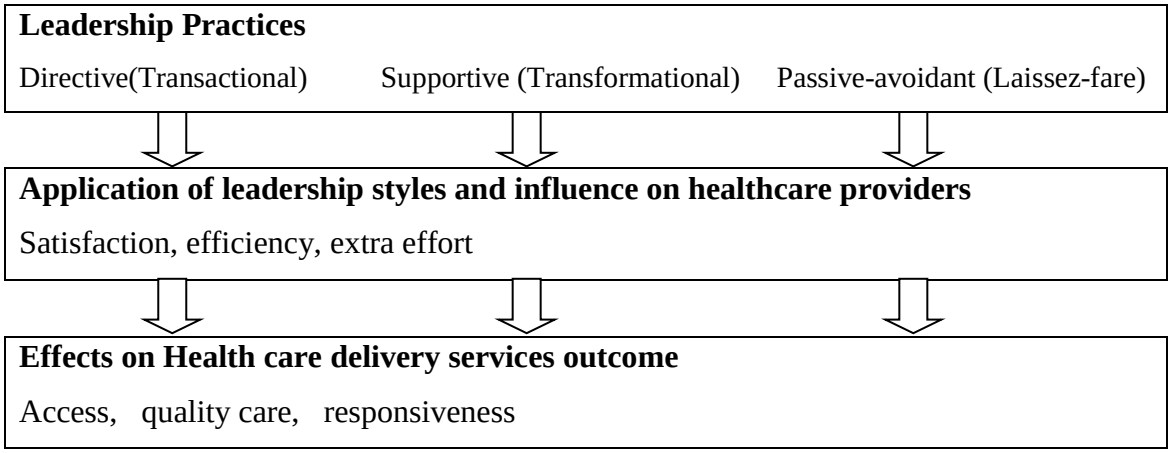
Effective leaders clarify the path to help their followers achieve goals thereby make the journey easier by reducing roadblocks and pitfalls (Northhouse, 2007). This theory is useful because it reminds leaders that their central purpose as leaders is to help subordinates define and reach their goals in an efficient manner Robbins and Coulter, (2014) citing Northhouse, (2007).

Northhouse,(2007) identifies four leadership practices; directive leader who lets subordinates know what's expected of them, schedules work to be done and gives specific guidance on how to accomplish tasks, supportive leader who shows concern for the needs of followers and is friendly, participative leader who consults with group members and uses their suggestions before making decision and achievement oriented leader who sets challenging goals and expects followers to perform at their highest level.

The purpose of the path goal theory is preferred in this study because it is envisaged that the recommendation from this study based on the findings would lead to effective healthcare providers who will deliver quality and responsive health care services in hospitals in Lusaka Province and the country as a whole. Therefore, the Path-Goal

theory model shows the influence of leadership practices on healthcare providers and the outcome on service delivery as shown below;

Figure 2.7-1Path-Goal theory model of leadership influence on healthcare provider's & service delivery



Derived: Northhouse, (2006)

The elements in this model and their relationship to each other inform the way the researcher perceives the effects of leadership practices. The conceptual framework informed the design and the way the researcher perceived the effects of leadership practices. The framework hinges on the type and application of leadership practices as a determining factor in all that follows on health care providers and in health care service delivery pathway. This was done by first establishing the common leadership practices and then identifies their influence on providers and service delivery.

Application of leadership style comes first in the framework as the most determining factor of everything else that follows in the model. For example if the leader exercises transformational leadership styles and applies it on all employees without segregation, the health care providers will get motivated, committed, develop a positive attitude towards work and end up performing and delivering quality care and responsive health service tasks and enabling people to access health services.

When this service is effectively delivered, patients will have a positive mindset and attitude towards health care services offered in hospitals and get attracted to always get to the hospital when need arises.

This case would be opposite if the leader exercises transactional type of leadership and applied it in a commanding way. Health care providers will be demotivated and develop negative attitude and negligence towards provision of health care delivery services.

The better the level of satisfaction among nurses for example influences the satisfaction levels among the patients, thereby improving the results of the organization (Schreuder et al., 2011).

2.8 Summary of literature review

Literature review has clearly shown that there are different leadership styles and that leadership influences the employee performance. The studies reviewed in this chapter clearly indicated that they are various styles of leadership such as transformational, transactional leadership, servant hood, situational and laissez-faire. It is also evident that, a particular leadership leads to a particular influence in subordinates. This chapter has also discussed the multifactor leadership questionnaire as one of the instruments used to measure leadership styles and leadership out come. The multifactor leadership questionnaire, in this study measured transformational, transactional and lasses-faire as styles of leadership and satisfaction, motivation, efficiency and extra effort as leadership out come. The path-goal model was the frame work adopted in this study and it has been discussed in this chapter as the path-goal theory of leader's effectiveness on which this study is anchored on.

CHAPTER THREE

METHODOLOGY

3.1 Study Design

This study used a mixed method design comprising of quantitative as well as qualitative component where the qualitative data was collected concurrently to explain the quantitative findings. The quantitative and qualitative strands were independent at data collection and analysis and only merged at interpretation of findings.

The quantitative component had taken a route of Likert scale type analysis. A series of 45 questions using a Multifactor leadership questionnaire to identify the common practiced leadership styles and leadership outcome were asked to elicit responses from health workers on a range of leadership domain using Likert scale (1=strongly disagree to 5= strongly agree.) This was summarised into three styles of leadership (laissez-faire, transformational, and transactional) and three leadership outcomes (extra effort, effectiveness, satisfaction).

In order to facilitate analysis and understanding, the findings were categorised into two parts; a self-rater part by leaders and a rater part by the healthcare providers.

The qualitative components elicited views and opinions from selected leaders through one to one in-depth interviews and the focus group discussion from health care workers to help identify the common leadership practices and ascertain ways in which they influence health care provider's and service delivery.

Participant observation and document review were done to help facilitate deeper understanding of common leadership practices and they influence on health care providers and effects on service delivery.

3.2 Study site

The study was conducted in Lusaka province and comprised of six (6) hospitals that were purposively selected from the 1stlevel hospitals in the province from both public (government), mission (non profit) and private (for profit). Lusaka Province has the

projected population of 2,760, 770 people (CSO 2010) and a total number of 429 health facilities, of which 139 were government institutions, 16 were military facilities, 12 were Mission institutions whilst 262 were Private Health Institutions (LPHO, 2016). Of these, there are twenty-three (23) 1st level hospitals (7 public or government hospitals, 4 mission hospitals and 12 private hospitals).

It is with this background that Lusaka province was chosen for having the largest number of health facilities and the largest number of 1st level hospitals from public, mission and private sector. These selected hospitals provided possible variations of leadership practices and their influence on healthcare providers and service delivery.

3.3 Study population

Maximum variation was used in coming up with the study population purposefully. This involved middle health care managers including hospital administrators and nursing officers as leaders. These are the overall leaders who are directly involved in the supervision of healthcare providers using their preferred leadership practices. The healthcare providers were equally recruited as the population who experience the leadership practices in relation to phenomenon being studied.

Table 3.1 Study sites and Participants

Source	Healthcare Providers (n)	Hospital Administrator (n)	Nursing Officer (n)	Total (n)	Total (%)
Lusaka	15	3	3	21	50.0
Chongwe	5	1	1	7	16.6
Rufunsa	5	1	1	7	16.6
Chirundu	5	1	1	7	16.6
TOTAL	**30**	**6**	**6**	**42**	**100**

Table 3.1 above shows the distribution of hospitals and participants in four districts of Lusaka province where a sample was drawn. Majority of participants were drawn from Lusaka district that housed three participating 1st level hospitals and contributed 21 participates.

Sample size considerations

This study was carried out in six (6) 1st level hospitals of Lusaka province and a total number of 42 health care workers were recruited. Of the 42 recruited participants, 30 were healthcare providers and 12 were leaders. All the 42 respondents participated in qualitative component and in quantitative component. This is because they were key informants in this study. This strengthened triangulation of participation and also assured the trustworthiness of the research results for this study.

3.4 Sampling method

3.4.1 Qualitative approach

Purposive sampling method was used to select six 1st level hospitals in Lusaka province that were falling under the government, mission and private. Two hospitals from each of the above different proprietors were selected. From the government 1st level hospitals, Chipata 1st level hospital in Lusaka District and Chongwe District Hospital in Chongwe district were selected. Mtendere Mission Hospital in Chirundu district and St. Luke's- Mphanshya Mission Hospital in Rufunsa District were selected from the mission facilities. Lastly, St.John's Medical Centre and MKP hospital were selected from the private facilities in Lusaka district. The above facilities were selected based on evident differences in senior/top management authority. A convenience sampling of 6 hospital administrators and 6 nursing officers one from each selected 1st level hospital was employed. This is because they were in top management positions and supervision in the day to day running of the hospital was invested in them and they were key informants in this study. Convenient sampling of 30 healthcare providers was employed by selecting whoever was found on duty on the material day from among different units' of healthcare providers.

This was to ensure adequate representation from different types of units of healthcare providers thus avoid obtaining a "bad sample".

Inclusion Criteria:

Hospital Administrators and nursing officers who had been leaders at the 1st level hospital for more than six months and/or had been responsible of over 5 employees for a minimum period of 6 months. Healthcare providers found at the targeted workplace were included in the study regardless of their work experience with the supervisors and had consented to participate.

Exclusion Criteria:

The administrators and healthcare providers who did not meet the criteria were excluded.

3.5 Data collection methods

3.5.1 a. Qualitative data

Unstructured interview guide was administered to the leaders and interview schedule for health care providers led the focus group discussion and one-to-one interviews to collect qualitative data on leadership practices and their influence on health care providers and service delivery. Participant observation schedule and document review guide were designed and employed by the researcher to gather information on common leadership practices and their influence on health care providers and effects on service delivery. Of the 30 healthcare providers, 10 participated in focus group discussion, 5 per group and the remaining 20 were engaged in one on one interview. This was done when it was realised that they were not free to express themselves in the group. A total of 12 leaders comprising of 6 hospital administrators and 6 nursing officers were engaged in one to one in-depth-interviews.

Other sources of data reviewed were hospital minutes, quality assurance assessment reports and quarterly performance assessment reports as invaluable part of triangulation to measure quality care and responsiveness. This was done to gain more insight into the leadership style found to be mostly practiced and associated with healthcare providers' satisfaction, motivation, efficient and extra effort. It also helped identify which practices hospital administrators and nursing officers should adopt to increase healthcare providers' satisfaction, motivation, efficient and extra effort.

This strengthened triangulation of participation and also assured the trustworthiness of the research results for this study.

3.5.2 b. Quantitative data

A Structured questionnaire called Multifactor leadership style questionnaire (MLQ) (Bass & Avolio, 1985) was used for quantitative data collection. The Multifactor Leadership Questionnaire (MLQ) measured three different leadership styles, transformational, transactional, and Laissez-faire as independent variables and also describes the measure of leadership outcome on followers' success: extra effort, effectiveness and satisfaction as dependent variables. It allows individuals to measure how they perceive themselves with regard to specific leadership behaviours and how the subordinates perceive their leader's behaviour. MLQ was scored by Likert five-point format, namely, 'strongly disagree', 'disagree', 'neither agree nor disagree', 'agree', 'strongly agree', scale scoring where by a questionnaire was formed by combining the questions related to transformational, transactional and laissez-faire and consisted of 45 questions. The questionnaire was prepared in two formats, one for the managers (to identify their leadership style in their own perspective) and the other one for the healthcare providers (to determine the leadership styles of their managers). Demographic information furnished the researcher with the respondents' biographical and educational information. To enhance the quantitative component and elicit rich data for the study, all the 42 respondents participated in the MLQ questionnaire.

3.5.3 Reliability and Validity

Leadership in most of the researches done, have been measured using multifactor leadership questionnaire as a well-established instrument in the measure of leadership styles and it has been found as an effective tool. Avolio and Bass MLQ show strong evidence for validity. MLQ is a well established instrument in the measure of leadership and extensively researched and validated. Reliability scores for MLQ subscales ranged from moderate to good.

3.6 Data processing

During data collection, all questionnaires were put into their respective categories of respondents and according to hospitals. Each questionnaire within the category was serial numbered and checked for completeness and internal consistency. An inventory of field instrument was made to check against actual respondents in relation to expected sampled respondents. Thereafter, cleaning and coding of data was done according to studied variables.

3.7 Study variables

1. **Independent variables**
    - Leadership practices (transformation, transaction, laissez-faire)
2. **Dependent variables** (looked at two outcome variables)
    - Motivation, satisfaction, efficiency/effectiveness, extra effort (Primary influence on health care providers' performance)
    - Quality care, responsiveness (Secondary influence on health care delivery services)
3. **Socio-demographic characteristics**
    - Educational status, sex, work experience and age

3.8 Data analysis methods

Qualitative and quantitative data was analysed separately and only merged at interpretation. Then qualitative data was used to build on the quantitative data to make conclusions and interpretations by providing prominent explanations.

3.8.1 Qualitative data

Qualitative data analysis was done by first transcribing audio-recorded interviews and grouping them into matrix where emerging themes were categorised manually. The researchers read the transcriptions four times to extract the meaning from the content. The most frequent words and phrases were underlined and were presented in matrix form for ease cleaning and coding. As suggested by McMillan and Schumacher (2006), the manual analysis of data was begun by first transcribing the verbatim counts from the focus group discussions and one to one interviews. Then the data segments were formed

and coded. The codes were formed from practices in each data set. The grouping of similar codes led to emergent categories. The data collected from interview guide questionnaires, participant observation schedule and document review were put in matrix segments then analyzed by noting the frequency of similar answers from each participant's responses which were also coded with themes or categories. For the analysis of data from participant observation and document review, there was open coding, creating categories and abstraction where notes and headings were written in the text while reading them. The written material were read through again, and as many headings as necessary were written down in the margins to describe all aspects of the content. This was informed by Elo and Kyngas, (2008).Themes were formed from the transcribed audio recorded interviews, in-depth interviews, participant observation schedule and document review data manually. The discussions and interpretations of data were focused on the most frequently repeated interview responses, observations and document review emerging practices.

3.8.2 Quantitative data

Quantitative data was analyzed using statistical package for social sciences version 20(SPSS 20). All the data was entered and cleaned then coded according to responses pointing to the study variables. In the analysis simple frequencies were used to explore the data and the chi-square tests were further used to test the association between variables. The findings are presented according to the themes on the types of leadership as proposed by the adopted theoretical framework to help answer objectives one and two. The major themes were Laissez-faire, Transformational, and Transactional leadership qualities as independent variables and the sub-themes as first outcome dependent variables (extra effort, effectiveness, satisfaction) were further presented from the employees' perspective to show their interactions with the major themes. In the analysis the responses strongly disagree/disagree and strongly agree/agree were combined as disagree and agree respectively in order to increase the power of the responses. The p- value of 5% was used to determine the significance.

Finally, summary tables are presented at the end from the leaders' (preferred) and providers' (perceived/experienced) respective views.

3.9 Data Storage and management

The data collected was stored and managed using external hard drive, stick and memory cards. Data storage facilities on computer and abbreviations were used to label saved data in soft copies on the lap top with the password for confidentiality. Hard copies were kept under locked cupboard. Data will be kept until after graduation after which all soft copies will be deleted permanently and hard copies burned.

3.10 Ethical considerations

The study was approved by the Biomedical Research Ethics Committee of the University of Zambia (UNZABREC Ref.No.011-06-16).Permission was sought from the Provincial Medical office (PMO), Churches Health Association of Zambia (CHAZ), District Medical Office (DMO), Proprietors of the two private hospitals and Hospital management teams to carry out this research in their institutions. Confidentiality and anonymity was guaranteed. Participation was voluntary and consent form was obtained after the individual participants read the participant information sheet provided to them. Privacy was enhanced by not allowing participants to write their names on the questionnaires. In addition, participants were informed that results of the study would be generalised and no kind of identification of any participants could be seen through it.

CHAPTER FOUR

4 QUANTITATIVE FINDINGS AND INTERPRETATION

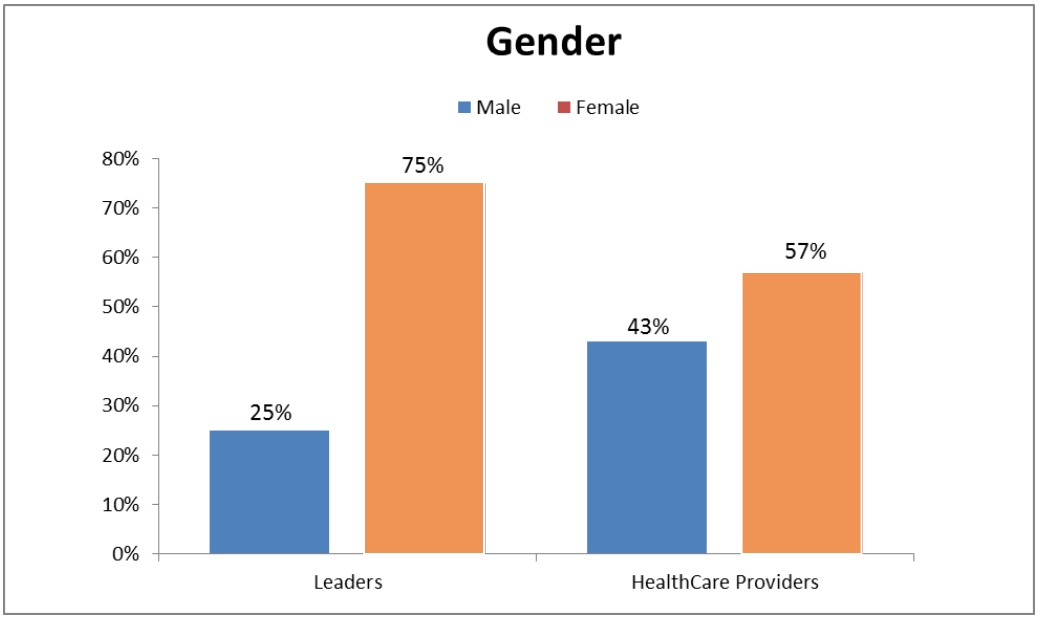
4.1 Quantitative Results

The findings are presented according to the themes on the types of leadership as proposed by the adopted theoretical framework to help answer objectives one and two. The major themes were Laissez-faire, Transformational, and Transactional leadership qualities as independent variables and the sub-themes were extra effort, effectiveness, motivation and satisfaction as first outcome dependent variables. These are further presented from the employees' perspective to show their interactions with the major themes.

4.2 Socio-demographic findings

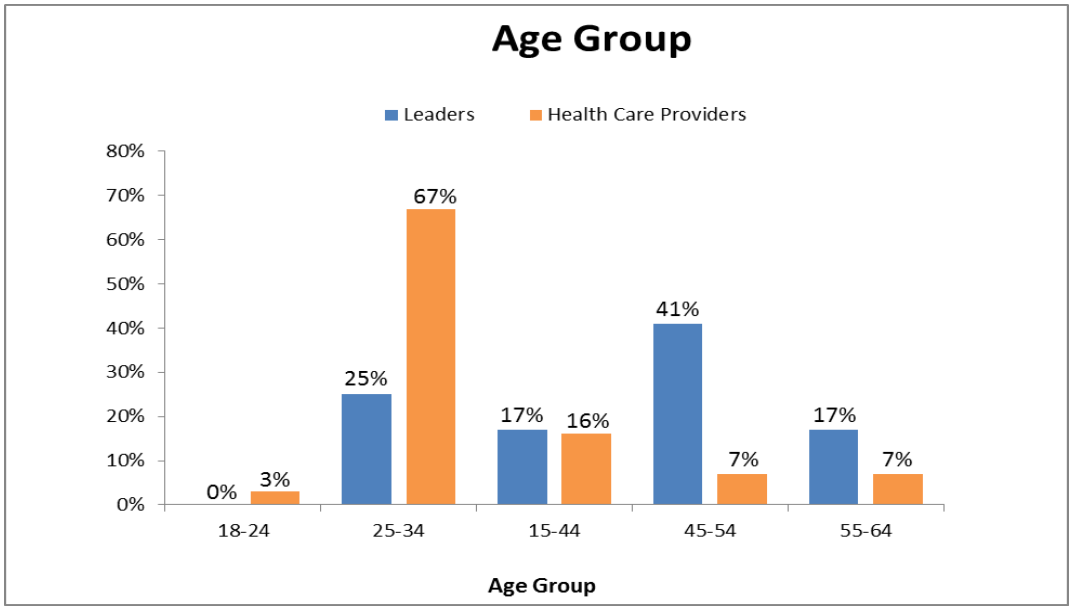
This section will present the background information on the healthcare providers and the leaders. The demographic result shows the participants' gender, age, race classification, educational level and work experience. Detailed demographic information is presented using the bar charts and tables below.

Figure 4.1 Gender



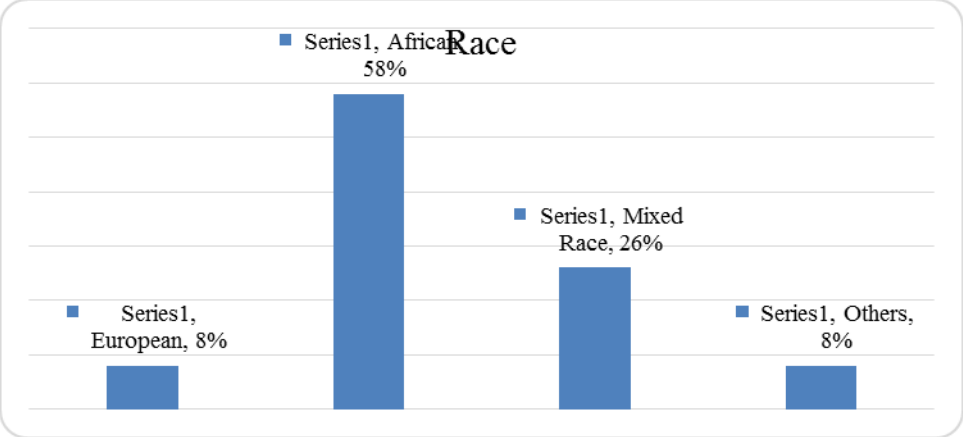
The bar chart in figure 4.1 above shows the gender classifications. The study had the total number of 42 participates among which 12 were leaders and 30 were healthcare providers. Of the 12 leaders 25% were males and 75% were females and of the 30 healthcare providers 43% were males and 57% were females. The results showed that they were more female participants than males from both the leaders and the healthcare providers.

Figure 4.2 Age group



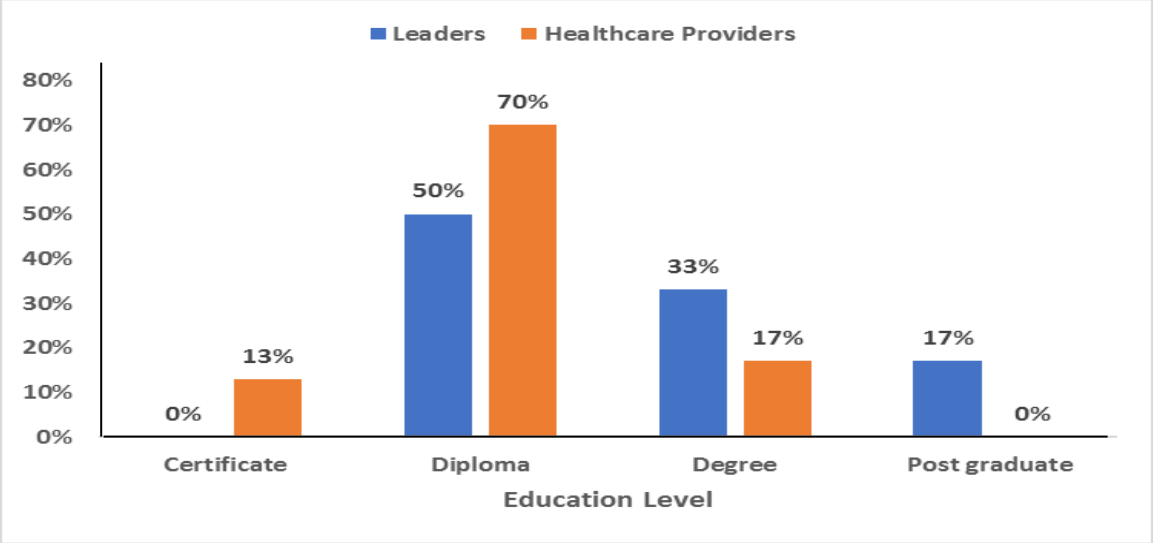
The figure above shows the age groups for both leaders' and healthcare providers. The age distribution of the participants were as follows; there were no leaders in the 18-24years age group,25% were in the age 25-34 years age group,17% in the 35-44 years age group,41% were in the 45- 54 years age group and another 17% were in the 55-64% years age group. Then for the healthcare providers,3% were in the 18-24 years age group, 67% were in the 25-34 years age group, 16% were in the 35- 44 years age group, 7% were in the 44- 54 years age group and another 7% were in the 55-64 years age group. A larger proportion for leaders accounting for 41% came from the 44-54 years age group and healthcare provider's age groups revealed that the majority of about 67% belonged to 25-34 years age group. This finding on healthcare providers is important as it gives hope that most of them are young who are capable of contributing effectively to the provision of quality health care services.

Figure 4.3 Race classification-Leaders



The race classification for leaders in figure 4.3 showed that 8% were European, 58% were African, 26% were of mixed race and 8% were from other races. The majority of the leader participants were African of about 58%. These findings showed that most facilities are managed by Africans, a good indicator that we are capable of running Zambian hospitals.

Figure 4.4 Education Level



Education level distributions were as follows; there were no certificate holder among the leaders, 50% were diploma holders, 33% had a degree and 17% had post-graduate qualifications. The healthcare provider's educational level revealed that 13% had certificates, 70% had diplomas, 17% had degrees and none of them had a post-graduate degree. This investigation on the education background showed that majority of the Leaders and healthcare providers had diploma qualifications. This finding support

government policy of upgrading all health training schools from a two year certificate programme to a three year diploma programme for pre-service.

Table 4.1 Distribution of leaders according to work experience

Work experience (yrs)	frequency (f)	Percentage (%)
1-5	2	16.7
6-10	3	25
11-15	4	33.3
16-20	2	16.7
Above 26	1	8.3
Total	**12**	**100**

The distribution of leaders according to work experience were as follows; 2 leaders had experience between 1-5years, 3 leaders had experience 6-10 years, 4 leaders had between 11-15 years experience,2 leaders had between 16-20 years old and only 1 leader had work experience above 26 years. Majority of leaders about 33.3% had work experience ranging from 11-15years. This shows that the data collected and its resultant findings contribute to the trustworthiness of research results because the participants have been leaders for a long time.

4.3 Identified the common leadership practices

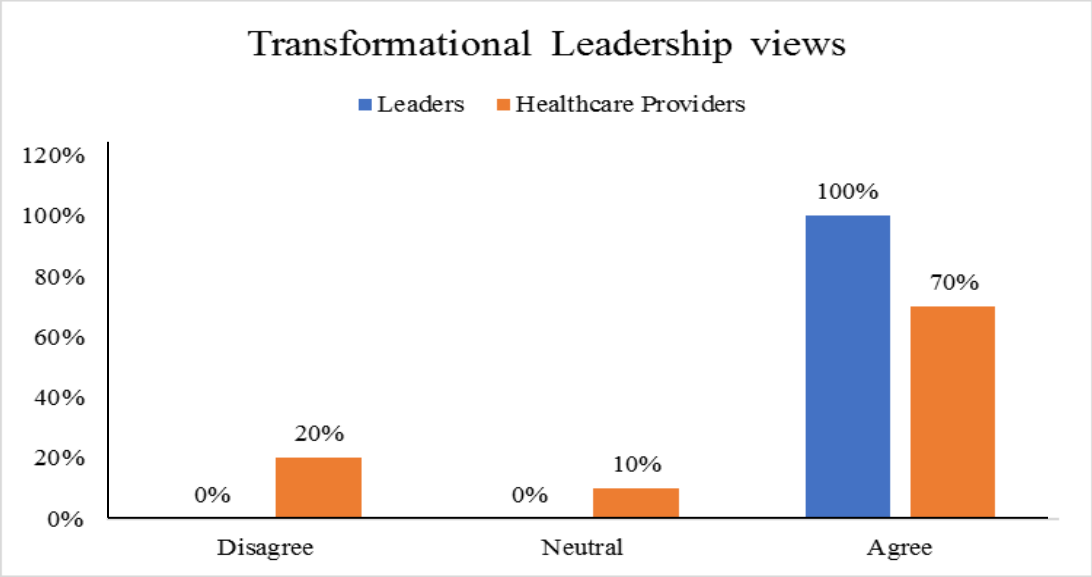
4.3.1 Preferred and perceived Common leadership practices

The first objective of this study was to identify the common leadership practices. This objective was guided by administering a Multifactor Leadership Questionnaire (MLQ) to both leaders and healthcare providers because of its leadership characteristic items pointing to specific leadership style. This questionnaire was selected to identify which leadership style was mostly preferred and perceived or experienced.

Leaders' and healthcare provider's views on Likert scale leadership practices.

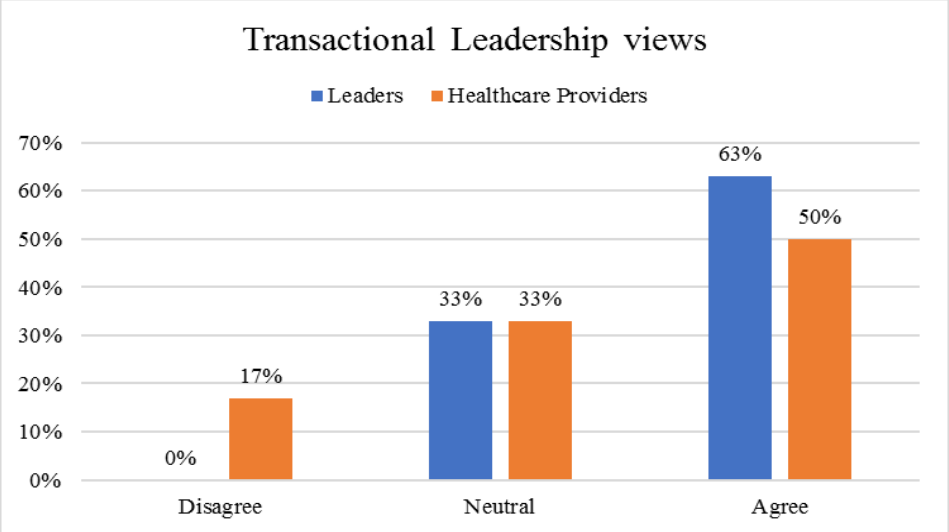
The following tables' presents views from leaders and healthcare providers. In the following tables the responses are "Disagree", "Neutral", and "Agree".

Figure 4.5 Transformational Leadership



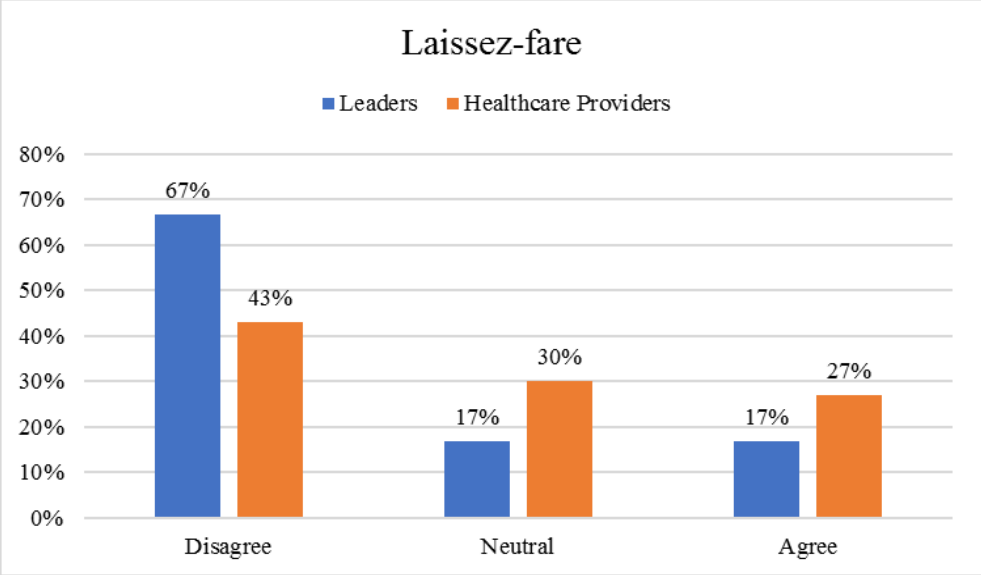
The distribution of the finding in figure 4.5 showed that none of the leaders disagreed nor were neutral to statements pertaining to transformational leadership but that all the leaders, 100% agreed to statements pertaining to transformational leadership. Among the healthcare providers, the findings showed that 20% of the healthcare providers disagreed and 10% were neutral to statement pertaining to transformational leadership whilst 70% agreed to statement pertaining to transformational leadership. The findings indicate that all the leaders 100 % and about 70% of the Healthcare providers agreed to the statements pertaining to transformational leadership style. This indicates that transformational leadership is preferred by leaders and experienced by healthcare providers.

Figure 4.6 Transactional Leadership



The distribution of the findings in figure 4.6 above showed that none of the leaders disagreed to statements pertaining to transactional leadership,33% were neutral and 63% agreed to statements pertaining to transactional leadership. Among the healthcare providers, the findings showed that 17% of the healthcare providers disagreed and 33% were neutral to statements pertaining to transactional leadership and 50% agreed to statement pertaining to transactional leadership. The findings indicate that majority of leaders about 63% and majority of the healthcare providers about 50% agreed to statements pertaining to transactional leadership. This finding points to indicate that transactional leadership is sometimes preferred by leaders and sometimes experienced by healthcare providers.

Figure 4.7 Laissez-faire Leadership



The findings in figure 4.7 above shows the following; 67% of the leaders disagreed to the statements pertaining to laissez-faire, 17% were neutral and another 17% agreed to the statements pertaining to laissez-faire. Among the healthcare providers 43% disagreed to statement pertaining to laissez-faire leadership, 30% were neutral and 27% agreed to statement pertaining to laissez-faire. The findings indicate that majority of leaders about 67% and majority of the healthcare providers about 43% disagreed to statements pertaining to laissez-faire leadership. This finding entails that both the leaders and the healthcare providers refuted to practicing and having experienced laissez-faire leadership respectively.

Summary on the preferred and perceived or experienced common leadership practices

The findings in the figures above shows that the styles of leadership preferred and perceived or experienced was mainly the transformational, followed by transactional leadership while laissez-faire is largely refuted. The finding demonstrates that transformational leadership was commonly practiced followed by transactional leadership.

4.4 Influence of the identified common leadership practices on healthcare providers

The second objective of this study was to determine the influence of the identified leadership practices on healthcare providers. This objective was also guided by administering a Multifactor Leadership Questionnaire (MLQ) to both leaders and healthcare providers. This questionnaire was selected to identify which leadership style was mostly associated with healthcare providers' satisfaction, motivation, efficient and extra effort.

Cross tabulation was used to assess the relationship between the independent variables as major themes and the dependent variables as sub-themes. Pearson Chi-square tests were further used to tests the association between the independent and dependent variables.

4.4.1 Responses on preferred leadership practices on healthcare providers

The tables below show the responses of the preferred leadership practices on leadership outcome.

Table 4.2 Leaders responses on effect of their leadership style on providers extra effort

	Disagree		Neutral		Agree	
	F	%	F	%	F	%
I get others to do more than they are expected to do.	3	25	2	17	7	58
I make (heighten) others desires to succeed					12	100
I increase others willingness to try harder					12	100

All the leaders agreed to the last two statements and about 58% agreed to the first statement on effect of leadership practices on extra effort. This means that their leadership practices influenced providers' extra effort.

Table 4.3 Leaders responses on effects of their leadership style on provider's effectiveness

	Disagree		Neutral		Agree	
	F	(%)	F	(%)	F	%
I help others to enjoy their work					12	100
I often interact with employees at this hospital					12	100
I provider advice when it is needed					12	100
I often communicate with others at this hospital					12	100

The findings show that all the leaders agreed to all the statements pertaining to effectiveness as can be seen from the table above. This means that their leadership practices influenced provider effectiveness.

Table 4.4 Leaders responses on effects of their leadership style on provider's satisfaction

	Disagree		Neutral		Agree	
	F	%	F	%	F	%
I work with others in a satisfactory way					12	100
I use methods of leadership that are satisfying					12	100

The finding shows that all the leaders (100%) agreed to the statements pertaining to satisfaction. This means that their leadership practices influenced providers' satisfaction.

Table 4.5 Summary of effects of Leadership practices on leadership outcome

Leadership Styles	Disagree		Neutral		Agree	
	Frequency (n)	%	Frequency (n)	%	Frequency (n)	%
Extra Effort	3	25	2	16.7	7	58.3
Effectiveness					12	100
Satisfaction					12	100

The findings according to the summary table 4.4 above shows the degree to which the practiced leadership style influenced healthcare provider's extra effort, effectiveness and satisfaction. This result indicates that leadership practices had influence on provider's satisfaction, effectiveness and extra effort.

4.4.2 Transactional leadership Cross Tabulations

Cross tabulation was further done to assess the interaction between the two common leadership practices and the leadership outcome.

Table 4.5 show the cross tabulations of transactional leadership and leadership outcome

Table 4.6 Transactional Leadership Cross Tabulations

		TRANSACTION					
		Disagree		Neutral		Agree	
		F (n)	%	F (n)	%	F (n)	%
SATISFACTION	Disagree	4	50	2	25	2	25
	Neutral					3	10
	Agree	1	5	8	42	10	53
EFFICIENCY	Disagree	5		2	29		
	Neutral		71	5	50	5	50
	Agree			3	23	10	77
EXTRA EFFORT	Disagree	3	100				
	Neutral	1	20	4	80		
	Agree	1	5	6	27	15	68

Transactional leadership was associated with increased efficiency and extra effort at 77% and 68% respectively and less with motivation and satisfaction at 57% and 53% respectively. These results mean that of all the providers who agreed to have experienced transactional leadership 77% also agreed to have been efficient in their work, 68% agreed to put in extra effort, 57% agreed to have been motivated and 53% agreed to have been satisfied.

4.4.3 Chi-Square tests

The Pearson Chi-square tests were used to check for association between the variables of interest. The **null hypothesis** of the Chi-square is that there is no association between the variables. While the **alternative hypothesis** is that there is an association between the variables.

Table 4.7 Association of Transactional Leadership with leadership effects

Pearson Chi-Square Tests on Transactional leadership

		Transactional
SATISFACTION	Chi-square	11.447
	Df	4
	Sig.	***0.022****
EFFICIENCY	Chi-square	23.104
	Df	4
	Sig.	***<0.001****
EXTRA EFFORT	Chi-square	24.436
	Df	4
	Sig.	***<0.000***

***The chi-square statistic is significant at the 0.05 level**

A positive relationship was observed between the overall score for transactional leadership and the entire leadership outcome at the significant level *p* 0.001. A significant association between the variables is shown by a probability value of less than 0.05 or 5 percent.

4.4.4 Transformation Leadership Cross Tabulations

The cross tabulation was done to show the interaction between transformational leadership and leadership outcome.

Table 4.8 Transformational Leadership Cross tabulation

		TRANSFORMATION					
		Disagree		Neutral		Agree	
		Frequency (n)	%	F (n)	%	F (n)	%
SATISFACTION	Disagree	6	75	2	25		
	Neutral			1	33	2	67
	Agree					19	100
EFFICIENCY	Disagree	5	71	1	14	1	14
	Neutral			2	20	8	80
	Agree	1	8			12	92
EXTRA EFFORT	Disagree	3	100				
	Neutral	2	40	1	20	2	40
	Agree	1	5	2	9	19	86

The transformation cross tabulation table above shows a close relationship between the variables of effect. All the providers who experienced transformational type of leadership also agreed to have been satisfied, motivated and efficient and put in extra effort to duty. These results indicates that of all the healthcare providers who agreed to have experienced transformational leadership, 100% agreed to have been satisfied, 92% agreed to be efficient in their work and 86% agreed to put in some extra effort in their work.

4.4.5 Chi-Square test

The Pearson Chi-square tests were used to check for association between the variables of interest. The **null hypothesis** of the Chi-square is that there is no association between the variables. While the **alternative hypothesis** is that there is an association between the variables.

Table 4.9 Association of Transformational leadership with leadership effects

The table below shows the association of transformational leadership with leadership outcome.

Pearson Chi-Square Tests on Transformational leadership

		TRANSFORMATIONAL
SATISFACTION	Chi-square	29.881
	df	4
	Sig.	***<0.001***
EFFICIENCY	Chi-square	18.841
	df	4
	Sig.	***0.001***
EXTRA EFFORT	Chi-square	17.630
	df	4
	Sig.	**0*.001****

***The chi-square statistic is significant at the 0.05 level**

The tests in the table above show that views on Transformational leadership significantly influence the satisfaction, motivation, efficiency, and extra effort of the employees. This is confirmed by the significant chi-square statistics of p <0.001

4.5 Responses on perceived or experienced leadership styles

The tables below shows the responses of leadership outcome as perceived or experienced by the healthcare providers.

Table 4.10 Providers responses on extra effort

	Disagree		Neutral		Agree		Total	
	F	%	F	%	F	%	F	%
Get others to do more than they are expected to do.	15	50	2	7	13	43	30	100
Make (heighten) others desire to succeed.	8	27	3	10	19	63	30	100
Increase others willingness to try harder	5	17	5	17	20	67	30	100

The finding in table 4.9 shows that the healthcare providers on average agreed to the statements pertaining to extra effort. This means that the leadership practices their experienced influenced their extra effort.

Table 4.11 Providers responses on satisfaction

	Disagree		Neutral		Agree		Total	
	F	%	F	%	F	%	F	%
Makes me back up opinion with good reasoning	7	27	1	3	22	75	30	100
Works with others in a satisfactory way	8	27	4	13	18	60	30	100
Uses methods of leadership that are satisfying	8	27	3	10	19	63	30	100

The finding in table 4.11 shows that majority of the healthcare providers 60% and above agreed to the statements pertaining to satisfaction. This means that the leadership practices their experienced influenced their job satisfaction.

Table 4.12 Providers response on effectiveness

	Disagree		Neutral		Agree		Total	
	F	%	F	%	F	%	F	%
In my mind she/he is a symbol of success and accomplishment	7	23	4	13	19	63	30	100
Helps others to develop their strength	8	27	2	7	20	67	30	100
Goes beyond self-interest for the good of the employees	7	23	6	20	17	57	30	100
Effective in representing others to higher Authorities	7	23	3	10	20	67	30	100

The finding in table 4.12 shows that majority of the healthcare providers of above 50% agreed to the statements pertaining to effectiveness. This means that the leadership practices their experienced influenced their effectiveness.

Summary: Preferred and Perceived leadership styles

Table 4.12 below shows the summary of responses on preferred and perceived or experienced leadership style. Overall transformational leadership style scored the highest followed by transactional as common leadership styles practiced in 1st level hospital Lusaka province

Table 4.13 Summary leadership styles

	Leaders		Providers	
Leadership style	**F**	**%**	**F**	**%**
Transformation	12	100	21	70
Transaction	8	67	15	50
Laissez-fare	2	17	3	27

Chi-square tests Summary

Table 4.14-Summary Chi-square tests

	Pearson chi-square test	P-value
Transformation Leadership outcome		
Satisfaction	29.881	*<0.001*
Effectiveness	18.841	0.001
Extra effort	17.630	0.001
Transactional leadership outcome		
Satisfaction	11.447	0.022
Effectiveness	23.104	*<0.001*
Extra effort	24.436	*<0.001*
Laissez-fare Leadership outcome		
Satisfaction	15.286	*<0.004*
Effectiveness	5.03	*0.284*
Extra effort	4.468	*0.346*

***The chi-square statistic is significant at the 0.05 level**

The results in table 4.14 above show that a positive relationship was observed between the overall score for transformational leadership and transactional leadership.

Transformational leadership appear to have a stronger relationship with the leadership outcome than transactional leadership at less than <0.05 significant. Conversely, the overall relationship between laissez-fare and the leadership outcome were found to have negative relationship at greater than>0.05. Thus the significant relationships were observed amongst various leadership styles and leadership outcome.

4.6 Summary of quantitative findings

The findings have shown that transformational and transactional leadership styles are commonly practiced while laissez-faire is rare type of leadership. The findings further revealed that a positive relationship existed between the leadership styles and leadership outcome. Transformational leadership had a strong significant positive relationship with the entire leadership outcome compared to transactional leadership style at less than <0.05 significant. This finding indicates that if a leader displays more transformational characteristics, healthcare providers are more satisfied, efficient and put in extra effort.

CHAPTER FIVE

QUALITATIVE FINDINGS AND INTERPRETATIONS

5.1 Qualitative Results

This chapter presents the evidence based findings on common leadership practices such as networking, interpersonal relationships, dictatorial tendencies and influences caused by such practices on health care providers and the impact on health care delivery services. The most frequent responses addressing all the three objectives are the one focused on in this chapter.

The findings from the participants are presented in categories of positive and negative practices. The responses on the practices were established from the questions that were soliciting for both positive and negative practices. An example of such question included questions like this which was asked to the leaders in the selected hospitals; what things enables you to ensure that the health care services are well delivered by the providers? A similar question was asked to healthcare providers; what specific leadership practices do you see as contributing to the way healthcare delivery services are done in the hospital where you work?

Questions soliciting for leadership influence on healthcare providers were asked to leaders as; In what ways do you think your leadership influence the way healthcare providers perform in their day to day delivery of health care services? Healthcare providers were similarly asked about the leadership influence as; do you think your supervisor's leadership influences the way you perform in your day to day delivery of healthcare services? Give reasons? Similar questions soliciting for positive and negative influence of leadership on service delivery were equally asked to leaders and to the providers. For example leaders were asked questions like; what specific leadership practices do you think influence health care delivery services? Healthcare providers were also asked questions like; what specific things do you like in your leaders at your hospital that make you to delivery health care services well? These questions solicited for practices that are contributing to effective and ineffective health care delivery services. Three major themes and the subsequent sub-themes emerged in relation to the study objectives.

The table below presents the major and the sub-themes that emerged in relation to leadership practices, influence on healthcare providers and the impact on service delivery.

Table 5.1 Major and Sub-themes

Major themes	**Sub-themes**
Common Leadership Practices	**Positive Leadership Practices** 1. Networking • Effective communication • Team work • meetings 2. Interpersonal relationships • Understanding staff • Allowing freedom • Being interactive • Leading by example 3. Human/Material resources management • Resource mobilization/provision • Continuous professional development • Annual performance appraisal system • Staff involvement 4. Monitoring and Evaluation • Monitoring • Target setting • Guidance **Negative Leadership Practices** 1. Dictatorial tendencies • Favouritism • Delayed response • Not exemplary • Disrespectfulness 2. Overworking employees

	• Selfishness • Absence of leaders
Types of influence enhanced by the practices	**Positive influence on providers attitude** 1. Confidence • Pay attention to duty • Work with a free mind • Makes them aware of their weakness/strength • Providers do they work well 2. Motivation for hard work • Encouragement • Shared solution • Clear direction **Negative influence on provider's attitude** 1. Compromised quality of work • Tiredness • Lack of concentration at work 2. Dissatisfaction • Disappointments • Conflicts • Safety and security • Unfair treatment
Ways in which the identified leadership practices affects the delivery of health care services	Direct(positive) effects of practices on service delivery 1. High quality performance • Avoiding mistakes • Togetherness and enhanced providers happiness • Increased providers confidence • Respect for clients • Independent mind Indirect(negative) effects of leadership practices on service delivery

	1.Poor performance • Compromised quality of care • Relaxes when carrying out tasks • Moving up and down instead of working • Offering of outdated services • Carrying out tasks carelessly • Working in fear

5.2 Common leadership practices and the influence caused on providers and effects exerted on health care service delivery

Common leadership practices

The two types of leadership practices were noted as positive and negative leadership and emerged in six sub-themes comprising of four positive and two negative practices. The positive leadership sub-themes are networking which included three categories of 'effective communication, team work and meetings' The second one was interpersonal relationship categorised as 'understanding employees, allowing staff to operate with freedom and being interactive'. The third sub-theme under positive practices was Human/material resources management and this had resource mobilization/provision, Continuous Professional Development (CPD), Annual Performance Appraisal System (APAS) and staff involvement as its categories. The last sub-theme under positive practices was monitoring and evaluation which included three categories 'monitoring, target setting and guidance'. However the leadership practices were also noted as negative practices and the emerged sub-themes were Dictatorial tendencies with favouritism, delayed response, not being exemplary, disrespectfulness as its categories and overworking employees with Selfishness and absence of leaders as its categories.

Types of influence enhanced by the leadership practices on healthcare providers

The leadership influence was noted as positive and negative influence on provider's attitude. The positive influence on providers' attitudes included two categories

'confidence and satisfaction'. Confidence was associated with paying attention to duty, working with a free mind, being aware of the weakness and strength and doing the work well. Whist satisfaction was associated with encouragement, shared vision and clear direction.

The negative influence on provider's attitudes was compromised quality of work and dissatisfaction. Compromised quality of care was associated with tiredness and lack of concentration at work whist dissatisfaction was associated with disappointment, conflicts, unfair treatment, safety and security.

Ways in which the identified leadership practices affects the delivery of health care services.

The ways in which the leadership practices affect the delivery of health care services as registered by the respondents was presented as direct (positive) and indirect (negative) effects of leadership practices on service delivery. The direct or positive effect of leadership practice on service delivery was 'high quality performance' which included *'avoiding mistakes, togetherness and enhanced providers happiness, increased providers confidence, respect for clients and work with an independent mind'. Then the indirect or negative effect of leadership practices on service delivery was 'poor performance' which included six categories 'compromised quality of care, relaxing when carrying out tasks, moving up and down instead of working, offering of outdated services, carrying out tasks carelessly and working in fear'.*

5.3 Positive Common Leadership Practices, influence on providers and service delivery

5.3.1 Networking

Communication

This practice was mentioned six times in four hospitals by the leaders and six times in three hospitals by healthcare providers. Communication was found to be important in ensuring tasks were performed accordingly and errors avoided. Leaders agreed to have been communicating to the staff through written memos and meetings. Providers also attested to the same fact.

Leader 7 at hospital 4 said that;

" *We do notify the staff of new policies or guidelines received from the Ministry, we also make sure that department are speaking to each other on the noted problem, it can be clinical, administrative or human resource issue and we take they suggestions"*

Provider 27 at hospital 6 alluded to this fact that;

"*They communicate to us and our suggestions are heard"*

The ways in which the practice of communication influence healthcare providers

The findings show that providers do their work well when communication flows from them to leaders and leaders respond to their needs. One of the health care providers, respondent number 26 at hospital 6 when asked about the practice that he liked in her leaders said:

"The leader does not just do what she wants but she asks us what we want every day and we tell them"

Another provider respondent number 14 at hospital 3 said*;*

"If there are any updates, people are informed if something need to be done it is taken up by management for action"

The ways in which the practice of communication influence service delivery

The practice of allowing communication to flow between healthcare providers and their leaders in hospitals directly influences the health care delivery services. It gives them joy and helps them plan their work effectively as can be seen from the verbatim quote above and as provider, respondent number17 at hospital 4 said;

"There is good communication… before you came here I was told that you will be coming, it helps to plan well and be ready".

Team work

The practice of team work was mentioned 9 times in 5 hospitals by 6 leaders. The leaders acknowledged that promoting team work made work easier and promoted good performance, efficiency and help to save life. Development can occur through the team

and the need for team spirit was agreed by leaders when leaders 6 at hospital 3 attested to this fact that;

" We have a lot of road traffic accidents, staff just come in good numbers they don't wait to be called, they all come when they hear the siren, i think this helps, it helps influence good practice of the staff"

Same leader at the same facility added that;

"Another thing for example, because of the shortage the midwives usually don't work in the ward but they work because they see me work in the general ward even when i am a midwife, so i think they is good influence"

The ways in which the practice of team work influences delivery of healthcare providers

The findings on this leadership practice were that, teamwork in hospitals motivates the health care providers. They feel encouraged especially when it involves their leaders teaming up with them in what they are doing in their service delivery. One health care provider respondent number 6 in hospital 2 when asked on the leadership practice they liked in their leaders said:

"*I get encouraged because if, for example, I have to do incision and drainage (I&D) and then I am uncomfortable, I ask for the leaders, they come and we do it together".*

The ways in which the practice of team work influences service delivery

The findings on this practice were that, team work directly influenced service delivery as the work got done together with their leaders joining in and this made providers comfortable to carry out the procedures. Respondent number 13, a provider from hospital 3 when asked if the supervisor's leadership practices influenced her performance, she mentioned that;

"They do yes, the administrator in as much as she sits in the office, she would go and work she is able to do it and she will show you as such it encourages us much"

Meetings

The third and most frequent practice in most of the data sets for leaders, healthcare providers, and document review and participant observation was the practice of holding meetings at various levels and for various purposes. This practice was mentioned twenty times in the six hospitals by all the leaders and six times in four hospitals by six providers. The verbal mention of this practice therefore totals to 18 times by 12 leaders and 6 times by healthcare providers. This was seen documented 9 times in total in the 3 hospitals. The meetings were held 4 times in four hospitals during participant observation. Leader 7 of hospital 4 gave the reasons why meetings were held and he said;

"We hold monthly medical meetings in order to review difficulties; we also hold weekly meetings to ensure all departments are working"

Leader 9 of hospital 5 said*;*

"We hold meetings as well where we allow the nurses to tell us the problems they have so that we can tackle them".

This shows that meetings are held regularly and with all the staff. Both leaders in hospital 1, 3 and 4 mentioned meetings and at least one leader out of 2 hospitals from the providers interviewed, meetings were the most frequently mentioned practice. Seven healthcare providers mentioned this practice 7 seven times in 4 hospitals.

The ways in which the practice of holding meeting influences healthcare providers

The findings here show that when meetings are held, they allow for shared solutions and challenges and issues solved as mentioned by one provider at hospital 3 who said that;

" *If things are not going on well sometimes meetings are called for, if there are any updates people are informed and it is in meetings where issues affecting staff are talked about and this encourages us if something need to be taken up by management then it is taken"*

The ways in which the practice of holding meetings influence service delivery

This leadership practice also directly influences the providers in their work. The providers proceed to do their work confidently when guidance is given in meetings because the direction on how they should operate becomes clear as registered by one provider respondent number 20 at hospital 4 who said:

"*We usually have meetings; we are called one by one, say where we are facing challenges and how we want things to be done. After that we become clear".*

5.3.2 Interpersonal relationships

Understanding Healthcare provider's situations

In five hospitals, health care providers mentioned understanding from their leaders as a common practice. They felt that their leaders understood employees' situation. The employees felt that their leaders tried to set aside their personal interest and made decisions that would benefit the group. Six (6) providers alluded to this sentiment in five hospitals.

The findings on this leadership practice were that when leaders understand the situations that befall the providers, they motivate them to do their best.

One healthcare provider respondent number 6 at hospital 2 alluding to the same practice and how it motivates them said:

"*Sometimes they understand, we had a sick nurse, relatives came to ask for help and they were given some bit of money".*

The ways in which the practice of understanding situations influence healthcare providers

According to the above findings, the way in which the leaders practice of understanding their employees' situation also directly impacts on the healthcare providers. This is so when they see that leaders quite understand by way of the response they give to their situations, they get motivated to work even harder. Leaders are expected to understand the expressed and unexpressed need of their providers and make them feel at ease. Leaders are appreciated when they listen and understand their provider's problems.

This is attested by one provider respondent number 19 at hospital 4 who said that;

"They quite understand sometimes if you have a sick child at home and you phone them they even come to visit the sick child. This motivates us and you put in your level best because you feel loved and cared for".

The ways in which the practice of understanding situations influence service delivery

When leaders show understanding of their employees situations they motivate them to work hard. Respondent number 24 a provider form hospital 5 said that;

" If I have a problem immediately I talk to the manager so that way this contribute to delivery of quality health services because they will understand me and solve the problem and that way I will continue working well then if they don't understand the situation"

Allowing freedom

The practice of allowing freedom created conducive operation environment. The providers indicated that their leaders allowed freedom in their operations and this makes them carry out their duties freely. This was mentioned 8 times by 6 healthcare providers in 3 hospitals. Leaders also indicated that they allowed providers freedom of expression as said by leader 3 in hospital 2 that;

"*We encourage them to be free, we value each ones contribution they are very free to tell me anything from patient care to personal issues"*

The ways in which the practice of allowing freedom influence healthcare providers

The findings on this practice were that when the providers are allowed to operate freely without any interference from the leaders, they work freely without fear or moods. One provider respondent number 26 from hospital 6 commenting on this practice as enjoyed at his hospital said:

"As clinicians, we have clinical meetings every day and we are free to tell them (leaders) what we want and we are allowed"

Provider respondent number 27 at the same hospital also said;

"They make us feel independent and trusted we even make suggestions and they give us what we want. It helps us to deliver services well because we have independent minds and high moods"

The ways in which the practice of allowing freedom influence service delivery

The way of influence of this practice is also direct because when leaders make healthcare providers work independent without interference they are allowed to operate freely, enjoy the freedom as it gives them a peace of mind and does not make them work with fear or develop moods which are dangerous if left to occur as they carry out their healthcare delivery services. Provider 29 in hospital 6 said that*;*

" They let us do our jobs, they don't bossy us around, like when you are doing your job they allow us freedom to work independently".

Another provider respondent number 23 at hospital 5 also said:

"I always feel free to talk to him (leader) on how to work out things. We interact freely and we have a say on what we think is supposed to be done"

Being interactive

The practice of the leaders interacting with healthcare providers was mentioned five times in three hospitals by 5 healthcare providers. This is in line with leaders who also agreed to guiding, supervising and involving providers as a form of interaction in their execution of their duties. When leaders interact with the providers they felt valued and considered. This practice made healthcare providers approach the leaders without fear and got satisfied. In hospital 3, provider respondent 14 said that;

"I like the interaction, these are people who come down to our level and I feel good to discuss with my supervisor"

Leader 6 from hospital 3 also mentioned that;

"When grant is delayed we try to sit with our staff and see how best we can give quality health to our patients, their suggestions help us really to move on"

The ways in which the practice of leaders being interactive influence healthcare providers

From the findings above, the free interaction of leaders with their health care providers makes providers to deliver services with happiness and free mind.

When leaders interact freely with their healthcare providers, the healthcare providers perform well because they do not harbour any anger or frustrations to make them perform their healthcare delivery services badly. This therefore is also a direct way of influencing health care performance whether realized by leaders in hospitals or not. One provider respondent number 24 at hospital 5 alluding to the same practice by the leaders in this hospital said;

"*And our leaders interact with us freely and this way I work with free mind and am content and not frustrated. This way I will not have any stigmas to project to patients, patients enjoy".*

The ways in which the practice of leaders being interactive influence service delivery

The practice of leaders being interactive has an indirect influence because when leaders make healthcare providers interact with them freely there are allowed to open up and talk about the challenges and it lessen misunderstandings. Respondent number 28 at hospital 6 said that;

"W*e interact freely with our leaders even when you are not sure you consult the boss about the condition or something you are not sure of he will help you and that way you deliver good services because every time you will be happy, there will be less misunderstandings".*

Leading by example

Some providers rated their leaders to be exemplary. This was mentioned eleven times in six hospitals by eleven health care providers. When leaders are consistent, they set an example by walking the walk so that everyone knows that what's heard at the bottom is practised at the top. The healthcare providers followed what their leaders did as one provider, respondent number 13 in hospital 3 indicated;

"You know the administrator in as much as she sits in the office, she would go and work, she leads by example, she is able to do it and she will show you, as such it encourages us much".

The ways in which the practice of leaders being exemplary influence healthcare providers

The findings on this leadership practice were that when leaders are seen being exemplary by doing what the providers do by way of demonstrating how particular tasks can be done, that encourages the healthcare providers. One provider respondent nmber13 at hospital 3 when asked what leadership practices she liked in her leaders said;

"*They led by example and that motivates us, if they see that I am lacking behind they come to help me so that I am able to perform the work."*

It encourages when leaders work together with healthcare providers.

The ways in which the practice of leaders being exemplary influence service delivery

As can be seen from the verbatim confessions above, the way in which the practice of leading by example influences the healthcare provider and service delivery is direct because the providers imitate their leaders as they see them do what they are supposed to do. When leaders respect providers and clients, they imitate them by also respecting patients as provider, respondent number 29 at hospital 6 alluding to this said:

"We respect clients because our leaders do respect them. They lead by example and that motivates me a lot"

5.3.3 Human resource/ material management

Resource mobilisation and provision

Apart from being mentioned most frequently by hospital leaders and health care providers, the practice of providing resources to providers was also most frequently

noted in documents which were reviewed (i.e. the files for top management meeting minutes, quality Assurance Assessment report and Quarterly Performance Assessment reports).This practice was also observed most frequently in the observations that were done by the researcher in the six hospitals. In hospital 2, 3 and 5 it was highly mentioned by all the leaders interviewed. In the remaining three hospitals it was mentioned by one of the two leaders.

In the data sets from the leaders, resource provision was mentioned fifty-six times by the twelve leaders in all the six hospitals. The thirty providers also mentioned it eleven times in four hospitals. It was also seen twenty times in the three documents that were checked. The researcher also observed the action of resource provision eleven times out of the twenty-nine findings that were made in all the three methods that were used to identify the common practices. Alluding to this fact leader 2 at hospital 2 said that;

'*We try our best to ensure that the items that they need to conduct the services and perform better are available, these we provide whenever they need in the department'*

The ways in which the practice of providing the required resources influences healthcare providers

This practice where leaders supply all the required resources to the providers exerted a positive influence on the providers. It makes the providers of health care services happy and enjoys their work when the resources are supplied. One healthcare provider, respondent number 28 in hospital 6 said;

"*Whenever we ask for things or when we suggest something that we need in our department, they (leaders) always make these things available, they always deliver and we are happy".*

Another provider respondent number 12 in hospital 3 mentioned that;

"When it comes to request, they are prompt, though they will not fulfil everything, they will supply you and the patients will benefit and it helps me work well".

The ways in which the practice of providing the required resources influence service delivery

The ways in which this practice affects the delivery of health care provision is direct. When leaders supply needed items for services, providers become happy to do their work. One provider, respondent number 25 in hospital 5 had this to say;

"O*ur leaders tell us to use all the materials we order and not to order something that is not going to be on the shelf or be seen on the shelf for a long time, this supports us very much"*

Continuing Professional Development (CPD)

The findings from the methods of data collection were that although no provider of healthcare service mentioned about CPD being commonly provided to them, 12 leaders in 5 hospitals mentioned that continuity professional development was one practice they conducted in order to ensure the health care delivery service was of quality. As it will be seen later in the negatives sense, most providers complained that the CPD was allowed in the biased manner. However the data collected showed that this practice scored the same highest in the interviews and scored the same scores in the document review results and participant observations.

In the interviews, CPDs was mentioned 13 times in 5 out of 6 hospitals. In the documents, CPD was noted 9 times and was observed 4 times during the 2 day participant observation exercises in hospital 4, in house training on maternal and child health was in session for selected medical staff. In hospital 2 and 3 some staff was reported to have gone to attend a workshop under the District on HIV/HAART. This showed that providers felt the need to develop professionally and to change and advance their daily practice.

Leader 5 of hospital 3 said**;**

"*I recommend them for studies when they want to go to school"*

The ways in which the practice of Continuing Professional Development (CPD) influence healthcare providers

The findings on this practice were that it makes the providers to be updated with the latest changes in their field and take measures to suit changes. Providers expect their leaders to create opportunities for professional development based on the potential of each staff. This helps them to be more autonomous and responsible. When asked on what practice the health care providers like in their leaders, one health care provider respondent number 19 at hospital 4 when leaders expose them to more short trainings or workshops for capacity building said;

"*We are taught on latest diseases and new things in the medical sector. This makes us take measures and know procedures for our work"*

The ways in which the practice of Continuing Professional Development influence service delivery

The way in which this practice influences the health care providers is direct, in that when leaders give providers new knowledge, they make them to change direction to improve their operations accordingly. Same respondent number 19 in hospital 4 alluding to this said;

"*We are enlightened on how the samples are to be collected and the measures to be taken so that samples are samples are of good quality"*

Staff Appraisal

Concerning the above mentioned leadership practice; the findings were that, like the practice of holding meeting, it was mentioned twenty (20) times in total in all the hospitals. It was mentioned by all the 2 leaders who were interviewed in hospitals 2, 3, 4 and 6. In the remaining hospitals it was mentioned by one of the two leaders only. This shows that it is a very common practice in hospitals. Document review showed that staff appraisal was being done using standard tools provided by the Ministry of Health. These tools are used to assess staff performance through quality assurance report, annual performance appraisal system (APAS) and quarterly performance appraisal (PA). Staff scoring low for example were not recommended to go to school

and not promoted to be in charge of the units. The documents reviewed were hospital human resources meeting minutes and different quarterly performance assessment reports. Providers need to realise that they are an important part of the team and the hospital vision through the appraisals from the leaders especially when it is coupled with mutual correction.

Leader 11 in hospital 6 confessed that APAS helps in the assessment of staff, she said;

"*The annual performance appraisal system (APAS) has helped us, people are now aware as it spells out targets and they try to meet the targets".*

In some hospitals, staff appraisal was first priority in their strategy, for example in hospital 4, leader 7 said*;*

"The first strategy we have put in place is APAS to identify strengths and weakness of employees".

The ways in which the practice of staff appraisal influence healthcare providers

The verbatim quoted above show that this practice directly influences the health care providers because they confirm that when the appraisal is done on the providers, they feel helped to know their weakness and work to avoid the noted weaknesses. The findings show that this leadership practice makes the providers to identify their strengths and weaknesses, as one respondent provider number 20 in hospital 4 answered when asked on the practices that they liked in their leaders said;

"*Yes we are appraised to know our weaknesses and improve"*

The ways in which the practice of appraising staff influence service delivery

Appraising healthcare providers has a direct effect on healthcare providers. When the providers are appraised they feel helped to know their weakness and work to avoid the noted weakness and perform effectively. Provider 4 in hospital 1 alluded to this fact that;

"We are appraised annually and the recommendations made help us to work on the weaknesses and have a better chance to go to school or be promoted"

Involvement of healthcare providers in management activities.

This practice scored the 5th position in the interviews held in this study. It was mentioned 16 times and by all the 12 leaders in all the 6 hospitals. In hospitals 1, 2 and 4 each leader mentioned it twice. Staff involvement was only mentioned by one leader in hospital 3, 5 and 6. Health care providers mentioned it 8 times in hospitals1, 3, 4, 5, and 6. It was only in hospital 2 where none of the providers mentioned it. This practice was mentioned once in the document reviewed. This suggests that it is done more practically than theoretically. During participant observation the healthcare providers were seen involved in hospital 1, 3, 6 for example providers were called to prepare for the performance assessment that was to be conducted by the Provincial team.

Leader 9 in hospital 5 commenting on this said that;

"Members of staff are involved, at the end of the year each department is given the task of writing the plan for the next year, so we empower them with the 'skill'

The ways in which the practice of involving staff in management activities influence healthcare providers

The findings on this practice by leaders in some hospitals was that when leaders involve health care providers in their leadership practices, the providers got motivated to work. One provider respondent number 30 in hospital 6, alluding to this practice in this hospital said:

"*The leaders here involve us in leadership, for example if the matron is not there you are given that capacity that you can also lead others I feel very much involved and very much motivated and not left out"*

The ways in which the practice of involving staff in management activities influence service delivery

By involving the healthcare providers in management activities such as being delegated to supervise others and making decision, they felt they were important and recognized. If this action by leaders in hospitals causes a feeling of being important and recognized, then this is a direct way of influencing service delivery. The same provider, respondent 30, stated that;

"When you are motivated you can put in more effort, like you are at home the matron calls you, you will always sacrifice your time and come and work".

5.3.4 Monitoring and evaluation

Monitoring

The findings showed that this was the second highly scored leadership practice, in the interviews this practice scored 32 meaning that it was mentioned this much in total. Although it was second from resource provision which scored 56, it was the only leadership practice which was mentioned in all the hospitals by all the leaders. Monitoring was highly mentioned seven (7) times in hospital 5 followed by hospital 2 where it was mentioned six (6) times. This practice scored the same frequencies (3 times) in hospital 1 and hospital 4 respectively. Its lowest score was in hospitals 3 and 6. The providers mentioned this practice 4 times in 2 hospitals. In documents reviewed it was found recorded. This suggests that it is mostly done practically.

In the participant observations, monitoring was seen to be done by leaders walking around the wards, departments and other units to check what was happening. Leader 10 in hospital 5 said;

"*Every morning, I go round to check each and every department to check what they are doing to make sure things are there, everything is there, staffs is there"*

The same Leader 10 in hospital 5 said;

"*For the doctors, there is a tally sheet, so we are able to check if patients are seen or if there are gaps"*

The ways in which the practice of monitoring influences healthcare providers

The findings here showed that when leaders in hospitals monitor the health care providers as they do their work, it makes them to pay much attention to what they are doing because they see their leaders care on how they are working by passing through to check how they are doing their work. One health provider (respondent number 22 from hospital 5) alluded to this fact that;

"*They check on us, how you are performing the work, they make you behave in a certain way, they have put CCTV everywhere to check what you are doing. We spend 90% of time working and being monitored"*

The ways in which the practice of monitoring influence service delivery

The way in which this practice influences the providers is indirect because when leaders monitor their healthcare provider's performance, providers feel cared for and also feel motivated. It happens that when leaders monitor their healthcare provider's performance by walking around, (management by walking around) the healthcare providers jack up and see to it that they are doing their delivery of healthcare services well. Healthcare providers feel cared for and also apply the same care to patients as provider, respondent number 18 at hospital 4 alluding to this practice in this hospital said:

"They try to motivate us by coming to the ward to see what we are doing and advise us, they (leaders) pass through to see that everything is well. They show care and so we also show care on our patients too"

Target Setting

This was yet another leadership practice which was noted as quite frequently mentioned in interviews, noted in documents which were reviewed. This practice was mentioned 19 times by leaders in 5 out of 6 hospitals. The highest score was in hospital 2 where leader 3 mentioned it twice and leader 4 mentioned it 4 times.

In hospital 3, both leaders mentioned target setting thrice in total. In hospital 1, only leader 2 mentioned it three times which was the same in hospital 5 and hospital 6 where leader 9 and 12 mentioned it five times and two times respectively. It was only in hospital 4 where none of the 2 leaders interviewed mentioned it. Majority of leaders mentioned this which shows that most of the hospital leaders in Lusaka province practice target setting for employees; leader 9 in hospital 5 said;

"*We give them some targets that they are supposed to meet and when time lapses we do some appraisals we follow them up, when targets are given, work is well done".*

The ways in which the practice of setting targets influences healthcare providers

This shows that targets are not just slapped on healthcare providers but leadership further take keen interest to guard against failure to achieve the set targets which enriches the meaning of this practice in hospitals. The findings on this leadership practice were that it motivated the providers to hard work. Provider number 27 said that;

"*Our leaders give benchmarks and you are given a period in which to achieve the assignment. This affects the way we perform we work to achieve goals"*

The ways in which the practice of setting targets influences service delivery

The findings from the providers as can be seen from the quotes are that, target setting when practiced by the leaders on health care providers directly affects their operations by way of alerting them to the expected performance achievements. This practice further motivates providers for hard work as eluded by provider, respondent number 26 in hospital 6 who said;

"*Our leaders give bench marks and you are given a period in which to achieve the assignment. This affects the way we perform; we work hard to achieve goals".*

Guidance

The findings on this practice were that the practice of giving guidance to healthcare providers corrects their mistakes in their operations and clears the direction in their operations. This practice lessens mistakes and the resentment that can stem from feeling 'ordered around'. Healthcare providers felt that their leaders recognized their services and they tried to transform them by guidance. One of the healthcare providers, respondent number 28 at hospital 6 said the following concerning this that:

"The leaders are attentive, listen to our views and guide us and give direction where it is necessary"

Leader 1 at hospital 1 also mentioned that;

"*Then every quarter we sit with down to review performance, we follow them to coach and give guidance and this help them to perform better when correct instructions are given"*

The ways in which the practice of guidance influence healthcare providers

From the above verbatim, it is clear then that when healthcare providers have a problem and leaders note it and take time to explain what to do to correct that mistake, the provider straight away change in the way they do the task which was problematic.

When mistakes are corrected it gives clear direction on operation as alluded by one provider responded number 20 at hospital 4 who said that;

"*We are corrected whenever we go wrong and when mistakes are noted we are called in the office to discuss and usually there is privacy".*

The ways in which the practice of guidance influence service delivery

This is a direct way in which this practice influences the delivery of health care services. When healthcare providers have a problem and leaders explain what to do they avoid the repeat of that problem in future. Capacity in problem solving is built as alluded by one provider responded number 29, at hospital 6 who said that:

"*If I am wrong my leader explain and next time I have that incident, I will know how to handle such kind of cases myself and do the correct thing on the patient"*

5.4 Negative common leadership practices, influence on providers and service delivery.

The negative practices and influences on providers and service delivery discussed below are from the negative findings such as; dictatorial tendencies, delaying response, favouritisms, selfishness, absence of leaders, disrespectfulness, leaders not being exemplary and overloading employees.

5.4.1 Dictatorial Tendencies

Dictatorial tendencies scored highest of all the negatives practices registered by the healthcare providers. It was mentioned in 5 hospitals by providers who registered to have experienced it and in only one hospital that it was not mentioned by the providers but mentioned by the leaders. Leaders also registered to have been practicing dictatorial leadership as it was mentioned in all the 6 hospitals and it was also noted under participant observation. The findings showed that dictatorial tendencies disturb healthcare providers in their performance. It causes conflicts between the written rules

and what leaders do towards the providers. This discourages their hard work. One provider respondent 21 in hospital 5 stated that;

"There is too much intimidation we are told only what has been decided, no way you can be involved, they know you cannot complain anywhere, I feel performance is going down"

Leader 7 in hospital 4 in her statement said;

"They say I am too strict because I don't play with issues; I want work to be done in the right way I don't change my opinion if someone proposes an opinion against the vision, I just say NO and it is a NO"

This makes them to look at the leaders as evil people who do not give them breathing space or time to complain.

The ways in which the practice of dictatorial tendencies influence healthcare providers

As stated above on the types of influences that dictatorial tendencies exerts on providers, it is clear that the way in which this practice of being dictatorial in the leadership approaches towards healthcare providers is that causing fear in the providers. One provider respondent number 25 in hospital 5 went on saying;

"Our supervisors influence us negatively because even when there is shortage of man power and we are overwhelmed, you cannot complain anywhere".

It cannot be doubted that fear causes poor or under performance because one does the work either hurriedly to please the harsh leader or slowly to avoid blame. For example if a healthcare provider is too tired due to being overwhelmed and is not allowed to complain as the case was in hospital 5, the chances of even neglecting the patients are high. One provider respondent 21 in hospital 5 said;

"If you can't beat them then join them"

The ways in which the practice of dictatorial tendencies influence service delivery

The statements above may mean that if you can't make the leaders stop practicing dictatorship, start dictatorship as well. And since the providers cannot be dictatorial to their leaders, they possibly exert the similar practice on the patients which is a kind of

projection of anger to innocent patients. Therefore if not motivated, there is less performance and has a negative impact on services offered by the providers. This is attested by one provider respondent number 9 at hospital 2 who said that;

"*There is too much too dictatorship, they always will tell you what you should do without even asking how your department is that day and sometimes you knock off late and again at night they call you, how can you perform it is frustrating"*

Favouritism

This negative practice was mentioned by providers as seeing in their leaders of some individuals being favoured. One provider, respondent number 8 in hospital 2 mentioned that;

"You have to lick their boots if you want to be their favourites you have to be their friends it actually affects us and the delivery of health services if you are their favourite you will find that all your leave days you get them maybe twice in a year or three times in a year but some people have worked maybe 5 years they have never gone on leave this affect us"

The ways in which the practice of favouritism influence healthcare providers

The findings on this practice were that it influences the healthcare provider's operation in the negative way. Mostly this practice was noticed in leaders when it came to the aspect of choosing who to send to workshops and who to go on leave. One healthcare provider respondent 9 at hospital 2 said that;

"Some of us we just work we are not involved like workshops, they always choose the same people so we feel discouraged, if you are not like yes 'bwana' every time you are not favoured"

The ways in which the practice of favouritism influence service delivery

The practice of picking the same health care providers for the tasks indirectly affects them once realized. When healthcare providers are left out of workshops they end up offering outdated health care services as stated by provider number 18 in hospital 4;

"*This affect performance when a workshop comes the leader calls a CDE instead of a nurse or clinical officer to go and attend or may be if there is a delivery or maternal issues they will use someone who is not even connected to that so they have favourites. Like that we feel demoralized and offer outdated health services because in workshops they upgrade us on new things. They call the CDEs and say come you do this when professionals are there. So quality of services is compromised, we are not updated with new knowledge".*

Delayed Response

This practice scored second after dictatorial tendencies, it was mentioned in 5 hospitals with an exception of 1 hospital and by seven healthcare providers.

The findings show that one negative practice which negatively affects the quality of health care delivery services is that where the leaders take too long to respond to the requests made by the providers it compromises quality of work. One provider respondent number 17 at hospital 4 said that;

"*Even when you report about a problem they take long to act on that"*

The ways in which the practice of delayed response influence healthcare providers

The waiting which the providers experience eventually begins to demoralize them. There performance becomes low. An example of the effects by way of demoralization can be confirmed from one health care provider in hospital 6 respondent number 30 who said the following when she was asked what she dislikes in her leaders;

"Sometimes they delay us, we try to order, they delay in providing, we don't have drugs they don't deliver on time it frustrates us, I feel this hampers the smooth running of health care delivery services to our clients".

The ways in which the practice of delayed response influence service delivery

The ways in which the delay to act on requests from the leaders affects health care delivery services are indirect. The influence that this practice enhances is that of causing work to slow down. This entails under performance. One provider in hospital 5, respondent number 23 stated that;

"They take long to decide on certain things that you may feel are urgent, they take time to come up with a decision, if I need medicine and I can't access there and then because of the process then everything is delayed and this hampers the smooth provision of health services to our clients".

Leaders not exemplary

Health care providers rated some leaders of not leading by example in some hospitals. The findings on this leadership practice where a leader does not give a good example or even show how work should be done discouraged providers. Providers felt the need for their leaders to show enthusiasm and exemplarily behaviour in their performance and even to go further to demonstrate to them how to carry out some tasks. One provider, respondent number 4, at hospital 1 alluding to this practice said that;

"A leader should lead by example not were by the leader let the subordinate do the work even when there is a shortage she can't even lift her finger, even when I am late or not coming she will start calling me, because at the end of the day it is the patient who will suffer. If I come late the supervisor should start work until I come. I feel motivated when the supervisor is working not when she just sits"

The ways in which the practice of not being exemplary influence healthcare providers

The findings were that when the leaders do not show good examples to the healthcare providers, they contribute to their erroneous performance. Providers felt discouraged, unhelped and unfairly treated. Health care provider respondent number 23, in hospital 5, also alluding to this lack of exemplary behaviour said that;

"*Just because one is a leader can come to the office any time they feel like. So I think the way they work influence us, because I will also say, if the boss can do that what will stop me from doing the same"*

The ways in which the practice of not being exemplary influence service delivery

The findings were that when the leaders do not give good example to the healthcare providers they contribute to erroneous performance. This may be an indirect way

because it leaves the providers to do a trial and error in their performance. This fact was noted when provider number 18, in hospital 4, gave this sentiment that;

"The leaders do not come to show us examples of how some tasks should be done, they just pass through instead of showing us, so we make mistakes, their just monitor instead of participating in what we do"

Disrespectfulness

The findings here were that when leaders in hospitals act in a disrespectful manner towards the healthcare providers, they make them feel embarrassed and disappointed. The healthcare providers registered their leaders of not giving them the respect they deserve. One provider, respondent number 2, in hospital 1, alluding to this influence narrated that;

"*At times we are treated like children, at one time the samples we took delayed to be ready, we were so disappointed, when the leader shouted at us in the presence of patients"*

In hospital 2, provider number 10 also said that;

"One should understand like if you take a complaint to them, they will just shout at you even if they do not want to act, they should show some concern because this is not just about me but for the patients "

The ways in which the practice of being disrespectfulness influence healthcare providers

The findings here were that when leaders in hospitals act in disrespectful manner towards the healthcare providers, they influence them negatively in that they make them feel embarrassed and disappointed as stated by one provider respondent number 22 at hospital 5 who complaint that;

"You may have a point to explain but they will shout at you, it frustrates"

The findings above indicate or show that when healthcare providers are not respected in the way they are handled by their leaders, they get disturbed due to embarrassment and frustration that result.

The ways in which the practice of being disrespectfulness influence service delivery

The ways in which disrespect influence providers is somehow direct because when the leader shout at the providers they go away and expected work to be done. But the provider interviewed said this frustrated them. One of them quoted in hospital 2, respondent number 10, gave an example of instances where the leaders (doctor) shouted at her;

"Patient came at 8hrs and I felt the urgent need for him to be seen by the doctor and started following the doctor, until 15hours then he started shouting at me saying why are you following me, has the patient paid you? Then you start to plead, if you do not plead, you will be following them everywhere and this affects performance".

5.4.2 Overworking employees

This is another negative practice that was registered by the health care providers in 4 hospitals. Leaders too consented to this fact that the providers are overworked due to staff shortages. The findings here were that when health care providers are overloaded, they get overwhelmed, tired and end up frustrated. Alluding to this practice and its influence in hospital 2, provider 8, said that;

"You get too tired because you do a lot of things, just like you saw in other departments, you are overwhelmed, and you are just alone, you get frustrated you don't rest at all".

The ways in which the practice of work overloads influence healthcare provider

From the verbatim counts of the providers, in hospital 2 above, it can be deduced that the way of influence where providers are overloaded is a direct way. When health care providers are overworked, there and then they become frustrated due to fatigue. Provider, respondent 4, at hospital 1 said that;

"When it gets too much of work, they say no, come back even when you have knocked off. You feel commanded and unfairly treated. So also instead of you feeling sorry for the patients you lie, you are like anyway let me just stop now, you just get frustrated"

When they are called back it inconveniences them and just go back annoyed and start doing own things.

The ways in which the practice of work overloads influence service delivery

The finding on the practice of work overload has a negative influence on quality of service delivery.

Provider number 10, at hospital 2 attesting to this said that;

"It's too much, these people overworks us, you knock off at 17 hrs then they call you back, they send the driver to pick you and driver refuses to take you back. you are in the hospital till 20hrs and you will have to look for transport to go back, so on that part instead of feeling sorry for these patients you go like let me just close"

This remarks showed that the effects of overloading providers is direct and it caused stoppages of work even when a provider is present. This type of influence exerted by the practice of overloading of employees with tasks is negative.

Selfishness

This practice was registered by healthcare providers in 3 hospitals. Selfishness causes providers to feel insecure and unprotected in their job. One provider, respondent number 18 at hospital 4 to this fact stated that;

"If someone dies they just tell us to take to the fridge without certifying what if it back fires? They just tell us to write in the file as if we are doctors, there is a gap they are on the safe side not us"

The ways in which the practice of selfishness influence healthcare providers

Another provider number 2 at hospital 1 said that;

"*Each department has rules and regulations but here there is that conflict when the leader want this to be done in that way, it has to be done regardless of the rules in that department samples take time to be ready and this delays results but without asking and ignoring what goes on he started shouting at us, we felt very discouraged and disappointed"*

The ways in which the practice of selfishness influence service delivery

This practice affect the providers and service delivery indirectly, when the providers are forced to do what is not right they felt insecure and do tasks carelessly and ineffectively as alluded by provider number 12, at hospital 3 that;

"*There is always that aspect of moving away from the regulations but you are scared to refuse, so I work so that I am not the topic of discussion"*

Another provider 16, at hospital 4 said;

"As professionals we want to perform professionally, but if a leader want to do things in the way he wants, I feel I am being hindered, there are times whereby we ran reports in the way they want not what the profession says, so we are hindered to report facts".

Absence of leaders

This negative practice was registered in 3 hospitals by the health care providers. The findings reviewed that providers are discouraged when their leaders are constantly absent from work and not found in office as it delays some activities. Provider 7, at hospital 2 said that;

"*Most of the time the leaders are out and they don't even say where they are and you remain doing their work, you are alone you become too tired, you just get frustrated"*

The ways in which the practice of leaders being absent influence healthcare providers

The absence of leaders from duty was indirectly influencing the healthcare providers negatively. When they saw no example, they also began eventually to lazy around in their work as can be seen from the quote above. This way was indirect because the leaders probably did not even realize it that their frequent outings from the wards/department or office caused their providers to lazy around. .

Absence of leaders causes lack of concentration at work due to absenteeism as mentioned by another provider number 9, at hospital 2 when he said that;

"Me, I am always here working and my supervisor he is always out so I don't get encouraged…"

One provider number 23, at hospital 5 also registered that;

"Just because they are leaders should not make them move up and down leaving the office and coming back anytime they feel like. That influences the way we work because I will also say if the boss can do that then I do the same. I don't concentrate too. This influence the way we work"

The ways in which the practice of leaders being absent influence service delivery

When leader is absent, work is affected because there is no supervision as stated by provider 13, at hospital 3;

"When leaders frequently go to town when they are suppose to be in office it paralyses work, there is no supervision if a supervisor is not there the second will refer matters to the same person she knows is not available; they don't take action, things moves very slow and patient care is delayed".

CHAPTER SIX

DISCUSSION OF FINDINGS

6. 1 Introduction

This study aimed at establishing the common leadership practices and the influence they exert on healthcare providers and service delivery. Using a two-phase, concurrent, mixed method design, this study examined 1st level hospital leadership through the perspective of hospital administrators, nursing officers and healthcare providers using a multifactor leadership questionnaire and in-depth interviews, focus group discussion, document review and participant observation schedule. The quantitative results identified transformational and transactional as common leadership practices in 1st level hospitals. The qualitative findings complemented the quantitative results by providing eminent explanations pointing to common leadership practices and how they influence the healthcare providers and the ways in which they affect health care delivery services. According to the participating leaders and providers, the study found that the common leadership practices were transformational that scored 85% (100% leaders and 70% providers) and transactional scoring 59% (67% leaders and 50% providers). This result is also supported by Bass, (2008) who also found that both kinds of leadership styles can be exhibited by the leaders simultaneously. These practices were explained as networking, interpersonal relationship, human/material resources management, monitoring and evaluation, dictatorial tendencies and overworking of employees.

The study has also shown a strong positive significant *p*-value of 0.0001 for the association between the practices and the effect on provider's extra effort, motivation, satisfaction and efficiency. These effects were further explained by the healthcare providers as shown from the results through enhanced confidence, motivation for hard work and compromised quality of care. These factors were seen to influence health provider's motivation, satisfaction, efficiency and extra effort. In addition, results have shown that these practices and effects on healthcare providers had an influence on service delivery as indicated through the direct effects such as high quality performance and indirect effects such as poor performance.

The aspect of job satisfaction was one of those addressed in the theoretical framework where this study was anchored. This study was based on the premise of the path-goal theory model of leadership influence on healthcare providers. This model or framework states in its flow diagram (Table 2.7-1) that when the leadership practice such as transactional or transformational are applied on health care providers, job satisfaction results and brings about quality health care delivery services. This was also attested independently when health care providers were being interviewed in the qualitative component of the study. When it was noted that the interviewees were not free to answer questions in focus group discussions, the approach was changed to one on one interview to allow for openness and confidentiality. It was during this one to one interview as counted in the verbatim quote in which one provider attested that he interacted freely with the supervisor. This practice registered by the providers made them enjoy the work because their leaders were free with them and are there to listen to their concerns. Most of the providers interviewed confessed that they were motivated by this type of approach. These results are consistent with Al-Ababneh, (2013) who found that job satisfaction was higher in employees who interacted with leaders in democratic leadership style.

Therefore it can be safely argued that the path-goal theory is a correct model to use in studies that are aligned towards relationships between leadership and health care delivery services in hospitals. Most of the providers chose options that stated that their leaders increase other's willingness to try harder and help them to develop their talents. Because of this they were highly motivated as stated above. The provider's independent attestations to the positive and negative influence that transformational and transactional leadership styles exerted on them strongly support the argument in the path-goal model that states that; leader's behaviour is contingent to the satisfaction, motivation and performance of his or her subjects Northhouse, (2007). Supporting this argument is Robins and Coulter, (2014) who stated that leadership behaviour and follower's perception is the degree to which following particular behaviour will lead to particular outcome. Therefore this model and theoretical basis can be applied in other settings like ours. This adds then to the authority to generalize the findings and consequently the need to learn more from these findings.

6.2 Identified common leadership practices

The first research objective was to identify the common leadership practices .This objective was guided by questions from both quantitative (appendix 3 & 4) and qualitative (appendix 5 & 6). This was done to get further information on common leadership practices as preferred and perceived or experienced.

The responses from leaders and providers on identification of their preferred and experienced leadership styles were pointing to the transformational and transactional. This wide choice of options related to these two leadership styles was not a mere coincidence. It indicates a natural trend in the practice which most leaders in level 1 hospitals employ. The fact that all leaders chose options pointing to transformational leadership, it also indicates a trend where hospitals are not stagnant in their operations but are very progressive. This means then that there are developmental changes that occur in hospitals which could be contributing to the improvements seen in healthcare delivery services where the patients now (for example) have the right to know what is being done on them and treatment being given. These findings are similar to studies done by Abdelhafiz et.al. (2015), Alloubani et.al. (2014) and Chiok Fooke Loke, (2001) that showed the highest score received by the transformational style of leadership followed by transactional leadership and the least was lasseize-faire style of leadership. The smaller percentage indicated by both leaders (67%) and providers (50%) on transactional leadership style is a clear indication that leadership in hospitals is shifting from transactional to transformational leadership culture, the one that is more collaborative in which a leader motivates followers to perform to their full potential over time by influencing a change in perception and providing a sense of direction for the benefit of the institution (Howkins and Thornton, 2002).Whereas transactional leadership involves a leader predefining objectives and goals and uses rewards and punishment to motivate subordinates, transformational leaders uplift morale, motivation and morals of subordinates.

Transformational style of leadership scored the highest (85%) from both the leaders and the providers. As argued by Lancaster, (1999), that males adopt a more transactional

style while females take on feminine approach of transformation leadership. This is probably the reason why transformational had higher percentage in this study because the study was mainly dominated by female (more than75%) healthcare workers. The transformational leadership practices was evidenced through resource provision, holding of meetings, enhancing professional development, appraising staff, targets setting, involving staff in management activities, guidance, monitoring, understanding staff, allowing freedom, leaders interacting with staff and leaders being always available. These were noted to motivate, satisfy and made healthcare providers carry out their work efficiently and put in some extra effort. This is in agreement with the studies done by Alloubani.et.al. (2014) and Miia et.al.(2006) who indicated that attributes and behaviours such as identifying qualification needs, professional development and other needs and aspiration of followers were associated with a transformational leader. This is also supported by Howkings and Thornton, (2002) who indicated that individual attention, clinical supervision and mentoring experiences can stimulate recipient in a creative way.

From the above practices for example, resource provision, the findings showed that supplying the providers of healthcare with the required materials makes health care provision to be well delivered. This is so especially when it is accompanied by the instruction to see to it that the supplied materials are not left unused. Since this practice makes the providers of health care happy as they do their work, it directly motivates them to offer the services to patients in a better way. Islam, (2007) indicated that resource provision such as essential medicines and supplies and equipment are deemed as core inputs and very necessary for effective health care delivery services. These inputs must be available and accessible for providers in order to have an impact on health outcome.

Holding of meetings is another leadership practice upheld by a transformational leader. This study showed that holding meetings with healthcare providers is a good leadership practice. The findings indicate that when meetings are called by leaders, there is an allowance for clarification that is why the providers stated in their verbatim counts that

they become clear when challenges are discussed during the meetings. This also indicated that the meetings were not only held to give information but also to allow for concerns to be clarified and duties shared. This is consistent with the findings by (Mutale et.al.2017) who indicated in their study that responsibilities were assigned during meetings. The manner in which the meetings are held matters in this case. Meetings can be used to get feedback on matters that could be promoting or negatively affecting the delivery of services such as the health care provision services in hospitals. Meetings especially medical clinical meetings are opportunities for updating providers of services in an organization with latest ideas or skills in their field of operation. Research shows that meetings help to keep employees abreast with new ideas and information in their fields of specialization (Mulundano, 2006). Robbins & Coulter, (2014) has also noted that meetings brings employees together and build team work in order to create more committed ,collaborative, and inclusive employees.

MoH, (2012) health policy document indicates that meetings help to identify weaknesses and deal with them in a timely manner. The findings from this study confirm the above statement from Ministry of Health where both leaders and providers stated that meetings were used to spot the challenges and monitor progress on the quality of service delivery. As quoted from the verbatim count of one of the providers that when things were not going on well, meetings were called for and staff were given correct information.

It is also clear from the findings that meetings are an opportunity to get feedback from workers so that challenges affecting them are addressed.

Under the practice of monitoring, it is clear from the findings confirmed by verbatim counts from the previous chapter that the practice of walking around to see how healthcare providers are delivering their health care services caused them to deliver these services well. This is supported by the notion “a good principal monitors implementation” (MOE, 2009). In this way then, management by walking around (MBWA) is an effective practice towards the enhancement of effective health care delivery. The opposite could be the case where such a practice is not done. Monitoring

employees is one way in which a leader can ensure that the tasks are well done. This leadership practice requires commitment and strategic thinking so that it is maximized in a way that does not frustrate those being monitored.

When leaders allow new ideas (as one option item in the likert scale indicated) to flow for improvements then the leaders are allowing for developmental ideas to flow. This has implications on the health care providers and leaders in hospitals. The implication in this finding is that the leaders in hospitals need to collect data on their particular practices that entail transformational leadership and make informed decisions to track the growth that these practices enhance. This way, deliberate effort can be made on how to maintain or even enrich the transformations of delivering health care services. Some of these ways may be to do further studies. The evidence from the providers interviewed was clear from the verbatim counts that some leaders allow for growth by involving them.

The other common leadership practice preferred and perceived or experienced was **transactional style** of leadership, commanding leadership practice characterized by an emphasis on compliance and control and leading through power and authority with a score of 59%. The transactional leadership was evidently supported as occurring according to the agreed options registered such as “Is alert for failure to met standards”. This indicates that power and authority prevailed in this leadership practice and this contextualizes the practices in the light of call to dictatorial governance. This is similar with the findings by Ewens et.al. (2000) who noted transactional leadership as main leadership style where doctors, managers, senior nurses controlled nurses through power and authority ascribed to their roles. They further indicated that new practitioners felt demoralized and undervalued and work environment was found to be stressful and full of conflicts.

The most prominent aspect of transactional leadership is that such leaders focus more on the basic physical and security needs of their followers (Bass, 1985). Therefore the relationship among leaders and followers in this type of leadership style is based on the

principal of returning rewards or incentives in response to appreciable performance of employees (Bass & Avolio, 1993). In this study healthcare providers did not perceive transactional leadership style as a good practice to be practiced by their leaders because it did not encourage them. This is consistent with the findings by Voon .et.al. (2011) who indicated that transactional leadership had a negative relationship with employees' job satisfaction but contrary to the findings by Calton, (2015) who indicated in their study that staff perceived transactional leadership as necessary to assure performance or to accomplish specific tasks.

This type of leadership practice was further explained by providers in this study that they experienced their leaders practicing this through dictatorial tendencies, favouritism, selfishness, and absence of leaders, disrespectfulness, being overworked and delayed response.

The findings on dictatorial tendencies presented in chapter 5 clearly indicate that there is a close link between the way providers are handled and the way they perform their tasks. Leaders could ask for employee's opinion on certain issues, but usually they have made decisions and this was not changed by the opinion of employees. When one leader indicated that she does not play with issues and that she does not change her opinion in the verbatim account from the previous chapter, it is a clear indication of dictatorial practice that does not give room for employee's consensus. When leaders closely monitor provider's performance, order what has to be done and keep tract of mistakes, it disturbs their performance and discourages and demoralizes their hard work. This implies that leaders practicing dictatorial tendencies use their power to achieve their personal objectives and goals and not those of the institution without paying much attention to the employee's rights. These results are consistent with Howkins and Thornton, (2002) who indicated in their study that nurses felt that managers did not listen or respect them and that this had a negative effect on their ability to provide good care through creating low motivation and poor morale. Consequently patients may fear accessing services due to negligence and lack of respect from the providers.

This is also in agreement with Deshpande and Hill, (2011) who noted that transformation of their institutions would not have been successful if authoritative leadership was utilized where knowledge and opinions were not shared and employees were assumed to be of no value and only adhere to directives. When providers indicated that there was too much intimidation and they could not complain anywhere then mistakes can be made such as wrong prescription, wrong dose of medication, or missed dose of medication for patients. This is consistent with the findings by Soili et.al. (2012) that a commanding leadership style prevents the empowerment of nurses because they do not have possibilities to participate in work planning. A similar trend was found in the results by Locker, (1976) who pointed out that autocratic leadership leads to lower levels of job satisfaction and substandard services.

The other practice registered under transactional leadership was favouritism. Whether leaders realize it or not, the practice of favouring some staff discouraged most healthcare providers who viewed leaders to favour some staff by sending them for workshops and granting them leaves. This created conflict among the staff as some providers felt not valued, not cared for and this reduced team work that led to reduced motivation and low performance with resulting inadequate patient care and lives being put at risk. This is in line with the statement by Atwater and Bass, (1994) and Lancaster, (1999) that when staff neither feels that they are not cared for, then they find it difficult to provide responsive care to patients. When this is the case patients will shun seeking medical attention when in need due to fear of being embarrassed or cared for.

Disrespectfulness was registered by the providers in the way they were handled by their leaders. They got disturbed due to the embarrassment caused to them when they were shouted at. This had a negative effect upon their ability to provide good care through creating low motivation and poor morale. This is supported by Howkins and Thornton, (2002) who stated that listening to patients was a very important part of providing quality care but nurses often felt that the leaders did not listen to them or respect them in order for them to do a good job and provide high quality services.

It is also important to note that in order for health care services to be well done, there should be enthusiasm in leaders to be always present and show exemplary behaviour in their performance and even go further to carry out the same tasks being done by the providers. These complaints above from the health providers show that they are expectant to see exemplary performance in their leaders and when they don't see it they get disturbed in their performance. This is in agreement with the findings by Abdelhafiz et.al. (2015) who indicated that the presence of managers resulted in better satisfied staff at the hospital.

Overloading employees was registered as a negative practice which caused stress among the health care providers and affected quality of health care service delivery. According to Howkins and Thornton, (2002) providers enter health professions to provide quality services but it is the pressure and conflicts within the organisations that often de-motivates them. This is consistent with the Ministry of Health survey (MoH, 2012) which indicated that, staff exhibited low morale due to long work hours because of the work overload and this caused dissatisfaction, arising from stressful workloads. They concluded that this dissatisfaction and low morale was compounded by systems and collective leadership failure. This is also supported by Howkins and Thornton, (2002) who noted that the pressure and conflicts arising from work overload attributed to unsound leadership practices within organizations which often de-motivated healthcare providers.

These findings give an opportunity to leaders to tap ideas from the healthcare providers to improve their leadership practices. The implication for this is that the Ministry of Health directly or through other support service providers such as cooperating partners can focus their attention on planning and implementing strategies that would strengthen the prevailing transformational and transactional leadership styles in hospitals. This is an important finding and provides opportunities for incremental knowledge and skills important in the leaders in hospitals especially in the context of strengthening systems and perfecting health care service delivery. To achieve this there is need to identify specific areas needing to be maintained in hospital leaders and those needing to be

introduced for the perfecting of leaders in hospitals. This is in agreement with Mutale et.al. (2017) who indicated that leadership and management training will be a key ingredient in health system strengthening in low-income settings.

6.3 Influence of the identified common leadership practices on healthcare providers.

The second research objective was to determine the influence of the identified leadership practices on healthcare providers and this was guided by responses from both quantitative and qualitative data. The study results showed that there was a positive relationship between leadership styles and leadership outcomes in healthcare providers. This is in agreement with the findings by Evans, (1970) who indicated that consideration of employees relates to supervisor's behaviours which include trust in employees, respect, open communication, concern for the needs of employees and their involvement in decision making. These have an impact on employees' motivational behaviours. The study further found that leaders in hospitals do not just practice the transformational and or transactional leadership anyhow but that they practice these styles to influence particular aspects in their healthcare providers .Their responses indicated that they influence the effectiveness of providers in their hospitals for example all the leaders said that they provide advice to healthcare providers when it is needed. The qualitative findings showed that the leaders in the selected hospitals were alert to note deficiencies in healthcare provider's operations or to welcome the call for guidance from the health providers. This confirms the findings in their leaders' readiness to give advice. Some healthcare providers' indicated in the qualitative responses that their leaders joined in what they were doing in order to demonstrate or give practical advice. These demonstrations made healthcare providers become confident and avoid mistakes.

The other finding on leadership outcome which is focused on in the transformational and transactional leadership styles of leaders was satisfaction. The responses in the Likert scale showed that leaders practiced or employed methods that are satisfying. This response was picked by all leaders who took part in the multifactor leadership questionnaire. This indicated that the practices of leaders in the selected hospitals were focused on making the healthcare providers deliver health care services effectively and at least satisfactorily. This was evidenced in the overwhelming selection of the

responses pertaining to satisfaction. This indicated that the leadership practices were embarked on in a direction of satisfying the healthcare providers. This is a more comforting stance in leaders because the implication is that there would be excellent performance by providers in all hospitals if this was ensured. The further implication would require the Ministry of Health to focus its attention on training hospital leaders on how to maximize job satisfaction so that quality health care and responsiveness can be achieved. If that were to be the case, then Zambia as a whole would be assured of being a healthy nation by 2030 (MoNDP, 2017) with a low disease burden and low mortality rates.

This also indicated awareness on the part of the leaders in those hospitals that what they do is done to ensure that the providers are satisfied. This suggests that there is an understanding that job satisfaction is a factor in the effective delivery of health care services in hospitals. This requires much attention to make leaders have capacity to not only enhance this job satisfaction in health providers but also to sustain or maintain it. The implication is that there is need to build capacity of leaders in hospitals to enable them increase and strengthen the methods they use to enhance job satisfaction in healthcare providers in hospitals. This is consistent with the findings by Morana (1987) and Kreitner (1995) that Leader's capacity and effectiveness is found to build followers to better performance and job satisfactions. The Zambian Ministry of Health developed the governance and management capacity building strategic plan (MoH, 2012) to focus on strengthening leadership in the health sector in order to enhance effective health care delivery services. This focus by the Zambian government through the Ministry of Health shows that there is growing recognition on the need to build capacity of leaders in hospitals. Findings in this study attests to the fact that some healthcare providers interviewed suggested that their leaders needed to be trained in leadership skills because they were too forceful and "*knew it all"*. This independent attestation to the negative influence of dictatorial leadership indicated that there was no job satisfaction. Healthcare providers confirmed that when they were not handled well there was no job satisfaction and this posed a big threat to the success of health care delivery services. This is consistent with the findings by Taunton et.al. (1997) who indicated that

manager's characteristics influences staff nurse's performance and organization perceptions.

Cross tabulation was done between transformational leadership style and the leadership outcome of extra effort, satisfaction, efficiency, motivation as well as between transactional leadership style and extra effort, satisfaction, efficiency, motivation. This was to ascertain the relationship between the independent variables and dependent variables of the commonly practiced leadership styles and leadership outcome respectively. Concerning transformational leadership style, although there were slight differences in the numbers of healthcare providers who stated the type of influence they experienced from this type of leadership, these numbers were all above 85% with motivation and satisfaction both scoring 100% and their significance were < 0.001 which indicated that a relationship existed between the transformation leadership practiced in hospitals and the influence that the healthcare providers attested to as resultant. Interestingly the study found that larger numbers of providers attested to the influence of being motivated, satisfied, efficiency and put in extra effort because of the transformational type of leadership which the leaders use in these practices to lead them. This is consistent with the findings by Abdelhafiz et.al. (2015) who indicated that transformational leadership led to better and more satisfied employees. Other studies supporting this were by Casida and Parker, (2011), Voon et.al. (2011) and Alloubani, (2014).

The results showed that increased levels of transformational leadership on providers was associated with increased levels of leadership outcome of extra effort with a score of 86%, satisfaction scored 100% and effectiveness scored 92%.This is consistent with Bass, (1999) who indicated that transformational leaders motivate their followers to achieve the vision and perform the work that must be done. Similarly, Al-Ababneh, (2013) found a positive relationship of transformational leadership and job satisfaction as did Abdelhafiz, (2015) and Laschinger et.al. (2009). Also Footit, (1999) indicated that transformational leadership offers opportunity for nurses to break free from negative practices, empowering them and lifting them to a higher level of motivation.

The Pearson Chi-square test showed that transformational leadership significantly influenced satisfaction, motivation, efficiency and extra effort with the *p-value* < 0.001.This is similar to the findings by Morrison et.al. (1997), Boumans & Landeweed, (1993) and Voon et.al.,(2010).

It can therefore be concluded that transformational leaders tend to encourage and motivate their followers to take on more responsibilities and autonomy thereby enhancing employees' sense of accomplishment and satisfaction with their job.
Transactional leadership was found to be another common style of leadership and it had a significant relationship with leadership outcome in providers. However the relationship was not so strong as compared to the transformational style of leadership. Similar results were found by Abdelhafiz et.al, (2015) and McGuire et.al. (2003). Pearson Chi-square tests showed that transactional leadership style and leadership outcome were significant with *p-value < 0.022.*

These results suggests that the influence enhanced by this practice on provider's performance had some elements of demotivation, undervalued, experience of compromised quality of work, tiredness, feeling of unfair treatment, stressful and conflicts hence they lower scores. This is confirmed by the healthcare providers when they stated that when they were not handled well there was no job satisfaction and this posed a big threat to the success of effective health care delivery services. This is consistent with the results from the survey by MoH, (2012) that indicated that healthcare providers were dissatisfied because of stress arising from work overload that led to staff absenteeism and tardiness. Supporting this, is also the findings by Howkins and Thornton (2002) who indicated that not listening or disrespecting nurses created low motivation and poor morale. This study showed that transactional leadership had not served providers well in that it had caused frustrations, discouraged hard work, resulted in healthcare providers working in fear and hospitals which relied on knowledge, skills, and attitude of its staff to provide high quality of patient care was affected by this leadership practice. This is consistent with the findings by Deshpande and Hill, (2011) who stated that authoritative style of leadership instil fear, intimidation,

increases isolation and it has a negative impact on team member performance. This is also supported by the Evans, (1970) who found that the role of the supervisor as well as environment have an impact on the motivational behaviour of employees, the attainment of goals and job satisfaction which authoritative leadership does not support. If leaders do not support the employees who work for them, performance will suffer which can have a negative impact on patient care. The providers already indicated that they are being overloaded and they were in short supply, so if this fact of key personnel is in short supply and leaders do not make an effort to understand those who work within them, retaining employees will be disastrous. When providers are not valued, supported and understood they are likely to leave the organization in search of an environment where they will feel more supported, valued and motivated Howkins and Thornton, (2002).

6.4 Ways in which the identified leadership practices affect the delivery of health care services.

The responses to answer this objective were attested from the qualitative data using semi-structured questions. Health care delivery services are the back bone of a health system and motivated healthcare providers are needed to delivery effective quality services as close to the family as possible if Zambia is to attain a healthy and productive citizens (MoH, 2012).Hospital administrators and nursing officers increase organizational and employee performance through their leadership practices that would effectively lead staff, encourage and motivate them to increase their performance and commitment in support of the hospital mission and vision.

Leadership styles influences patients care and its quality at least indirectly. A leader has a significant role in using leadership styles that promotes good patient care, Soili et.al. (2012).This is because manager's leadership style affects the personnel job satisfaction and commitment thereby influences performance. In this study, the findings on the ways in which the identified leadership practices affected delivery of health care services were in two, the direct and indirect ways as counted by both leaders and healthcare providers. Under the direct ways for example providers mentioned that they were happy when the leaders provided them with the needed resources and that they felt supported

when leader supervised, monitored performance and gave them guidance. This helped them to do the work well; felt motivated and satisfied, worked confidently and avoided making mistakes. This in itself will mean that providers will provide quality care to patients and when patients receive that quality health care they will always want to go to the hospital when unwell. This is consistent with the findings by Solil et.al. (2012) who indicated that nurses who worked with leaders who supervised them were more satisfied with their job. They added that, when employees were allowed to express their opinions and take part in decision making, it promoted their commitment and performance. Providers in verbatim count mentioned that when you are motivated you can put in more effort and remain committed to duty. This statement would result to providing quality care. Supporting this is the findings by Soili et.al. (2013) who indicated that nurses were committed to their patients when managers were committed to supporting them.

Indirectly, the leadership practices were found to have some negative effects on service delivery as indicated by the findings from the healthcare providers who in their verbatim counts for example indicated that when one had a point to explain, leaders did not listen and or understand but just shouted at them. This affected their ability to provide good care through creating low motivation and generation of fear. This is supported by Howkins & Thornton,(2002) who indicated that listening to patients is a very important part of providing high quality care but providers often feel that leaders does not listen to them or respect them. When staff feel that they are not cared for or listened to, then they find it difficult to care for patients (Atwater and Bass, (1994); Lancaster, (1999). Consequently patients will shun accessing health services when providers fail to listen to them or at least respect them. Providers also registered that when they are left out of workshops they offered outdated health care services and they felt demoralized because they lack new knowledge on latest case management. This will have a negative effect on disease prognosis if the providers lack new knowledge on case management and quality care. Similar findings were noted by Soili et.al., (2013) in their study that most nurses indicated that their skills and knowledge were insufficient

and were not able to keep up to date with their profession and newest treatment and care modalities due to limited chances for continuing education.

It is important for leaders to identify practices that motivate employees to enhance commitment and hard work so that organisational goals are achieved. As noted by Gunderman, (2009) that the failure of leaders to understand human motivation, commitment and dedication negatively impacts on employees and organization performance. He further said that in order to improve employee dedication, job satisfaction and performance, leaders need to examine their leadership practices within their organizations. This study has shown that leadership practices have some positive and negative effects on provider's commitment to service delivery.

CHAPTER SEVEN

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

7.1 Conclusion

The main leadership styles preferred and perceived or experienced in first level hospitals in Lusaka Province was the transformational type of leadership followed by transactional leadership while laissez-faire is rare type of leadership as attested by the practices from the leaders and experiences from the healthcare providers. This conclusion was reached because all the respondents interviewed chose options that pointed to the characteristics of transformational and transactional leadership styles. Transformational leadership offers an opportunity for healthcare providers to break free from the negative approach, empowering them and lifting them to a higher level of motivation, job satisfaction and commitment which translate into higher performance.

Transactional leadership which was also experienced by providers had not served them well in that it led to disempowerment and de-motivation because providers did not get the support and encouragement from managers who practiced this leadership style.

Leadership styles affect employees' commitment, motivation, satisfaction, extra effort and efficiency. This in turn has a bearing on performance and directly or indirectly influences patient care and its quality. Health system managers have a significant role in using leadership styles that promote good practice. However this will not come by chance but that health care organization must ensure that leadership and management training programs for health system managers are promoted and encouraged to improve leaders self reflection through which they are better able to vary their leadership style.

Given the differences between transformational and transactional style of leadership, one can conclude that transformational leadership which is a more participative leadership style is the best style to improve processes within hospitals as well as increase employee performance and the quality and safety of care for patients.

It can be safely concluded that hospital performance and quality health care delivery services is a product of several factors. The analysis of leadership practices in this study shows two of the factors influencing hospital performance. The first factor is the

effectiveness of leaders within the hospital to include hospital administrators and nursing officers in supporting the healthcare providers as well as conveying the organization values, mission and culture by adopting good leadership practices. Secondly it is the dedication, motivation, commitment and performance of employees that will improve health care services.

7.2 Study limitations

The healthcare providers feared assessing their leaders for fear of losing their positions, victimization, and dismissal. The researcher upon arrival at the facilities found out that human resources officers were not in charge of healthcare providers in wards/departments thus lists of names were provided either by the nursing officer, hospital administrator or medical officer in charge who would list names according to their preferences. The sampling of the healthcare providers did not focus on specific target group but generalized to different health care provider cadres. It is also important to note that leadership is not the only factor that has an influence on healthcare providers and service delivery but there are other confounders. Finally this study was only carried out in one province as such generalization of results to other provinces must be done with caution.

7.3 Recommendations

In recent times, the concept of leadership and leadership styles has been the centre of attraction for all types of organizations. Therefore the implications are most appropriate for enhancing health care provision and health policies as follows;

Employees are the most important asset in an organization. Therefore, government must ensure that hospital organizations have rightful and capable leaders to do the right job of leading and motivating their employees in their daily operation in order to increase their job performance and ability and achieve the organization goals.

Since this study had illustrated that transformational leadership is more important in terms of empowering and lifting of providers to higher levels of job satisfaction, motivation and commitment than transactional leadership, then leadership training models can act as a powerful tool for enhancing leadership skills and the value of such

training models must be recognized, incorporated in any health care organization policies.

Furthermore, the results of this study suggest that there is active leadership in first level hospitals and this might need to increase the levels of commitment in the organization by increasing satisfaction through resource provision, holding of meetings, hands on supervision, staff involvement, allowing freedom etc and reducing the vices such as dictatorial tendencies, favouritism, disrespectful and work overload.

The findings suggest that leadership development program must be an integral part of the health care providers' career development that should be commenced at an early stage in order to develop an understanding about the essential requirements to be effective leaders. These leadership programs must involve training, coaching and mentoring of health care providers.

7.4 Recommendations for Future research

1. Future research could look at comparing impact of leadership styles between government and private or mission hospitals
2. Future studies could also look at the perception of leadership styles within interdisciplinary teams in public hospitals.
3. Future researches can do a similar study in other provinces in order to generalize the results.

REFERENCES

Abdelhafiz, I. M., Alloubani, A. M. D. & Almatari, M. (2015). Impact of leadership styles adopted by head nurses on job satisfaction: A Comparative study between governmental and private hospitals in Jordan. *Journal of Nursing Management*. *European Scientific Journal,vol 24(3) 384-392*

Abdelhafiz, I. M., Mah'd Alloubani, A., Klaledeh, M., Mutari, N. & Almukhtar, M. M. (2015b).Impact of leadership styles among head nurses on level of job satisfaction among staff nurses. *European Scientific Journal, Esj,* 11.(10)

Al-Ababneh, M. (2013). Leadership style of managers in five-star hotels and its relationship with employees job satisfaction. Ijmbs vol.3, 93-97

Amerioun, A., Sm, H. S. & Mahmoudi, N. (2011). Hospital manager's leadership style from staffs viewpoint and its relationship with hospital indicators. *Journal Mil Med*, 13**,** 125-132.

Armstrong, A. (2002). Human Resource Management in international context. Chicago: St. Claire Press.

Avolio,B.J.,Bass, B. M., & Jung, D. I. (1999). Re-examining the components of transformational and transactional leadership using the Multifactor leadership questionnaire. Journal of occupational and organizational psychology, 72, 441–462.

Bass.B.M .& Avolio.B.J.(1985).Improving organizational effectiveness through transformational leadership. Sage thousand oaks, California, USA.

Bass, B. M. & Aviolo, B. J. (1990b). Multifactor Leadership Questionnaire Palo Alto, Ca: Consulting Psychologists Press.

Bass, B.M.(1999).Two decades of research and development in transformational leadership. European Journal of work and Organisational psychology, 8, 9-32

Bass.B. M. & Avolio, B.J.(2000).MLQ multifactor leadership questionnaire sampler set (2nd ed.).Redwood city.CA; Mind Garden

Biggerstaff Jr, R. P. & Syre, T. R. (1991). The dynamics of hospital survival: Leading your organization through change. *Hospital Topics,* 69**,** 34-36.

Carlton, E. L., Holsinger, J. W., Riddell, M. C. & Bush, H. (2015). Full-Range Public Health

Centerfor Creative Leadership, (2011).http://insights.ccl.org/wpcontent/uploads/2015/

04/addressingleadershipgaphealthcare.Ppdf accessed on internet 26th February,2016 at 2030 hours

Chiok Foong Loke, J. (2001). Leadership behaviours: Effects on job satisfaction, productivity and organizational commitment. *Journal of Nursing Management,* 9**,** 191-204.

Dóci, E., Stouten, J. & Hofmans, J. (2015). The Cognitive-behavioral system of leadership: Cognitive antecedents of active and passive leadership behaviors. *Frontiers in Psychology,* 6**,** 1344.

Fiery, B. M. (2008). *Contextual influences affecting transformational leadership in Northwest Virginia Multiple Non-profit Hospital Systems.* University of Phoenix).

Frank, B., Eckrich, H. & Rohr, J. (1997). Quality nursing care leadership makes the difference. *Journal of Nursing Administration,* 27**,** 13-14.

Ghorbanian, A., Bahadori, M. & Nejati, M. (2011). The Relationship between Managers' Leadership Styles and Emergency Medical Technicians' Job Satisfaction. *The Australasian Medical Journal,* 5**,** 1-7.

Girma, S.(2016). The relationship between leadership style and employee job satisfaction,stdy of federal and Addis Ababa sport organisation management setting in Ethiopia.international Journalofapplied Research ,2(3) pp 92-96

Locke, E.A.(1976) The nature and cause of job satisfaction in M.D Dunnette(ed).Handbook of industrial and organisational psychology chicago.R and McNally

Goel,S.L.(1994). Advanced Public Administration. Sterling Publishers Private Company L-10,Green Park Extention,New Delhi-110016.

Gilson, L. & Daire, J. (2011). Leadership and Governance within the South African Health System. *South African Health Review***,** 69-80.

Goodwin, N. (2000). Leadership and the Uk Health Service. *Health Policy,* 51**,** 49-60.

Gunderman, R. B. (2009). *Leadership in Healthcare*, Springer Science & Business Media.

Greenleaf centerforservantleadership (2016).http:// www.greenleaf.org.uk/whatissi. html.accessed on internet 24 July,2017 at 2200hrs

Health Research & Educational Trust, (2014) Building a leadership team for the health Care organization of the future. Chicago, Il: Health Research & Educational Trust accessed at www.hpoe.org on 23rd July, 2016 at 2000hrs

Health Systems 20/20. (2012).*The health system assessment approach: A How-To Manual. Version 2.0*. www.healthsystemassessment.org

Herser,P Blanchard K.H.(1988).Management of oganisation behaviour (5thed.) Englewood Cliffs NJ: Prentice Hall

Herser,P Blanchard K.H, Dewey E.J(1996).Management of oganisation behaviour Utilizing Resources (7th ed.) Upper Saddle River,NJ: Prentice Hall

Huber, D. (2013). *Leadership and Nursing Care Management*, Elsevier Health Sciences.

Islam, M. (2007). Health Systems Assessment Approach: A How-To Manual. *Health Systems Assessment Approach: A How-To Manual*.

Josefien Van Olmen et al.(2012) Analysing Health System Dynamics.A Framework,2nd Edition

Koontz, H. (2010). *Essentials Of Management*, Tata Mcgraw-Hill Education.

Kreitner, R. (1995). Management Boston. *Houghtoon Mifflin Group Company*.

Elo, S. & Kyngäs, H. (2008). The Qualitative content analysis process. *Journal of Advanced Nursing,* 62**,** 107-115.Leadership, Part 2: Qualitative analysis and synthesis. *Frontiers in Public Health,* 3**,** 174.

Lemay,N and Ellis A.(2008).Management sciences for health, occassional papers No.8,1- 26.USAID

Lombe S,Michelo N,Chakwe M (15 September,2007) *Nurses beatings are justified*, www.postzambia.com, accessed on internet 24 February,2016 at 21 hrs

Long, J. D. (2004). Factors that influence nurse attrition: *An analysis of the relationship between supervisor leadership style and subordinate job satisfaction.* Capella University.

Mohammad, S. I. S., Al-Zeaud, H. A. & Batayneh, A. (2011). *The relationship between transformational leadership and employees' satisfaction at Jordanian Private Hospitals*. *Business and Economic Horizons,* 5**,** 35-46.

Mulundano,M. (2006).Managing professional development of teachers in selected basic schools of Livingstone district,University of Zambia

Mullins,L.J.(2005).Management and organisational behaviour,7th ed.London finanacial Tithes Pitman Publishing

Mutale W,Mutale A,T,V,Kachemba A,Mukondi R,Kupela C,Mulenga D(2017) Leadership and training as a catalyst to health system strentheing in low income settings: Evidence from implemetation of Zambia Management and Leadership course in Zambia,PLOS pp 1-14

Morrison A.(2006).The relationship between leadership style and empowerment onthe Job. The journal of nursing management,vol.5,pp 27-34

Morana, C. (1987). Employee Satisfaction: A key to patient satisfaction. *Perioperative Nursing Quarterly,* 3**,** 33-37.

Mouton, J. (2001). "How to succeed in your master's and doctoral studies. Pretoria." Rsa: Van Schaik Publishers.

Northouse P.G (2006).Leadership: theory and practice, 4th edition sage publications.

Northouse, P. G. (2014). *Introduction to leadership: concepts and practice: concepts and practice*: Sage Publications.

Nyberg, A., Bernin, P. & Theorell, T. (2005). *The impact of leadership on the health of subordinates*, National Institute for Working Life [Arbetslivsinstitutet] Stockholm.

Ojokuku, R., Odetayo, T. & Sajuyigbe, A. (2012). Impact of leadership style on organizational performance: A case study of Nigerian Banks. *American Journal of Business and Management,* 1**,** 202-207.

OregonLegislature,(2013)HealthcareServices.Http://Www.Oregonlaws.Org/Glossary/Definition/Health_Care_Services. Accessed on Internet on 27th February 2016 at 22; 20hrs

Oso, W. Y. And D. Onen (2009). A general guide to writing research proposal and report, Jomo Kenyatta Foundation.

Ramey, J. W. (2002). *The Relationship Between Leadership Styles of Nurse Managers and Staff Nurse Job Satisfaction In Hospital Settings.* Citeseer.

Robbins, S. P. & Coulter, M. (2014). Management (12th-Ed). Boston: Pearson.

Robbins, S. P., Decenzo, D. A. & Gao, J. (2007). *Fundamentals of Management*, Pearson Prentice Hall.

Rosengren,K.,Athlin,E.,Segesten K.(2007).Presence and availability: staff conceptions of nursing leadership on an intervisive care unit Journal of nursing management,vol.15,no.5 pp 522-529.

Rwandani Ministry of Health-Minisante,(2010).Rwandan Health Governance Assessment Report

Sanford, P. (1973). Introduction to Educational Administration. Boston. Ally & Bacon.

Schreuder, J. A., Roelen, C. A., Van Zweeden, N. F., Jongsma, D., Van Der Klink, J. J.

Sellgren,S.,Ekvalla,G.,Tomson G (2006).*Leadership style in nursing management;Preffered and Perceived*,Journal of nrsing management Vol.14,pp 348-355

Shawn T.M.(2009). Relatioship between the leadership style of principals and school culture,electronic thesis and dissertation .269-360

Soili, V.,Suhonen,M.,Isola, A.,Paasivaara, L(2012).Nurse managers leadership style in finland, Hindawi Publishing corporation,ISRN Nursing

Soili, V.,Suhonen,M.,Isola, A.,Paasivaara, L(2013).Nurse managers perceptions related to their leadership knowledge and skills in these areas-Aview point;Case of health cetre wards in Finland.Hindawi Publishing corporation,ISRN Nursing

Groothoff, J. W. (2011). Leadership Effectiveness and Recorded Sickness Absence Among Nursing Staff: A Cross- Sectional Pilot Study. *Journal of Nursing Management,* 19**,** 585-595.

Schumacher, S. and J. Mcmillan (2006). Research in Education Evidence–Based inquiry, Usa: Pearson Education.

Walshe, K. & Rundall, T. G. (2001). Evidence-based management: From theory to practice in

cealth Care. *The Milbank Quarterly,* 79**,** 429.

Voon,M.L.,Lo,M.C.,Ngui K.S.Ayob,N.B.(2011).The inflence of leadership style on employees job satisfaction in public sector organisations in Malaysia,intrnational journal of business,management and social sciences,vol.2,No.1,pp 24-32

Watson,T(2013).Leadership in hospitals https://www.towerswatson.com/en-us/ services/services/leadership-in-hospitals **a**ccessed on internet on 23rd February, 2016 at 22hrs

Weberg, D,(2010) 'Transformation leadership and staff retention an evidence review with implications for health care systems', nursing administration.quartely,vol.34.no.3 pp 246-258

WHO, (2007) Healthcare services http://www.who.int/management/strengthen/en/. accessed on internet on 27th February at 23 00hrs

World Health Organization (2000) *The World Health Report 2000. Improving Performance*, World Health Organization, Geneva.

WHO, (2012) Governance for Health in the 21st Century, WHO Regional office for Europe

WHO,(2016),HealthcareServices http://www.who.int/healthsystems/topics/delivery/en/. accessed on internet on 27th February 2016 at 22;40hrs

WHO, (2016) Healthcare services http://www.who.int/topics/health_services/en/ accessed on internet on 27 February, 2016 at 2300hrs

Zambia National Broadcasting corporation-ZNBC TV 1, Main news on 7th October, 2017 at 1930hrs

Zambia-Ministry of Education (2008).Providing equitable and accessible education and skills growing opportunity for sustainable livelihood and development, infrastructure operation plan

Zambia-Ministry of Health, (2008) Quality of service delivery survey Report-Lusaka

Zambia-Ministry of Health, (2012) Governance & management capacity building strengthening plan, Final Report (2012-2016)

Zambia-Ministry of Health, Lusaka Provincial Health Office (2015), 2016-2018 MTEF Action Plan

Zambia-Ministry of Health Lusaka-Provincial Health Office (2015).*Activity Report* - Public Health Sector and Private Health Institutions Consultative Meeting Held at Hotel Intercontinental- Lusaka-Unpublished

Zambia-Ministry of Health-Lusaka Provincial Medical Office,(2016), Implementation Plan to improve Primary Health Care Services in Lusaka District(Unpublished)

Zambia- Ministry of Health Lusaka Provincial Health Office (2016), 2015 Annual Progress Report

APPENDICES

APPENDIX 1: PARTICIPANT INFORMATION

Title of study:

AN ANALYSIS OF LEADERSHIP PRACTICES AND THEIR INFLUENCE ON PROVIDERS AND SERVICE DELIVERY IN LUSAKA PROVINCE

Investigator: Regina Mulenga (Sr)

Brief introduction:

I am Sr.Regina Mulenga, a Catholic religious nun with a nursing background. I have worked in different mission hospitals as Nursing Officer, Hospital Administrator and Nurse Tutor. I am currently pursuing a master degree in public health at University of Zambia, School of medicine - Ridgeway campus. My major is health policy and management.

I am conducting a research in leadership practices in hospital administrators and Nursing Officer and their influence on health care providers and service delivery in Lusaka Province. My study will involve six 1st level hospitals selected from different districts of the Province.

Purpose of the study

The purpose or aim of the study is to determine the influence which leadership practices exert on health care providers and service delivery in hospitals of Lusaka province.

Why you are asked to participate?

You are asked to participate as a primary key person in providing the needed information that will help in establishing the leadership practices and its effect on health care providers and service delivery in 1st in level hospitals in Lusaka province.

Anonymity (hiding the identity of participants)

You will be asked to participate in an anonymous manner because the focus of the study is on the practices that are done by the leaders in level 1st hospitals. Therefore you are not required to write the name on the questionnaire. The questionnaire shall take about 15 minutes to complete.

Risks/Discomforts

The risks associated with participation in this study are minimal. A small risk to you is that some of the questions (in the questionnaire/interview) may make you feel uncomfortable. If this occurs, you may skip the question and continue with other questions. To protect you, I have limited the information on your particulars that you should write down on consent form/questionnaire so that you cannot be identified.

Benefits

There may not be a direct benefit to you personally for participating in this study. However the information you provide will enrich the knowledge to plan the needed leadership capacity that will help strengthen health care delivery services in Lusaka province and beyond. Consequently, health care services in hospitals will be delivered in an attractive manner to our patients. This will ultimately reduce the negative impact that unbecoming health care provision causes on the health of the people of Zambia. The study will also yield knowledge needed for effective health care service delivery in hospitals.

Payments

The study will involve no payments to you but refreshments will be provided for during the survey.

Protecting data confidentiality

The questionnaire is completely anonymous and your confidentiality will be maintained all the time. All data collected will be kept under lock and key and shall be disposed off by burning after data analysis and dissemination of findings.

The tape recording that will be made will be used for this purpose and will only be shared with the research team.

Interviews will be done in venues where you as participants will feel secure and comfortable within the hospital premises.

What happens if you do not want to participate?

Your participation in this study is completely voluntary. Your refusal to participate will involve no penalty or loss of the benefits to which you are otherwise entitled at work.

What do you do if you have questions or concerns related to your participation in this study?

If you have any question or problems now or in future please feel free to contact me on;

- Sr.Regina Mulenga Cell No. 0977862161/ 0966632565
  Email; mulengaregina@gmail.com
- Contact the University of Zambia's Biomedical Research Ethics Committee office for any ethical queries by writing or calling:
  The Chairperson
  UNZA BREC
  Ridgeway campus
  PO Box 50110
  Lusaka
  Email: Telephone: +260-1-256067 Fax: + 260-1-25075
  Email: unzarec@zamtel.zm

APPENDIX 2; CONSENT FORM FOR PARTICIPATION IN RESEARCH

Title: AN ANALYSIS OF LEADERSHIP PRACTICES AND THEIR INFLUENCE ON PROVIDERS AND SERVICE DELIVERY IN LUSAKA PROVINCE

If you agree with the information provided and you wish to take part in this study, your signature on this form means;

1. Details of procedures and any risks have been explained to my satisfaction.
2. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference
3. I understand that:
    - I may not directly benefit from taking part in this research and I am free to withdraw from the project at any time.
    - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
    - Whether I participate or not, or withdraw after participating, will have no effect on my execution of duties.
    - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
    - I agree to the tape recording being made to other researchers who are only part of this research team.

What does your signature mark on this consent form mean?

Your signature mark on this consent form means;

- You have been informed about this study and the ethical conditions under which you will take part in this study.
- You have agreed to take part in this study voluntarily and you will give the required information adequately.

Participant's statement of informed consent:

Having read, understood and accepted the explanation provided to me, I voluntarily agree to participate in this study.

_____ _____ _____

Print name of participant Signature of participant Date

_____ _____ _____

Print name of person obtaining consent Signature of Person Obtaining Consent Date

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…… Researcher's signature……

The Chairperson
UNZA BREC
Ridgeway campus
PO Box 50110
Lusaka
Email: Telephone: +260-1-256067
Fax: + 260-1-25075 Email: unzarec@zamtel.zm

Sr. Regina Mulenga
Department of Public Health
School of Medicine
PO Box 50110
Lusaka
0977862161/0966632565
mulengaregina@gmail.com

RESEARCH TOOLS

Appendix 3 Multifactor Leadership Questionnaire-01 (MLQ)

For Hospital administrators & Nursing Officers

MULTIFACTOR LEADERSHIP QUESTIONNAIRE (MLQ) (Bernard M. Bass & Bruce J. Avolio (1996, 2002)

(FOR LEADERS)

INSTRUCTIONS;

1. **Please do not write your name on this questionnaire**
2. This questionnaire is divided in two parts;
   Part 1 is on the demographic information for participants and Part 2 is on leadership rating information.
3. You are required to rate yourself on how frequently each statement fits you
4. All questions may be answered.
5. **Tick or circle** the most appropriate **answer** from the options provided

PART 1 - DEMOGRAPHIC INFORMATION

1. What is your gender?
   - Female
   - Male
2. What is your age?
   - 18 to 24
   - 25 to 34
   - 35 to 44
   - 45 to 54
   - 55 to 64
   - Above 65

3. What is your race, please choose one
   - European

- African
- coloured
- Others (specify)

4. What is the highest level of school you have completed or the highest degree you have received?
    - Secondary school
    - Some college with a certificate
    - Diploma
    - Bachelor degree
    - Post graduate degree
    - Other (specify)

PART 2 - LEADERSHIP INFORMATION

Instructions:

Indicate the degree to which you agree or disagree by **ticking or circling** one of the responses. The word "others" may mean your followers, clients, or group members.

1. I make others feel good to be around me
    - Strongly agree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
2. I express with few simple words what they could or should do:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
3. I enable others to look at existing problems in new ways:
    - Strongly disagree

- Disagree
- Neither agree or disagree
- Agree
- Strongly agree

4. I help others develop themselves:
   - Strongly disagree
   - Disagree
   - Neither agree or disagree
   - Agree
   - Strongly agree
5. I tell others what to do if they want to be rewarded for their work
   - Strongly disagree
   - Disagree
   - Neither agree or disagree
   - Agree
   - Strongly agree
6. I am satisfied when others meet agreed upon standards:
   - Strongly disagree
   - Disagree
   - Neither agree or disagree
   - Agree
   - Strongly agree
7. I am content to let others continue working in the same way always:
   - Strongly disagree
   - Disagree
   - Neither agree or disagree
   - Agree
   - Strongly agree

8. My subordinates have complete faith in me:

- Strongly agree
- Disagree
- Neither agree or disagree
- Agree
- Strongly agree

9. I model about what should be done:
   - Strongly disagree
   - Disagree
   - Neither agree or disagree
   - Agree
   - Strongly agree
10. I ensure workers maintain the usual ways of looking at things:
   - Strongly disagree
   - Disagree
   - Neither agree or disagree
   - Agree
   - Strongly agree
11. I provide rewards for workers who work hard towards the attainment of institutional goals:
   - Strongly disagree
   - Disagree
   - Neither agree or disagree
   - Agree
   - Strongly agree
12. As long as things are working, I do not try to change anything:
   - Strongly disagree
   - Disagree
   - Neither agree or disagree
   - Agree
   - Strongly agree
13. Whatever others want to do is OK with me:

- Strongly disagree
- Disagree
- Neither agree or disagree
- Agree
- Strongly agree

14. Others are proud to be associated with me:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
15. I help others find meaning in their work:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
16. I get others to rethink ideas that they had never questioned before:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
17. I give personal attention to others who seem rejected:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
18. I call attention to complaints concerning the performance of my subordinates:

- Strongly disagree
- Disagree
- Neither agree or disagree
- Agree
- Strongly agree

19. I tell others the standards they have to know to carry out their work:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
20. I ask no more of others about what is very important:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
21. I watch employee behaviour for sometime before I take action:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
22. I avoid making decisions:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
23. I keep track of all mistakes:

- Strongly disagree
- Disagree
- Neither agree or disagree
- Agree
- Strongly agree

24. I demonstrate a high degree of confidence in subordinates' ability to establish & achieve challenging goals
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
25. I help others to enjoy their work:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
26. I examine critical assumptions/suggestions from others to question whether they are appropriate:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
27. I talk optimistically about the future of the hospital:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree

28. I consider the moral and ethical consequences of the decision made at my hospital:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
29. I go beyond self interest for the good of the institution:
    - Strongly disagree
    - Disagree
    - Neither agree or disagree
    - Agree
    - Strongly agree
30. I often interacts with employees at this hospital
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree

31. I treat others as individuals rather than just a member of the group
    - Strongly disagree
    - Disagree
    - neither agree or disagree
    - agree
    - strongly agree
32. I make corrections only when things go wrong
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree

- strongly agree

33. I work out an agreement with others on what they will receive if they do what needs to be done
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
34. I articulate a vision of future opportunities for the development of my hospital:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
35. I listen to concerns of others
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
36. I offer special rewards for good work
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
37. I am a firm believer in “if it isn’t broken, don’t fix it”
    - Strongly disagree
    - disagree
    - neither agree or disagree

- agree
- strongly agree

38. I provide advice when it is needed:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
39. I make back up opinion with good reasoning
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
40. I often interact with others at this hospital
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
41. I get others to do more than they expected to do
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
42. I make (heighten) others desires to succeed
    - Strongly disagree
    - disagree
    - .neither agree or disagree
    - agree

- strongly agree

43. I increase others wiliness to try harder
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
44. I work with others in a satisfactory way
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
45. I use methods of leadership that are satisfying
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree

Appendix 4 Multifactor Leadership Questionnaire-02 (MLQ)

For Healthcare providers

MULTIFACTOR LEADERSHIP QUESTIONNAIRE (Bernard M.Bass & Bruce J.Avolio (1996, 2002)

(FOR EMPLOYEES)

INSTRUCTIONS;

1. **Please do not write your name on this questionnaire**
2. This questionnaire is divided in two parts;

   Part 1 is on the demographic information for participants and Part 2 is on leadership rating information.
3. You are required to rate your leaders as you perceive or experience their leadership.
4. All questions may be answered.
5. **Tick or circle** the most appropriate **answer** from the options provided.

PART 1 - DEMOGRAPHIC INFORMATION

1. What is your gender?
   - Female
   - Male
2. What is your age range?
   - 18 to 24
   - 25 to 34
   - 35 to 44
   - 45 to 54
   - 55 to 64
   - Above 65
3. What is your race, please choose one
   - European
   - African
   - Coloured
   - Others (specify)

4. What is the highest qualification that you have attained?
    - Certificate
    - Diploma
    - Degree
    - Masters degree
    - Others (specify)

PART 2 - LEADERSHIP RATING

Indicate the degree to which you agree or disagree by ticking or circling one of the responses provided in each item stated below:

1. Talks optimistically about the future
    - strongly disagree
    - disagree
    - neither agree nor disagree
    - agree
    - strongly agree
2. Treats me as an individual rather than just a member of group
    - Strongly disagree
    - disagree
    - neither agree nor disagree
    - agree
    - strongly agree
3. Things have to go wrong for him/her to take action
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
4. Works out an agreement with me on what I will receive if I do what needs to be done
    - strongly disagree
    - disagree

- neither agree nor disagree
- agree
- strongly agree

5. Is alert for failure to meet standards
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
6. Articulate a vision of future opportunities
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
7. Listens to my concerns
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
8. Offers special rewards for good work
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
9. Cares little on how things go on in the hospital?
    - strongly disagree
    - disagree
    - neither agree or disagree

- agree
- strongly agree

10. Focuses attention on irregularities, mistakes, exceptions and deviations from what is expected:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
11. If I don't bother him/her, he/she doesn't bother me:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
12. Provides advice when it is needed:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
13. Serves as a role model:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
14. Makes me back up opinion with good reasoning:
    - strongly disagree
    - disagree
    - neither agree or disagree

- agree
- strongly agree

15. Make others feel good to be around him/her
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
16. Keeps careful track of mistakes and acts constructively corrects them:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
17. Often interacts with employees at this hospital:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
18. Introduces new projects, facilitates the identification of their possible challenges and solutions:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
19. As long as work meets minimal standards, he/she avoids trying to make improvements:
    - strongly disagree
    - disagree

- neither agree or disagree
- agree
- strongly agree

20. Avoids getting involved when important issues arise:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
21. Demonstrates how to look at problems from new angles:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
22. Tells me what to do for me to be rewarded for my efforts:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
23. Avoids making decision:
    - strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
24. Problems have to be chronic before he/she will take action:
    - strongly disagree
    - disagree
    - neither agree or disagree

- agree
- strongly agree

25. Mobilizes a collective sense of mission:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
26. Specifies what I will receive if I do what is required:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
27. Monitors performance for error needing corrections:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
28. Instils pride in being associated with him/her:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
29. Engages in words and deeds which enhances his image of competence:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree

- strongly agree

30. Makes me aware of strongly held institutional values, ideas and aspirations which are held in common:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
31. Demonstrates in his/her actions a strong conviction in his/her beliefs and values:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
32. Projects in a courteous manner a powerful, dynamic and magnetic pressure on employees:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
33. I am ready to trust him/her to overcome my obstacles:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
34. I have complete confidence in him/her
    - Strongly disagree
    - disagree
    - neither agree or disagree

- agree
- strongly agree

35. In my mind he/she is a symbol of success and accomplishment:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
36. Displays extraordinary talents and competence in whatever he/she decides and does:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
37. Helps others to develop their strength:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
38. Goes beyond self-interest for the good of the employees:
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree

39. Considers moral and ethical consequences of the decisions that he/she makes:
    - Strongly disagree
    - disagree

- neither agree or disagree
- agree
- strongly agree

40. Effective in representing others to higher authorities
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
41. Get others to do more than they expected to do
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
42. Make (heighten) others desires to succeed
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
43. Increase others wiliness to try harder
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree
44. Works with others in a satisfactory way
    - Strongly disagree
    - disagree
    - neither agree or disagree

- agree
- strongly agree

45. Uses methods of leadership that are satisfying
    - Strongly disagree
    - disagree
    - neither agree or disagree
    - agree
    - strongly agree

Appendix 5: interview guide 01- for in-depth- information

INTERVIEW SCHEDULE FOR THE HOSPITAL ADMINISTRATORS AND NURSING OFFICER

Brief introduction:

I am Sr.Regina Mulenga, a Catholic religious nun with a nursing background. I have worked in different mission hospitals as Nursing Officer, Hospital Administrator and Nurse Tutor. I am currently pursuing a master degree in Public Health at University of Zambia, School of medicine - Ridgeway campus. My major is health policy and management**.**

SECTION A: GENERAL INFORMATION

1. Position held ……..……**……**
2. Job responsibility …….
3. Length in service …….

SECTION B: EXPERIENCE

4. What strategies have you put in place to ensure that;
   a. The healthcare providers receive the support
   b. There are effective healthcare delivery services in your hospital
5. Who is involved in strategizing the hospital plans?
6. How do you as a leader ensure that healthcare delivery services are well implemented in your hospital?
7. From your experience, what things if any make it difficult for you not to ensure healthcare providers receive the needed support in the delivery of services in wards and other departments?
8. What things if any enable you to ensure healthcare delivery services are well done in wards and other departments?

SECTION C: PRACTICE

9. Who do you directly supervise among your subordinates?
10. How is this supervision done?
11. What local policies (if any) have you come up with at your hospital to prevent poor healthcare delivery services?
12. What policies have you put in place to maximize performance by the healthcare providers?
13. What leadership role do you play in the day to day healthcare delivery service at your hospital?

SECTION D: AWARENESS

14. What type of leadership do you think you particularly practice at your hospital?
15. In what ways do you think your leadership influences the way healthcare providers perform in their day to day delivery of healthcare services?
16. What comments (if any) do you get on your leadership style from your subordinates?

SECTION E; OPINION

17. a. In your own view, does your leadership at various levels in your hospital influence healthcare providers and how delivery services are implemented?
    b. Give reasons for your answer pointing out specific practices that influence healthcare providers in their healthcare delivery services?

Appendix 6: interview guide 02- for in-depth- information

INTERVIEW SCHEDULE FOR THE FOCUS GROUP DISCUSSION WITH HEALTHCARE PROVIDERS (Nurses, clinical officers, laboratory & pharmacy technologist, radiographers)

Brief introduction:

I am Sr.Regina Mulenga, a Catholic religious nun with a nursing background. I have worked in different mission hospitals as Nursing Officer, Hospital Administrator and Nurse Tutor. I am currently pursuing a master degree in public health at University of Zambia, School of medicine - Ridgeway campus. My major is health policy and management.

SECTION A– KNOWLEDGE

1. What do you know about leadership and how it affects the performance of healthcare delivery services in hospitals?
2. What specific leadership practices do you see as contributing to the way healthcare delivery services are done in the hospital where you work?

SECTION B: EXPERIENCE AND OPINION

3. a. Do you think your supervisors' leadership influences the way you perform in your day to day delivery of healthcare services?

b.. Give reasons for your answer above with examples?

4. How would you describe the type of leadership that you receive from your immediate supervisors up to the hospital administrator in your hospital?
5. What specific things do you like in your leaders at your hospital that make you to deliver healthcare services well?
6. What specific things do you dislike in your leaders at your hospital that make you not to deliver healthcare services well?
7. What are your recommendations concerning leadership at your hospital?

Appendix 7: Participant Observation sheet

OBSERVATION SCHEDULE (By the Researcher)

No	AREA OF FOCUS	OBSERVATION	COMMENT
1.	**Attitude** and **handling** of human and other resources such as time, information etc by leaders.		
2.	Administrative **support** towards healthcare providers		
3.	Motivation • Strategies • Levels		
4.	Leadership influence on **climate** and **culture** in the hospital among leaders, among healthcare providers, leaders and healthcare providers, healthcare		

	providers and patients		
5.	**Decision making** processes		
6.	**Communication**		
7.	Interpersonal **relationships** between leaders and fellow leaders, leaders and healthcare providers		
8.	**Meetings:** • Frequency		
	• Agendas		
	• Types		
	• Management of meetings held between leaders and between leaders and healthcare providers		
9.	**Internal quality assurance strategies** (e.g. physical facilities, incentives, monitoring and supervision distribution etc) to ensure effective healthcare delivery services.		
10	**Responsiveness** Prompt attention, access to socio support network, choice of provider		

Appendix 8: Document analysis sheet

OBSERVATION SCHEDULE (By the Researcher)

No	SOURCE OF DATA	AREA OF FOCUS	FINDINGS
1	**Hospital minutes** • Management meetings • Human resources meetings	Motivation plans e.g. staff development, award giving etc. Job satisfaction-staff training plan, amenities, respect, disciplinary actions	
2	Quality assurance assessment reports (care & responsiveness)	Infrastructure elements Appropriate funding Working environment Staff development Protocols in place Continuinity of care Patient dignity Confidentiality Autonomy Prompt attention amenities	
3	Quarterly performance assessment reports • Annual performance appraisal system(APAS)	Work plan Level of performance Understanding job Training needs Promotion needs Strength & weakness	

	• Performance Assessment (PA)	Clear of job expectations Availability of reviewed action plan Hospital meetings held & recommendations addressed Human resources development recommendation implemented Patients treated according to treatment protocols Patients reviewed daily Patients managed according to nursing care Availability of laboratory reagents Availability of x-ray supplies Clinical meetings held Availability of essential drugs for all depts.	

APPENDIX 9: QUANTITATIVE OUTPUT

LEADERS

GENDER

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	FEMALE	9	75.0	75.0	75.0
	MALE	3	25.0	25.0	100.0
	Total	12	100.0	100.0	

AGE GROUP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	25-34 YEARS	3	25.0	25.0	25.0
	35-44 YEARS	2	16.7	16.7	41.7
	45-55 YEARS	5	41.7	41.7	83.3
	55-64 YEARS	2	16.7	16.7	100.0
	Total	12	100.0	100.0	

RACE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	EUROPEAN	1	8.3	8.3	8.3
	AFRICAN	7	58.3	58.3	66.7
	COLOURED	3	25.0	25.0	91.7
	OTHERS	1	8.3	8.3	100.0
	Total	12	100.0	100.0	

EDUCATION LEVEL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DIPLOMA	6	50.0	50.0	50.0
	BACHELOR DEGREE	4	33.3	33.3	83.3
	POST GRADUATE DEGREE	2	16.7	16.7	100.0
	Total	12	100.0	100.0	

Hospital

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Chipata	2	16.7	16.7	16.7
	Chongwe District	2	16.7	16.7	33.3
	St Lukes Mphanshya	2	16.7	16.7	50.0
	Mtendere Mission	2	16.7	16.7	66.7
	St Johns Medical Centre	2	16.7	16.7	83.3
	MKP	2	16.7	16.7	100.0
	Total	12	100.0	100.0	

Leaders-Transactional responses

TRANSACTION	DISAGREE		NEUTRAL		AGREE		Total	
	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %
I tell others what to do if they want to be rewarded for their work	4	33%	1	8%	7	58%	12	100%
I am satisfied when others meet d upon standards:	4	33%			8	67%	12	100%
I provide rewards for workers who work hard towards the attainment of institutional goals:	2	17%	1	8%	9	75%	12	100%
As long as things are working, I do not try to change anything:	9	75%	1	8%	2	17%	12	100%
I call attention to complaints concerning the performance of my subordinates:	1	8%			11	92%	12	100%
I tell others the standards they have to know to carry out their work:	1	8%	1	8%	10	83%	12	100%
I watch employee behaviour for sometime before I take action:	1	8%	3	25%	8	67%	12	100%
I keep track of all mistakes:	3	25%	2	17%	7	58%	12	100%
I make corrections only when things go wrong	9	75%	1	8%	2	17%	12	100%
I work out an ment with others on what they will receive if they do what needs to be done	4	33%	3	25%	5	42%	12	100%
I offer special rewards for good work			2	17%	10	83%	12	100%
I am a firm believer in “if it isn’t broken, don’t fix it”	5	42%	5	42%	2	17%	12	100%

Leaders-Laissez-faire responses

LAISSEZ FAIRE	DISAGREE		NEUTRAL		AGREE		Total	
	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %
I am content to let others continue working in the same way always:	8	67%			4	33%	12	100%
I ensure workers maintain the usual ways of looking at things:	8	67%	1	8%	3	25%	12	100%
Whatever others want to do is OK with me:	9	75%	1	8%	2	17%	12	100%
I ask no more of others about what is very important:	9	75%			3	25%	12	100%
I avoid making decisions:	11	92%	1	8%			12	100%

Leaders-Transformational responses

TRANSFORMATION	DISAGREE		NEUTRAL		AGREE		Total	
	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %
I make others feel good to be around me			2	17%	10	83%	12	100%
I express with few simple words what they could or should do:	2	17%			10	83%	12	100%
I enable others to look at existing problems in new ways:					12	100%	12	100%
I help others develop themselves:	1	8%	1	8%	10	83%	12	100%
My subordinates have complete faith in me:	1	8%	3	25%	8	67%	12	100%
I model about what should be done:	4	33%			8	67%	12	100%
Others are proud to be associated with me:			3	25%	9	75%	12	100%
I help others find meaning in their work:					12	100%	12	100%
I get others to rethink ideas that they had never questioned before:			1	8%	11	92%	12	100%
I give personal attention to others who seem rejected:	1	8%	1	8%	10	83%	12	100%
I demonstrate a high degree of confidence in subordinates' ability to establish & achieve challenging goals	1	8%			11	92%	12	100%
I examine critical assumptions/suggestions from others to question whether they are appropriate:					12	100%	12	100%
I talk optimistically about the future of the hospital:					12	100%	12	100%
I consider the moral and ethical consequences of the decision made at my hospital:					12	100%	12	100%
I go beyond self interest for the good of the institution:					12	100%	12	100%
I treat others as individuals rather than just a member of the group	1	8%			11	92%	12	100%
I articulate a vision of future opportunities for the development of my hospital:			1	8%	11	92%	12	100%
I listen to concerns of others					12	100%	12	100%
I make back up opinion with good reasoning	1	8%			11	92%	12	100%

Leader's perspective-cross tabulation

Leadership Styles	Disagree		Neutral		Agree	
	Frequency	Row N %	Frequency	Row N %	Frequency	Row N %
Transformative					12	100%
Transactive			4	33%	8	67%
Laissez	8	67%	2	17%	2	17%

EXTRA EFFORT	DISAGREE		NEUTRAL		AGREE		Total	
	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %
I get others to do more than they expected to do	3	25%	2	17%	7	58%	12	100%
I make (heighten) others desires to succeed					12	100%	12	100%
I increase others wiliness to try harder					12	100%	12	100%

EFFECTIVENESS	AGREE		Total	
	Freq.	Row N %	Freq.	Row N %
I help others to enjoy their work:	12	100%	12	100%
I often interacts with employees at this hospital	12	100%	12	100%
I provide advice when it is needed:	12	100%	12	100%
I often interact with others at this hospital	12	100%	12	100%

SATISFACTION	AGREE		Total	
	Freq.	Row N %	Freq.	Row N %
I work with others in a satisfactory way	12	100%	12	100%
I use methods of leadership that are satisfying	12	100%	12	100%

Effects of Leadership Styles	Neutral		Agree	
	Frequency	Row N %	Frequency	Row N %
Extra Effort	2	17%	10	83%
Effectiveness			12	100%
Satisfaction			12	100%

	DISAGREE		NEUTRAL		AGREE		Total	
	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
I get others to do more than they expected to do	3	25%	2	17%	7	58%	12	100%
I make (heighten) others desires to succeed	0	0%	0	0%	12	100%	12	100%
I increase others wiliness to try harder	0	0%	0	0%	12	100%	12	100%

	DISAGREE		NEUTRAL		AGREE		Total	
	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
I listen to concerns of others	0	0%	0	0%	12	100%	12	100%
I am a firm believer in “if it isn’t broken, don’t fix it”	5	42%	5	42%	2	17%	12	100%
I often interact with others at this hospital	0	0%	0	0%	12	100%	12	100%

	DISAGREE		NEUTRAL		AGREE		Total	
	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
I listen to concerns of others					12	100%	12	100%
I am a firm believer in “if it isn’t broken, don’t fix it”	5	42%	5	42%	2	17%	12	100%
I provide advice when it is needed:					12	100%	12	100%
I often interact with others at this hospital					12	100%	12	100%

	AGREE		Total	
	Count	Row N %	Count	Row N %
I work with others in a satisfactory way	12	100%	12	100%
I use methods of leadership that are satisfying	12	100%	12	100%

HEALTH CARE PROVIDERS –OUTPUT

HOSPITAL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Chipata	5	16.7	16.7	16.7
	Chongwe District	5	16.7	16.7	33.3
	St Lukes Mphanshya	5	16.7	16.7	50.0
	Mtendere Mission	5	16.7	16.7	66.7
	St Johns Medical Centre	5	16.7	16.7	83.3
	MKP	5	16.7	16.7	100.0
	Total	30	100.0	100.0	

GENDER

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	FEMALE	17	56.7	56.7	56.7
	MALE	13	43.3	43.3	100.0
	Total	30	100.0	100.0	

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-24 YEARS	1	3.3	3.3	3.3
	25-34 YEARS	20	66.7	66.7	70.0
	35-44 YEARS	5	16.7	16.7	86.7
	45-55 YEARS	2	6.7	6.7	93.3
	55-64 YEARS	2	6.7	6.7	100.0
	Total	30	100.0	100.0	

RACE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	AFRICAN	30	100.0	100.0	100.0

EDUCATION LEVEL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SECONDARY SCHOOL	4	13.3	13.3	13.3
	COLLEGE CERTIFICATE	21	70.0	70.0	83.3
	DIPLOMA	5	16.7	16.7	100.0
	Total	30	100.0	100.0	

Health care providers-Transactional responses

TRANSACTION	Disagree		Neutral		Agree		Total	
	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %
Things have to go wrong for him/her to take action	16	53%	1	3%	13	43%	30	100%
Works out an agreement with me on what I will receive if I do what needs to be done	11	37%	1	3%	18	60%	30	100%
Is alert for failure to meet standards	12	40%	2	7%	16	53%	30	100%
Offers special rewards for good work	16	53%	4	13%	10	33%	30	100%
Cares little on how things go on in the hospital	23	77%	2	7%	5	17%	30	100%
Focuses attention on irregularities, mistakes, exceptions and deviations from what is expected	13	43%	4	13%	13	43%	30	100%
If I don't bother him/her, he/she doesn't bother me	14	47%	2	7%	14	47%	30	100%
Keeps careful track of mistakes and acts constructively corrects them	3	10%	5	17%	22	73%	30	100%
Tells me what to do for me to be rewarded for my efforts	17	57%	6	20%	7	23%	30	100%
Problems have to be chronic before he/she will take action	18	60%	2	7%	10	33%	30	100%
Specifies what I will receive if I do what is required	16	53%	4	13%	10	33%	30	100%
Monitors performance for error needing corrections	7	23%	4	13%	19	63%	30	100%

Laissez-fare responses

LAISSEZ-FAIRE	Disagree		Neutral		Agree		Total	
	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %
Introduces new projects, facilitates the identification of their possible challenges and solutions	7	23%	2	7%	21	70%	30	100%
As long as work meets minimal standards, he/she avoids trying to make improvements	16	53%	8	27%	6	20%	30	100%
Avoids getting involved when important issues arise	24	80%	2	7%	4	13%	30	100%

Transformational response

TRANSFORMATION LEADERSHIP	Disagree		Neutral		Agree		Total	
	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %
Talks optimistically about the future	7	23%	1	3%	22	73%	30	100%
Treats me as an individual rather than just a member of group	5	17%	3	10%	22	73%	30	100%
Articulate a vision of future opportunities	6	20%	2	7%	22	73%	30	100%
Listens to my concerns	7	23%	2	7%	21	70%	30	100%
Provides advice when it is needed	5	17%	2	7%	23	77%	30	100%
Serves as a role model	8	27%	4	13%	18	60%	30	100%
Make others feel good to be around him/her	7	23%	4	13%	19	63%	30	100%
Often interacts with employees at this hospital	6	20%	4	13%	20	67%	30	100%
Introduces new projects, facilitates the identification of their possible challenges and solutions	7	23%	2	7%	21	70%	30	100%
Demonstrates how to look at problems from new angles	8	27%	2	7%	20	67%	30	100%
Mobilizes a collective sense of mission	7	23%	3	10%	20	67%	30	100%
Instils pride in being associated with him/her	12	40%	5	17%	13	43%	30	100%
Engages in words and deeds which enhances his image of competence	7	23%	7	23%	16	53%	30	100%
Makes me aware of strongly held institutional values, ideas and aspirations which are held in common	4	13%	4	13%	22	73%	30	100%
Demonstrates in his/her actions a strong conviction in his/her beliefs and values	4	13%	4	13%	22	73%	30	100%
Projects in a courteous manner a powerful, dynamic and magnetic pressure on employees	12	40%	3	10%	15	50%	30	100%
I am ready to trust him/her to overcome my obstacles	9	30%	4	13%	17	57%	30	100%
I have complete confidence in him/her	8	27%	5	17%	17	57%	30	100%
Displays extraordinary talents and competence in whatever he/she decides and does	8	27%	6	20%	16	53%	30	100%
Considers moral and ethical consequences of the decisions that he/she makes	5	17%	2	7%	23	77%	30	100%

Leadership Styles	Disagree		Neutral		Agree	
	Frequency	Row N %	Frequency	Row N %	Frequency	Row N %
Laissez	13	43%	9	30%	8	27%
Transaction	5	17%	10	33%	15	50%
Transformation	6	20%	3	10%	21	70%

Pearson Chi-Square Tests

		TRANSACTION
SATISFACTION	Chi-square	11.447
	df	4
	Sig.	***0.022****
MOTIVATION	Chi-square	17.743
	df	4
	Sig.	***0.001****
EFFICIENCY	Chi-square	23.104
	df	4
	Sig.	***0.000****
EXTRA EFFORT	Chi-square	24.436
	df	4
	Sig.	.000*,b,c

***. The Chi-square statistic is significant at the 0.05 level.

Pearson Chi-Square Tests

		TRANSFORMATION
SATISFACTION	Chi-square	29.881
	df	4
	Sig.	***0.000****
MOTIVATION	Chi-square	48.750
	df	4
	Sig.	***0.000****
EFFICIENCY	Chi-square	18.841
	df	4
	Sig.	***0.001***
EXTRA EFFORT	Chi-square	17.630
	df	4
	Sig.	**0*.001****

***.** The Chi-square statistic is significant at the .05 level.

EXTRA EFFORT	Disagree		Neutral		Agree		Total	
	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %
Get others to do more than they expected to do	15	50%	2	7%	13	43%	30	100%
Make (heighten) others desires to succeed	8	27%	3	10%	19	63%	30	100%
Increase others wiliness to try harder	5	17%	5	17%	20	67%	30	100%

EFFECTIVENESS	Disagree		Neutral		Agree		Total	
	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %
In my mind he/she is a symbol of success and accomplishment	7	23%	4	13%	19	63%	30	100%
Helps others to develop their strength	8	27%	2	7%	20	67%	30	100%
Goes beyond self-interest for the good of the employees	7	23%	6	20%	17	57%	30	100%
Effected in representing others to higher authorities	7	23%	3	10%	20	67%	30	100%

SATISFACTION	Disagree		Neutral		Agree		Total	
	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %	Freq.	Row N %
Makes me back up opinion with good reasoning	7	23%	1	3%	22	73%	30	100%
Works with others in a satisfactory way	8	27%	4	13%	18	60%	30	100%
Uses methods of leadership that are satisfying	8	27%	3	10%	19	63%	30	100%

Effects of Leadership Styles	Disagree		Neutral		Agree	
	Frequency	Row N %	Frequency	Row N %	Frequency	Row N %
Satisfaction	8	27%	3	10%	19	63%
Efficiency	7	23%	10	33%	13	43%
Extra Effort	3	10%	5	17%	22	73%