HUMAN RESOURCE MANAGEMENT PRACTICES AND HEALTH SERVICE DELIVERY IN KAMPALA, UGANDA

A Thesis
Presented to the
College of higher Degrees and Research
Kampala International University
Kampala, Uganda

In Partial Fulfillment of the Requirement for the Degree of

Doctor of Philosophy in Public Management

By

Wandiba Augustine

November, 2011

DECLARATION

"This dissertation is my original work and has not been presented for a Degree or any other academic award in any University or Institution of Learning".

WANDIBA AUGUSTINE 

Name and Signature of Candidate

08/04/2015.

Date

APPROVAL

"We confirm that the work reported in this dissertation was carried out by the candidate under my/our supervision".

Prof Malcia Allas

Name and Signature of Supervisor

10-04-2015

Date

DR STELLA KYOHAIRWE

Name and Signature of Supervisor

15/04/2015

Date

DEDICATION

To my father Mr. Wandiba Lumonya Vincent and mother Dinah Nandege Wandiba. Not only did they give me informal education but supported me to where I have reached. May God bless them abundantly.

ACKNOWLEDGEMENT

First and foremost, I am humbled before the creator of Heaven and Earth (Almighty God) for the gift of life. The wisdom, blessings, courage and perseverance that enabled me go this far in academics are worth noting and remembering. God you brought me from far.

I am very grateful to my supervisors Professor Alhas. N. Maicibi and Dr. Stella Kyohairwe for their constructive criticisms, guidance and encouragement, which kept me moving on.

I further convey countless thanks to all my lecturers who taught me during the Ph.D programme. In particular want to recognize Professor. S, Owolabi, Professor (Post humus), Professor E. Fagbamiye, Professor. J. C. Musaazi, Dr. E. Ongodia, Dr. F. K. Bakkabulindi, Dr. G. Tukahebwa, Dr. Senoga, and Dr. S. Oyabade for professional guidance they gave me.

My deep gratitude go to the Chairman Board of Trustees, Kampala International University, Hajji H. Basajabalaba, for the scholarship and his unending vision to form a competent and sustainable workforce of scholars that I am delighted to be part.

I thank members of my family for their support. It would not have been easy to accomplish this work without their love and moral support.

I thank my colleagues in the class of public management; Tom Mulegi, Agnes Tagulwa, without their support this study could not have been a reality.

I would like to extend my gratitude to Mr. Muhammad Kibuuka from whom I gained my first background about research methodology, which helped me a great deal in this subsequent undertaking.

Lastly, I extend my appreciation to all the respondents, research assistants, non teaching and support staff of College of Higher Degrees & Research of Kampala International University for their assistance rendered to the research process.

ABSTRACT

The study investigated the relationship between human resource management practices and health service delivery in Kampala, Uganda. The specific objectives of study were to: (1) to determine the perception of health workers on human resource management practices in Kampala; (2) to determine the perception of health workers on health service delivery in Kampala; (3) to establish the relationship between reward management practices and health service delivery in Kampala and (4) to establish the relationship between employee development management practices and health service delivery in Kampala .Descriptive correlation research design, cross-sectional and expost-facto designs with mixed methods were employed. Through a self-made questionnaire and interview, data was collected to answer three specific questions on reward management practices, employee development management practices and difference on the perceptions of health workers on human resource management practices and health service delivery in Kampala. Sample size of 220 respondents was selected using purposive, stratified and simple random sampling techniques. Data analysis was done using frequencies, means, one way ANOVA, Pearson's correlation coefficient and regression analysis. The findings revealed that the human resource management practices in terms of reward management (1.62) had a poor perception value while development management (2.21) had a fair perception and effectiveness of health service delivery (3.45) were rated very satisfactory. On testing the research hypotheses, the results showed that reward and development management practices differed significantly among the division urban councils while in effectiveness of health service delivery among division urban councils; setting services standards ($F=0.643$, at $p=0.05$), responsiveness ($F=0.702$, at $p=0.05$), productivity ($F=0.776$, at $p=0.05$) and availability of health worker ($F=0.180$, at $p=0.05$) had no significant difference. The findings further revealed that there was no significant relationship between human resource management practices and health service delivery and regression results showed that human resource management practices in terms of reward (Beta=-0.182) and development (Beta=-0.216) cannot significantly explain effectiveness of health service delivery. The study also revealed that there are other factors that may affect health service delivery like employee attitudes, teamwork and environment other than human resource management practices. It was recommended that the Directorate of Public Health and Environment of KCCA and in charge of health centers should promote human resource management practices and other related management practices to attain effective service delivery. The compensation policy should be harmonized for health workers to reduce the gap that exist between the workers of ministry of health and KCCA pay structure to motivate workers for better service delivery

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

AGR—Auditor General Report

ANOVA--Analysis of Variance

CHSSR--Centre for Health Science and Social Research

CSOs--Civil Society Organizations

DFID--Department for International Development

DUC(s)--Division Urban Council(s)

EDP--Employee Development Management Practices

EMR--Eastern Mediterranean Region

FY--Financial Year

GDP--Gross Domestic Product

GOU--Government of Uganda

HC II--Health Center II

HC III--Health Center III

HC IV--Health Center IV

HC V--Health Center V

HC(s)--Health Center(s)

HPEP--Health promotion and Education Programmes

HRM--Human Resource Management

HRMP--Human Resource Management Practices

HSD-- Health Service Delivery

HSDs-- Health Sub Districts

HSSIP --Health Sector Strategic Investment Plan

HSSP --Health Sector Strategic Plan

HW--Health Work

IGGR--Inspector General Government Report

IHSCKP--Improvement Health Services in the City of Kampala Project

JLI--Joint Learning Initiatives

KCCA—Kampala Capital City Authority

KDS-- Kampala Declaration on Sanitation

KIIDP--Kampala Institutional Infrastructure Development Project

LCI--Local Council I

MBO—Management by Objectives

MDGs-- Millennium Development Goals

MOFPED-- Ministry of Finance, Planning and Economic Development

MOH-- Ministry of Health

MOLG-- Ministry of Local Government

NGO-- Non-Governmental Organization

NHS --National Health System

NPM--New Public Management

PHPs--Private Health Practitioners

PLCC--Pearson's Correlation Coefficient

PNFP -- Private Not for Profit

PSRRC--Public Service Review and Reorganization Commission

RMP--Reward Management Practices

SHRM--Strategic Human Resource Management

SPSS--Statistical Package for Social Sciences

SSA--Sub Saharan Africa

TCMPs--Traditional and Complimentary Medicine Practitioners

TQM—Total Quality Management

UBOS--Uganda Bureau of Statistics

VHT -- Health Team

WB---World Bank

WHO--World Health Organization

CHAPTER ONE

INTRODUCTION

1.0 Introduction

The aim of this research was to understand the relationship between human resource management practices and health service delivery in the health centers in Kampala, Uganda. The concept of human resource management practices (HRMP) in this study is defined as the implementation of interrelated activities and processes with the purposes of attracting, developing, and maintaining employees in organizations and health service delivery is a way of providing equitable, comprehensive, and continuous health services to a defined population.

The delivery of health service in Uganda is undertaken through a National Health System comprising of all institutions, structures and actors whose actions have a purpose of achieving and sustaining good health (MOH, 2006, Lutwama, 2011). The public sector includes all Government of Uganda health facilities under the Ministry of Health, health services of the Ministries of Defense (Army), Education, Internal Affairs (Police and Prisons) and Ministry of Local Government (MOLG). The private health delivery system consists of Private Not for Profit

(PNFP) providers, Private Health Practitioners (PHPs), and the Traditional and Complementary Medicine Practitioners (TCMPs).

Despite the ongoing health sector reforms in Uganda, health services have remained poor. The inadequate performance of health workers coupled with lack of adequate support from the central and local governments are believed to have partly contributed to this deterioration and stagnation of some of the important health indicators under the second Health Sector Strategic Plan-HSSPII, (MOH, 2010 a). Furthermore, the annual report for 2007/2008 of the Ministry of Health in Uganda clearly states that some health indicators are either stagnating or deteriorating, due to inadequate health worker performance.

This study describes the organization and management of the health and delivery of health services in public health centers in Kampala. It was based on the public health centers that are government owned and offer free health services to people in Kampala as their services seems not the best when compared to private ones (MOH, 2002). Human resources have been acknowledged as the corner stone to organization development (Armstrong, 2003) because of its ability to organize all the other resources in a way that they are maximally utilized which can only be achieved through relevant human resource

practices. Human resource is principal input in health systems, besides physical capital and consumables thus quality health care (Ssengooba *et al.,* 2005).

Health care delivery is labour intensive human services in terms of knowledge, skills, motivation and commitment (Ssengooba *et al.,* 2005). World Health Organization (WHO, 2006) launched the health workforce decade (2006-2015) with more priority given to countries to develop effective workforce strategies through; improving recruitment, performance, and reducing attrition of health workers through a number of practices. Yet there is widespread inadequate performance of health care workers, inspite of interventions (Okuonzi, 2004). Consequently effective human resources strategies are required to achieve better outcomes from health care in Kampala Capital City Authority (KCCA). Therefore increased research attention should be focused on human resource practices in order to develop new approaches that maximize the human resources.

This chapter is organized to include the: background, problem statement, purpose, specific objectives; research questions, hypotheses, scope, significance and definition of key terms of the study.

1.1 Background of the Study

The background is presented in four perspectives, namely; historical, theoretical, conceptual and contextual (Amin, 2005).

1.1.1 Historical perspective

The emergence of HRM as a specific label in the public service coincided with the rise of New Public Management (NPM) in the 1980s. People management policies and practices which are usually termed 'HRM' originated in manufacturing industry in the USA during the late 1970s and early 1980s (Henderson, 2011). These represented a significant end to the personnel management paradigm. A number of factors led to this new management thinking, principally loss of faith in the traditional approach to mass production (Henderson, 2011). Human Resource Management is responsible for maintaining good human relations, development of individuals and achieving integration of goals of the organization and those of the individuals.

Reforms in the public sector in the last three decades have substantially shifted the focus of HRM in the health care systems from the conventional personnel administration (attention to rules and inputs) to an increased emphasis on performance and results-oriented service delivery (Shims, 2001); from centralized to decentralized health services to fairer levels (Ssengooba *et al.,* 2005).This new concern has

underlined the need for the public sector to reform its human resource practices to motivate employees towards higher performance and accountability (Olum, 2003). Such reforms include ability to recruit, retain, motivate, reward, and develop workers that can provide services effectively to their constituencies.

Local governments worldwide, however, face numerous challenges ranging from continuous reforms, budgetary constraints, to higher demand for quality services (Fastone & Mary, 2008). In the face of all these they are expected to ensure that they have the right employees to achieve the prescribed performance levels through commitment and team work among others.

In the last three decades the concept of human resource management practices (HRMP) has globally gained great attention as a critical element to achieve sustained competitive advantage (Schuler & Jackson, 1998; MacDuffie, 1995).

Human resource management and its dimensions, has been a subject of considerable discourse both among practioners and management academia as the central approach to sustaining organizational growth through effective service delivery (Barney, 1995). The increasing focus on New Public Management (NPM) system such as Total Quality

Management (TQM), Management by Objectives (MBO) and Balanced Scorecards by managers, consultants and academicians in the recent years, shows the increasing pressure leading to competition that has exerted pressure on organizations to improve their performance in order to survive by enhancing the way services are delivered (Hassain & Hoque, 2002). The adoption of NPM may have opened the possibility for managers to develop sophisticated human resource management techniques to achieve better services.

However, this has created a lot of uncertainty and challenges for managers in both public and private sector thus, underpinning the need for organizational efficiency (Tawfik-Shukor, *et al.*, 2007). Consequently most governments worldwide have introduced reforms in the public sector for better service delivery (WHO, 2000). The 1990s saw a substantial amount of empirical research carried out to find evidence on the link between HRM practices and performance. Much of the research in the 1990s did find statistical evidence for an association between HRM practices and performance (Huselid, 1995; Arthur, 1994).

Researchers also have shown an increasing interest in the concept of HRM practices and the link between HRM practices and organizational

performance that may lead to better service delivery, but their studies are limited to developed countries and mainly in private sector. There is no empirical evidence on service delivery in most developing countries and Uganda is one of them (Khurram *et al.*, 2008), and much of the debate on HRMP was generalized on all practices (Pfeffer, 2005), thus justifying the study because it concentrates on reward (financial and non financial) and employee development practices on health service delivery. For instance, Kramer and Schmalenberg (2004) found that, in the United States of America, if working environment contains those elements that nurses consider important like recognition, promotion etc, this leads to job satisfaction and increased productivity.

Other studies by (Tessema & Soeters, 2006; Gould-Williams, 2003; Wright *et al.*, 2003; Park *et al.*, 2003; Guest, 2002; Harley, 2002) reported that human resource practices may have positive link with organizational and employee performance. Despite the established information on HRMP and performance connection, the linkage process remains an area yet to be unlocked for breakthrough in human resource management research (Becker and Gerhart, 1996; McMaham *et al.,* 1998).

Even in the absence of direct linkage between HRMP and service delivery, there are some practices that significantly contribute to

organizational success through the intervening process. Analysis of the previous research works on HRM has identified some immediate effects of HRMP, known as HRM outcomes. Such HRM outcomes include skill, knowledge and competence (Schuler, 1989; Becker *et al.,* 1997), motivation (Pfeffer, 2005), organizational commitment (Beer *et al.*, 1993), team work (Ulrich, 2013; Storey, 2001), employee attitude, employee behaviour, and organizational climate, (Ferris *et al.*, 1998).

In many low income countries, human resources management is a neglected aspect in the health policies and plans of many health sectors (Buchan, 2004). It is widely recognized that health systems in many low-income countries are not strong enough to enable the efficient delivery of good quality health services that are accessible to the most vulnerable people in society (Fastone & Mary, 2008). Health service delivery is the backbone of any health system. Historically, African governments provided the majority of health services through a vast infrastructure (MOH, 2011c). However this public health service delivery system has changed dramatically in the last 20 years in many developing countries.

Uganda is no exception to this trend and in fact, the health service delivery system includes a wide array of public and private health care providers working in many different clinical settings (MOH, 2010 b).The challenge when assessing health services is to capture how inputs and services are organized and managed among all health actors to ensure access, quality, safety, and continuity of care, across health conditions and across different locations and time (WHO 2007). This study focuses on health service delivery outcomes (health indicators), utilization of health services, coverage and availability of services among the public health centers, ensuring quality in health service delivery, and community participation.

1.1.2 Theoretical perspective

While motivation is not the direct focus in this study, it is the underlying theoretical base upon which managing human resources rests. Besides, reward and development, key component of the study are inseparable with motivation. For these reasons, it is important to discuss the concept briefly. To begin with, what motivates people to work remains a debatable concept mainly because there are many theories about motivation.

The study was guided by and based on three theories; Stancy Adams' Equity theory (1963), Herzberg's (1966), two factor theory of Motivation and Maslow's hierarchy of needs theory (1954), which were highly focused to the nature of human resource management practice in an organization. There are three main aspects of equity theory: 1) Employee perceives a fair return for his/her contribution at work; 2) employees compare the return they received to the return received by others for the same job and; 3) employees who are in an inequitable position compared to others will try to do something to reduce the difference (Carrell & Dittrich, 1979).

The equity theory distinguishes between employees' inputs and outputs. Inputs are understood as the number and value of contributions that person make to his or her work. Outputs are described as the nature and quantity of received rewards for doing the job (Pinder, 1998). Generally, equity theory is relevant to this study as it explains how person's motivation to act in a certain way is propelled by feeling of inequity.

Herzberg, on his part, determined which factors caused satisfaction or dissatisfaction and found out that the factors causing job satisfaction are different from the ones causing job dissatisfaction. He therefore developed the Motivation Hygiene theory to explain these results. He

called the satisfiers, motivator factors and the dissatisfiers' hygiene factors. The motivators were closely connected to the job while hygiene factors were closely connected with the environment (Cole, 2002). This means that his theory is purely an analysis of human resource practices and will provide a niche for the current study since the study will concentrate on establishing the linkage and thus makes it principal theory to study.

The third theory applied in this study is Maslow's hierarchy of needs. Maslow's theory remains one of the most used to explain the aspects that indicate the value of understanding the workplace in order to succeed in organizational performance. An obvious conclusion of Maslow's theory is that employees first need a wage sufficient to feed, shelter to protect them and their families satisfactorily as well as a safe environment. Then their security needs must be met such as job security, freedom from coercion or arbitrary treatment and clearly defined regulations. According to Maslow when all these organization and individual needs have been adequately met, employees will become motivated to work hard which will generate results. This theory guided the researcher to identify independent constructs such as extrinsic and intrinsic reward systems, training, appraisal systems and management of innovations.

1.1.3 Conceptual perspective

The concept of HRMP remains debatable as it has attracted numerous definitions. Senyucel (2009) takes human resource management as a combination of people-centered management practices that recognizes employees as assets and geared to creating and maintaining skilful and committed workforce for achieving organizational goals. Armstrong (2009) describes human resource management as a strategic and coherent approach to the management of an organization's most valued assets, the employees, who individually and collectively contribute to the achievement of the objectives of the business.

According to Cole (2004) and Armstrong (2009), HRMP is a process of dealing with human beings as critical resources, with a purpose to achieve efficiency and effectiveness in pursuing organizational goals.

In general HRMP is conceptualized broadly in terms of human resource planning, recruitment and selection, performance appraisal, reward management, employee development, employee relations, union management and employee welfare. Koontz and Weihrich (2002) conceptualize human resource management practices as a description of the processes involved in the managing people in organizations. Becker and Gerhart (1996), operationalize HRMP in terms of recruiting of workforce, maintaining and compensating their service, appraising in line with their job and organization requirements in order meet the

individual and organization goals. However the researcher's interest was the individual practices related to the management of people at the place of work and how well these practices are carried out in the urban councils of Kampala, so the outcomes can lead to quality health service delivery.

In this study only reward management (extrinsic and intrinsic rewards) and employee development management (training, appraisal and innovation encouragement) practices will be examined to attain in depth research inquiry. Reward management is concerned with all the strategies, an organization rewards its people fairly equitably while employee development is a system for assisting employees to develop within their current jobs or advance to fulfill their goals for the future. Reward and employee development were selected because prior studies focused on single HRM practices (Gerhart & Milkovich, 1992; Balkin & Gomez-Mejia, 1987). Most studies done are on financial aspects which is part of extrinsic rewards while non financial have been neglected that are part of intrinsic rewards (Liu *et al.*, 2007).

Additionally prior studies have established a positive link between incentives in terms of financial rewards and performance of workers (Liu *et al.,* 2007; WHO, 2006). The link has been established in performance of employees not in relation to service delivery and done

in developed. Advances in medical field such as treatment and diagnosis, and the changing roles and responsibilities within the health sector require continuous professional development (Dieleman & Harnmeijer, 2006). A review of the literature reveals that there are two primary perspectives on HRMP.

The universalistic" approach states that there is an identifiable set of "best" practices, which when implemented could result in organizational improvements (Pfeffer, 1994). The contingency approach, on the other hand attempts to contextualize the various HRM practices to different organizational settings and strategies (Youndt, 1996). Nevertheless, the "universalistic" approach has received more empirical support than the "contingency" approach (Huselid, 1995). Researchers that adopted the former approach argued that some HR practices are always better than others (Delery & Doty, 1996).

Despite some differences, evidence indicates some HRM practices are common across the two perspectives. These practices include: (1) training (2) rewards and (3) performance appraisal (Tang & Tang, 2012; Yang, 2011; Wei, et al, 2010; Wang, 2010; Paré & Tremblay, 2007; Liao and Chuang, 2004; Mendelson *et al.,* 2001). Constant learning process must be developed at the commencement of a health

profession career (WHO, 2006). Therefore these two practices look alike thus motivated the researcher to bundle them together may have an impact on performance and this leads to better service delivery (MacDuffe, 1995). The definition of rewards encompasses the overall value proposition that the employer offers to the employee according to Armstrong (2009). Reward practice is used to capture the employee compensation practices of the organization ranging from, financial rewards and non-financial rewards.

It is a total package that includes compensation (Comprising of base pay, short-term incentives and long-term incentives), benefits (including health, retirement and work/life benefits, which account for an increasing portion of the rewards package) and careers (including training and development, lateral moves, stretch assignments and career incentives). Other reward systems consist of financial rewards (fixed and variable pay) and employee benefits, which all together may comprise total remuneration.

The system also incorporates non-financial rewards like recognition, praise, achievement, responsibility and professional growth, and in many cases, performance management processes (Armstrong, 2009). In a corporate environment rewards can take several forms. It includes, cash bonuses, recognition awards, free merchandise and free

trips. It is very important that the rewards have a lasting impression on the employee and it will continue to substantiate the employee's perception that they are valued (Silbert, 2005).

An organization's reward system can affect the performance of the employee and their desire to remain employed (Bamberger and Meshoulam, 2000; MacDuffie, 1995). In a nutshell, reward management deals with the strategies, policies and processes required to ensure that the contribution of people to the organization is recognized by both financial and non-financial means. It is about the design, implementation and maintenance of reward systems (reward processes, practices and procedures), which aim to meet the needs of both the organization and its stakeholders (Armstrong, 2007).

The overall objective is to reward people fairly, equitably and consistently in accordance with their value to the organization in order to further the achievement of the organization's strategic goals. Reward management is not just about pay and employee benefits. It is equally concerned with non-financial rewards such as recognition, learning and development opportunities and increased job responsibility (Armstrong, 2007).

Employee development is a process directed towards creating ongoing learning opportunities so that employees can improve over longer period of time and learn more skills over and above those required for the job (Kleynhans *et al.,* 2007). Employee development refers to those learning opportunities designed to help employee grow in all respects (Armstrong, 2009). Development is not primarily skills-oriented. Instead, it provides general knowledge and attitudes which will be helpful to employees in higher positions. Efforts towards development often depend on personal drive and ambition. Development activities, such as those supplied by management development programmes are generally voluntary. Armstrong (2009) adds that development takes the form of learning activities that prepare staff to exercise wider responsibilities. Employee development means to develop the abilities of an individual employee and organization as a whole so; hence employee development consists of individual or employee and overall growth of the employee as when employees of the organization would develop the organization, organization would be more flourished and the employee performance would increase (Elena, 2000).

The employee development programs are training, performance appraisal and innovation encouragement for this study. Training typically refers to process through which employee capacity is developed to improve on their current and future performance skills by imparting knowledge and changing in attitudes and increasing skills (Dessler, 2003). Ivancevich (2001) define training as the process that attempts to provide an employee with information, skills, and an understanding of the organization and its goals. Insufficient knowledge, skills and improper attitudes can be impediments to quality health care.

Performance appraisal is defined by (Luecke, 2006) as "a formal method for assessing how well an employee is doing with respect to assigned goals". Armstrong (2009) describes performance appraisal as a formal assessment and rating of individuals by their managers at and after a review meeting. Employee development has come to represent a range of learning opportunities that focus on accomplishing broad career or professional goals (Jacobs & Washington, 2003; Noe, 2008).

Service delivery is getting services effectively to the intended people. Service delivery is the way inputs are combined to allow the delivery of a series of interventions (WHO, 2001). In most instances service delivery implies a degree of excellence on the part of the organization.

A service is an activity or benefit that one party can offer to another that is essentially intangible and does not result in the ownership of anything (Kotler & Keller, 2006).

Public service is a critical phrase that refers to services offered by governmental or authoritative organ in region to its constituencies. Its production may or may not be tied to a physical product, (Kotler & Armstrong, 2009). In this study, service refers to health care activities that are carried out by the health workers and are geared towards improving the well being of clients or their communities.

Health service delivery is the way health care activities/inputs are combined to allow the delivery of a series of interventions to improve the well being of clients or their communities (WHO, 2001). Delivery of health services in Uganda has been decentralized since the 1990s. The decentralization of health care services was part of the reform processes that were initiated in 1993 (Jeppsson & Okuonzi, 2000). Health service delivery is described by health worker performance in several dimensions such as productivity, responsiveness, availability, setting services standards and work quality (WHO, 2006). Once the dimensions are adhered to and maintained then health service delivery is effective.

There are also additional factors that may lead to effective delivery of health services once incorporated with human resource management practices (independent variable); these are the moderating or intervening variables (WHO, 2006). Intervening variables are factors that influence health service delivery though the independent variables may creep in and this can impact positively or negatively on the services. The factors include employee competence, team work, employee attitudes, environment, motivation and organizational commitment. Employee competences are the knowledge, skills and abilities one possesses to do something (Huselid, 1995; Barney & Wright, 1997). Competence refers to the specific capabilities, such as leadership, and comprises knowledge, skills and attitudes (Armstrong, 2009).

He further adds that competence is an individual ability that results in the actions that meet the requirements of the job. The Joint Learning Initiative (2004) defines competencies as 'knowledge, skills, and attitudes that an individual acquires and develops through learning and work experiences". Team work is the cooperation and working in groups (Barney & Wright, 1997) and; organizational commitment is the readiness of the organization to exert considerable efforts and support to its people (Beck & Wilson, 2000).

Attitudes are the feelings and beliefs that largely determine how employees will perceive their environment, commit themselves to intended actions, and ultimately (Velnampy, 2007). Greenberg and Baron (2003) define motivation as "The set of processes that arouse, direct, and maintain human behaviour towards attaining some goal". The environment is man's immediate surrounding which he manipulates for his existence (Ajala, 2012). These factors individually and collectively influence organizational performance parameters such as employee productivity, product quality, speed of delivery and operational costs (Kaplan & Atkinson, 1998; Becker & Gerhart, 1996 Huselid, 1995).

1.1.4 Contextual perspective

Africa, unlike the other continents, faces severe human resources crisis in the health sector (Dieleman *et al.*, 2006). The continent's economic performance has been poor, which has affected the ability of countries in the Sub-Saharan Africa (SSA) with a few exceptions, to sustain credible health services and to train, employ and use health workers most effectively (Delanyo, 2005). Therefore many countries in Sub-Saharan Africa are unable to provide adequate quality and coverage of health care services because of poor economic performance and dwindling resources (Delanyo, 2005).

A number of articles and documents have reported problems relating to service provision due to poor performance of health workers (WHO, 2006; Rowe *et al.*, 2005). Most performance problems can be attributed to unclear expectations, skills deficit, resource shortages, lack of motivation and human resource practices (Hughes *et al.*, 2002). This has prompted many countries to advocate for the implementation of health sector reforms with a view to maximizing the use of available resources in improving access, efficiency and quality of health care services provided (Agyepong, 1999).

In the years after independence until late 1970's, the public service of Uganda was regarded as one of the most effective in sub-Saharan Africa (McPake *eta l.*, 1999). There was an effective referral system from the village dispensaries and district hospitals to the national referral hospital. However, health services began to deteriorate in 1970s and persisted to 1980s (Corkery, 2000; Streefland, 2005), due to the decline in gross domestic product (GDP) of about 25%, because of the dictatorial governments and civil unrests in the country, its breakdown led to poor health services (Jitta *et al.*, 1996).

Descriptions of the deterioration process mention shortage of drugs, highly qualified staff members (Doctors, Nurses) leaving the services

and migrating to another country, delays in payments of salaries (McPake *et al.*, 1999). Since 1986, the government of Uganda began reconstruction and rehabilitation programmes by nurturing the political and economic environment conducive for growth through the Public Service Review and Reorganization Commission (PSRRC) from 1986 to 1989. In the health sector, the reforms started with the establishment of the Health Policy Review Commission.

Since the early 1990s the government of Uganda (GOU) has placed high priority to improving the health status of the people, yet, the health indicators have remained poor (MOH, 2009b). As part of the health sector reforms which began in the early 1990s, among the anticipated benefits of health sector reforms were responsiveness, efficiency, and accountability in decision making among stakeholders; also improve the delivery of medicines and medical services (Awio & Northcott, 2001; Ssewanyana *etal.*, 2010). The GOU, produced the first three national health plans in 1993 along with 1993 Local Government Statute, and subsequently the Health Sector Strategic Plan 2000 (MOFPED, 2002).

These documents outlined plans for decentralizing health services to districts and cities such as having national, regional referral hospitals,

and the district health system. The delivery of health services in Uganda is by both public and private sectors with government of Uganda being the owner of most facilities (MOH, 2011c; MOH, 2009b). In order to deliver better health services to the public, the health sector adopted a number of health service delivery levels (AGR, 2006; MOH, 2002). For the public sector, the Uganda National Minimum Health Care Package has been developed for all levels of the system, and services are supposed to be based on this package.

The public health system in Uganda consists of the national and regional referral hospitals, and the district health system. The national and regional referral hospitals are autonomous and self-accounting institutions (MOH, 2002). The district health care systems are managed by the local governments which are aligned to the administrative structures as shown in Table 1.1.

Table 1.1: The district health system structure in Uganda

Administrative structure	**Local council level**	**Corresponding health care structure**
Village	I	Village Health team (VHT)
Parish	II	Health Center II (HC II)
Sub-county	III	Health Center III (HC III)
County	IV	Health Center IV (HC IV)
District	V	District General Hospital (HC V)

Source: Ministry of Health Uganda (2002)

As indicated in Table 1.1, the district health care system consists of the district general hospitals, health centers (HC) level II, III IV, and the village health teams. At the district level, the district hospital is the highest level of health care and serves approximate population of at least 500,000 people. These HCs offer all services offered at HC IV in addition to in-service training, consultation and research in community based health care programmes.

The district health system is further subdivided into health sub-districts (HSDs) or health centre level IV (HC IV), and serve a population of approximately 100,000 people. The health sub-district is headed by a medical doctor, assisted by two (2) clinical officers, registered nurses, and enrolled nurses, midwives, and laboratory technician. Every county is divided into sub-counties. This is the lowest level of local governments. At this level, the health care services are provided by health centre level III (HC III) and serve a population of approximately 20,000 people. Usually a clinical officer heads the services at this level assisted by a nurse and midwife, laboratory technician, and nursing assistants.

The services provided at this level include maternity, laboratory services, as well as in and outpatient services. Both level III and IV

offers preventive, promotive, out-patient curative, maternity, inpatient health services and laboratory services, in addition health center IV deal with emergency surgery, blood transfusion and laboratory services (MOH, 2002:2009b). The sub-counties are further sub-divided into parishes or wards. The health care facility at the parish or ward level is health centre level II (HC II), and serves approximate population of at least 5000 people.

It is responsible for providing preventive, promote outpatient curative health services and outreach care. An enrolled nurse and midwife manage the HC IIs. This is the lowest level of health care facility and offers primary health care services. These health centers do not offer any maternity, theatre, laboratory or inpatient services (MOH, 2002; 2006). Lastly, parishes/wards are divided into villages (LCIs), which are the lowest administrative units. At this level there are village health teams, which are teams of local residents appointed to oversee the performance of health activities in their communities (Kavuma, 2009). Generally, the management capacity at the districts is still very limited due to inadequate leadership, poor management, lack of specialist skills and high attrition rates which inhibit capacity building initiatives (MOH, 2009b).

Health promotion and education programmes (HPEP) are implemented through different channels (e.g. local councils, VHTs, Civil Society Organizations (CSOs), mass media and schools) and aim at influencing behavioural change (MOH, 2009b). Such programmes are affected by inadequate political support, human and financial resources and transport. Therefore, the functionality of the health system in Uganda remains a challenge such as system strengthening; especially at district level is required to facilitate effective service delivery (MOH, 2009b). Other health reforms include government partnering with private not for profit organizations (PNFP), working with private health care providers, the traditional and complementary medicine practitioners, development Partners and the communities; encourage the autonomy of public hospitals and planning and resource allocation system (MOH, 2002:2009b).

The human resource management reforms were: pay employees a living wage, develop human resources, employees reduced to almost a half, employees be accountable and be committed and have transparent performance appraisals (PSRRC, 1989). These reforms were to develop a Public Service that delivers timely, high quality and appropriate services aimed at the development and facilitation of growth of a wealth creating private sector (Olum, 2003).

The civil servants pay structure was to show fairness as compared to one's job and to yield results of quality in the whole scheme of performance (Olum, 2003). Specifically for the health sector, improvement was expected in the form of increased utilization of health services, better access to health services, more coverage of the population with basic services, better quality of healthcare and, ultimately, a decline in the rate of illness and death (Jeppsson & Okuonzi 2000). However, according to (Ssewanyana *etal.*, 2010; MOH, 2009b; Okuonzi 2004), existing data show no improvement in health services or people's quality of life during the period of the reform.

Government investment in HCs (II- IV) dramatically improved physical access to the health facilities. Today, 72 percent of households live within 5km of a health facility (public or NGO). The challenge is that while physical access improved, effective access to medicines has not. Evidence shows that utilization is limited because of inadequate medicines and health supplies, worsened by the low functionality of wards at HC IVs, the shortage of qualified health workers, and the demotivation of the few that exist, unfair salaries, lack of accommodation at health facilities, corruption, lack of employee development and other factors that further constrain access to quality service delivery (MOH, 2010 b; MOH, 2009b).

The 1997 Kampala Declaration on Sanitation (KDS) guides the promotion of hygiene and sanitation in Uganda but indicators are still poor and the targets for some indicators were not achieved (MOH, 2010 b). For example: while the target was that by 2008/09, 70% of the households at national level would have a pit latrine, 67.5% recorded as having a pit latrine although this was an improvement from 62.4% the previous year.

1.1.4.1 Health service delivery in Kampala

Provision of quality services by all agencies of government of Uganda to its citizens is a constitutional mandate (Articles 30 and 39). Services in the Division urban councils (DUCs) of Kampala include clean and safe water, sanitation, refuse removal, education, primary health care, electricity, city planning, infrastructure and trade management. Although service delivery policies and procedures are well streamlined in KCCA Act (2010) and Local Government Act 1997, it is disappointing to note that health service delivery in urban councils of Kampala has not improved (MOH, 2009b).

There are poor roads network, health, education, tendering procedures and general mismanagement of public funds have continuously persisted. This is supported by (Ssewanyana *et al*, 2010; Auditor General Report, 2010; MOH, 2009a; MOH, 2009b & MOH, 2010a), that

established that health centers had problems like lack of transport facilities, shortage of health personnel, lack of drugs, poor infrastructure and capital development underfunding that greatly affected provision of health services in general. This is supported by Nakkazi (2010) who observed that "Uganda health service delivery is poor", despite of increased fund allocations. Information available is based on human resource management practices or models of private sector but not in public institutions like KCCA (Khurram *etal.*, 2008; Buchan, 2004). World Bank (2008) revealed very poor employees' performances in the local governments in Uganda which significantly affects service delivery and increases the opportunities for corruption to take hold and continue.

Over the past decade, Government has focused on expanding its health infrastructure through construction of health facilities in an effort to bring services closer to the people (MOH, 2000).The government of Uganda through ministry of health and KCCA has tried to improve health service delivery through a number of strategies such as; training of employees on health service issues through seminars and workshops (MOH, 2010a). This helps health workers to gain new skills and knowledge for them to be innovative and creative leading to better service delivery.

Government through KCCA has raised the health workers pay and put in place incentives for like hard to reach, lunch and risk allowance. To maintain set standards there is performance appraisal for health workers is done annually (MOH, 2010a), but set standards seem not to improve and be maintained in public health centers as indicated in Auditor General Report (AGR) for period 2010/2011 and Inspector General of Government Report (IGGR) for 2011. In FY, 2011/2012, there was significant increase in the budgetary allocation to the purchase of drugs realized. However, the problem of lack of drugs at health facilities persists. It is against this background, that the researcher carried out this study to fill knowledge gaps on human resource management practices of health workers in the services.

1.2 Statement of the Problem

Despite all these health reforms in place, decentralization of health services, abolition of user fees, public-private partnership, working with private health care providers, encourage the autonomy of public hospitals, planning and resource allocation system (bottom-up Vs Top-down practice) and human resource management (MOH, 2009a); the delivery and utilization of health services is still poor in the Uganda, Kampala inclusive (AGR, 2010).

Health workers and administrators give little time to the clients or patients and office work (AGR, 2011), and this may lead to poor health service delivery. No increased continuity of better services, drugs not available, none adherence to clinical standards by service providers, low vaccination of children, erratic supply of drugs to patients, low rate of diagnosis of diseases and poor health behaviours still exist in Government health centers (MOH, 2009b; IGGR, 2011).

This persists amidst increasing efforts by Central Government and donor agencies to improve the quality of health services delivered to the public through funding a number of activities like infrastructure building, salary and staff development enhancement (MOH, 2011b). This is evidenced by large share of budget funding to Kampala as compared to other Local Governments; a few to mention (Wakiso, Mpigi, Mukono etc.) according to budget estimates 2012/2013 financial year (MOFPED, 2013). This study is therefore intended to explore the relationship between human resource management practices and health services delivery at health centers in Division urban councils of Kampala.

1.3 Purpose of the study

The purpose of this study was to establish the relationship between human resource management practices and health service delivery in the health centers in Kampala, Uganda.

1.4 Specific Objectives

1. To determine the perceptions of health workers on reward and employee development management practices in Kampala
2. To determine the perceptions of health workers on health service delivery in Kampala
3. To establish the relationship between reward management practices and health service delivery in Kampala.
4. To establish relationship between employee development management practices and health service delivery in Kampala.

1.5 Research Questions

1. What are the perceptions of health workers on human resource management practices in Kampala?
2. What are the perceptions of health workers on health service delivery in Kampala?

3. What is the relationship between reward management practices and health service delivery in Kampala?
4. What is the relationship between employee development management practices and health service delivery in Kampala?

1.6 Hypotheses

1. There is a significant relationship between reward management practices and health service delivery.
2. There is a significant relationship between employee development practices and health service delivery.

1.7 Scope of study

1.7.1 Geographical Scope

Geographically, the study concentrated on Kampala because it is the administrative capital city of Uganda (map appendix VI). It was carried out in the eight government health centers in five Division urban councils that make up Kampala; Kitebi and Kawala in Rubaga division urban council, Kisenyi in Central division urban council, Kiswa in Nakawa division urban council, Kisugu and Kiruddu in Makindye division urban council; Kawempe and Komamboga in Kawempe division urban council. Kampala is located on the northern shores of Lake Victoria at 0 15° 32 30° E. Kampala has grown from an area covering

seven hills in 1962 to the current extent covering twenty four hills (UBOS, 2011). Kampala has an estimated area of 197 km2 with a resident population of 1.66 million people (UBOS, 2011), thus large enough for representative results.

1.7.2 Content Scope

In content, the study focused on employee reward management (extrinsic and intrinsic rewards) and employee development management (training, appraisals and innovation) practices as the independent variable and health service delivery (increased continuity of better services, clinical standards are adhered to by service providers, vaccinated children, drugs supplied to patients, diagnosis of diseases and health behaviours) as the dependent variable that will be investigated for significant difference and correlation. Also other factors like teamwork, competence, employee attitude and organizational commitment that may influence in achieving better health service delivery was looked at.

1.7.3 Theoretical Scope

Theoretically, the study was based on three theories namely; (1) Equity theory, which distinguishes between employee's inputs and

outputs. Inputs are understood as the number and value of that person make to his or her work. Outputs are described as the nature and quantity of received rewards for doing the job. (2) Herzberg motivation hygiene theory is about the motivator factors (satisfiers) and the hygiene factors (dissatisfiers).

The motivators were closely connected to the job while hygiene factors were closely connected with the environment. That is, when the employees' efforts are recognized, it brings about job satisfaction and motivation. Environmental factors, such as poor lighting, poor ventilation, poor working conditions, low salaries, and poor supervisory relationships are causes for dissatisfaction in a job. Herzberg calls them basic needs and for that matter, is the responsibility of society's businesses and industrial institutions to provide for its people in order to self-actualize. According to Herzberg, the work one considers to be significant leads to satisfaction. Thus factors that depict job satisfaction are completely different from those factors that lead to job dissatisfaction. Therefore, these feelings are not polar opposites: in other words the opposite of job dissatisfaction is not job satisfaction, but no job satisfaction. (3) Maslow's Hierarchy of Needs states that we must satisfy each need in turn, starting with the first, which deals with the most obvious needs for survival itself.

The basic, low-level needs such as physiological requirements and safety must be satisfied before higher-level needs such as self-fulfillment are pursued. Only when the fairer order needs of physical and emotional well-being are satisfied are we concerned with the higher order needs of influence and personal development. In this hierarchical model, when a need is mostly satisfied it no longer motivates and the next higher need takes its place. The Hierarchy of Needs theory is important in training, employee development and thus it remains valid for the study. In this study Herzberg's Two factor theory was the principal theory.

1.7.4 Time Scope

This study based on data on human resource management practices, reforms in health sector and service delivery in Kampala for period of five years from 2006 to 2010. The research (aspects of field data, analysis, conclusions and recommendations) was conducted over period of two years.

1.8 Significance of the Study

The research findings are expected to benefit the following:

The researcher envisages that this study will add to the existing body of knowledge and understanding of how health services are delivered in health sectors.

Study will generate greater awareness among public health sector managers on the importance of having a practical health service framework as tool for service effectiveness.

The study will contribute to the available knowledge and so that the gaps between them could be filled, thus used for future reference by other researchers to make sure that the right human resource practices are adopted for effective service delivery to be attained that can upgrade health workers.

The finding will help the human resource departments to put in place human resource management practices that are flexible and realistic thus compatible with the workforce, to enable them identify concepts and frameworks of performance management that acknowledge the nature of work and the setting of the decentralized health systems

The central, local government and non government agencies that are responsible for quality services will be provided with the findings that can serve as a basis for improving the policies on the delivery of services in relevant institutions.

The findings from this study will help the directorate public health and environment at KCCA in developing effective human resource management practices to motivate and elevate customer-contact health workers' behaviors and commitment to health centers. The employee's positive behaviors and commitment will lead to enhance organizations' competitive advantage and organizational performance leading better health service delivery.

1.9 Organization of the Thesis

The thesis is arranged in five chapters. Chapters one describes the research topic, background of the study, identify the research problem, objectives of the study, conceptual framework with hypotheses of the study, scope of the study and significance of the study. The second chapter looks at the relevant theoretical review, and the findings of empirical studies which have examined the effects of distinctive human resource management practices on health service delivery. Chapter three presents the methodology of the study, the statistical analysis techniques and Hypotheses testing. Chapter four deals with the data presentation and analysis of general information. Finally chapter five presents the discussion of the results, conclusions and recommendation.

1.10 Operational Definitions of key terms

For the purpose of the study, the following terms were operationally defined;

Demographic Characteristics refers to characteristics of respondents as division where they reside, gender, age, level of education and length of service.

Human Resource Management Practices (HRMP) refers to ways or habits in which the workforce is motivated and developed in organizations. Human resource management practices were characterized by reward and employee development management practices.

Heath service refer to health care activities that are carried out by the health workers and are geared towards improving the well being of clients or their communities in division urban councils.

Service Delivery (SD) refers to the process by which public functions, activities and responsibilities are disseminated to the clients or communities in division urban councils.

Health Service Delivery (HSD) refers to the process by which health activities/programmes and responsibilities are disseminated in division urban councils to improve well being of the clients or their communities.

Health workers (HW) refer to health service providers that are directly engaged in the delivery of health services like medical doctors, nurses/midwives and clinical officers.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter covers recent discourse on human resources practices as related to reward management, employee development and health service delivery in terms of setting service standards, health workers responsiveness, productivity and availability. The first section will address theoretical aspects, then conceptual issues and empirical review.

2.1 Theoretical Review

This study employed Adam's (1963) Equity theory, Herzberg's (1966) Two factor theory and Maslow's (1954) Hierarchy of needs theory, in explaining the link between human resource management practices and health service delivery in Kampala, Uganda. Herzberg's Two factor theory was the principal theory for this study as it looks at work place aspects like pay, working environment, achievement of workers/employees etc. These theories are reviewed below.

2.1.1 Adam's Equity theory

Adam's (1963) Equity theory asserts that employees seek to maintain equity between the inputs that they bring to the job and the outcomes that they receive from it against the perceived inputs and outcomes of

others (Robbins, 2001). This implies that people value fair treatment which causes them to be motivated to keep the fairness maintained within the relationships of their co-workers and organization. The theory emphasizes that structure of equity in the workplace is based on the ratio of inputs and outcomes.

Equity Theory suggests that there will be a regression towards the mean, even in additive tasks (Adams, 1963, 1965). According to Equity Theory, people desire the ratio of their outcomes and investments to be roughly equivalent to the ratio for some other referent person or group. If ratios are not equal, and the difference is beyond some individual threshold level, emotional responses occur and the desire to restore equity manifests itself. In order to restore equity, people have a number of choices. They can change their outcomes, change their inputs, distort the value of either their outcomes or inputs, leave the field, change the outcomes of inputs of another, or change the referent person or group. Generally, equity theory of motivation attempts to explain how people strive for fairness and as a process theory, it explains how person's motivation to act in a certain way is propelled by feelings of inequity.

It further explains the social comparisons that people make when they compare inputs such as work efforts, time spent on work, qualifications and skills with outputs such as pay promotion, relations etc they receive (Kreitner and Kinicki, 2008). The problem arises when comparison is made and there is perception of unfairness (inequity). Thus, employees of urban councils who might perceive inequity in say pay, promotion, reward or other outputs may for example change their attitude towards customers they serve. These perceptions of inequity are perceptions of organizational justice or more specifically, injustice thus the theory has wide reaching implications for employee morale, efficiency, productivity and turnover.

The equity theory has its limitations, it is simplicity of the model, as a number of demographic and psychological variables affect people's perceptions of fairness and interactions with others. Furthermore, much of the research supporting the basic propositions of equity theory has been conducted in laboratory settings, and thus has questionable applicability to real-world situations (Huseman, Hatfield & Miles, 1989).

People also might perceive equity/inequity not only in terms of the specific inputs and outcomes of a relationship, but also in terms of the overarching system that determines those inputs and outputs. Thus, in

a workplace setting, one might feel that his or her compensation is equitable to other employees', but one might view the entire compensation *system* as unfair (Carrell & Dittrich, 1979). For example an employee who believes he/she is over-compensated may increase his/her effort. However he/she may also adjust the values that he ascribes to his/her own personal inputs. It may be that he or she internalizes a sense of superiority and actually decrease his efforts.

2.1.2 Herzberg's (1966) Two factor theory

Herzberg's (1966), two factor theory that states that employee motivation is achieved when employees are faced with challenging but enjoyable work where one can achieve, grow, and demonstrate responsibility and advance in the organization. That is, when the employees' efforts are recognized, it brings about job satisfaction and motivation. Environmental factors, such as poor lighting, poor ventilation, poor working conditions, fair salaries, and poor supervisory relationships are causes for dissatisfaction in a job.

These for Herzberg are basic needs and for that matter, is the responsibility of society's businesses and industrial institutions to provide for its people in order to self-actualize. According to Herzberg

(1974), the work one considers to be significant leads to satisfaction. Thus factors that depict job satisfaction are completely different from those factors that lead to job dissatisfaction.

Therefore, these feelings are not polar opposites: in other words the opposite of job dissatisfaction is not job satisfaction, but no job satisfaction. The hygiene factors are also referred to as the maintenance factors and comprise of the physiological, safety and love needs from Maslow's hierarchy of needs. They are factors that are not directly related to the job but the conditions that surround doing the job.

They operate primarily to dissatisfy employees when they are not present, however, the presence of such conditions does not necessarily build strong motivation, (Gibson *et al*, 2000). These factors include; company policy and administration, technical supervision, interpersonal relations with supervisor, interpersonal relations with peers and subordinates, salary, job security, personal life, work conditions and status.

Herzberg called these hygiene factors, since they are necessary to maintain a reasonable level of satisfaction and can also cause dissatisfaction. The hygiene factors are not direct motivators but are necessary to prevent dissatisfaction and at the same time serve as a

starting point for motivation. However, improvements in these conditions do not create motivation, (Huling, 2003). According to Herzberg, the motivator factors pertain to the job content, they are intrinsic to the job itself and do not result from "carrot and stick incentives".

They comprise the physiological need for growth and recognition. The absence of these factors does not prove highly dissatisfying but when present, they build strong levels of motivation that result in good job performance. They are therefore called satisfiers or motivators. These factors include; achievement, recognition, advancement, the work itself, the possibility of personal growth and responsibility. The disadvantages are that Herzberg's model is more of a generalization that may not be appropriate to all groups of employees or individuals within a group. Herzberg based his theory on interviews with accountants and engineers (Stello, 2014). His findings are not necessarily directly applicable to vastly different employee groups.

Hourly employees may not be particularly interested in job enlargement and enrichment, and may be more motivated by increased pay. Some employees may be more motivated by flexible work arrangements (Smerek & Peterson, 2007). Additionally, too much of a good thing can be bad: giving an employee responsibility

they are not prepared for can be overwhelming and become a demotivator (Stello, 2014). They will blame dissatisfaction on the external factors such as salary structure, company policies and peer relationship. Also, the employees will give credit to themselves for the satisfaction factor at work (Smerek & Peterson, 2007).

2.1.3 Maslow's (1954) Hierarchy of needs theory

Maslow's (1954) Hierarchy of needs theory suggests that humans are motivated to satisfy five basic needs. These needs are arranged in a hierarchy, and he said that we seek first to satisfy the fairest level of needs. Once this is done, we seek to satisfy each higher level of need until we have satisfied all five needs. The hierarchy of needs theory is relevant to this study as the theory is applicable to organizational orientation and employee motivation (Greenberg & Baron, 2003).

They further argue that the theory is able to suggest how managers can lead their employees or subordinates to become self-actualized. The idea implies the dual role of the theory first to organizations and second to employees on the basis that both the organization and the employees must decide on the performance of their organization, and that when employees put in their best in the service of the organization, the culture and human resource practice should also

ensure that the employees' level of needs are reflected in the values the organization holds with high esteem (Greenberg & Baron, 2003).

The cultural framework of the organization should reflect the fact that employees' physiological and security needs are paramount; therefore, when such needs became culturally focused, performance will be improved tremendously in that organization (Maslow, 1954). This argument implies a reversed effect that if the need is not culturally focused on, the performance standard will not be met. Organization benefits can also play a large role in an employee's satisfaction and performance. This can include tuition performance or allocations to attend specialized conferences.

These sorts of ancillary benefits can stimulate an employee to take on new opportunities to improve themselves and, as a result, improve his or her performance in their current position. It can also set his or her career path in a better direction, for future growth and promotion (McNamara, 2005). The method an organization chooses for performance reviews and evaluations can have the biggest effect on employee performance. Organizations that fail to review their employee's performance or recognize a job well done may soon find disgruntled employees. Furthermore, organizations that stringently

monitor employee work without providing employees the opportunity to provide feedback may also result in non-motivated employees (Cardy & Selvarajan, 2004).

The performance reviews to keep employees motivated and performing well include periodic, regular, honest and objective feedback to the employee (Collins, 1998). However, the organization should also have some mechanisms in place for the employee to give feedback about ways the organization could also improve itself and make itself a better place to work. Allowing open communication in both directions will keep the employees more satisfied with their performance review and happier with their compensation level in relation to their work.

It is therefore important for managers of urban councils to fully comprehend such theories and be aware of its implications when they make decisions concerning such things such as pay, bonus, fringe benefits, promotions etc. Unfortunately, the situation in the urban councils of Kampala does not look good as accusations about favoritism and nepotism still exists concerning pay and promotion of health personnel thus not promote equity theory spirit (AGR, 2011)).

Maslow's hierarchy of needs theory has its limitations, as it is over simplified and is based on human needs only and there is lack of direct

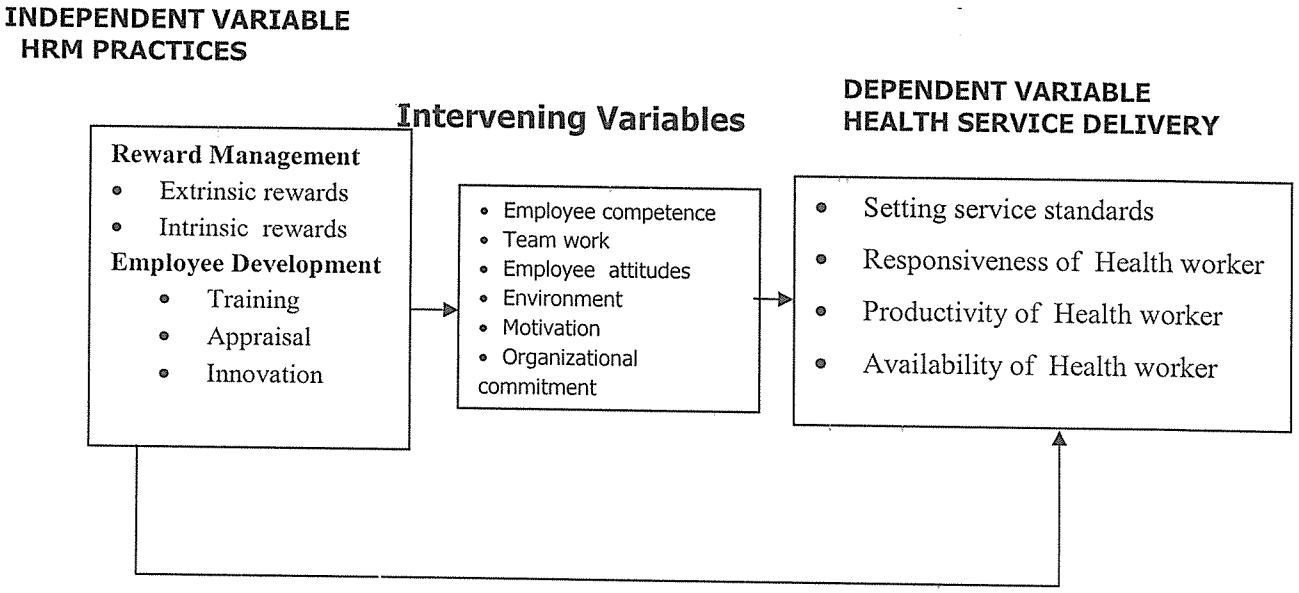
cause and effect relationship between need and behavior (Wahba & Bridwell, 1987). Needs of all employees are not uniform as many people are satisfied only with physiological needs and security of employment (Alderfer, 1969). Therefore the pattern of hierarchy of needs as suggested by Maslow may not be applicable uniformly to all categories of employees. Maslow's assumption of 'need hierarchy' does not work in the present age as each person has plenty of needs to be satisfied, which may not necessarily follow Maslow's need hierarchy (Wahba & Bridwell, 1987). This is often due to the fact that different individuals are driven to satisfy different needs at a certain time.

To illustrate, take a certain health worker who find himself hard to be accepted by others, but presents very innovative ideas that makes the manager favouring him and appraising him more than anyone else within the company.

Based on Maslow's theory, the employee is at esteem needs should focus on doing more things that pleases his boss so he can move up to self-actualization needs. However in reality, the health worker has a strong urge to fulfill social needs and it is possible that he/she might put in less effort at work in order to fulfill the unsatisfied motivator of his/her. The point of this illustration is that in the real world, the needs

are not fulfilled in chronological order, as people will make the effort eventually to satisfy latent needs in the hierarchy.

2.2 Conceptual Framework



Source: Adapted from Anantharaman *etal* (2003)

Fig.1: Conceptual Frame work Relating Human Resource Management Practices and Health Service Delivery

Human resource management practices (independent variable) in terms of reward management and employee development once practiced well will lead to better health service delivery (Guest, 1997). Therefore HRMP have a direct linkage to health service delivery as per setting service standards, health workers responsiveness, availability and productivity (MacDuffie & Kracfcik, 1992).

Employees are internally motivated to do their work (intrinsic reward) or by the pay like salary, incentives etc (extrinsic rewards). Development means the growth of an employee in all respects. This is done through training, appraising and innovation encouragement to assist an employee improve their skills and knowledge for better performance leading to quality service delivery. Training means learning skills and knowledge for doing a particular job and it increases job skills of an employee to perform better.

Training further helps them to be innovative. Therefore both reward and employee development motivates employees to perform better service delivery. Furthermore, the conceptual frame work reveal that there moderating/intervening factors such as competence of employees, Team work, employee attitudes, environment (such as size of office, ambient temperature, friends, colleagues) and organizational commitment that compete with the independent variables to have an effect on the dimensions of health service delivery (Huselid, 1995; Becker & Gerhart, 1996).

That is to say, the competence one possesses can determine the degree to which performs thus better services delivered in the society and once health workers work as a team, increases cooperation among themselves to performance well leading to yields and better services.

The environment ones is subjected to can induce his or her performance that may affect service delivery, the environment can be either internal or external. Also the attitude of individual health workers towards work and his/her job motivates one to performance well thus leading to better services delivery to the defined population; and organizational commitment improves employee/workers attitudes towards work which improves organizational productivity. In the study while the intervening variables were briefly introduced, the research was limited to the independent variables and dependent variable.

The above frame can be explained by the following developed model equation:

$Y_1 = \alpha + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \beta_5 X_5$

Where;

Y_1 = Setting Service Standards

Y_2= Responsiveness of Health Worker

Y_3 = Productivity of Health Worker

Y_4= Availability of Health Worker

α= Constant

β= Beta/Coefficients of the explanatory variables

X_1= Extrinsic Reward

X_1= Intrinsic Reward

X_1= Training

X_1= Appraisal

X_1= Innovation

2.3 Human Resource Management Practices

HRMP refers to organizational activities directed at managing the pool of human resources and ensuring that the resources is employed towards the fulfillment of organizational goals (Schuler & Jackson, 1987; Schuler & MacMillan, 1984). HRMP include: job analysis, orientation, performance appraisal, human resource planning, labour relations, selection and recruitment, compensation, and training and development (Dessler, 2007). Studies show that researchers only focus on one HRMP in their studies, such as staffing (Stavrou, 2005), compensation (Austin & Crespin, 2006) and training (Noe *et al.*, 2007).

Compensation which is part of reward practice is the partially studied (Stavrou, 2005; Frye, 2004; Cooke, 2000). There are also researchers who study bundles of different HRMP (Snell & Youndt, 1996). Wright and MacDuffie (1995) establish that particular bundles of HRMP are correlated with efficiency and quality of public services. McMahan (1992) suggests that researchers should investigate bundles of HRMP

instead of individual HRMP and their effect on performance. Peck (1994) argues that HRMP are interdependent, and as a whole they create specific outcomes for the firm.

Different HRMP bundles have different effects on performance (Huselid, 1995). As to date, there is no standardized list of satisfactory performance HRM practice bundles (Pfeffer, 2005; Guest, 2002; Becker & Gerhart, 1996). Nevertheless, HRMP are the most important tools which can influence the attitudes and behaviour of individuals, and therefore, their performance at work (Collins & Clark, 2003; MacDuffie, 1995). This study focused on employee reward and employee development management practices which have not widely been researched on and have great impact on the performance employees hence may lead poor service delivery.

2.3.1 Reward Management Practices

Reward is the thing that an organization gives to the employee in response of their contribution or performance so that the employees become motivated for future positive behavior. In a corporate environment rewards can take several forms. It includes, cash bonuses, recognition awards, free merchandise and free trips. It is very important that the rewards have a lasting impression on the employee

and it will continue to substantiate the employee's perception that they are valued (Silbert, 2005).

Managers believe that high employee performance followed by an incentive reward system will make future high performance more likely. Indeed, Delaney and Huselid (1996) find that a compensation system based on excellence results in increased employee performance. DeCenzo and Robbins (1999), Conceptualized rewards most obviously as pay given to employees for work effective in service delivery. They also content that rewards include promotions, desirable work assignments, and a host other less obvious payoffs a smile, acceptance by a peer, a covert or overt implication that you are doing a good job, or a kind word of recognition. Malhotra *et al.,* (2007), defines rewards as all forms of financial return, tangible services and benefits an employee receives as part of an employment relationship.

According to Kreitner (1995), rewards are material and psychological payoffs for working or delivery a particular service. Therefore, rewards may be taken to mean both financial and non-financial offers that are part of the employer's contract with the employees. Linda (2001) and Cushway (1999) observed that reward is something, which is given or received for behaviour that is commendable and valuable. However,

different people use different terminology to describe what an employee receives in exchange for work efforts. They include benefits, compensation, remuneration, reward, salary, wages and disposable earnings.

Traditionally, the word payment was implied to refer to all the above terms. However, it is important to say that the management of rewards is contingent on the system and strategy. On the other hand, the reward strategy should be congruent with and support the corporate values and beliefs, but generally exhibiting the characteristics of Adam Stacy equity theory.

Reward refers to all of the monetary, non-monetary and psychological payments that an organization provides for its employees in exchange for the work they deliver. Gratton and Gold (2005), have this to say:

> *Although economic rewards play an important part in security adherence to organizational goals and management authority, they are limited in their effectiveness. Organizations would be far less effective systems than they actually are if such rewards were the only means, or even the principal means, of motivation available. There is no such thing as a good pay*

system; there is only a series of bad ones. The trick is to choose the least bad one.

Musaazi (2005) observed that reward is people oriented with a focus on why people work, why they are motivated and why they choose one employer over another. This includes the traditional package, how the organization deals with the degree of challenge and interest in the work, level of freedom and autonomy given to employees, the leadership accorded and the ability of employees to achieve an acceptable work life balance.

Reward management is concerned with the formulation and implementation of strategies and policies in order to reward people fairly, equitably and consistently in accordance with their value to the organization (Maicibi, 2007).

In a related development, reward is considered an important factor in motivation that indicates whether employees perceive the reward structure as being fair. One way of addressing this issue is through the equity theory, which refers to an individual's subjective judgment about the fairness of the reward received, relative to the inputs, which include many factors such as effort, experience and education in contrast with the rewards of others (Koontz & Weihrich, 2002). However, it is important to note that a triangulation of the various

categories of rewards identified by different scholars put rewards into two broad categories, notably: extrinsic and intrinsic rewards (Hunt, 1986).

2.3.1.1 Extrinsic Rewards

Extrinsic rewards include salary and wages, benefits, bonuses, office furnishing, cars, pensions, prizes. Hence, extrinsic rewards are tangible that determine performance of employees. Extrinsic rewards pertain to rewards that are given by another person, such as a health care organization giving bonuses to teams of workers when quality and patient satisfaction are demonstrated to be exceptional (Shanks, 2003). Extrinsic rewards provided by employers in the form of pay will help to attract and retain employees and, for limited periods, may increase effort and minimize dissatisfaction. Manion (2005) also notes five types of extrinsic rewards which can be summarized as healthy relationship, meaningful work, competence, progress, and choice.

2.3.1.2 Intrinsic Rewards

Intrinsic rewards include flattery (praise of pretence to get something), praise, achievement, challenges, freedom and so on (Kreitner, 1995). Intrinsic rewards are intangible in nature but make motivated do their work without ones inducement by another. According to Shanks, intrinsic rewards are internal to the individual and are in many ways

less tangible. In fact, they are highly subjective, in that they represent how the individual perceives and feels about work and its value' (2007). Malhotra *et al.* (2007), argue that 'intrinsic rewards are inherent in the content of the job itself' and include 'motivational characteristics such as skill variety, autonomy and feedback' as well as employee participation in decision making and role clarity. Intrinsic rewards are derived from within the individual. For a healthcare employee this could mean taking pride and feeling good about a job well done (Shanks, 2003).

Intrinsic non-financial concentrates on the needs people have. These needs could be the need for achievement, responsibility, influence and personal growth. Intrinsic motivation arises from the work itself (Thomas, 2002). Workers feel satisfied and they get feeling of success from work and that way are more motivated at work. Intrinsic non-financial could also be for example flexible work hours, long lunch time, interesting projects, support, appreciation, time off, extra vacation days or simply movie tickets, paid lunch or dinner (Stone, 2003). Intrinsic non-financial rewards related to responsibility, achievement and the work itself may have a longer-term and deeper impact on motivation. Reward systems should therefore include a mix of extrinsic and intrinsic rewards (Armstrong, 2007).

2.3.1.3 Compensation

Grobler *et al.* (2006) emphasize that compensation does not only refer to extrinsic rewards such as salary and benefits but also to intrinsic reward such as achieving personal goals, autonomy and more challenging job opportunities. Indeed, Noe *et al.* (2008) point out the need to align the compensation policy with the overall organization strategy. Compensation is one of the most important dynamics affecting job choice. It determines whether the prospective worker will accept or reject the job. Ideally, the compensation system should promote the organizational culture and employee behaviours necessary for achievement of the organization's strategic goals.

Liu et al (2007) maintain that attractive compensation helps to build the organization's image as an employer of choice and further leads to attraction and retention of high quality workers. In highly routinised work such as health care delivery, staff with satisfactory level of knowledge, skills and abilities has less opportunity to make improvements. Additionally, paying extra to have knowledgeable and skilled employees is of little value if there is lack of motivation or workers confront problems in applying their skills. While investing in higher compensation pays off, managers have to ensure that they are

able to take advantage of the higher knowledge, skills and abilities, which such compensation generate (Liu *et al.*, 2007).

2.3.1.4 Reward Management in Organizations.

Reward management is concerned with all the strategies by an organization in formulation and implementation of policies that aim at rewarding people justly, fairly equitably but differently and consistently in accordance with their value to the organization (Maicibi, 2007).

The cardinal purposes of an organization's reward management (pay systems) are to: attract sufficient and suitable employees, maintain workers who are good performers, pay workers for effort, loyalty, experience and achievement, recognize the value of jobs in relation to each other, ensure optimum productivity and satisfactory quality level of output, and comply with employment laws (Maicibi & Nkata, op cit).

Reward management procedures are therefore important to monitor the implementation and achievement of the reward policies.

They deal with methods of fixing pay on appointment or promotion and dealing with anomalies. They also include methods of appealing against grading or pay decisions, usually through the organization's normal appeals procedures. When it comes to organizational rewards there are some key theories that are of particular help to managers.

However, as far as reward for work is concerned, both distributive justice and procedural justice are significant. Distributive justice relates to an employee's belief about the fairness of the reward system. However, procedural justice describes a situation where an individual believes that the procedures for the allocation of rewards used within the organization are fair (Linda, 2001).

Generally it is important for organizations to motivate their employees, use of equity theory to ensure good performance and commitment, set fair and consistent pay structures/rates for an effective compensation scheme, pay competitive and attractive packages, monitors the environment to retain competitive advantage and above all considers the doctrine of distributive and procedural justice.

Considering the purposes and goals of an organization's reward systems, it was observed that there are several factors that affect the reward management systems in an organization. These include both internal and external factors. What any organization can afford to pay to its workers affects the reward management system and depends on the financial success of the organization and is also a question of reasonable judgment of the top management committee, (Maicibi & Nkata, 2005). Other factors of importance to acknowledge are: what

other organizations in the area pay for similar jobs, the national and, or international rates of pay within the organization, the legislation and the minimum wage level.

The reward system should be audited regularly to assess its effectiveness, the extent to which it is adding value and its relevance to the present and future needs of the organization. This audit should include an assessment of opinions about the reward systems by its key users and those who are affected by it. This leads to a diagnosis of strengths and weaknesses and an assessment of what needs to be done and why, (Armstrong, 2009). The operation of the reward system should be monitored continually by the personnel department through such auditors and by the use of comparative ratios and attrition analysis.

Several studies have been done about reward management. Nankinga (2006), empirically showed that salary does not always drive the teacher to perform better in Kakungulu Memorial Secondary School, especially if it is perceived not to be equivalent to the efforts put in and not paid on time.

Studies done on commissions and performance .Pei (2007), in his study of correlation between management and employee motivation in

Sasol polypropylene South Africa which established that drive employees to work harder as they expect more commission for extra effort put in and this to better service delivery. Hume (1993), in his study on remuneration and performance of employees in the United Kingdom food industry established that employee benefits affects employee's performance among other factors. Maicibi (2003), observed that if employee benefits match individual needs and interests, it makes the employee's performance to increase, although the benefits will create more costs to the organization.

2.3.2 Development Management Practices

Human resource development comprises the procedures and processes that purposely seek to provide learning activities to enhance the skills, knowledge and capabilities of people, teams and the organization so that there is a change in action to achieve the desired outcomes, (Bratton & Gold, 2003). Another view held that human resource development is a business led approach to developing employees within a strategic framework. The main focus is the provision of learning, education, training and development to improve on the skills, knowledge and capabilities of employees, teams and the organization as a whole (Armstrong, 2009). According to George and Jones (2002) career development or growth is the need for self development.

Employees always views career development as a path to upward mobility, the manager sees it as a retention and motivational, and the management's view is that it is a tool for successful planning as a result organizations focuses on developing the career path of its employees increases the morale and the productivity of employees (Applebaum & Shappiro, 1991). As when employees would be more developed, they would be more satisfied with the job, more committed with the job and the performance would be increased. When employee performance would increase, this will lead to the organization effectiveness thus better service delivery (Champathes, 2006).

2.3.2.1 Training

Training is defined by Horgan and Mühlau (2006) as organizations' planned and systematic efforts to shape or develop the knowledge, skills, and attitudes of employees through their learning experiences. Training pertains to the formal training given to employees (Delery & Doty, 1996). Training develops employees' skills and behaviors to motivate them in applying their skills and knowledge to their work activities (Way, 2002; Way & Thacker, 2001).

In addition, training also enhances employees' knowledge and skills in performing their tasks more effectively (Pathak *et al.*, 2005). Strober (1990) was of the opinion that employees understand the training provided by organizations implies their prolong employment and better wages in the irrespective organizations. When the staff is trained they are expected to improve in performance because the process acts as a motivator giving the staff greater sense of loyalty, feeling of belonging and commitment. Delaney and Huselid (1996) agreed that training improves employees' competencies to complete tasks and solve problems more effectively and efficiently.

A service organization should provide training to customer-contact employees in order for them to have a better understanding about their role (Hartline & Jones, 1996). Training is vitally important for customer-contact employees because they have to solve problems using their knowledge, abilities, and skills. Training and employee commitment is closely related which lead to higher productivity and satisfied employee.

Bartlett (2001) explored effects of training on organizational commitment and found that perceived access to training produced the

highest correlations with organizational commitment. The results showed that employees perceived the availability of training as support from their employer, which made them more committed to their organization. Developing human capital through continuing training may increase the productive output from each employee either through improvement in skill level or through improvement in morale and job satisfaction (Dessler, 2003).

2.3.2.2 Performance Appraisal

According to Flippo, (2008) says that "Performance appraisal is the systematic, periodic and an impartial rating of an employee's excellence in matters pertaining to his present job and his potential for a better job." Performance appraisal is the process of evaluating how well employees perform their jobs when compared to a set of standards, and then communicating that information to those employees (Mathis & Jackson ,2003).

The primary goal of performance appraisal is to provide feedback to employees on how well they are doing their work and to provide direction for future development and accomplishments (Armstrong, 2009). Performance appraisal is generally conducted annually, with follow-ups as required. Additionally, performance appraisal also helps

the workers and managers to focus on the goals and performance expectations that affect salary, merit increase, and promotions (Luecke, 2006). Performance appraisal serves as a tool for managers to; identify who is eligible for promotions and salary increments, recognize training and development needs for the workers, provide feedback required for improvement; place workers according to their ability encourage goal setting for future accomplishments and measure attainment. This helps individual employee and organizations to performance thus better service delivery.

2.3.2.3 Innovation Encouragement

Both public and private organizations/enterprises would like to see public services improve through innovation. Many dedicated public servants, particularly those who serve the public directly, are frustrated by systems and procedures which are often a barrier to good service rather than to support it. It is essential for the program to succeed; commitment, energy and skills of these people are harnessed to tackle inefficient, outdated and bureaucratic practices, to simplify complex procedures, and to identify new and better ways of delivering services, (Neale, 1994).

Performance appraisal should include an assessment of the performance of individual staff in contributing to improving service to the public. This will be particularly important in the case of staffs who serve the public directly, where a key indicator will be how they rate in their dealings with the public. An award scheme should be introduced to recognize and reward outstanding performance in improving public services, (O'Fairchealaigh, Wanna & Weller, 1999).

2.4 Health Service Delivery

The public health system in Uganda has a mechanism for regular performance appraisals and development plans for all staff (MOH, 2011c). However, evidence shows that the appraisals have not been used consistently (MOH, 2011a). Moreover, staff development activities are organized not in response to staff skill needs, but rather in an adhoc manner. The lack of promotional avenues and incentives within the district health system may explain in part why performance appraisal is viewed more as a ritual than a tool for performance improvement and career development (Ssengooba *et al.*, 2007).

The success of all service delivery programs depends on commitment of the workers, their availability, quality of facilities and clients (Hoque, 1999).The service sector has an increasingly important role in the economy and public service delivery needs to evolve to meet the

emerging challenges. It is widely recognized that service delivery needs to be more joined up, so that services are more consistent and less fragmented over time and between providers.

There must be scope for greater efficiency in service delivery through standardization and sharing. In engaging with citizens and communities to design services, there is need to understand what they need, both from asking them directly, and from making the best possible use of the information we gather through service delivery. To close the loop, we need to know how well we are performing and communicate this to our communities, so they hold us accountable, (Molloy, 2006). Jegers and Lapsley (2001), group service orientation is put under three subgroups namely efficiency, user convenience and citizen centricity.

To measure user convenience, ease of access to the service, user dependence of time availability and existence of alternative processes in case of serious problems of suitability of service locations to socially and economically backward areas are used. On the other hand, the attributes used to measure citizen-centricity include extent to which user requirements are covered in service design, use of local language in user interfaces, number of visits to higher level offices to complete

transactions and extent to which the staff of the service provider at service delivery station familiar with the services packaged for different user groups (Rao & Bhatnagar, 2004).

2.4.1 Setting Service Standards

National departments and local administrations have to publish standards for the level and quality of services they provide (MOH, 2009b; MOH, 2010a). Service standards must be relevant and meaningful to the individual user. This means that they must cover the aspects of service which matter most to users, as revealed by the consultation process, and set in terms which are relevant and easily understood. Standards must also be precise and measurable, so that users can judge for themselves whether or not they are receiving what was promised (Dolea & Zurn, 2004).

Examples in health departments may include stipulating the key standards a patient can expect in a hospital which may include: how long they can expect to wait at the outpatient clinic; the maximum waiting time for a non-urgent operation; the name of the person responsible for their case; the information they are entitled to receive about their treatment (MOH, 2010a). Where citizens have little or no

choice about the services they receive, information is one of the most powerful tools, sometimes the only tool that they have to exercise their right to good service. Implementing the principles of public service delivery calls for a complete transformation of the way in which local administrations communicate with those who use their services, (Dixon & Kouzmin, 1994).

The service standards are set by the government of Uganda through the ministry of health in conjunction with world health organization. The services standards are important better service delivery thus managers put in place yard-sticks against which the performance of health workers is to be evaluated. Staff participation and staff involvement is an important human resource management function. It permits making the best use of the health workers knowledge, hands-on experience and ideas for improvement. In addition, staff participation involves recognition and appreciation of their competencies. In Kampala this may not be realty as workers are not part of the planning.

2.4.2 Responsiveness of health workers

Responsiveness of workers is the willingness or readiness of employees to provide a service (Heizer & Render, 2008). The Department for International Development (DFID) 2006 refers responsiveness as the extent to which service providers demonstrate receptiveness to the opinions, grievances and propositions of the clients by transforming its organizational strategy. Hence it is important to pay particular attention to those aspects that affect the efficiency and receptiveness of health workers. The health workforce must have the skills and enthusiasm to appreciate and deal with the health needs of their clients.

Freedman (2005) maintains that focusing on health workers" receptiveness allows for a more holistic approach to quality service provision by taking into consideration the technical aspects and client satisfaction. A number of factors impede the responsiveness of health workers. These may be the social, cultural, and political economy. Others factors that could hinder health worker responsiveness include lack of interpersonal communication skills, lack of public recognition for the value of health workers, and poor terms and conditions of services.

The responsiveness of health workers can be improved through a number of mechanisms like increase in remuneration and provision of other types of incentives like hardship allowances for health workers in the hard-to-reach areas. Once incentives are offered, health workers tend to improve on their performance and make them to like job thus satisfactory retention (DFID, 2006). Responsiveness of health workers is important for quality services thus workers should been given monetary incentives like hard to reach allowances, empowered and be recognized to increase their responsiveness (DFID, 2006).

2.4.3 Productivity of health workers

Productivity is defined as the ratio of outputs to inputs or the relationships between inputs and outputs (Heizer & Render, 2008). The Joint Learning Initiative (JLI) 2004 defines productivity as the outputs extracted from given inputs, such as patients seen per worker or number of procedures per provider. Other authors, such as Kurowski, Wyss, Abdulla and Mills (2007) define productivity based on two concepts of productivity. They define health worker productivity as the time spent on health service related activities such as patient care or staff meetings. 'They also define service productivity as the proportion of useful staff time used in provision health priority interventions. Manuwa-Olumide (2009) also describes productivity as

the ability of health workers to provide efficient services and favorable outcomes. In this study, productivity is about achieving improved health outcomes" from the current contributions of the health workforce without compromising quality of services provided.

Hornby and Forte (2002); Manuwa-Olumide (2009) describe human resource indicators that can be used to monitor health workforce performance. The productivity of a health worker is affected by a number of factors that include inadequate medical equipment and supplies; poor health management structures; inadequate knowledge and skills; and insufficient receptiveness of workers (Dieleman & Harnmeijer, 2006; Hagopian *et al.*, 2009) and high-level forum on MDGs (2004), says that there are many complex reasons for the deterioration of health system in the African region; however, the main cause is the neglect of health worker.

On productivity of workers is seen in terms of interventions delivered per health worker such as outpatient or home visits, bed occupancy rates, and patients' contacts but as far as health centers in Kampala, there inadequate medical equipment and supplies; poor health management structures; inadequate knowledge and skills; insufficient receptiveness of workers and high rates of absenteeism and rampant

dualism, thus productivity is fair (MOH, 2010a). The inadequate performance of workers emanates from a number of multifaceted yet interrelated variables. For instance, inadequate wages my result in increased rate absenteeism, since workers will be looking for work elsewhere to earn extra income. Studies also report that poor salaries may lead to fair motivation of the workforce which generally hinders performance (Dieleman & Harnmeijer 2006).

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

2.4.4 Availability of health workers

Availability is the distribution and attendance of health workers Manuwa-Olumide (2009). They assist in the execution of health service delivery (Anyangwe & Mtonga, 2007). Internationally, there is increasing recognition that health worker shortages affect nearly all countries. Amidst the shortages, there is also a challenge of global mal-distribution of the available workers. Chen, *et al.* (2004) observe that in order to achieve the health related MDGs, the minimum level of health workers required is estimated to be 2.5 health workers per 1000 people.

In sub-Saharan Africa, the health workforce averages to only 0.8 health workers per 1000 people, which is considerably fairer compared to other regions of the world (Chen *et al.,* 2004). In Kampala is about one health worker to 500 patients (MOH, 2010a; kiapi, 2010). Unless the situation is altered, central government and donor agencies efforts towards effective health service delivery are likely to be frustrated .In ideal situations, most of the sub-Saharan countries with the highest burden of disease should have the largest health workforce but regrettably, they have the fairest concentration of health workers. Studies have reported disparities in the distribution of health workers

even within the same country, with large concentrations of well qualified health personnel in urban areas (Anyangwe & Mtonga, 2007).

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

Health workforce shortages in health facilities increase the workload on those who remain. The shortage also limits access and reduces the quality of health services. Furthermore, waiting times are longer and often facilities are staffed with unqualified health personnel. Sometimes even clients seen by qualified personnel are put at risk due to time constraints and fatigue of health workers (Padarath, *et al.*, 2003). It is therefore imperative for urban councils to focus on the availability of health workers by providing some incentives as one way to attract and retain them in their jobs.

2.5 Human Resource Management and Health Service Delivery

El-Jardali, *et al.* (2007) pointed out that lack of development in human resource for health issues in the Eastern Mediterranean Region (EMR) had an effect on service delivery. The authors report inadequate information on health workers delivery of services and lack of informed human resources policies to guide planning of health workers. Therefore, without credible information on existing health workers' service delivery, it is almost impossible to implement interventions for improving delivery of health service. (Dieleman *et al.,* 2009) indicated that human resource management interventions in health sectors such as training and payment combined with organizational change can improve delivery of health services.

Ninsiima (2003), in her study involving staff members of Uganda Revenue Authority significant positive correlation between competencies and empowerment and concluded that the more competent an employee may be the more he or she feels empowered to do her or his tasks. She found out that competent employees perform their tasks in line with the goals of the organization they work for. Nahabwe (2005) who assessed the relationship between competencies and commitment, empowerment and commitment,

empowerment and individual performance, all had significant positive relationships and leads to better service delivery.

Guest (1997) in his study have shown human resource management practices have positive influence on the performance, which leads to better service delivery. Evidence shows that intrinsic motivation is associated to high levels of empowerment and service delivery (Malhotra *et al.*, 2007). Bowen and Lawler (1992; 1995) suggested that service in organizations can determine the level of empowerment to their employees basing on the type of services them offering to their client. The organizations have to strike a balance on consistence and efficiency in service delivery.

They urge that soliciting suggestions from employees, giving them a way to communicate to management tends to enhance consistence whereas greater employee involvement in the destiny of their service delivery and how the organization is run enhance customer relationships through efficiency consequently leading to effective service delivery.

Knowledge that is relevant for a job is limited to the information that is directly useful in the performance of a service, specific knowledge

competencies are required in order to perform any activity. Knowledge can be acquired through formal education, training and experiences. Service delivery is the employee's end result offered by those who are employed whereby they deploy the competencies needed at their duty stations (Cascio, 1998). Related studies done by Delaney and Huselid (1996), Huselid (1995), Koch and McGrath (1996) and MacDuffie (1995), on employee development showed that training is a satisfactory performance human resource management practices.

Generally, a positive relationship has been established between employee training and organization performance. A well functioning company career planning systems may also encourage employees to take more responsibility for their own development, including the development of skills viewed as significant in the company (Doyle, 1997). Studies by researchers such as (Huselid, 1995; Delaney, 1996; Ramsay, 2000), suggest that the relationship between human resource management practices and quality service delivery may be mediated by employee behaviours and attitudes. MacDuffie and Kracfcik (1992), established a partial significant relationship between human resource management practices and service delivery in connection to other factors like competence and behaviour. Researches provide evidence to show that HRM practices help the organization to improve the quality

of services. Tsaura and Lin (2004) empirically explored the relationship among human resource management practices, service behavior and service quality in the tourist hotels. The results indicated that HRM practices had partially a direct effect on customer perceptions of service quality and an indirect effect through employees' service behavior. This means that service behaviour only partially mediates the relationship between human resource management practices and service quality.

The productivity and commitment of employees can be enhanced with performance appraisal systems (Brown & Benson, 2003). Performance appraisal causes a higher productivity effect (Brown & Heywood, 2005). Rewards and performance appraisal performs a role in developing companies operations by growing competence (Ruwan, 2007). In an empirical study involving respondents from multi-levels working in 25 franchised restaurants in the United States, Liao and Chuang (2004) concluded that HRM practices tend to enhance a firm's service climate, in turn, motivates service employees to display discretionary behaviors such as meeting customers' demands, delivering higher service quality and increasing employees' willingness to go beyond their call of duty. Similarly, Zerbe *et al.* (1998), in their study of 452 airline employees that provide direct customer service to

passengers, found that HRM practices has an impact on service culture which in turn influenced the employees service behaviors. Nayyab., (2011), in their study found that HRM practices contribute to the enhanced banks performance. Further, the result indicated that HRM practices like training, employee participation in decision making was found significantly related with banks performance. Further, Osman *et al.* (2011) found that the effectiveness of implementing HR practices in a company does indeed have a major impact towards a firm's performance.

The findings also show that HR practices have an impact of nearly 50 percent on firm performance. Fey, (2000) investigated the relationship between human resource management (HRM) practices and the performance of 101 foreign-owned subsidiaries in Russia. The study's results provide support for the assertion that investments in HRM practices can substantially help a firm perform better. Further, different HRM practices for managerial and no managerial employees are found to be significantly related with firm performance. The foregoing review reveals that there is insufficient attention on human resource practices in the public sector generally and KCCA health centers are potential areas to carry out such a study. Soomro *et al.* (2011), in their study established that HRM practices (training, selection, career planning,

employee participation, job definition, compensation, performance appraisal) were correlated positively with the employee performance and services.

Panayotopoulou and Papalexandris (2004), found that HRM has a more significant influence on growth or innovation indices as opposed to financial performance that leads to better services. Li, *et al.* (2006) examined the relationship between HRM, technology innovation and performance in China and found that employee training, immaterial motivation and process control have positive effects on technological innovation, while material motivation and outcome control have a negative influence on technological innovation. It is also found that technological innovation is positively related with performance and better service delivery.

Studies of (Cully *et al.*, 1999; Boselie & Wiele 2002), established that pay schemes, do motivate workers and generate higher labour productivity. HRM activities providing informal and formal training as well as recruitment and selection have also shown to have an impact on productivity and market value (Huselid, 1995, Delery & Dotty, 1996).

2.6 Summary of Literature Review

A brief history of human resource management and health service delivery was outlined followed by a theoretical review and then a conceptual review of the independent and dependent variables, and lastly the review of related studies. The literature reviewed in this chapter is the testimony that many scholars have conducted several studies to establish the general linkage of human resource management practices and delivery of services at various sectors, countries, companies or the organizations of the world. Besides, the literature reviewed does not seem to touch the human resource management practices touching linkage of health services in particular reward and development management practices also were not exhaustively handled.

The organizational experiences mentioned there in are in most cases in countries of the western world and private sectors. This study will be conducted to specifically find out how human resource management practices (independent variable) identified in the conceptual framework affect the health service delivery (dependent variable) with specific reference to Kampala, Uganda. Despite this there is limited information on human resource management practices in local governments generally and Kampala specifically. Information that is

available is based on national policy rather than practice. Much of the information is based on models of private sector best practices, largely drawn from the developed world. Even where studies on human resource aspects of health service delivery have been done, they narrowly focus narrowly on human planning and training, yet (Bach, 2001; WHO, 2006; Hagopian *et al.*, 2009), human resource management practices is much wider.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter reports on how the study was conducted. It includes the research design, the area and population of study, sample size, methods of sample selection and data collection, instruments, data quality control procedures, data analysis and the problems encountered in the process of data collection, ethical considerations and limitations. The study employed both qualitative and quantitative approaches (mixed methods) and information was obtained using a variety of techniques ranging from interviews with purposively selected respondents and structured questionnaires and on Kampala, especially on human resource management practices and health service delivery.

3.1 Research Designs

A research design consists of a plan, a roadmap, that allows the researcher to test the validity of his or her hypothesis or answers of research questions, taking in account the factors he or she believes might affect the relationship between independent and dependent variables (Webb & Auriacombe, 2006). This study adopted a descriptive comparative, correlational, cross sectional survey and ex-post facto designs, with quantitative and qualitative approaches (Creswell & Plano-Clark, 2007).

It was descriptive comparative as it intended to describe the HRMP used in the health centers in the urban councils of Kampala, how the public perceive the levels of service delivery and whether they get what they are supposed to get. Correctional research design represents a general approach to research that focuses on assessing the covariation among naturally occurring variables (Bryman & Cramer, 2005). According to Simon and Francis (2001), a correlational research design "displays the relationships among variables by such techniques as cross-tabulation and correlations. The aim of correctional design is to identify predictive relationships.

The study was correlational as it intended to find out the link between a number of human resource management practices and health service delivery and why some urban council's health services are better than others though the same practices and resources are used (Amin, 2005). It was ex-post facto as the researcher had no control over variables because the study reports only what is taking place as recommended by Cooper and Schindler (2008).

It was a cross sectional survey since it involved large sample and at a particular point in time (Creswell, 2005). The study was quantitative in that variables were measured and analyzed using numbers, hypotheses

pre-determined, a population and procedure defined health workers as the major sources of data. The qualitative approach was used on the data got from interviews and to test and verify the validity of the theory adopted for this study on the independent and dependant variables (Creswell, 2005).

The rationale for combining both kinds of data within one study is grounded in the fact that neither quantitative nor qualitative methods are sufficient by themselves to capture the trends and details of the situation. If both are combined, qualitative and quantitative methods can complement each other to foster a healthy analysis, by putting much emphasis on the strengths of each other and limiting the weaknesses (Creswell, 2005).

3.2 Area of Study

This study was conducted in five Division urban councils of Kampala (KCCA Act, 2010) namely; Rubaga, Makindye, Central Kampala, Kawempe and Nakawa (Appendix VI). Kampala is located on the northern shores of Lake Victoria at 0 15° 32 30° E (UBOS, 2011). Being an administrative city of Uganda with high number of health facilities (UBOS, 2010), where new information on health aspects is collected, tested and extend to other administrative units in the

country, there was need to examine how human resource management practices are applied to attain better health service delivery to people in Kampala.

Kampala was chosen because it is administrative city of Uganda and it takes large share of budget allocation than other local governments (FY 2012/2013; 2013/2014), has the highest number of health facilities of all categories public, private and not-for-profit, and the public outcry of poor health services; negative attitude and fair motivation of health workers; limited opportunities for career advancement and performance reward systems (WHO, 2000). The study was carried only in government health centers, as most of the recent studies on HRMP relating to high performance and effective service delivery in the health sector has been conducted mainly in private health units (Buchan, 2004). Therefore it is against such a background, Kampala was taken as case study and it is hoped that other administrative units in the country will borrow a leaf on best they can manage and implement health reforms basing on the findings from this study.

3.3 Research Population

Population refers to individuals who possess specific characteristics (Strydom, 2011). A population is the totality of persons, events

organization units' case or other sampling units with which the research problems is concerned (Disoloane, 2012). In this study, the target population involved only health workers who were accountable to the public at health centers in Kampala. This target population of study was 488 health workers (i.e. Medical doctors, Nurses, Midwives, Clinical officers, laboratory assistants, pharmacist, and nursing assistants) sourced from the eight governments Health centers in the five urban councils of Kampala (Health Workers Registers at Health Centers, 2013).

Government health centers were targeted because they provide free health services thus majority of the population have access to them. In this study, the term health workers refer to medical doctors, nurses, midwives and clinical officers. Other categories of people that were targeted by this study were those (Patients) who get health services from the health centers in each urban council in Kampala.

3.4 Sample Size

In this study, given the population of 488 health workers in the health centers of Kampala, 220 health workers were selected using the Slovene's formula stated as follows;

$n = \frac{N}{1+N(e^2)}$, Where n=the required sample size; N = the known population size; and e= the level of significance, which is = 0.05. Table 3.1 shows the sample size distribution;

Table 3.1: Population and Sample Size Distribution

Mode of Data collection	Category	Target Population	Sample Size	Sampling Technique
Questionnaires	Health Workers	488	220	Stratification and random Simple Sampling
Interviews	Administrators of health centers	32	32	Purposive
	Patients	Unknown	80	Snowball
Total			**332**	

Source: Health Workers Register at Health Centers (2013)

Out of the 488 health workers of public health centers in Kampala, 220 were identified as sample population since all of them could not participate in the study using Slovene's formula and this were for questionnaire use. The same formula was applied for determining the different sample populations in different Division urban councils in Kampala (Appendix XI). All the 32 administrators of health centers were sampled as they had knowledge on the management and application of human resource practices at health centers in Kampala and all were sampled as their number was small hence easy to handle during the interview process. The actual population of patients could

not be identified for the fact the researcher used snowball sampling technique which does not predetermine population size since the first respondent leads the researcher to the next till the last one. Here the last respondent becomes the sample size and in this study, the researcher interviewed were 80 in number hence total sample size to 332 respondents.

3.5 Sampling Procedure

In this study, purposive sampling technique was used to select the administrators using the following inclusion criteria; male or female; full time health administrators and are from the selected government health centers in Kampala. Stratified and simple random sampling was used to select individual health worker in their different categories as respondents were not selected at once. Each health center formed a stratum from which lists of staff were acquired and then simple random sampling was applied, after which only the selected health worker were contacted.

Snowball sampling was used to get the patients who receive health services from the health centers and gave vital information on health service delivery in Kampala. Sampling techniques were used to enable the researcher to select a suitable sample of the population for purposes of eliciting information from respondents in depth, so that

conclusions are drawn easily. All participants (health workers) were licensed registered health workers ranging in ages, and occupying various positions and levels within the selected health centers in Kampala while patients were any person who gets service from mentioned public health centers.

3.6 Research Methods

The researcher used the questionnaire and interviews as the main research methods in the study. By and large, it is very difficult to say which the best method of data collection is. O' Leary (2004), remarks "collecting credible data is a tough task, and it is worth remembering that one method of data collection method is not inherently better than another." Therefore, which data collection method to use would depend upon the research goals, the advantages and disadvantages of each method.

3.7 Data Collection Methods and Instruments

The researcher used both the questionnaires and interviews to collect data.

3.7.1 Questionnaires

This researcher used self administered questionnaires for the respondents. The justification for using this instrument is that

questionnaires are easy to quantify and analyze. They are also simple, and relatively in expensive and can provide information from large numbers of subjects (Enarson *etal.*, 2001). In addition, the questionnaire was used because the study focused on opinions, attitudes and perceptions of health workers. These were distributed among the health workers in their respective health centers in Division urban councils of Kampala. There were two sets of closed ended questionnaires used in the study. One was on human resource management practices and the other on health service delivery by health Workers.

The questionnaire consisted of the main title, an introductory, with a section of seven bio data questions, for easy classification of respondents (appendix iv). The questionnaire on human resource management practices (independent variables) consist 21 questions; 11 questions on reward management practices (items 1-11) and 10 questions on development management practices (items 12-21). The questionnaire on health service delivery (dependent variable) consist 27 questions, 6 questions on setting service standards (items 1-6), 8 questions on responsiveness of health workers (items7-14), 8 questions on productivity of health workers (items 15-22) and 5 questions on availability of health workers (items 23-27). A four point

Likert scale was used ranging from 1 - strongly disagree, 2 - disagree, 3 - agree and 4 - strongly agree. A Likert scale measures attitudes and behaviors using answer choices that range from one extreme to another (Lirket, 1932). Having a range of responses also helped the researcher to identify areas of improvement easily because the questionnaire was to understand the levels of effectiveness of the services one was rendering, or gathering clients' opinions on the quality of services at each health center. The questions asked were trying to measure respondents' attitudes or behaviors; hence a Likert scale was appropriate. According to Dolnicar, *etal*, (2011) seven point likert items are less stable than binary answer formats. Both five and seven point Likert items take longer to complete. In studies comparing the time it takes respondents to complete a questionnaire using different answer formats. Dolnicar, (2003) concluded that binary answer format were completed faster than multi category answer formats thus four likert scale was adopted for this study.

3.7.2 Interviews

This study used a semi-structured interview technique for data collection. Interviewing is a technique of gathering data from humans by asking them questions and getting them to react verbally. Semi-structured interviews were used to collect data from administrators and patients. According to Amin (2005), semi-structured interviews are

non-standardized and frequently used in qualitative analysis. The interviewer does not do the research to test a specific hypothesis. The researcher has a list of key issues and questions to be covered. In this type of interview the order of the questions can be changed depending on the direction of the interview.

An interview guide is also used, but additional questions can be asked. The advantages of using semi-structured interview technique to this study are: providing depth to the data, allowing for probing, and improving the confirmation of quantitative data. A potential disadvantage of the interview technique is the perceived lack of anonymity by the respondents (Polit & Beck, 2008). For this reason, the respondents were assured of their anonymity throughout the study. The interviews were administered to four administrators of each health center (In charge, assistant and two head of department) giving a totaling to thirty two administrators in number. The patients that receive health services like treatment and counseling were interviewed, ten patients from each health center totaling eighty in number using snowball technique, so that unbiased information is minimized.

This was done, through question and answer method to qualitative data to supplement the quantitative data. Interviews help to collect

information that cannot be directly and difficult to be put down in writing (Amin, 2005). The administrators of health centers were interviewed on issues related to HRMP and patients on health service delivery, since they are recipients of these services.

The researcher selected the administrators of health centers and patients to participate in qualitative study using purposive or judgmental sampling method. Purposive sampling is a non-probability sampling method in which the researcher uses his own judgment regarding the participants from whom information is collected (Polit & Beck, 2008). The semi-structured interview guide was used and consisted mainly of open-ended questions. The interview guide had 13 open-ended questions on human resource management practices and health service delivery for administrators and 6 questions for health service delivery for patients (Appendix IV and V). These questions were meant to probe about factors that enhance or impede health service delivery and how human resource management practices have affected of health service delivery.

3.8 Validity of the Instrument

Amin (2005) describes validity as the ability to produce findings that are in agreement with theoretical or conceptual values. The construct

and criterion validity of the human resource management practices and health service delivery survey questionnaires which are non-standardized was tested for validity. Content validity was measured through content review by experts- senior lecturers who were requested to evaluate the relevance of each item in the aforesaid instruments (Appendix XA). Corrections were made accordingly before pre-testing the instruments using the master students in the College High Degrees Research. Corrections from pre-testing was considered, thus items in these study instruments was not only considered relevant but also sufficiently covered the content relevant to the study variables (Treece & Treece, 1986).

3.9 Reliability of the Instrument

Thus for study instruments to be reliable, they should be able to produce consistent results under similar circumstances. To this effect, in this study, reliability of the data collected was tested using Cronbach's alpha method as provided by statistical package for social scientists (SPSS) to determine how well all items in the test relate to all other items and to the total test. The Cronbach's alpha method was chosen because it is particularly appropriate for instruments that use Likert scale,that was used in this study so as to be consistent with the cross- sectional survey design (Amin, 2005; Kathuri & Palls, 1993). The

Cronbach's coefficient (α) was used and computed from the following formula;

$\alpha = \frac{k}{k-1}\left(1 - \frac{\sum \sigma_k^2}{\sigma^2}\right)$ Where k is the number of items and $\sum \sigma_k^2$ is the sum of variances of the k parts of the test. σ is the standard deviation of the K parts of the test .The results from the calculated Cronbach's coefficient suggested that, all items had high reliability with alphas above 0.7 (Appendix XB) and thus considered highly reliable in eliciting the data that was required for this study (Amin, 2005).

3.10 Data Gathering Procedures

The following stages were implemented during data collection:

The first stage was to request for an introduction letter from the School of Postgraduate Studies and Research addressed to authorities of the urban councils of Kampala under study to be permitted to conduct this study. It included among others; the criteria for selecting the respondents of the study. It was also used by the researcher to guide him in identifying participants of the study. Pre-testing of the research information on the variables under study.

This second stage specifically involve research assistants (2) who work under the instruction of the research specifically the researcher

ensured that research assistant under him adhere to the principle, signing informed consent, answer all questions, avoid biases and to be objective in answering the questionnaire. All the above were under polite request, so as to ensure a quick response rate of data sought from respondents.

The third stage focused on ensuring that collected data be organized, categorized/coded entered, summarized/presented and use of SPSS when treating statistical issues especially on establishing the relationship between the variables and later testing the hypotheses.

3.11 Data Analysis

The Relative frequencies and percentages were used to determine the profile of respondents. Since all responses or data on health workers' profile were nominal, relative frequency and percentages were the only feasible statistical tool (Douglas, *et al.*, 2008). Means and standard deviation were used to compute the perceived fairness of human resource management practices and effectiveness of service delivery among the urban councils of Kampala.

Since these two variables could easily be measured at ordinal numerical level, hence the statistical measures of central tendencies such as average (means) and standard deviation became an

appropriate tool of analysis. To interpret the obtained data, the following numerical values and interpretations were used.

Mean Range	Response Mode	Interpretation
3.26-4.00	Strongly Agree	Very Satisfactory
2.51-3.25	Agree	Satisfactory
1.76-2.50	Disagree	Fair
1.00-1.75	Strongly Disagree	Poor

For significant difference in the perceived fairness of human resource management practices and effectiveness of service delivery among the urban councils Fisher's One Way Analysis of Variance (ANOVA) was employed as it is the statistical tool used to test statistical differences among variables (Cooper & Schindler, 2008).

The Pearson's Correlation Coefficient (r) was used to establish a correlation between HRMP and HSD. The 0.05 or 0.01 level of significance was used to establish whether the computed statistical values are statistically significant so that the decisions on hypotheses are taken (Amin, 2004). Multiple Linear Regression analysis was used to test for the strength of the effect of independent variables on dependent variable. The adjusted R square (R^2) helped to determine the overall contribution of all human resource management practices towards health service delivery and to determine whether the

independent variables in this study are the true explanatory variables of the dependent variable.

The Beta coefficients were used to determine the strength of each of the two human resource practices and which of the two is more important in explaining the variations in effectiveness of health service delivery. Analysis of interviews responses was done in two ways namely; some responses were presented in verbatim way and others thematically (i.e. basing on the sub themes discussed with the administrators and patients), basing on Saunders *et al.,* (2009), procedures for generating meaning from transcribed and interview data below:

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

- making conceptual coherence by moving from constructs to theories to explain the phenomena.

3.12 Ethical Consideration

The researcher adhered to ethical practice throughout the stages of this study and this was attained through, all the questionnaires were coded to provide anonymity of the respondent.

1. Permission to conduct the study was sought from the College of Higher Degrees and Research and the Directorate of Public Health and Environment of Kampala Capital City Authority.
2. Signing informed consent on request by the researcher to all respondents.
3. Writing a communication to the authors of the standardized instrument on the variables under study.
4. The purpose of inquiry was explained to the respondents a partial fulfillment of the requirements for the award of Doctoral Degree of Public Administration and Management of Kampala International University
5. Presentation of findings was done in generalized manner.
6. Authors quoted in the study are recognized through citation/referencing.

7. After successfully defending the thesis through the viva voce, there will be debriefing of the concerned stakeholders on the findings of the respondents study and giving copies of the research report them.
8. Confidentiality of information, respondents to the study were assured utmost confidentiality of the information they give and their responses will remain anonymous. Secondly, they were informed of access to the report if they so wish or request.

3.13 Limitations of the Study

1. The researcher did not claim 100% error free findings; as such a 5% margin of error was used for testing of study hypotheses. This means that findings are valid up to 95% level.
2. Testing differences in conditions and time when the data were obtained from respondents in different categories at a given time period. This was minimized by continuous briefing of research assistants on how to build rapport, and general methodology of this study.
3. Instrumentation; research instrument were not very perfect since they were not standardized. However, validity and reliability tests were computed before further analyses were made, as indicated in appendix X A and B.

4. Other factors; the research did not have control over extraneous variables like respondents' bias, local government human resources policies and work environments, all of which had potential effects on study findings. As such, study findings were presented with an acceptable error margin of 0.05.
5. Questionnaire retrieval; the researcher had anticipated that the number of respondents stated would not be reached as some could not return questionnaires due to circumstances beyond researcher's control. In response to this anticipated threat to validity, the researcher gave out more questionnaires than the required number, which helped to reduce this threat to almost a zero level.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 Introduction

This chapter gives demographic characteristics of the respondents; description of the independent and dependent variables; and ends with the testing of pertinent hypotheses.

4.1 Demographic Characteristics of the Respondents

The demographic characteristics of health workers in the health centers in Kampala were important to the researcher because health worker affect performance and thus health service delivery. To achieve this, seven questions were asked in the questionnaire on the different characteristics of health workers. Frequencies and percentages distributions were used to summarize the demographic characteristics in terms of division urban council, gender, age, educational level and length of service by category as in Table 4.1.1 to 4.1.5.

Table 4.1.1 Frequency distribution of respondents by Division Urban council

Division Urban council	Frequency(F)	Percentage (%)
Central	43	19.5
Rubaga	55	25.0
Makindye	50	22.7
Nakawa	23	10.5
Kawempe	49	22.3
Total	**220**	**100.0**

Table 4.1.1, showed that respondents were sampled from each health center depending on the enrollment at each center; that is Central (19.5%), Rubaga (25.0%), Makindye (22.7%), Nakawa (10.5%) and Kawempe (22.3%). This suggests that the number of health workers at each health center differed from one division urban council to other. This may be due to facilities at each health center that determines the number of health workers per center and also the number of health center are not the same per each division urban council. This implies that health services are not equally delivered to the people thus this proves that some division urban councils better in terms of service delivery than others.

Table 4.1.2 Frequency distribution of respondents by gender

Gender	Frequency(F)	Percentage (%)
Male	47	21.4
Female	173	78.6
Total	**220**	**100.0**

The results on gender in Table 4.1.2 showed that the most of respondents were females (78.6%) and the rest were males (21.4%). This tentatively implies that the health centers in the division urban councils of Kampala employ more female health workers than males. This may be due to the myth and stereotype that most health workers such as midwives, nurses and clinical offers are supposed to be women hence attracting few men in the areas mentioned.

Table 4.1.3 Distribution of respondents by age

Age group	Frequency(F)	Percentage (%)
20 - 39years	170	77.3
40-59 years	50	22.7
60 years and above	0	0.0
Total	**220**	**100.0**

The results on age distribution of respondents are shown in Table 4.1.3. The majority of the age of respondents ranged between 20 and 39 years (77.3%), followed by 40 to 59 years (22.7%) and none in age group 60 years and above. This implies that there was variation in age and majority of health workers at the health centers in Kampala are quiet young hence they may not be very effective to offer better health services, as they are less experienced.

Table 4.1.4 Frequency distribution of respondents by education level

Education level	Frequency(F)	Percentage (%)
Certificate	118	53.6
Diploma	63	28.6
Degree	33	15.0
PGD	06	2.7
Total	**220**	**100.0**

The results on level of education distribution of respondents are shown in Table 4.1.4. The majority of the respondent, were certificate holders (53.6%) followed by diploma (28.6%), then degree (15.0%) and post

graduates (2.7%) respectively. This implies that most of the health workers at the health center are certificate holder in the division urban councils of Kampala since the minimum entry to health training institutions is Uganda certificate of education. There were fewer respondents with post graduate qualifications (certificate, diploma, master degrees, and doctorate degrees). This is mainly because post graduate staffs are always consultants that mainly work at regional or national referral hospitals.

Table 4.1.5 Frequency distribution of respondents by period of service

Length of service	Frequency(F)	Percentage (%)
Less than one year	43	19.5
2 -6 years	84	38.2
7-11 years and above	47	21.4
12-16 years	24	10.9
17 and above	22	10.0
Total	**220**	**100.0**

The results on period of service distribution of respondents in Table 4.1.5 revealed that the majority of the respondents sampled had served for 2-6 years (38.2%) , followed by those of 7-11 years (21.4%), less than 1 year (19.5%), 12-16 years (10.9%) and 17 years and above (10.0%). This suggests that the majority of health workers at the health centers had served between 2-6 years and the

least was 17 years and above. This is due to new establishment of KCCA act that called for disbandment of all the old staff and new ones were recruited. This may also have affected the health service delivery as most of senior health workers were not absorbed.

Table 4.1.6 Frequency distribution of respondents by Level of Health Center

Health center	Frequency(f)	Percentage (%)
Health center III	153	69.5
Health center IV	67	30.5
Total	**220**	**100.0**

On level of health center, Table 4.1.6 showed that 69.5% of the respondents were working in health center III while 30.5% of the respondents were at health center IV. This implies that there more health center III's than IV's in Kampala and also majority of health worker in health center III's are certificate holders as compared to those of health center IV's that are diploma and degree holders as revealed by that 4.1.4.

4.2 Health Workers' Perceptions on Human Resource Management Practices in the Division Urban councils.

This section presents empirical finding on the perceived fairness of each of the two human resource management practices investigated upon in this study. Respondents were asked through closed ended

questions, to rate themselves on each of the two human resource management practices (reward and development management practices). All questions were rated using a four point Likert Scale, where 1=Strongly Disagree, 2=Disagree, 3=Agree and 4=Strongly Agree. The ratings on the two human resource management practices were analyzed using means and standard deviations per item. Thereafter, the overall mean index was computed since the researcher was interested in a composite score for each construct investigated upon, as supported by Boone and Boone (2012).

4.2.1 Health workers' perceptions on Reward management practices

The ratings of health workers on reward management practices in the five Division urban councils are indicated in Tables 4.2.1.1- 4.2.1.5. The means were interpreted using the following mean ranges and descriptions:

Mean Range	Response Mode	Interpretation
3.26-4.00	Strongly Agree	Very Satisfactory
2.51-3.25	Agree	Satisfactory
1.76-2.50	Disagree	Fair
1.00-1.75	Strongly Disagree	Poor

are properly communicated ($\overline{X}$=1.72). These rating compared the average mean (1.56) further suggest that application of reward practices is poor in Central division urban council. Therefore, according to health workers in Central Division Urban Council, the administrators are not doing well as far as reward management is application is concerned.

Table 4.2.1.2: Mean Values and Standard Deviations of Respondents on Reward Management Practices in Rubaga Division Urban Council

Indicators	Mean ($\overline{X}$)	Std. Dev.	Interpretation	Rank
Promotions are fairly done based on merit	2.35	0.865	satisfactory	1
Payment and promotion structures are properly communicated	2.02	0.805	Fair	2
Allowances always influence workers output.	1.96	0.881	Fair	3
Salary and Wages are generally satisfactory.	1.76	0.838	Fair	4
Allowances and bonuses are fair to employees.	1.75	0.821	Poor	5
All our payment and rewards come in time.	1.73	0.891	Poor	6
Salary I receive is equitable to my efforts.	1.60	0.807	Poor	7
Salary and other benefits are comparable to the market.	1.60	0.735	Poor	7
Payment days are timely communicated to all employees.	1.55	0.715	Poor	9
Payments, recognitions and promotions are well balanced with workloads and competences of employees	1.53	0.690	Poor	10
Payment system is reviewed frequently to accommodate changes in cost of living.	1.51	0.767	Poor	11
Average mean	**1.76**	**0.801**	**Fair**	

Table 4.2.1.2, showed that indicators of employee reward management practices indicated a fair average mean (1.76) and standard deviation (0.801). Table 4.2.1.2, showed that the one indicator was rated satisfactory; three indicators were rated fair and the rest of the indicators assessed were rated poor.

Promotions are fairly done based on merit was rated satisfactory ($\overline{X}$=2.35), of those rated poor, the least rated was salary and wages are generally satisfactory ($\overline{X}$=1.76), and the most rated was Payment and promotion structures are properly communicated ($\overline{X}$=2.02); of those rated poor, Payment system is reviewed frequently to accommodate changes in cost of living was least rated ($\overline{X}$=1.75) and allowances and bonuses are fair to employees was the most rated ($\overline{X}$=1.51). These rating compared the average mean (1.76) further suggest that application of reward practices is fair in Rubaga division urban council. Therefore, according to health workers in Rubaga Division Urban Council, the administrators are to some extent doing well in reward management application.

Table 4.2.1.3: Mean Values and Standard Deviations of Respondents on Reward Management Practices in Makindye Division Urban Council

Indicators	Mean ($\bar{X}$)	Std. Dev.	Interpretation	Rank
Promotions are fairly done based on merit	1.72	0.948	Poor	1
All our payment and rewards come in time.	1.65	0.775	Poor	2
Allowances always influence workers output.	1.64	0.851	Poor	3
Payment and promotion structures are properly communicated	1.60	0.833	Poor	4
Payment days are timely communicated to all employees.	1.46	0.788	Poor	5
Payments, recognitions and promotions are well balanced with workloads and competences of employees	1.40	0.728	Poor	6
Allowances and bonuses are fair to employees.	1.38	0.635	Poor	7
Salary I receive is equitable to my efforts.	1.36	0.598	Poor	8
Salary and other benefits are comparable to the market	1.30	0.614	Poor	9
Payment system is reviewed frequently to accommodate changes in cost of living.	1.28	0.573	Poor	10
Salary and Wages are generally satisfactory.	1.22	0.465	Poor	11
Average mean	**1.46**	**0.710**	**Poor**	

Table 4.2.1.3, showed that indicators of employee reward management practices are poor, average mean (1.46) and standard deviation of (0.710). Table 4.2.1.3, indicated that all the indicators assessed were rated poor; and the least rated was salary and wages are generally satisfactory ($\bar{X}$=1.22) and the most rated was Promotions are fairly done based on merit ($\bar{X}$=1.72). These rating compared the average mean (1.46) further suggest that application of reward practices is poor in Makindye division urban council. Therefore,

according to health workers in Makindye Division Urban Council, the administrators are not doing well as far as reward management is application is concerned.

Table 4.2.1.4: Mean Values and Standard Deviations of Respondents on Reward Management Practices in Nakawa Division Urban Council

Indicators	Mean ($\bar{X}$)	Std. Dev.	Interpretation	Rank
Allowances always influence workers output.	2.09	0.793	Fair	1
Promotions are fairly done based on merit	1.65	1.027	Poor	2
All our payment and rewards come in time.	1.65	0.775	Poor	2
Payment and promotion structures are properly communicated	1.57	0.896	Poor	4
Payments, recognitions and promotions are well balanced with workloads and competences of employees	1.52	0.730	Poor	5
Salary and other benefits Division comparable to the market.	1.43	0.590	Poor	6
Allowances and bonuses are fair to employees.	1.35	0.573	Poor	7
Salary and Wages are generally satisfactory.	1.30	0.559	Poor	8
Salary I receive is equitable to my efforts.	1.22	0.518	Poor	9
Payment days are timely communicated to all employees.	1.17	0.491	Poor	10
Payment system is reviewed frequently to accommodate changes in cost of living.	1.09	0.288	Poor	11
Average mean	**1.46**	**0.658**	**Poor**	

Table 4.2.1.4, showed that indicators of employee reward management practices are poor, average mean (1.46) and standard deviation (0.658). Table 4.2.1.4, indicate that allowances always influence workers output was rated fair ($\bar{X}$=2.09) and the rest of the indicators assessed were rated poor, and of those rated poor, the least

rated payment system is reviewed frequently to accommodate changes in cost of living ($\overline{X}$=1.09), and the most rated was Promotions are fairly done based on merit ($\overline{X}$=1.65). These rating compared the average mean (1.46) further suggest that application of reward practices is poor in Nakawa division urban council. Therefore, according to health workers in Nakawa Division Urban Council, the administrators are not keen as far reward management application is concerned.

Table 4.2.1.5: Mean Values and Standard Deviations of Respondents on Reward Management Practices in Kawempe Division Urban Council

Indicators	Mean ($\overline{X}$)	Std. Dev.	Interpretation	Rank
Allowances always influence workers output.	2.20	1.040	Fair	1
Promotions are fairly done based on merit	2.04	0.889	Fair	2
Payment days are timely communicated to all employees.	1.98	0.989	Fair	3
Payment and promotion structures are properly communicated	1.98	0.829	Fair	4
Payments, recognitions and promotions are well balanced with workloads and competences of employees	1.88	0.857	Fair	5
Allowances and bonuses are fair to employees.	1.84	0.825	Fair	6
Salary and other benefits are comparable to the market.	1.80	0.935	Fair	7
Salary I receive is equitable to my efforts.	1.80	0.735	Fair	8
All our payment and rewards come in time.	1.78	0.896	Fair	9
Salary and Wages are generally satisfactory.	1.73	0.930	Poor	10
Payment system is reviewed frequently to accommodate changes in cost of living.	1.59	0.814	Poor	11
Average mean	**1.88**	**0.885**	**Fair**	

Table 4.2.1.5, showed that indicators of employee reward management practices are fair, average mean (1.88) and standard deviation (0.885). Table 4.2.1.5, indicate that nine indicators were rated fair; and only two of indicators assessed, were rated poor. Those rated poor are salary and wages are generally satisfactory ($\overline{X}$=1.73) and payment system is reviewed frequently to accommodate changes in cost of living ($\overline{X}$=1.59). Of those rated fair, the least rated was all our payment and rewards come in time ($\overline{X}$=1.78) and the most rated was allowances always influence workers output (2.20). These rating compared the average mean (1.88) further suggest that application of reward practices is fair in Kawempe division urban council. Therefore, according to health workers in Kawempe Division Urban Council, the administrators are to some extent doing well in reward management application.

The administrators of health centers in each division urban councils were interviewed to cross check the finding of the questionnaires in Tables 4.2.1.1-4.2.1.5 and common responses are:

- *Not satisfied with the salary because it does not meet my needs as person*
- *Salary is un predictable i.e. it is paid early or late*

- *Salary at health center is fair for staffs on ministry health payroll compared KCCA salary structure.*
- *The salary pay does not meet the market standards*
- *Benefits received are only work related only; no other benefits are given like transport, accommodation, lunch, risky allowance etc.*
- *Awards to good performers are not given*
- *Rewards are un evenly distributed health workers*
- *Paying workers well is not automatic they well, this may depend other factors like individual attitudes, job itself, code of ethics etc.*
- *The working environment is not good at health centers.*

On reward management practices, all the administrators (n=32; 100%) interviewed confessed they are not satisfied with the salary they get and it is worse for the fairer staffs. Further they revealed that their colleagues at KCCA head quarters earn more than them. The salaries and allowances are not paid in time, some the administrators (n=8; 25%) from Kawala, Kisugu and Kiswa health centers said that they had not received salaries for the last four months and the same to newly recruited junior staffs. Majority of the administrators (n=28; 87.5%) interviewed confessed that only work related allowances are given to them and not evenly distributed to the health workers, worse for all no

recognitions are done to the best performers. On whether one can perform better when paid well, majority of (n=27; 84.3%) administrators interviewed said workers cannot perform better with good pay only but others factors like individual attitudes, job itself, code of ethics of the profession of an employee do influence one's performance and only (n=5; 15.6%) agreed that good pay makes employee to perform well. An administrator from Kawempe health center said

> "...*Money motivates some people, but not everybody is motivated by money alone...others are motivated by the responsibility or assignments...additional assignments make somebody feel recognized...the job itself makes feel happy ...*"

All the interviewed administrators (n=32; 100%) confessed that their pay is the lowest in the region and may hinder better employee performance. The administrators (n=10; 31.3%) from Kisugu, Kawala, Kiswa and Kitebi health centers lamented that health workers in Uganda are the least paid in East African region that is why you see our doctors and nurses moving to other countries where pay is better. On the working environment, Almost all the administrators (n=30; 93.8%), from the eight health centers interviewed said that it is not good and one administrator from Komamboga health center said this

"...the working environment here is not conducive at all...how do you expect me to work to the best..."

Another administrator from Kisenyi health center commented;

"...patient wards are too small, patients sleep on floors, the workspace is inadequate, it is really frustrating for us..."

Table 4.2.1.6: Summary of Reward Management Practices in Division Urban Councils

Division Urban Council	Mean ($\bar{X}$)	Std. Dev	Interpretation	Rank
Central	1.56	0.733	Poor	3
Rubaga	1.76	0.801	Fair	2
Makindye	1.46	0.710	Poor	4
Nakawa	1.46	0.658	Poor	4
Kawempe	1.88	0.885	Fair	1
Overall Mean	**1.62**	**0.757**	**Poor**	

From the data the (Tables 4.2.1.6) and interview responses, it was revealed that Makindye, Central and Nakawa Division Urban Councils rarely do practice the reward management practices as most of the ratings were poor while Rubaga and Kawempe Division Urban Councils do apply reward management on a small scale as they were rated fair.

Basing on the responses from Tables. (4.2.1.6), and interviews of administrators on reward management practices it concluded that these practices are not oftenly practiced by health administrators for management of health centers and this may lead to poor health services delivery. The data on reward management practices depicts the principal theory (Two factor theory) as health workers insist that money is not a motivator and poor work environment is demotivator.

4.2.2 Health workers' perceptions on Employee Development management practices

The ratings of health workers on employee development management practices in the division urban councils are indicated in Tables (4.2.2.1-5). The means were interpreted using the following mean ranges and descriptions:

Mean Range	Response Mode	Interpretation
3.26-4.00	Strongly Agree	Very Satisfactory
2.51-3.25	Agree	Satisfactory
1.76-2.50	Disagree	Fair
1.00-1.75	Strongly Disagree	Poor

Table 4.2.2.1: Mean Values and Standard Deviations of Respondents on Employee Development Management Practices in Central Division Urban Council.

Indicators of Development Management Practices	Mean ($\bar{X}$)	Std. Dev.	Interpretation	Rank
Training needs identified are realistic, useful and based on health strategy	2.60	1.027	satisfactory	1
There are formal training programs to teach new employees the skills they need to perform their jobs.	2.28	0.984	Fair	2
Training needs are identified through a formal performance appraisal mechanism.	2.26	0.875	Fair	3
Our organization conducts extensive training programs for its employees in all aspects of quality.	2.12	0.981	Fair	4
Innovation and creativity are encouraged in this organization	2.05	0.899	Fair	5
There are regular on job and off job training programs in this organization.	2.02	0.988	Fair	6
Provision of priority to seniority in promotion decision.	1.98	0.859	Fair	7
The selection for staff training and development are conducted according to needs assessment center and therefore free and fair.	1.93	0.936	Fair	8
Organization has well structured training and development programs for all the employees to benefit from	1.91	0.840	Fair	9
Equal opportunities for development of all staff in this organization.	1.84	0.843	Fair	10
Average mean	**2.10**	**0.923**	**Fair**	

Table 4.2.2.1, showed that indicators of employee development management practices indicated a fair average mean (2.10) and standard deviation (0.923). One indicator was rated satisfactory, training needs identified are realistic, useful and based health strategy of the organization ($\bar{X}$=2.60) and the rest of the assessed, indicators

were rated fair, of those rated fairly, the least was equal opportunities for development of all staff in this organization ($\bar{X}$=1.84) and most rated was there are formal training programs to teach new employees the skills they need to perform their jobs ($\bar{X}$=2.28). Therefore, according to health workers responses from Central Division Urban Council, the administrators are to some extent doing well in development management application.

Table 4.2.2.2: Mean Values and Standard Deviations of Respondents on Employee Development Management Practices in Rubaga Division Urban Council

Indicators of Development Management Practices	Mean ($\bar{X}$)	Std. Dev.	Interpretation	Rank
Training needs identified are realistic, useful and based on health strategy	2.65	1.004	satisfactory	1
Innovation and creativity are encouraged in this organization	2.42	0.937	Fair	2
There are formal training programs to teach new employees the skills they need to perform their jobs.	2.33	0.840	Fair	3
There are regular on job and off job training programs in this organization.	2.31	0.920	Fair	4
Training needs are identified through a formal performance appraisal mechanism.	2.20	0.779	Fair	5
The selection for staff training and development are conducted according to needs assessment center and therefore free and fair.	2.15	0.951	Fair	6
Provision of priority to seniority in promotion decision.	2.15	0.951	Fair	6
Equal opportunities for development of all staff in this organization.	2.09	0.888	Fair	8
Our organization conducts extensive training programs for its employees in all aspects of quality.	2.09	0.867	Fair	8
Organization has well structured training and development programs for all the employees to benefit from	2.02	0.850	Fair	10
Average mean	**2.24**	**0.899**	**Fair**	

Table 4.2.2.2, showed that indicators of employee development management practices indicated a fair average mean (2.24), and standard deviation (0.899). One indicator was rated satisfactory, training needs identified are realistic, useful and based health strategy of the organization ($\overline{X}$=2.65) and the rest of the indicators assessed were rated fair, of those rated fair, the least was organization has well structured training and development programs for all the employees to benefit from ($\overline{X}$=2.02) and the most rated was innovation and creativity are encouraged in the organization ($\overline{X}$=2.42). Therefore, according to health workers responses from Rubaga Division Urban Council, administrators are to some extent doing well in development management application.

Table 4.2.2.3: Mean Values and Standard Deviations of Respondents on Employee Development Management Practices in Makindye Division Urban Council

Indicators of Development Management Practices	Mean ($\bar{X}$)	Std. Dev.	Interpretation	Rank
Training needs identified are realistic, useful and based on health strategy	2.59	0.956	satisfactory	1
Innovation and creativity are encouraged in this organization	2.50	0.974	satisfactory	2
There are formal training programs to teach new employees the skills they need to perform their jobs.	2.30	0.953	Fair	3
There are regular on job and off job training programs in this organization.	2.30	0.909	Fair	3
Training needs are identified through a formal performance appraisal mechanism.	2.26	1.103	Fair	5
The selection for staff training and development are conducted according to needs assessment center and therefore free and fair.	2.08	0.986	Fair	6
Our organization conducts extensive training programs for its employees in all aspects of quality.	2.04	0.989	Fair	7
Organization has well structured training and development programs for all the employees to benefit from	2.00	0.990	Fair	8
Equal opportunities for development of all staff in this organization.	1.90	0.995	Fair	9
Provision of priority to seniority in promotion decision.	1.78	0.815	Fair	10
Average mean	**2.17**	**0.967**	**Fair**	

Table 4.2.2.3, showed that indicators of employee development management practices indicated a fair average mean (2.17) and standard deviation (0.967). Two indicators were rated satisfactory, training needs identified are realistic, useful and based health strategy of the organization ($\bar{X}$=2.59) and innovation and creativity are encouraged in this organization ($\bar{X}$=2.50). The rest of the indicators

assessed were rated fair, of those rated fair, the least was provision of priority to seniority in promotion decision ($\overline{X}$=1.78), while the most rated was there are formal training programs to teach new employees the skills they need to perform their jobs and there are regular on job and off job training programs in this organization ($\overline{X}$=2.30). Therefore, according to health workers responses from Makindye Division Urban Council, administrators are to some extent doing well in development management application.

Table 4.2.2.4: Mean Values and Standard Deviations of Respondents on Employee Development Management Practices in Nakawa Division Urban council

Indicators of Development Management Practices	Mean ($\bar{X}$)	Std. Dev.	Interpretation	Rank
Training needs identified are realistic, useful and based on health strategy	2.83	0.989	satisfactory	1
The selection for staff training and development are conducted according to needs assessment center and therefore free and fair.	2.39	0.891	Fair	2
Innovation and creativity are encouraged in this organization	2.22	0.850	Fair	3
Organization has well structured training and development programs for all the employees to benefit from	2.09	1.125	Fair	4
There are regular on job and off job training programs in this organization.	1.96	.767	Fair	5
There are formal training programs to teach new employees the skills they need to perform their jobs.	1.83	0.984	Fair	6
Training needs are identified through a formal performance appraisal mechanism.	1.83	0.984	Fair	6
Provision of priority to seniority in promotion decision.	1.83	0.834	Fair	6
Our organization conducts extensive training programs for its employees in all aspects of quality.	1.74	0.964	Poor	9
Equal opportunities for development of all staff in this organization.	1.52	0.730	Poor	10
Average mean	**2.02**	**0.912**	**Fair**	

Table 4.2.2.4, showed that indicators of employee development management practices indicated a fair average mean (2.02) and standard deviation (0.912). One indicator was rated satisfactory, training needs identified are realistic, useful and based health strategy of the organization ($\bar{X}$=2.83); eight of the indicators assessed were

rated fair, of those rated fair, the least was Provision of priority to seniority in promotion decision ($\overline{X}$=1.83), and the selection for staff training and development are conducted according to needs assessment center and therefore free and fair ($\overline{X}$=2.39). Two indicators were assessed poor that is, our organization conducts extensive training programs for its employees in all aspects of quality ($\overline{X}$=1.74) and equal opportunities for development of all staff in this organization ($\overline{X}$=1.52). Therefore, according to health workers responses from Nakawa Division Urban Council, administrators are not doing well as far as development management application is concerned.

Table 4.2.2.5: Mean Values and Standard Deviations of Respondents on Employee Development Management Practices in Kawempe Division Urban council

Indicators of Development Management Practices	Mean ($\bar{X}$)	Std. Dev.	Interpretation	Rank
Training needs identified are realistic, useful and based on health strategy	2.92	1.017	satisfactory	1
There are formal training programs to teach new employees the skills they need to perform their jobs.	2.80	0.935	satisfactory	2
There are regular on job and off job training programs in this organization.	2.65	0.911	satisfactory	3
Innovation and creativity are encouraged in this organization	2.63	0.955	satisfactory	4
Training needs are identified through a formal performance appraisal mechanism.	2.63	0.929	satisfactory	4
The selection for staff training and development are conducted according to needs assessment center and therefore free and fair.	2.49	0.982	Fair	6
Organization has well structured training and development programs for all the employees to benefit from	2.47	1.023	Fair	7
Our organization conducts extensive training programs for its employees in all aspects of quality.	2.33	0.966	Fair	8
Equal opportunities for development of all staff in this organization.	2.31	1.084	Fair	9
Provision of priority to seniority in promotion decision.	2.18	0.858	Fair	10
Average mean	**2.54**	**0.966**	**satisfactory**	

Table 4.2.2.5,showed that indicators of employee development management practices indicated a satisfactory average mean (2.54) and standard deviation (0.966). Five indicators assessed were rated satisfactory, among those rated satisfactory training needs are

identified through a formal performance appraisal mechanism ($\overline{X}$=2.63) was least rated while training needs identified are realistic, useful and based health strategy of the organization ($\overline{X}$=2.92). The rest of the indicators assessed were rated fair, of those rated fair, the least was provision of priority to seniority in promotion decision ($\overline{X}$=2.18) and the selection for staff training and development are conducted according to needs assessment center and therefore free and fair ($\overline{X}$=2.49). Therefore, according to health workers responses from Kawempe Division Urban Council, administrators are to some extent doing well in development management application.

The common responses of administrators interviewed on development management practices are:

- *Unfair promotions are common at the centers*
- *Unfair selection health workers to attend workshops and seminars*
- *Monthly workshops and seminars are used to develop the employees*
- *Age and the number of years in service are not considered in promotion.*
- *Innovation and creativity not encouraged to health workers at center*
- *On appraisal of health workers forms are filled for sake.*

On development management practices, all the administrators (n=32; 100%) interviewed complained that promotions are not fairly done; workshops and seminars are conducted once a month with few health staffs selected to attend. Furthermore they confessed that workshops and seminars do not encourage innovation and creativity to employees so that more skills and knowledge gained to employees for better work performance. One female administrator from Kawala health center said;

> *"We lack health services with quality care, support and monitoring from the centre, and transport and accommodation for patients. There is too much bureaucracy involved in the requisition of funds or any support to provision of health services locally. Yet most of the time, there is urgency, which when not attended to leads to loss of life!"*

All the administrators (n=32; 100%) said that promotion is done without basing on age and experience of health workers at the centers. An administrator from Kiswa health center has this to say;

> "...In this health center the criteria used to select who should go for further studies is not clear. For example, I am pursuing a master degree in Public Health myself but I had to go to the bank for a loan..."

On appraising of health workers almost all the administrators (n=30; 94%), admitted that they fill appraisal forms without *sitting and discussing we individual health workers* but for the sake, because they need them at directorate of public health and environment while only (n=2; 6.3%) said they do appraise their thoroughly according to set regulations. Agreeing with this, an administrator from Kisenyi health center said;

> "We hardly plan for this ...I would say it is just a routine that you fill these appraisal forms, you don't even sit to discuss with the person concerned, you also just tick and evaluate without making realistic comments".
>
> Also another administrator from Komamboga health center said
>
> "...yes we have these meetings on paper but not in practice..."

Table 4.2.2.6: Summary of Employee Development Management Practices in Division Urban Councils

Division Urban Council	Mean($\bar{X}$)	Std. Dev	Interpretation	Rank
Central	2.10	0.923	Fair	4
Rubaga	2.24	0.899	Fair	2
Makindye	2.17	0.967	Fair	3
Nakawa	2.02	0.912	Fair	5
Kawempe	2.54	0.966	Satisfactory	1
Overall Mean	**2.21**	**0.933**	**Fair**	

On employee development practices, both the data of Table (4.2.2.6) and interview responses reveals that; Central, Rubaga, Makindye and Nakawa urban councils do apply the development management practices but on small scale as their ratings were fair while Kawempe urban council does it on large scale as rating was satisfactory. This suggests that employee development practices are practiced frequently by the administrators of Kawempe Division urban council than the other urban councils, and this may to use of strategic management. The data on employee development practices also depict the Two factor theory as most development activities are not fairly done as health workers expectations were low as seen in their responses given in the research.

4.2.3: To determine the perceptions of health workers' on human resource management practices in Division urban councils of Kampala

To establish if there is a significant difference on perceptions of health workers' on the human resource management practices among the division urban councils of Kampala, the researcher hypothesized that human resource management practices among the division urban councils of Kampala significantly differ. To achieve this objective, the computed mean values of human resources management practices in

the different division urban councils of Kampala were compared using Fisher's One Way Analysis of Variance (ANOVA), as shown in Table 4.2.3.1

Table 4.2.3.1: One way ANOVA for differences in Human Resource Management Practices among the Division Urban Councils of Kampala

HRMP	Division Urban councils	Mean	F	Sig	Interpretation	Decision on Hi
Reward	Central	1.56	6.357	0.000	Significant difference	Accepted
	Rubaga	1.76				
	Makindye	1.45				
	Nakawa	1.46				
	Kawempe	1.87				
Development	Central	2.10	4.140	0.003	Significant difference	Accepted
	Rubaga	2.24				
	Makindye	2.20				
	Nakawa	2.02				
	Kawempe	2.54				
Overall HRMP	Central	1.83	5.786	0.000	Significant difference	Accepted
	Rubaga	2.00				
	Makindye	1.83				
	Nakawa	1.74				
	Kawempe	2.21				

(Level of Significance=0.05)

Results in Table 4.2.3.1 at P=0.05, showed that two of human resource management practices; reward management practices (F=6.357, sig=0.000) and employee development management practices (F=4.140, sig=0.003), differed significantly among the division urban councils of Kampala. The overall F-value of human resource management practices was (F=5.786, sig=0.000). The finding showed that reward and development practices have significant difference in the division urban councils and suggesting that the services were not uniformly delivered by health workers in the division urban councils of Kampala.

As a result it is perceived that some division urban council do better than others as indicated in Table 4.2.3.1. This is may be due to the application of human resource practices in a special way, know as strategic human resource management (SHRM) by some of the division urban councils hence performing better than others and that is why Kawempe Division Urban Council, was rated better than Makindye, CentraL, Rubaga and Nakawa Division Urban Councils. Data on perceptions of health workers on HRMP reveals that most arguments raised in research base on the Two factor theory and few on equity and hierarchy of needs theory.

4.3 Health Workers' Perceptions on Health Service Delivery in the Division Urban Councils

This section presents empirical findings on health workers' perceptions on health service delivery. Health service delivery in the study was operationalized into four constructs (setting service standards, responsiveness, productivity and availability of health workers) measured using twenty seven (27) indicators statements and respondents were requested to rate the effectiveness of health service delivery by indicating agree or disagree with each statement using numbers that best describes their respective opinions. All questions were rated using a four point Likert Scale, ranging between 1 – 4, where 1=Strongly Disagree, 2=Disagree, 3=Agree and 4=Strongly Agree. The ratings on effectiveness of health service delivery were analyzed using means and standard deviations as indicated in Tables (4.3.1-4.3.1.5). The means were interpreted using the following mean ranges and descriptions:

Mean Range	Response Mode	Interpretation
3.26-4.00	Strongly Agree	Very Satisfactory
2.51-3.25	Agree	Satisfactory
1.76-2.50	Disagree	Fair
1.00-1.75	Strongly Disagree	Poor

Table 4.3.1: Health Workers Perceptions on Health Service Delivery in Central Division Urban Councils

Variables	Mean ($\bar{x}$)	Std. Dev.	Interpretation	Rank
Setting services standards I always give equal treatment to all patients irrespective of their status	3.67	0.606	Very Satisfactory	2
I always try to give my clients the best quality of health services I can afford	3.65	0.573	Very Satisfactory	3
I am always transparent in serving all patients	3.65	0.573	Very Satisfactory	3
I always ensure good sanitation in my unit	3.47	0.797	Very Satisfactory	6
I always research for new insights and innovative solutions to health problems	2.91	0.811	Satisfactory	1
I always ensure there is enough drugs and equipments in my unit	2.58	0.932	Satisfactory	5
Average mean	**3.32**	**0.715**	**Very Satisfactory**	
Responsiveness of health workers I always give clear directions to my clients to get what they want.	3.65	0.613	Very Satisfactory	2
I always assist my clients to understand drug prescriptions.	3.65	0.613	Very Satisfactory	2
I always try to identify health problems to clients.	3.67	0.566	Very Satisfactory	1
I always communicate to patients consistently	3.35	0.650	Very Satisfactory	7
I always serve patients quickly and timely	3.44	0.629	Very Satisfactory	5
I always try to ensure safety of my patients.	3.40	0.728	Very Satisfactory	6
I always make proper diagnosis before I give services to my clients	3.47	0.550	Very Satisfactory	4
I always try to get feedback from clients on health issues and respond to them	3.00	0.724	Satisfactory	8
Average mean	**3.45**	**0.634**	**Very Satisfactory**	
Productivity of health workers I always educate clients about the available health services in my unit.	3.70	0.558	Very Satisfactory	1
I always serve a big number of patients as expected	3.65	0.573	Very Satisfactory	2
I always serve my patients on basis of first come first served	3.60	0.623	Very Satisfactory	4
I always take care to ensure that patients are given standard and genuine drugs	3.42	0.852	Very Satisfactory	7
I never bark at or abuse my patients even if am annoyed	3.63	0.536	Very Satisfactory	3
I always give enough counseling to my clients.	3.49	0.631	Very Satisfactory	6
I do not make people I know jump lines	3.14	1.060	Satisfactory	8
I always make follow-up on my patients.	2.53	0.909	Satisfactory	5
Average mean	**3.40**	**0.718**	**Very Satisfactory**	
Availability of health workers I am always committed to give health care to my patients when at job	3.86	0.351	Very Satisfactory	1
I am always easily accessible to all clients who come around my unit	3.51	0.703	Very Satisfactory	2
I always available for patients for all, my scheduled periods	3.47	0.667	Very Satisfactory	3
I am available to my clients whenever they need me	3.35	0.783	Very Satisfactory	4
I always give enough drugs and attention to my clients	3.28	0.882	Very Satisfactory	5
Average mean	**3.49**	**0.677**	**Very Satisfactory**	

Results in Table 4.3.1 revealed that assessment of setting services standards indicate a very satisfactory average mean (3.32) and standard deviation of (0.715), of the indicators assessed, new insights and innovation in health services ($\bar{X}$=2.91) and availability of enough drugs and equipment ($\bar{X}$=2.58) were rated satisfactory. All the other indicators were considerably rated very satisfactory, of those rated very satisfactory, the least rated was to ensure good sanitation ($\bar{X}$=3.47) and the most rated was equal treatment to all patients irrespective of status ($\bar{X}$=3.67). This suggests that most of the indicators on setting service standards are observed by health workers in Central division urban council as part of ethical requirements of the profession.

The responses on health service indicators on responsiveness of health workers indicate a very satisfactory mean (3.45) and standard deviation (0.634), of the service indicators assessed only feedback from clients on health issues was rated satisfactory ($\bar{X}$=3.00), and all the remaining indicators were considerably rated very satisfactory, of those rated very satisfactory, the least rated was proper diagnosis before services are given to clients ($\bar{X}$=3.47), and the most rated was clear directions are given to clie*nts* ($\bar{X}$=3.65). This rating suggests health workers in Central division urban council provide their services

with enthusiasm and have interest in the job thus handling health needs of their clients.

Assessment of the productivity of health workers indicate a very satisfactory average mean (3.40) and standard deviation (0.718), of the indicators assessed, people I know do not jump lines (mean=3.14) and make follow-up to my patients ($\bar{X}$=2.53) were rated satisfactory while the remaining indicators were considerably rated very satisfactory, of those rated very satisfactory, the least rated was enough counseling is given to clients ($\bar{X}$=3.49), and educate clients about the available health services in my unit ($\bar{X}$=3.70). The responses suggest that health workers in Central division urban council attend to patients and provide needed services by them when they visit the health centers. On the responses of the availability of health workers indicate a very satisfactory average mean (3.49) and standard deviation (0.677). All the indicators on availability were rated very satisfactory, the least rated was enough drugs and attention given to clients ($\bar{X}$=3.28), Committed to give health care to patients was most rated ($\bar{X}$=3.86). This implies that health workers at health centers in Central division urban council are available at their centers most of time serving the clients in health problems.

4.3.2: Health Workers Perceptions on Health Service Delivery in Rubaga Division Urban Councils

Variables	Mean ($\bar{X}$)	Std. Dev.	Interpretation	Rank
Setting services standards I always give equal treatment to all patients irrespective of their status	3.62	0.527	Very Satisfactory	2
I always try to give my clients the best quality of health services I can afford	3.64	0.485	Very Satisfactory	1
I am always transparent in serving all patients	3.60	0.531	Very Satisfactory	3
I always ensure good sanitation in my unit	3.38	0.733	Very Satisfactory	4
I always research for new insights and innovative solutions to health problems	3.11	0.737	Satisfactory	5
I always ensure there is enough drugs and equipments in my unit	2.65	0.985	Satisfactory	6
Average mean	**3.33**	**0.666**	**Very Satisfactory**	
Responsiveness of health workers I always give clear directions to my clients to get what they want.	3.45	0.835	Very Satisfactory	5
I always assist my clients to understand drug prescriptions.	3.65	0.480	Very Satisfactory	1
I always try to identify health problems to clients.	3.49	0.540	Very Satisfactory	4
I always communicate to patients consistently	3.53	0.539	Very Satisfactory	2
I always serve patients quickly and timely	3.36	0.557	Very Satisfactory	7
I always try to ensure safety of my patients.	3.44	0.601	Very Satisfactory	6
I always make proper diagnosis before I give services to my clients	3.53	0.634	Very Satisfactory	2
I always try to get feedback from clients on health issues and respond to them	3.09	0.646	Satisfactory	8
Average mean	**3.44**	**0.604**	**Very Satisfactory**	
Productivity of health workers I always educate clients about the available health services in my unit.	3.49	0.505	Very Satisfactory	3
I always serve a big number of patients as expected	3.53	0.539	Very Satisfactory	2
I always serve my patients on basis of first come first served	3.58	0.498	Very Satisfactory	1
I always take care to ensure that patients are given standard and genuine drugs	3.45	0.662	Very Satisfactory	4
I never bark at or abuse my patients even if am annoyed	3.42	0.599	Very Satisfactory	5
I always give enough counseling to my clients.	3.33	0.546	Very Satisfactory	6
I do not make people I know jump lines	3.20	0.704	Satisfactory	7
I always make follow-up on my patients.	2.89	0.685	Satisfactory	8
Average mean	**3.36**	**0.592**	**Very Satisfactory**	
Availability of health workers I am always committed to give health care to my patients when at job	3.67	0.474	Very Satisfactory	1
I am always easily accessible to all clients who come around my unit	3.56	0.501	Very Satisfactory	2
I always available for patients for all, my scheduled periods	3.45	0.633	Very Satisfactory	3
I am available to my clients whenever they need me	3.42	0.567	Very Satisfactory	4
I always give enough drugs and attention to my clients	3.36	0.825	Very Satisfactory	5
Average mean	**3.49**	**0.600**	**Very Satisfactory**	

Results in Table 4.3.2 revealed that assessment of setting services standards indicated a very satisfactory average mean (3.33) and standard deviation (0.666), of the indicators assessed, new insights and innovation in health services ($\bar{X}$=3.11) and availability of enough drugs and equipment ($\bar{X}$=2.65) were rated satisfactory. The rest of indicators assessed were rated very satisfactory, of those rated very satisfactory, the least rated was to ensure good sanitation ($\bar{X}$=3.38) and the most rated was equal clients are given the best quality of health services I can afford ($\bar{X}$=3.64). This suggests that setting service standards is done by health workers in Rubaga division urban council as part of ethical requirements of the profession.

The responses on health service indicators on responsiveness of health workers indicated a very satisfactory mean (3.44) and standard deviation (0.604), of the service indicators assessed only feedback from clients on health issues was rated satisfactory ($\bar{X}$=3.09), and all the remaining indicators were considerably rated very satisfactory, of those rated very satisfactory, the least rated was serve patients quickly and timely ($\bar{X}$=3.36), and the most rated was assist my clients to understand drug prescriptions ($\bar{X}$=3.65). This rating suggests health workers in Rubaga division urban council provide their services willingly and have interest in the job thus handling health needs of their clients.

Assessment of the productivity of health workers indicate a very satisfactory average mean (3.36) and standard deviation (0.592), of the indicators assessed, people I know do not jump lines ($\bar{x}$=3.20) and make follow-up to my patients ($\bar{x}$=2.89) were rated satisfactory while the rest of indicators were rated very satisfactory, of those rated very satisfactory, the least rated was enough counseling is given to clients ($\bar{x}$=3.33), and serve patients on basis of first come first served ($\bar{x}$=3.58). The responses reveal that health workers in Rubaga division urban council attend to patients and provide services to them when they visit the health centers.

On the responses of the availability of health workers, indicate a very satisfactory average mean (3.49) and standard deviation (0.600). All the indicators on availability were rated very satisfactory, the least rated was enough drugs and attention given to clients ($\bar{x}$=3.36), committed to give health care to patients was most rated ($\bar{x}$=3.67). This implies that health workers at health centers in Rubaga division urban council are available at their centers most of time serving the clients in health problems.

4.3.3: Health Workers Perceptions on Health Service Delivery in Makindye Division Urban Councils

Variables	Mean ($\bar{X}$)	Std. Dev.	Interpretation	Rank
Setting services standards I always give equal treatment to all patients irrespective of their status	3.70	0.707	Very Satisfactory	2
I always try to give my clients the best quality of health services I can afford	3.76	0.555	Very Satisfactory	1
I am always transparent in serving all patients	3.66	0.688	Very Satisfactory	3
I always ensure good sanitation in my unit	3.66	0.717	Very Satisfactory	3
I always research for new insights and innovative solutions to health problems	3.10	0.789	Satisfactory	5
I always ensure there is enough drugs and equipments in my unit	2.82	1.044	Satisfactory	6
Average mean	**3.45**	**0.750**	**Very Satisfactory**	
Responsiveness of health Workers I always give clear directions to my clients to get what they want.	3.72	0.573	Very Satisfactory	1
I always assist my clients to understand drug prescriptions.	3.56	0.675	Very Satisfactory	5
I always try to identify health problems to clients.	3.58	0.785	Very Satisfactory	4
I always communicate to patients consistently	3.62	0.697	Very Satisfactory	3
I always serve patients quickly and timely	3.72	0.671	Very Satisfactory	1
I always try to ensure safety of my patients.	3.50	0.707	Very Satisfactory	6
I always make proper diagnosis before I give services to my clients	3.48	0.677	Very Satisfactory	7
I always try to get feedback from clients on health issues and respond to them	3.32	0.741	Very Satisfactory	8
Average mean	**3.56**	**0.691**	**Very Satisfactory**	
Productivity of health workers I always educate clients about the available health services in my unit.	3.68	0.713	Very Satisfactory	3
I always serve a big number of patients as expected	3.74	0.723	Very Satisfactory	1
I always serve my patients on basis of first come first served	3.70	0.735	Very Satisfactory	2
I always take care to ensure that patients are given standard and genuine drugs	3.60	0.756	Very Satisfactory	4
I never bark at or abuse my patients even if am annoyed	3.34	1.022	Very Satisfactory	6
I always give enough counseling to my clients.	3.50	0.544	Very Satisfactory	5
I do not make people I know jump lines	3.26	0.965	Very Satisfactory	7
I always make follow-up on my patients.	2.96	0.925	Satisfactory	8
Average mean	3.47	0.798	Very Satisfactory	
Availability of health workers I am always committed to give health care to my patients when at job	3.76	0.657	Very Satisfactory	1
I am always easily accessible to all clients who come around my unit	3.52	0.839	Very Satisfactory	3
I always available for patients for all, my scheduled periods	3.60	0.728	Very Satisfactory	2
I am available to my clients whenever they need me	3.46	0.788	Very Satisfactory	4
I always give enough drugs and attention to my clients	3.34	0.939	Very Satisfactory	5
Average mean	**3.54**	**0.790**	**Very Satisfactory**	

Results in Table 4.3.3 revealed that assessment of setting services standards indicated a very satisfactory average mean (3.45) and standard deviation (0.750), of the indicators assessed, new insights and innovation in health services ($\bar{X}$=3.10) and availability of enough drugs and equipment ($\bar{X}$=2.82) were rated satisfactory. All the other indicators were rated very satisfactory, of those rated very satisfactory, the least rated were being transparent when serving the patients and ensure good sanitation ($\bar{X}$=3.66) and the most rated was equal clients are given the best quality of health services I can afford ($\bar{X}$=3.76).

This suggests that setting service standards is done by health workers in Makindye division urban council as part of ethical requirements of the profession. The responses on health service indicators on responsiveness of health workers indicated a very satisfactory average mean (3.56) and standard deviation (0.691), all the indicators assessed were rated very satisfactory, of those rated very satisfactory, the least rated was to get feedback from clients on health issues and respond to them ($\bar{X}$=3.32) and the most rated was give clear directions to my clients to get what they want and serve patients quickly and timely ($\bar{X}$=3.72). This rating suggests health workers in Makindye division

urban council are responsible for their duties and have interest in the job thus handling health needs of their clients.

Assessment of the productivity of health workers indicate a very satisfactory average mean (3.47) and standard deviation (0.798), of the indicators assessed, make follow-up to my patients ($\bar{x}$=2.96) was rated satisfactory while the rest of indicators were rated very satisfactory, of those rated very satisfactory, the least rated was do not make people I know jump lines ($\bar{x}$=3.26), and serve a big number of patients as expected ($\bar{x}$=3.74). The responses reveal that health workers in Makindye division urban council attend to patients and provide services to them.

On the responses of the availability of health workers, indicate a very satisfactory average mean (3.54) and standard deviation (0.790). All the indicators on availability were rated very satisfactory, the least rated was enough drugs and attention given to clients ($\bar{x}$=3.34), committed to give health care to patients was most rated ($\bar{x}$=3.76). This implies that health workers in Makindye division urban council are available at their centers most of time serving the clients in health problems.

Table 4.3.4: Health Workers Perceptions on Health Service Delivery in Nakawa Division Urban Councils

Variables	Mean ($\bar{X}$)	*Std. Dev.*	Interpretation	Rank
Setting services standards I always give equal treatment to all patients irrespective of their status	3.96	0.209	Very satisfactory	3
I always try to give my clients the best quality of health services I can afford	3.70	0.703	Very satisfactory	1
I am always transparent in serving all patients	3.70	0.559	Very satisfactory	1
I always ensure good sanitation in my unit	3.52	0.790	Very satisfactory	4
I always research for new insights and innovative solutions to health problems	2.91	0.596	satisfactory	5
I always ensure there is enough drugs and equipments in my unit	2.65	0.982	satisfactory	6
Average mean	**3.41**	**0.640**	**Very satisfactory**	
Responsiveness of health workers I always give clear directions to my clients to get what they want.	3.83	0.491	Very satisfactory	1
I always assist my clients to understand drug prescriptions.	3.78	0.422	Very satisfactory	2
I always try to identify health problems to clients.	3.57	0.728	Very satisfactory	4
I always communicate to patients consistently	3.39	0.722	Very satisfactory	6
I always serve patients quickly and timely	3.61	0.583	Very satisfactory	3
I always try to ensure safety of my patients.	3.43	0.590	Very satisfactory	5
I always make proper diagnosis before I give services to my clients	3.17	0.887	Very satisfactory	7
I always try to get feedback from clients on health issues and respond to them	3.13	0.815	satisfactory	8
Average mean	**3.49**	**0.655**	**Very satisfactory**	
Productivity of health workers I always educate clients about the available health services in my unit.	3.70	0.559	Very satisfactory	3
I always serve a big number of patients as expected	3.70	0.703	Very satisfactory	3
I always serve my patients on basis of first come first served	3.74	0.541	Very satisfactory	2
I always take care to ensure that patients are given standard and genuine drugs	3.78	0.518	Very satisfactory	1
I never bark at or abuse my patients even if am annoyed	3.65	0.714	Very satisfactory	5
I always give enough counseling to my clients.	3.39	0.722	Very satisfactory	6
I do not make people I know jump lines	3.35	0.714	satisfactory	7
I always make follow up on my patients.	2.70	0.822	satisfactory	8
Average mean	**3.50**	**0.662**	**Very satisfactory**	
Availability of health workers I am always committed to give health care to my patients when at job	3.83	0.650	Very satisfactory	1
I am always easily accessible to all clients who come around my unit	3.57	0.662	Very satisfactory	2
I always available for patients for all, my scheduled periods	3.13	0.869	Very satisfactory	5
I am available to my clients whenever they need me	3.57	0.728	Very satisfactory	2
I always give enough drugs and attention to my clients	3.43	0.788	Very satisfactory	4
Average mean	**3.51**	**0.739**	**Very satisfactory**	

Results in Table 4.3.4 revealed that assessment of setting services standards indicated a very satisfactory average mean (3.41) and standard deviation (0.640), of the indicators assessed, new insights and innovation in health services ($\bar{X}$=2.91) and ensure there is enough drugs and equipments in my unit ($\bar{X}$=2.65) were rated satisfactory. The rest of indicators assessed were rated very satisfactory, of those rated very satisfactory, the least rated was to ensure good sanitation ($\bar{X}$=3.52) and the most rated were give clients the best quality of health services I can afford and being transparent in serving all patients ($\bar{X}$=3.70). This implies that setting service standards is done by health workers in Nakawa division urban council as part of ethical requirements of the profession.

The responses on health service indicators on responsiveness of health workers indicated a very satisfactory mean (3.49) and standard deviation (0.655), of the service indicators assessed only, feedback from clients on health issues was rated satisfactory ($\bar{X}$=3.13), and all the rest of indicators were rated very satisfactory, of those rated very satisfactory, the least rated was make proper diagnosis before I give services to my clients ($\bar{X}$=3.17), and the most rated was clear directions are given to clients ($\bar{X}$=3.83). This rating suggests health workers in Nakawa division urban council provide their services

willingly and have interest in the job thus handling health needs of their clients.

Assessment of the productivity of health workers indicate a very satisfactory average mean (3.50) and standard deviation of (0.662), of the indicators assessed, people I know do not jump lines ($\bar{X}$=3.35) and make follow-up to my patients ($\bar{X}$=2.70) were rated satisfactory while the rest of indicators were rated very satisfactory, of those rated very satisfactory, the least rated was enough counseling is given to clients ($\bar{X}$=3.39), and the most was to ensure that patients are given standard and genuine drugs serve patients on basis of first come first served ($\bar{X}$=3.78). The responses reveal that health workers in Nakawa division urban council attend to patients and provide services to them.

On the responses of the availability of health workers, indicate a very satisfactory average mean (3.51) and standard deviation (0.739). All the indicators on availability were rated very satisfactory, the least rated was enough drugs and attention given to clients ($\bar{X}$=3.43), committed to give health care to patients was most rated ($\bar{X}$=3.83). This implies that health workers at health centers in Nakawa division urban council are available at their centers most of time serving the clients in health problems.

Table 4.3.5: Health Workers Perceptions on Health Service Delivery in Kawempe Division Urban Councils

Variables	Mean ($\bar{X}$)	Std. Dev.	Interpretation	Rank
Setting services standards I always give equal treatment to all patients irrespective of their status	3.65	0.631	Very Satisfactory	1
I always try to give my clients the best quality of health services I can afford	3.65	0.663	Very Satisfactory	1
I am always transparent in serving all patients	3.57	0.645	Very Satisfactory	3
I always ensure good sanitation in my unit	3.51	0.582	Very Satisfactory	4
I always research for new insights and innovative solutions to health problems	3.04	0.763	Satisfactory	5
I always ensure there is enough drugs and equipments in my unit	2.69	0.962	Satisfactory	6
Average mean	**3.35**	**0.708**	**Very Satisfactory**	
Responsiveness of health workers I always make proper diagnosis before I give services to my clients	3.76	0.560	Very Satisfactory	1
I always assist my clients to understand drug prescriptions.	3.67	0.591	Very Satisfactory	2
I always try to identify health problems to clients.	3.55	0.647	Very Satisfactory	4
I always communicate to patients consistently	3.61	0.533	Very Satisfactory	3
I always serve patients quickly and timely	3.39	0.671	Very Satisfactory	6
I always try to ensure safety of my patients.	3.41	0.643	Very Satisfactory	5
I always make proper diagnosis before I give services to my clients	3.37	0.809	Very Satisfactory	7
I always try to get feedback from clients on health issues and respond to them	3.12	0.781	Satisfactory	8
Average mean	**3.49**	**0.654**	**Very Satisfactory**	
Productivity of health workers I always educate clients about the available health services in my unit.	3.65	0.597	Very Satisfactory	1
I always serve a big number of patients as expected	3.59	0.643	Very Satisfactory	2
I always serve my patients on basis of first come first served	3.47	0.739	Very Satisfactory	4
I always take care to ensure that patients are given standard and genuine drugs	3.53	0.616	Very Satisfactory	3
I never bark at or abuse my patients even if am annoyed	3.47	0.739	Very Satisfactory	4
I always give enough counseling to my clients.	3.39	0.640	Very Satisfactory	6
I do not make people I know jump lines	3.37	0.782	Very Satisfactory	7
I always make follow-up on my patients.	2.73	0.700	Satisfactory	8
Average mean	**3.40**	**0.682**	**Very Satisfactory**	
Availability of health workers I am always committed to give health care to my patients when at job	3.80	0.539	Very Satisfactory	1
I am always easily accessible to all clients who come around my unit	3.49	0.739	Very Satisfactory	3
I always available for patients for all, my scheduled periods	3.67	0.516	Very Satisfactory	2
I am available to my clients whenever they need me	3.43	0.736	Very Satisfactory	4
I always give enough drugs and attention to my clients	3.43	0.645	Very Satisfactory	4
Average mean	**3.56**	**0.635**	**Very Satisfactory**	

Results in Table 4.3.5 revealed that assessment of setting services standards indicated a very satisfactory average mean (3.35) and standard deviation (0.708), of the indicators assessed, new insights and innovation in health services ($\bar{X}$=3.04) and enough drugs and equipment ($\bar{X}$=2.69) were rated satisfactory. The rest of indicators assessed were rated very satisfactory, of those rated very satisfactory, the least rated was to ensure good sanitation ($\bar{X}$=3.51); the most rated were give equal treatment to all patients irrespective of their status and equal clients are given the best quality of health services I can afford ($\bar{X}$=3.65). This implies that setting service standards is done by health workers in Kawempe division urban council as part of ethical requirements of the profession.

The responses on health service indicators on responsiveness of health workers indicated a very satisfactory mean (3.49) and standard deviation (0.654), of the service indicators assessed only feedback from clients on health issues was rated satisfactory ($\bar{X}$=3.12), and all the rest indicators were rated very satisfactory, of those rated very satisfactory, the least rated was make proper diagnosis before I give services to my clients ($\bar{X}$=3.37), and the most rated was make proper diagnosis before I give services to my clients ($\bar{X}$=3.76). This rating

suggests health workers in Kawempe division urban council provide their services well and have interest in the job thus handling health needs of their clients.

Assessment of the productivity of health workers indicate a very satisfactory average mean (3.40) and standard deviation (0.682), of the indicators assessed, make follow-up to my patients (mean=2.73) were rated satisfactory while the rest of indicators were rated very satisfactory, of those rated very satisfactory, the least rated was do not make people I know jump lines ($\bar{X}$ =3.37) and clients about the available health services in my unit ($\bar{X}$=3.65). The responses reveal that health workers in Kawempe division urban council attend to patients and provide services to them when they visit the health centers.

On the responses of the availability of health workers, indicate a very satisfactory average mean (3.56) and standard deviation (0.635). All the indicators on availability were rated very satisfactory, the least rated was enough drugs and attention given to clients ($\bar{X}$=3.43), committed to give health care to patients was most rated ($\bar{X}$=3.80). This implies that health workers at health centers in

Kawempe division urban council are available at their centers most of time serving the clients in health problems.

Patients who receive services from the health centers were also interviewed supplement on the findings of Table (4.3.1-5) of the health workers, their responses are summarized below;

- *Health workers are available all the time at health center*
- *Health workers are easily accessed by patients*
- *Health workers do counsel and make a follow -up to few special cases*
- *Health workers are committed to their work though their pay is fair*
- *Health centers do not have enough drugs but ones like pandol and aspirins*
- *Health centers lack supplies such as gloves and equipments like microscopes.*

All the patients (n=80; 100%) interviewed said that most the health staffs are committed to their work though their pay is fair may be, due to job status and the code ethics. Some patients (n=4; 5%) from Kiruddu and Kawempe health centers revealed that the nurses care more to them like their own relatives. All the patients (n=80; 100%) interviewed from the eight health centers confessed that there are

inadequate drugs, supplies such as gloves and equipments like microscopes for diagnosis of diseases at the centers. A Patient from Kawala health center supplemented on this saying;

"....you find that our health workers perform their duties with any protective gear likes gloves. Sometimes they depend on us who buy them from the shops."

Furthermore this was supported by another patient from same center who said that;

"...stock outs of drugs is a common occurrence here, and sometimes they accuse health workers of stealing drugs when actually the amount of drugs supplied to the center cannot even last for a month..."

Majority of the patients (n=65; 81.3%) said that drugs like pandols, and aspirins are available and whenever they visits health centers they are referred to private clinics for service and this make patients to say that health workers are not committed to their duties. This seems to create problems not only in the context of duty execution but also impacts on the relationships between health workers and the communities.

unmotivated. If health workers are given more responsibility in the day-to-day running of the health facilities, this is likely to enhance their motivation and performance thus better health delivery.

On the productivity of health workers, average mean (3.40), this was supported by a few administrators intervened (n=10; 31.3%) said that though a number of factors hinder the desired levels of productivity but individual drive and commitment are important determinant of productivity. They also said availability of health workers affect the productivity. Finally on the responses of the availability of health workers, average mean (3.56), this was supported an administrator from Kitebi health center who stated that:

> *"...this has to do with attitude, a lot to do with someone's drive to work, some people are lazy, and they just want to have excuses not to do work. There are those who feel that they have an obligation to do their duties".*

This was further supported majority of patients (n=70; 87.5%) interviewed that said health workers are available and easily accessed by patients at center most of the time attending to patient demands like counseling, diagnosis of diseases and offering treatment. This shows that health workers do their work effectively as most of the

indicators that were rated by health workers scored very satisfactory mean scores thus indicating better service delivery to people.

Though human resource management practices were rated fair, health workers' services were effective because all were rated satisfactory. This implies that though human resource management practices are not practiced frequently but health workers at health centers do their work effectively. This further reveals that there may be other practices and factors that influence performance of health workers like self motivation for the job and the regulations and code of ethics of the job. This reveals that the health workers perceive that they are to attain their needs one after another through a period of time, thus in line with hierarchy of needs theory largely and partly equity and Two factor theory.

4.3.7 To determine significant difference in Health Service Delivery among the Division urban councils of Kampala

To establish if there was a significant difference in health service delivery among the division urban councils of Kampala, the researcher computed mean values on the effectiveness of health service delivery in the different division urban councils of Kampala were compared

using Fisher's One Way Analysis of Variance (ANOVA), as indicated in Table 4.3.7

Table 4.3.7: Significant Difference in Health Service Delivery among the Division Urban Councils of Kampala

Health Service Delivery	Division Urban Council	Mean($\bar{x}$)	F	Sig	Interpretation	Decision on H1
Setting Services Standards	Central	3.3200	0.643	0.632	Insignificant difference	Rejected
	Rubaga	3.3333				
	Makindye	3.4500				
	Nakawa	3.4058				
	Kawempe	3.3537				
Responsiveness of Health Worker	Central	3.4535	0.702	0.591	Insignificant difference	Rejected
	Rubaga	3.4432				
	Makindye	3.5625				
	Nakawa	3.4891				
	Kawempe	3.4847				
Productivity of Health Worker	Central	3.3953	0.776	0.542	Insignificant difference	Rejected
	Rubaga	3.3614				
	Makindye	3.4725				
	Nakawa	3.5000				
	Kawempe	3.4133				
Availability of Health Worker	Central	3.4930	0.180	0.948	Insignificant difference	Rejected
	Rubaga	3.4945				
	Makindye	3.5360				
	Nakawa	3.5043				
	Kawempe	3.5633				
Overall Health Service Delivery	Central	3.4159	0.540	0.706	Insignificant difference	Rejected
	Rubaga	3.4081				
	Makindye	3.5052				
	Nakawa	3.4748				
	Kawempe	3.4537				

(Level of Significance=0.05)

The results of Table 4.3.7 at P=0.05 showed that the computed F-values of the effectiveness of health service delivery among the division urban councils of Kampala in terms of setting services standards (F=0.643, sig= 0.632), responsiveness of health worker (F=0.702, sig=0.591), productivity of health worker (F=0.776, sig=0.542) and availability of health worker (F=0.180, sig=0.948) are higher than the significant values. The overall health service delivery computed F-value was (F=0.540, sig=0.706). All the computed F-valve was higher than the significant valves and this suggests that there was no significant difference in health service delivery among the division urban councils of Kampala. The findings showed that all the health service indicators had the same rating potential thus no difference in health service delivery in five division urban councils though human resource practices differed. This may be due to the profession of health worker that mandates them to worker under oath and other factors like the work environment and self motivation. This argument in line of hierarchy of needs theory that health workers do better hoping for achievement after some time.

4.4 Hypothesis one: To establish the relationship between reward management practices and health service delivery among the centers in division urban councils of Kampala

To establish if there was a significant relationship between reward management practices and health service delivery, the researcher tested a research hypothesis that; there is relationship between reward management practices and health service delivery among the division urban councils of Kampala. To test this research hypothesis the researcher correlated the mean scores for reward management practices (Table 4.2.1-5) and those for health service delivery (Table 4.3.1-5) using Pearson's correlation coefficient (r), results of which are indicated in Table 4.4.

Table 4.4: Pearson Correlations for Reward Management Practices and Health Service Delivery

Variables Correlated	r-value	Sig	Interpretation	Decision on H1
Rewards Vs Setting of Standards	-0.071	0.294	No significant correlation	Rejected
Rewards Vs Responsiveness of Health Worker	-0.121	0.073	No significant correlation	Rejected
Rewards Vs Productivity of Health Worker	0.007	0.922	No significant correlation	Rejected
Rewards Vs Availability of Health Workers	-0.035	0.610	No significant correlation	Rejected
Rewards Vs Overall Health Services Delivery	-0.062	0.358	No significant correlation	Rejected

(Level of Significance=0.05)

Pearson's Correlation Coefficient results in Table 4.4 at p=0.05 revealed that reward management practices had no significant correlation with health service delivery in terms of setting of standards (r=-0.071, sig=0.294), responsiveness of health worker (r=-0.121, sig=0.073), productivity of health worker (0.007, sig=0.922), availability of health worker (r=-0.035, sig=0.610) and also with the overall health service delivery (r=-0.62, sig=0.358). Hence the research hypothesis was rejected and null hypothesis accepted .This suggests that reward practices do not directly influence health service delivery aspects. To this effect, this why the reward practices were poorly rated but health services were effectively delivered by health workers at all the health centers.

4.5 Hypothesis Two: To establish relationship between employee development practices and health service delivery among the centers in division urban councils of Kampala

To establish if there was a significant relationship between employee development practices and health service delivery, the researcher tested a research hypothesis that; there is relationship between employee development practices and health service delivery among the centers in urban councils of Kampala. To test this research hypothesis the researcher correlated the mean scores for employee development

management practices (Table 4.2.1-5) and those for health service delivery (Table 4.3.1-5) using Pearson's correlation coefficient (r), results of which are indicated in Table 4.5.1.

Table 4.5.1: Pearson Correlations for Employee development Management Practices and Health Service Delivery

Variables Correlated	r-value	Sig	Interpretation	Decision on H1
EDMP Vs Setting of Standards	0.121	0.074	No significant correlation	Rejected
EDMP Vs Responsiveness of Health Worker	0.053	0.434	No significant correlation	Rejected
EDMP Vs Productivity of Health Worker	0.138	0.041	Significant correlation	Accepted
EDMP Vs Availability of Health Workers	0.058	0.391	No significant correlation	Rejected
EDMP Vs Overall Health Services Delivery	**0.106**	**0.119**	**No significant correlation**	**Rejected**
HRMP Vs Overall HSD	**0.038**	**0.577**	**No significant correlation**	**Rejected**

(Level of Significance=0.05)

The data in Table 4.5.1 revealed that employee development management practices had no significant correlation with health service delivery in terms of setting of standards(r=0.121, sig=0.074), responsiveness of health worker (r=0.053, sig=0.434) and availability of health worker (0.058, sig=0.39), implying development practices have no influence one setting standards, responsiveness and availability of health workers. However development management

practices had a significant correlation with productivity of health worker, this reveals development practices has an effect on productivity of health workers and this suggests that there is need to develop employees for them to perform better.

There was a weak correlation with development management practices with overall health service delivery (r=0.106, sig=0.119). The overall human resource management practices and overall health service delivery had no significant correlation (r=0.038, sig=0.577).The computed overall r-value (0.038) is less than the critical significant value (0.577), hence the research hypothesis was rejected and the null hypothesis was accepted, in other words this suggest that there was no significant relationship between human resource management practices and health service delivery and this suggests that human resource practices does not influence health service delivery in Kampala.

4.6 Regression Analysis on Influence of the Dependent Variable on the Independent Variable

4.6.1 Regression Model Equation

$Y = \alpha + \beta_1 X_1 + \beta_2 X_2 + \varepsilon$

Where; Y is the dependent variables - HSD

α is the constant, which shows the level at which the dependent variables (Y) is at when all the independent variables are Zero.

X_1 and X_2 are the independent variables; X_1 is the rewards and X_2 is development.

β_1 and β_2 are the coefficients, which show the strength of each of the independent variables in explaining the dependent variable. i.e. β_1 shows the strength or the predictive power rewards have on the dependent variable (HSD), While β_2 shows the strength or predictive power development has on dependent variable (HSD).

Estimated Model

HSD $= \alpha - 0.182 X_1 + 0.216X_2$

HSD $= 3.381X1 - 0.182X_2$

Regression analysis was done to assist in ranking the effect of human resource management practices on the effectiveness of service delivery as indicated in Table 4.6.1.

Table 4.6.1: Regression Analysis on the Influence of the Dependent Variable on the Independent Variable

Variables regressed	Adjusted R^2	F	Sig.	Interpretation	Decision on H1
HRMP Vs HSD	0.024	3.720	0.026	Significant effect	Accepted
Coefficients	Beta				
(Constant)	3.381	34.826	0.000	Significant effect	Accepted
REWARD	-0.182	-2.196	0.029	Significant effect	Accepted
DEVELOPMENT	0.216	2.603	0.010	Significant effect	Accepted

(Level of Significance=0.05)

The results in Table 4.6.1 showed a significant difference between health service delivery and human resource management practices (F = 3.720, sig. = 0.026, at p=0.05) hence the research hypothesis was accepted, implying that there was a significant effect between the dependent and independent variables. The results suggest that, human resource management practices (independent variable) do not determine the health service delivery (dependent variable). The coefficient of determination R^2 is 0.024; therefore, about 2.4% of the variation in human resource management practices is explained by effectiveness of service delivery.

This implies that the human resource management practices have little or no effect on health service delivery as a result it may not did affect

performance of health workers. This explains the very satisfactory rating of health services indicators and poor ratings of human resource management practices. This may be due to other factors like attitude of an individual, love for the job and ethical code of conduct as a motivational tool to workers to perform well thus better health service delivery.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.0 INTRODUCTION

This chapter presents and discusses the findings. The data collected both questionnaire and interview recordings, are structured and analyzed in relation to the framework established to the purpose, objectives and hypothesis.

5.1 Summary of Findings

The study investigated the relationship between human resource management practices and the service delivery in urban councils of Kampala. It was guided by four specific objectives which included; 1) to determine the perception of health workers on human resource management practices in Kampala; 2) to determine the perception of health workers on health service delivery in Kampala; 3) to establish the relationship between reward management practices and health service delivery in Kampala; and 4) to establish the relationship between employee development management practices and health service delivery in Kampala. The findings of the study are discussed here under following:

The main findings of the study are summarized as follows; Results of the finding showed that majority of the respondents were females

below age of 40 years and are certificate holders who have been in service for at least 5 years.

Reward management practices were perceived to be generally poor ($\bar{X}$=1.62; standard deviation=0.757) while employee development practices were perceived by the respondents to be generally satisfactory ($\bar{X}$=2.21; standard deviation=0.933), although the overall average for the two human resource management practices happened to be fair ($\bar{X}$=1.92; standard deviation=0.845), Tables 4.2.1.6 and 4.2.2.6. The effectiveness of health service delivery was rated very satisfactory in terms of setting service standards (average mean =3.35; standard deviation=0.708), health worker responsiveness (average mean=3.35; standard deviation=0.654), productivity (average mean=3.40; standard deviation=0.682) and availability (average mean=3.56; standard deviation=0.635), Table 4.3.6.

Human resource management practices differed significantly among the urban councils of Kampala (F=5.786; Sig=0.000), where Kawempe division urban council surpassed the rest in all aspects and may due to application of SHRMP, Table 4.2.3.1. However, there was no significant difference in the effectiveness of health service delivery among the division urban councils of Kampala (F=0.540; sig=0.706), Table 4.3.7

The study established no significant relationship between human resource management practices and health service delivery was found (r=0.038; sig=0.577), Table 4.5.1. However, regression analysis results showed that human resource management practices in terms of reward and development management can significantly explain effectiveness of health services delivery, Employee development practices proved to exert a bigger positive and significant effect on health service delivery (r=0.216; sig=0.01) while reward management practices were found to exert a negative influence on health service delivery (r=0.182; sig=0.029), Table 4.6.1.

5.2 DISCUSSION OF FINDINGS

5.2.1 Perceptions of health workers' on the human resource management practices and health service delivery among the division urban councils of Kampala

Human resource practices were discussed as one unit as the two practices are interlinked with each other. The findings from Fisher's One Way ANOVA revealed that human resource management practices (reward and development management practices) differed significantly among the division urban councils of Kampala, where Kawempe division urban council proved to be better than the two practices. From

the findings it suggests that not all human resource management practices have the same impact as advanced by a number of studies like Delaney and Huselid (1996), that practices are divided into those to enhance employee skills, help to motivate and how workplace is structured. This study established that though the HRMP do not have the same impact on performance and service delivery, they are interlinked together if better services are to be achieved but this was not pointed out by Delaney and Huselid. Tsaura and Lin (2004), in their studies established that HRM practices had partially a direct effect on customer perceptions of service quality and an indirect effect through employees' service behavior. Collins and Clark (2003) have provided one of the best empirical tests to date of the argument that human resource practices influence outcomes through their impact on relationships among employees. They argue that the social networks of top management teams enhance a firm's information-processing capability and that human resource practices like incentives, and performance appraisals, can be designed to encourage the development of these social networks. They then demonstrate that the impact of these high-performance work practices on firm performance is mediated by the strength of firms' top management team social networks. The research found out that social networks need to be promoted among all employees/health workers to build strong

employer-employee relationship for better health service delivery, not only to top management as pointed out by Collins and Clark. The findings proved that reward and development practices showed significant difference in the urban councils. Health service delivery and productivity of workers both were rated very satisfactory yet in the preceding discussion on reward and development management practices were rated fair. This seeming contradiction could be due to the fact that health professionals are strongly shaped by values of self-regulation and professionalism. In this context intrinsic rather than extrinsic factors are major motivating factors moderating poor HRMP in KCCA.

Frey and Osterloh (2002) explain three forms of intrinsic motivation; first people engage in an activity for its own sake, since they find the activity itself as a source of joy and satisfaction. Examples can be hobbies that one chooses to pursue, or in the work context fulfilling an interesting task. Secondly, activities which are tedious and unexciting, but their accomplishment is a source of pleasure. For instance, meeting a deadline at work brings a sense of achievement, albeit the process is sometimes arduous. Finally, the third form of intrinsic motivation is a matter of compliance with standards for their own sake that propels people to act. These may be ethical standards one feels a need to

respect, commitment to group members, or the desire to act according to values of material or procedural fairness and concur with Herzberg's two factor theory (1966). Therefore this explains the very satisfactory rated health service delivery by health workers against fair HRMP. Also there is no proven linkage that explains that fair HRMP definitely affects performance of workers and poor service deliver (Pfeffer, 2005 and Guest, 2001).

The overall findings indicated lack of concerted attention to contemporary human resources best practices in KCCA (Tables 4.2.1-6 and 4.2.2.1-6), this was consistent with Jamal and Adwan (2008), in their study that revealed institutions do not engage workers in the planning processes of the workforce sufficiently, and that the influential considerations of administrative structure regulatory in the process of workforce planning is characterized by lack of clarity, as well as the professional experience in manpower planning and top management support for the process of workforce planning was ineffective. The researcher further established that most of the employees/health workers of KCCA are below the age of 40 years and have been in service for about 5 years. Therefore this shows that knowledgeable and experienced health workers are minimal or lacking in KCCA health centers and thus professional and experienced workers

are far more limited in KCCA health centers than what Jamal and Adwan pointed out.

This low priority on HRMP may not be confined to the health sector, but also to other sectors too like education and social services (Ssewanyana *eta l*, 2010). The research also found out that poor infrastructure, low performance of staff and low standards in social services in KCCA exist largely, other than health services the researcher studied in depth. Invariably the biggest recurrent expenditure in the health sector goes to staff. This study evidenced from most of health workers interviewed confirmed that 85% of health funds in KCCA health centers are utilized in workshops and seminars, transport allowances of those in management and office imprest. It reflects a low and narrow agenda to human resources. The other reason is on the establishment of terms and conditions of service. Usually these are a preserve of the Ministry of public service working in hand with the Ministry of Finance. Hence human resource policies are centralized leaving Ministry of Health and local government's benefit of personnel and influence over human resource management (Okwero, 2010). Consequently human resource management practices were found in this study to be even to be far more limited in scope than

what Okwero, had pointed out thus have minimal or no magnitude to alter set policies.

In some cases attempts have been made to circumscribe these through special donor funded projects. These projects have better reward structures and facilitation for health workers compared to the national ones. For example projects like Kampala institutional infrastructural development project (KIIDP) and Improvement of health Services in the City of Kampala project (IHSCKP) under the ministry of health, among others in KCCA. Expectedly, this generates conflicts among health workers. Issues of fairness and unfair creep to undermine the commitment and team work. Consequently performance is compromised and different aspects of health service delivery severely suffer in urban councils. The research found out even where projects are supplemented to improve on health service delivery, still health services remain poor as it has its shortcomings contrary to what others scholars' pointed out

High performance of health employees/workers leading to better health service delivery against fair rating of HRMP may have surfaced due other factors like employee behaviours and attitudes as advanced by (Huselid, 1995; Delaney, 1996; Ramsay, 2000). Therefore the

relationship between human resource management practices and quality service delivery may be mediated by employee behaviours and attitudes. More recently, Vogus (2006) has argued that high-performance work practices such as innovation, training, performance appraisal, performance-based rewards, and job security contribute to high-quality interactions and informing employees the importance of relationships.

Vogus continues by postulating that these high-quality interactions contribute to higher-quality outcomes for hospital patients. The researcher established a contrary view from that of Vogus that high performance practices leads to high quality basing on individual workers attitudes and working environment. Though the types of employer-employee relationships explored in these studies are varied, including relational coordination (Gittell, 2000); social networks (Collins & Clark 2003), Gant et al. (2002), social capital; Evans & Davis (2005) and mindful interacting, Vogus (2006), these studies suggest that high-performance work practices can enhance performance through the pathway of employer-employee relationships. This study established that the relationships must be purely work related but not behaviour related type which was not pointed out by the previous scholars.

5.2.2 Relationship between reward management practices and health service delivery among health centers in division urban councils of Kampala

The Pearson's Correlation Coefficient (r) findings revealed that reward management practices had no correlation with health service delivery. The findings are consistent with Farrant (1982), who stated that rewards have a direct bearing on service quality but this only happens when employees are incorporated in decision making process such that all needs and aspirations are considered, otherwise it may lead to regression and poor services. A contrary view from Farrant's was established by the researcher that workers should not only participate in decision making but all other high performance activities must be practiced together. This activities include; workers/employees motivation, delegation, recognition, attitudes and working environment. The finding does not agree with many scholars, such as Guest, (1997), Davies, (1982) and Maicibi, (2005), who maintained that there is a link between reward management and service delivery. The research found out that link is not permanent but depends on the prevailing conditions like environment at work, individual behaviours and relationships between employer-employee which was not revealed by the previous scholars. Mathauer and Imhoff (2006), observed that in Kenya and Benin, health workers are motivated by their desire to

help patients, professional advancement, and the recognition they get from the clients and managers. Therefore, increasing health workers' intrinsic motivation that makes them be satisfied with their job, and attainment of personal objectives, thus improving their performance.

5.2.3 Relationship between employee development management practices and health service delivery among the centers in division urban councils of Kampala

Employee development management practices and health service delivery had no significant correlation. The findings suggest that employee development management practices do not affect delivery of services. This is inconsistent with a number of scholars like Guest (1997), Doyle (1997), who observed that there is a positive link between employee development and performance and this is contrary view to the research as it was established that employees/health workers behaviours and attitudes makes the link prominent.

The finding showed no significant relationship and contradicts Delaney and Huselid (1996), and Guest (1997), who observed that training is positively related to the organizational performance but it concurs with scholars like Huselid (1995), Delaney (1996), and Ramsay (2000), who showed that the relationship between development management practices and service delivery exists but may be mediated by employee

behaviours and attitudes. The research found out other intervening variables which Delaney, Huselid and Ramsay did not discover. The intervening variables are the following: employee competence, attitudes, commitment, motivation and teamwork that makes the relationship evident. The finding is consistent with Guest (1997), who states that human resource management practices have a positive influence on the performance of an organization as result better service delivery.

5.3 Theoretical discussion

According to equity theory employee perceptions of what they contribute to the organization, what they get in return, and how their return-contribution ratio compares to others inside and outside the organization,' determine how fairly they perceive their employment relationship to be (Adams, 1963). Perceptions of inequity are expected to cause employees to take actions to restore equity. Some such actions include quitting or non-commitment, lack of cooperation, corruption, all of which contribute to counterproductive behaviours on health workers' performance (Adam, 1965).

In the KCCA setting we notice how respondents rated equal training opportunities, salary discrimination (even if 37% perceived inequity),

and promotions fair. Reports from the (AGR,2011) documenting corruption, absenteeism; evaluation studies such as employee performance and job satisfaction reveal manifestations of perceived inequities in form of different salary scales, selective promotion and training may be perceived discriminative if some staff are subjectively selected to go for training abroad. Similarly, inequity is perceived if some staffs are posted to work on a donor funded health project, and the criteria of selection is contested.

The salary structure of KCCA exhibits large differential between higher levels and fairer levels and between those within KCCA and those working for KCCA but under government payroll. Under such salary inequities health workers may reduce their effort in order to achieve equity. The results in this study support the equity theory, suggesting that organizations need to be careful of the outcomes of theory and not to forget the adverse motivational consequences of inequities in its various forms. Thus, consistent with prior studies (Robbins, 2001; Kreitner & Kinicki, 2008), equity theory only provides a partial explanation.

It explains some of the causes and consequences of HRMP inequities impacting health care workforce. Nevertheless, equity theory provides a partial explanation. To provide a fuller explanation of

equity/inequities in the public sector there is need to consider the wider contingency analysis and this may explain the very satisfactory ratings by health workers in KCCA health units. This does not reveal any distress at all from the health workers as pointed out by Adams (1963, 1965), despite existence of inequities in pay, promotions and development careers of health workers as per their interview responses, thus not in line with Adam's equity theory

The two-factor theory (Herzberg) of motivation explains the factors that employees find satisfying and dissatisfying about their jobs. These factors are the hygiene factors and motivators. The hygiene factors when absent can lead to dissatisfaction in the work place but when fully catered for in the work environment on their own are not sufficient to satisfy workers whereas the motivators referring to the nature of the job, provide satisfaction and lead to higher motivation.

In Uganda all health institutional managers, KCCA health centers inclusive, perhaps because of societal norms and expectations emphasize bureaucratic practices with total reliance on rules and regulations that workers obey without questioning or offering constructive criticisms. The bureaucratic practice usually creates an impersonal organizational climate, often not conducive to the

achievement of health institutions goals. This leads to the employees working as robots and following rules and regulations without taking initiatives of their own.

Consequently, workers behaviour as a result of this is often directed towards meeting their personal needs instead of those of the institution. Furthermore, managers, engaged in these bureaucratic practices, are often more interested in exercising absolute power over their employees than in working towards institutional goals and objectives through their employees. Employees who work under such environments are often not motivated to do their work; they feel powerless, reluctant, hostile and unable to take initiative of their own. Basing on the above analysis on the two factor theory, the KCCA managers and administrators of centers should do more to make the work environment more challenging and interesting.

It is an acknowledged fact that, a bored employee is not motivated or productive. More often than not, workers in health centers are accused of being unmotivated and unproductive at the work place. Health workers in KCCA cannot be said to be lazy, just that their jobs are often not designed in a way that will constantly challenge them to be innovative and doing away with repetitions and monotony in their

work. Cognizant of this, managers/administrators in collaboration with human resource departments should redesign jobs and responsibilities so that new challenges are presented to workers on a regular basis. This, Herzberg termed as 'Job Enrichment', that is, augmenting routine tasks with special assignments.

In addition, it is essential for managers to assure their employees of commensurate pay but essential to emphasize to employees that pay is based on performance and that 'bonuses' and other benefits are awarded for extra effort put in by those who are committed to advancing the fortunes of the health centers they work for. Tying performance and salary increases to work outputs may be one of the ways to encouraging commitment and advancing centers aspirations. Furthermore workers are motivated not only by the financial rewards but also by the recognition that they get from their managers.

Additionally, KCCA health employees can be motivated through building effective and efficient work groups or teams where health center goals are personalized for teams and departments and emphasis placed on the importance of each department in the overall performance of the centers. Also avoid micromanaging, ensuring fairness in pay structures, promotions and work allocations and

eschewing favoritism, nepotism and cronyism by managers would be essential to addressing employee motivation issues in health centers in Kampala.

Finally on the hierarchy of needs theory, Maslow theorized that people have five types of needs and that these are activated in a hierarchical manner. This means that these needs are aroused in a specific order from lowest to highest, such that the fairest-order need must be fulfilled before the next order need is triggered and the process continues. If you look at this in a motivational point of view Maslow's theory says that a need can never be fully met. The rationale behind the theory lies on the fact that it's able to suggest to managers how they can make their employees or subordinates become self-actualized. This is because self-actualized employees are likely to work at their maximum creative potentials.

Therefore it is important to make employees meet this stage by helping them meet their need. Health centers can take the following strategies to attain this stage. Recognizing employee's accomplishments is an important way to make them satisfy their esteem needs. This could take the form of awards, pledges etc. But it should be noted that according to Greenberg and Baron a wards are

effective at enhancing esteem only when they are clearly linked to desired behaviours. Awards that are too general fail to meet this specification.

Financial security is an important type of safety need. So health institutions to motivate their employees need to make them financially secured by involving them in profit sharing of the institution. Socialization is one of the factors that keep employees feel the spirit of working as a team. When employees work as a team they tend to increase their performance. Health centers can help in keeping their employees physiological needs by providing incentives to keep them healthy both in health and mentally. Therefore the directorate of Public health and environment, and health center administrators should support employees so that they attain their needs to perform as a result better health service delivery.

5.4 CONCLUSIONS

From the preceding discussion, the following conclusions were derived.

5.4.1 Objective One and Two

From the findings of the study, it was established that human resource management practices differed significantly while health service delivery among urban councils did not differ significantly among the

division urban councils of Kampala, suggesting that human resource management practices are not uniformly practiced in division urban councils in Kampala. It shows that Kawempe and Rubaga division urban councils do better as far as application of HRMP is concerned, may due practice of SHRM while Central, Makindye and Nakawa division urban councils are doing poorly. Health service delivery in division urban councils seems to be the same, suggesting that health workers averagely perform well in work and this is due other factors like the job itself, environment one operates in and attitude or behaviours of individual health worker (Liu *et al.*, 2007). Banker et al. (1996), contends that cross functional teams, job rotation, quality circles and integration of functions may all contribute positively to labor productivity.

5.4.2 Objective Three

From the findings of the study, it was established that reward management practices does not directly affect health service delivery among the health centers in the division urban councils of Kampala. This is because there were very satisfactory ratings in health services offered by health workers though the human resource practices on overall average were poorly rated by the respondents. This suggests

that health workers at health centers performed their work well despite low application reward practices.

This further suggests that irrespective of rewards or no rewards given to one, still better health services can be attained through other factors (WHO, 2006). Factors like, the job one has can motivate him to perform better, attitudes of individual employee, and organizational commitment and code of ethics also influences one's performance that may lead to better health service delivery. The findings of this study clearly revealed insufficiency in the rewarding system within the health centers of KCCA (Table 4.2.1.1-5). This may hinder the performance of health workers in many ways thus affecting health service delivery.

The health service administrators should recognize that monetary rewards are not the only means health workers" performance can be rewarded or recognized. This is consistent with studies of Manion (2005) who argues that it is critical for managers to remember that typically a combination of factors motivates employees, not just one type of extrinsic or intrinsic reward; And Shanks (2007), who argues that; 'while rewards may serve as incentives and those who bestow rewards may seek to use them as motivators; the real motivation to act comes from within the individual'. This is because managers can only influence employees with a combination of rewards to motivate

them to perform better but cannot force them. The onus therefore lies on the individual to choose to perform or act.

5.4.3 Objective Four

From the findings of the study, it was established that employee development management practices do not affect health service delivery among the centers in the division urban councils of Kampala. This is as seen from the findings, health services provided by health workers were rated very satisfactory whereas employee management practices were fairly rated, implying that health services at the health centers are delivered with low application of development practices.

Therefore this reveals that irrespective of development practice in place or not, better health services are offered and this may be to other factors like competence and attitudes of health workers (Armstrong, 2009), environment within one operates and job itself (Liu *et al* ,2007). This is inconsistent with Hassan and Fuadah (2014), who urged that human resources management has a strong impact on health care quality, and most of literatures show the importance of human resources management to achieve the goals of health organizations, and emphasize to develop the performance of hospital staff and nurses through periodic training in order to improve the

quality of healthcare service, also a strong, well-motivated and highly trained medical profession is critical to the success of the national healthcare reform

5.5 CONTRIBUTION OF THE STUDY

The findings of this study have provided more understanding and awareness about the factors that may facilitate or hinder the performance of health workers in Kampala public health centers as a result affects health service delivery. Contrary to prior related studies that human resource practices have an effect on performance of workers thus having positive or impact on health service delivery, it was established that human resources management practices have no effect on the health service delivery as practices were rated fair but services were rated very satisfactory.

This further reveals that performance of health workers may be driven by intrinsic motivation, employee behaviours and attitudes inculcated through their professional values thus effective health service delivery. This adds new knowledge to the existing body of knowledge on human resource management by generating greater awareness among the stakeholders in the health sector.

5.6 RECOMMENDATIONS

Basing on the findings of the study, the following recommendations were brought forward:

Kampala Capital City Authority management should make sure that reward and employee development management practices are practiced with other non human management practices like result oriented management, strategic management, total quality management and favourable working conditions to attain effective service delivery in its health centers.

There is a need for the Ministry of Health and the Directorate of Public Health and Environment to ensure that the drug supply chain is consistently maintained. Proper quantification of drug requirements should be done in order to avoid health facilities running out of stocks of essential drugs. In addition, the ministry has to ensure that medical equipment are provided to all health facilities and the health workers are trained in preventive maintenance of these equipment

The Ministry of Health in collaboration with the Ministry of Public Services should look into dual salary structure and be harmonized as this will motivate workers to improve their performance thus effective service delivery at the health centers will be attained as fair justice will

be recognized by them as the equity theory proposes. For the health workers who work overtime, there should be a compensation mechanism developed to reward them for the extra time they devote to their work. This will improve their performance and that of the health sector.

The human resource management practices seem not to have an effect on health service delivery therefore there is need for KCCA management to conduct a research to establish why services are not effective in the urban councils for to offer better health services to the its people.

5.7 AREAS FOR FURTHER RESEARCH

The process and outcome of this study demonstrated that human resource management practices are broad. Therefore the influence of these practices can be exhaustively handled, if a further research is done focusing on specific management practices like reward management and employee development independently.

Qualitative research should be carried out among health workers in public health centers to obtain more in-depth information about the factors that enhance their performance in Kampala.

Research should be carried out to investigate the human resource management practices and health service delivery; in both public and private health centers, in Kampala

REFERENCES

Action Aid (2007).*Making Aid Accountable and Effective.* The challenge for the third satisfactory level Forum on Aid effectiveness, Accra, Ghana 2008.

Adams, J. S. (1963). *Towards an Understanding of Inequity.* Journal of Abnormal and Social Psychology, 67, 422–436.

Adams, J. S. (1965*). Inequity in Social Exchange.* In L. Berkowitz(Ed.), Advances in Experimental Social Psychology, 2, 267-299. NY: Academic Press.

Aguinis, H. (2009). *Performance Management.* 2nd edition, Person Education, Inc., publishing as Prentice Hall.

Agyepong, I. (1999) *Reforming Health Service Delivery at District Level in Ghana: the Perspective of a District Medical Officer.* Health Policy and Planning; 14 (1): 59-69.Oxford University Press.

Ahmad, H., Ahmad, K., and Syah, I.A. (2010) *Relationship between Job Satisfaction, Job performance Attitude towards Work and Organizational Commitment.* European Journal of Social Sciences, 18, 2, 257-267

Ajala, E. M. (2012). *The Influence of Workplace Environment on Workers' Welfare, Performance and Productivity.* University of Ibadan

Alderfer, C.P. (1969). *An Empirical Test of a New Theory of Human Needs*. Organizational Behavior and Human Performance, 4, 142-175.

Amin, E.M.(2004), *Foundations of statistical Inference for Social Science Research*. Makerere University Printery. Kampala: Uganda.

Amin, E.M. (2005). *Social Science Research Conception, Methodology* and *Analysis*. Makerere University Printery. Kampala: Uganda.

Anwar Khan (2005). '*Relationship of Training with Employees' Performance in Hotering* Industry. (Unpulished)

Anyangwe, SCE. and Mtonga,C.(2007). *Inequalities in the Global Health Workforce: The Greatest Impediment to Health in Sub-Saharan Africa*. International Journal of Environmental Research and Public Health, 4(2):93-100.

Applebaum, S.and Shippiro, B. (1991). *Pay and Performance: Implantation of Individual and Group Plans*. Journal of management development, 10, pp 30-40.

Armstrong, M. (2003). *Human Resource Management Practices*. (8th edition) Great Britain, the bath press.

Armstrong, M.(2009). *A Handbook of Human Resource Management Practice.* (11th Ed), London: UK , kogan page.

Armstrong, M.(2007). *A Handbook of Employee Reward Management*

and Practice. (2nd edn) London and Philadelphia, Kogan Page

Arthur,J. B. (1994) .*Effects of Human Resource Systems on Manufacturing Performance and Turnover.* Academy of Management Journal, Vol.37, pp.670-687.

Auditor General (2010). *Local Government Annual Report.*Vol.3, Government of Uganda.

Austin, Z., Crespin, R. N., (2006). *Impact of Culture on Human Resource Management Practices:* A 10-Country Comparison, Applied Psychology: An International Review, 49(1), 192-221.

Awio, G and Northcott, D. (2001). *Decentralization and Budgeting: the Uganda Health Sector Experience.* International Journal of Public Sector Management, 14(1): 75-78.

Bach, S. 2001. *Human Resource and new Approaches to Public Sector Management: Improving HRM Capacity.* Geneva: World Health Organization.

Balkin, D. and Gomez-Mejia, L. (1987). "*Toward a Contingency Theory of Compensation Strategy,"* Strategic Management Journal, 8, 169-182.

Bamberger, P., and Meshoulam, I.(2000). *Human resource strategy: Formulation, implementation, and impact.* Thousand Oaks, CA: Sage.

Banker ,R. D., Seok-Young, L., Gordon, P., and Dhinu, S, (1996), "Contextual Analysis of Performance Impacts of Outcome Based Incentive Compensation". Academy of Management Journal, Vol. 39, pp. 920-949.

Barney. J .(1995). *Looking inside for Competitive Advantage.* Academy of Management Executive 9 (4), 49-61

Barney, J.B. & Wright, P.M. (1997). "*On Becoming a Strategic Partner: The Role of Human Resources in Gaining Competitive Advantage".* Human Resource Management, 37, 31-46.

Bartlett, K. R. (2001*). The Relationship between Training and Organizational Commitment: A study in the Health care Field. Human Resource Development Quarterly, 12* (4).333-352.

Beck, K. and Wilson, C. (2000). '*Development of Affective Organizational Commitment: A Cross-Sequential Examination of with Tenure'.* Journal of Vocational Behaviour. 56: 114-36.

Becker, B. E; Huselid, M.A; Piskus, P.S, and Spratt, M.F. (2013).*Human Resource as a Source of Shareholder Valve: Resource and Recommendation.* Human Resource Management Journal,*36,* p. 39-46.

Becker, B. and Gerhart, B.(1996). *The Impact of Human Resource Management on Organizational Performance: Progress and Prospects', Academy of Management Journal, 39.779-801.*

Beer, M., Eisenstat, R., Spector, B. (1993), 'Why Change Programs don't produce Change', in T.D. Jick (ed), *Managing Change, Concepts and Cases*, Boston: Irwin.

Boone, H.N. and Boone, D.A. (2012). *Analysis Likert Data.* Journal Extension (On-line). Vol. 2.

Boselie, P. and Van der Wiele,T. (2002), "*Employees Perception of HRM and TQM, and the Effects on Satisfaction and Intention to Leave".* Managing service Quality, Vol. 12, No.3, pp.165-172.

Bossyns, P and Van Lerberghe, W. (2004). *The weakest link: Competence and Prestige as a Constraint to Referral by Isolated Nurses in Rural Niger. Human Resource for Health*, 2(1):1-8.

Bratton and Gold (2003).*The Human Resource Management Phenomenon.* Kampala: Department of higher Education, Makerere University.

Bratton and Gold (1999). *The Human Resource Management.* MaCmillan, Hampshere.

Brown, M. and Benson, J., (2003). *Rated to Exhaustion? Reaction to Performance Appraisal Processes, Industrial Relations Journal*, 34(1), 67 81.

Brown, M. and Heywood, J. (2005). *Performance Appraisal Systems: Determinants and Change, British Journal of Industrial Relations,* 43 (4), 659-679.

Buchan, J. (2004). What difference does (good) HRM make? Human Resource for Health, 2004 2;6.

Cardy, R. L. and Selvarajan T.T. (2004). *Assessing Ethical Behavior.* Development of behaviorally anchored rating scale, proceeding of Southern Academy Management Meeting

Carrell, M.R. & Dittrich, J. E. (1979). *Organizational Equity Perceptions, Employee Job Satisfaction, and Departmental Turnover Rates.* Organizational Behavior and Human Performance, 24, 29-40.

Cascio Wyne, (1998). *Managing Human Resource*: Productivity, Quality of work life, Profits (5th edn) Irwin McGraw Hill (Boston)

Fastone, M. and Mary Tabu, (2008). *Human Resources for the Delivery of Health Services in Zambia: External Influences and Domestic Policies and Practices.* A case study of four districts in Zambia, University Zambia Lusaka.

Champathes, M. R. (2006), *Coaching for Perforance Improvement*: The coach model. *Development and Learning in Organizations*, Volume 20, No. 2, pp.17-18.

Chapins, A. (1995). *Workplace and the Performance of Workers.* Reston: USA.

Chen, L.C, Evans, T, Anand, S, Boufford, J, Brown, H, Chowdhury, M, Cueto, M, Dare, L, Dussault, G and Elzinga, G. (2004). *Human Resources for Health: Overcoming the Crisis. The Lancet,* 364:1984-1990

Corkery (2000*). Public Service Reforms and their Impact on Health Sector Personnel in Uganda.* Geneva,ILO and WHO.

Cole, G. A. (2002). *Personnel Human Resource Management,* 5thedn, Continuum, London.

Cole, G.A. (2004). *Personnel Management, Theory and Practice.* 4th edn, London: DP Publications Ltd.

Collins, D. (1998). *Organizational Change: Sociological Perspectives,* USA: Routledge.

Collins, C. J. and Clark. K. (2003). *Strategic Human Resource Practices, Top Management Team Social Networks, and Firm Performance.* Academy. Management J. 46 740–751.

Collins, C. and Clark, M. (2003). *Human Resource Management Practices and Firm Performance in Small Business.* pp 10 Cornell University/Gevity Institute.

Cooke, F. L.(2000). *Human Resource Strategy to improve Organizational Performance:* A Reoute for British Firms". Working paper No.9 EWERC, Manchester School of Management.

Cooper, D. R and Schindler, P.S.(2008), *Business Research Methods.* 10th edition. Boston: McGraw-Hill Irwin.

Greenberg, J., and Baron, R. A.(2003). *Behavior in Organizations: Understanding and Managing the Human Side of Work.* Englewood Cliffs, NJ: Prentice

Creswell, E (2003). *Research Design: Qualitative, Quantitative and Mixed Methods. Approaches,*(2nd.) Thousand Oaks, London.

Creswell, JW and Plano-Clark, V.L. (2007).*Designing and Conducting mixed Methods Research.* Thousand Oaks, CA: Sage.

Cronbach, L.J. (1951). *Coefficient, Alpha and the Internal Structure of Tests.* Psychometrica 16, 297-334

Cully,M. Woodland , S. O'Reilly, A. and Dix, G.(1999) ,*Britain at Work: As depicted by the 1998 Workplace Employee Relations Survey.* Routledge, London.

Cushway, B. (1999). *Human resource management.* London: Kogan Page Ltd. 120 Pentonville Road.

David, M. and Sutton, D (2004).*Social Research the Basics.* London: Sage Publications.

Decenzo, D.A. and Robbins, S.P.(1999). *Personnel Human Resource Management.*(3rd Ed), New Delhi: Prentice Hall of India.

Sector workers in Mali. Human Resources for Health 4(2):1-7.

Disoloane, V.P.P.(2012). *Reception of a Code of Conduct at the Capricorn District Municipality in the Limpopo Province.* Published ph.D Dissertation, University of South Africa.

Dixon, J. and Kouzmin, A.(1994). *'The Commercialization of the Australian Public Sector: Competence, Elitism or Default in Management Education*? International Journal of Public Sector Management, vol. 7, no. 6, pp.52-73.

Dolea, C and Zurn, P. (2004). *Mission to Evaluate the Project of Clinical Professional Development and Management System (CPDMS) for Nurses and Midwives in Hospitals and Health Centers in Indonesia.* Geneva: WHO.

Dolnicar,S. (2003). *Simplifying Three-way Questionnaires- Do the Advantages of Binary Answer Categories Compensate for the loss of information?* Australia and New Zealand Marketing Academy (ANZMAC) CD Proceedings.

Dolnicar,S.,Grun, B.,Leisch, F. and Rossiter, J.(2011). *Three good reasons NOT to use five and seven point Likert items, CAUTHE*: 21ST CAUTHE National Conference, Adelaide, Australia.

Douglas, A.L, William, G.M. and Samuel, A.W. (2008). *Basic Statistics for Business and Economics.* (6th ed.). McGraw Hill higher Education

Doyle, M. (1997). *Management Development.* In Ian Beardwell and Len Holden (Eds), Human Resource Management. A contemporary perspective. London: Pitman

Elena, P. A. (2000). *Employee Development through Self-development in three Retail Banks." Journal of Personnel Review,* Vol. 29 No. 4, pp. 491-508.

El-Jardali, F, Jamal, D, Abdallah, A and Kassak, K. (2007). *Human Resources for Health Planning and Management in the Eastern Mediterranean Region*: Facts, Gaps and forward thinking for Research and Policy. *Human Resources for Health*, 5(9): [1-12].

Enarson, A.D, kennedy, S.M, Miller, D.C and Bakke , P. (2001).*Methods for Promotion of Lung Health Research.* A Guide to Protocol Development for Fair Income Countries. Paris: IUAT LD.

Ferris, G.R, Arthur, M.M, Berkson, H.M, Kaplan, D.M, Harrell-Cook, G. and Frint, D. D. (1998). '*Towards a Social Context Theory of the Human Resource Management-Organization Effectiveness Relationship.'* Human resource management Review, 8:235-64.

Fey, C. F., (2000), "*The Effect of Human Resource Management Practices on MNC Subsidiary Performance in Russia".* SSE/EFI Working Paper Series in Business Administration No. 2000:6

Freedman, L.P. (2005). *Achieving the MDGs: Health Systems as Core Social Institutions. Development*, 45(1):19-24.

Frye, M. B. (2004*). Equity-Based Compensation for Employees: Firm Performance and Determinants,* The Journal of Financial Research, 27(1), 31-54.

Gant, J., C. Ichniowski, K. Shaw. (2002). *Social Capital and Organizational Change in High-Involvement and Traditional Work Organizations. J. Economics.* Management Strat. 11 289– 328.

Gerhart, B., and Milkovich, G.T.(1992). *Organizational differences in Managerial Compensation and Firm Performance. Academy of Management Journal*, 33: p. 663-691.

Gibson, J., Ivanevich, L., John, M. and Donnelly, J. H. (2000), "*Organisations Behaviour Structure Processes*". 10th Edition. Boston. McGraw-Hill.

Gittell, J. H. 2000. *Organizing Work to Support Relational Coordination.* Internat. Journal, Human Resource Management 11, 517–539

Gratton, J. and Gold (2005*). Human resource management, Theory and Practice.* (3rd Ed), New York: Palgrave Macmillan 175 Fifth Avenue.

Greenberg, J., and Baron, R. A.(2003). *Behavior in Organizations: Understanding and Managing the Human Side of Work.* Englewood Cliffs, NJ: Prentice

Gould-Williams, J. (2003*). The Importance of HR Practices and*

Workplace Trust in Achieving Superior Performance: a study of Public-sector Organizations, International Journal of Human Resource Management, 14(1), 28-54.

Guest, D. (2002). *Human Resource Management, Corporate Performance and Employee wellbeing: Building the worker into HRM."* The Journal of Industrial Relations 44:3, 335-358

Hagopian, A, Zuyderduin, A, Kyobutungi, N, and Yumkella, F. (2009). *Job Satisfaction and Morale in the Ugandan Health Workforce.* Health Affairs, 28(5):w863-w875

Harley, B. (2002). *Employee Responses to High Work Performance System Practices*: An Analysis of AWIRS95 Data, The Journal of Industrial Relations, 44(3), 418-434.

Harris, P. R., and Harris, K. G. (1996). *Managing effectively through teams*. Team Performance Management: An International Journal, 2 (3), 23-36

Hartline, M. D. and K. C. Jones (1996), "*Employee Performance Cues in a Hotel Service Environment: Influence on Perceived Service Quality, Value, and Word-of Mouth Intentions."* Journal of Business Research, 35 (March), 207-215.

Hassan, M. E. and Fuadah J., (2014). *The Impact OF Human Resources Management on Healthcare Quality Asian Journal of*

Management Sciences and Education.Vol.3, No.1.Negeri Sembilan, Malaysia.

Hassain, M. M.and Hoque, Z.(2002). *Understanding Non-financial Performance Measurement Practices in Japan Banks*. Accounting, Auditing and Accountability Journal, Volume 15 Issue 2, pages 162-183.

Heizer, J. and Render, B.(2008). *Operations Management*. 9th edition. New Jersey: Prentice Hall.

Henderson, I. (2011). *Human Resource Management for MBA Students*. 2nd Edition Published by the CIPD.

Herzberg, F. (1966). Work and the Nature of Man, Cleveland: World Publishing Company.

Herzberg, F. (1974). *New Perspectives on the will to Work. Management Review, 63* (11), 52-54.

High-Level Forum on Health MDGs.(2004). *Report Addressing Africa's Workforce Crisis*. An Avenue for Action. Geneva

Horgan, J. P. Muhlau. (2006). *Human Resource Systems and Employee Performance in Ireland and the Netherlands: A test of the Complementarily hypothesis*. Internat. J. Human Resource Management 17 414–439.

Hughes, R. L, Ginnet, R.C, Curphy, G.J (2002). *Leadership, enhancing the lessons of experience*. New York, McGraw-Hill/Irwin.

Huling, E. (2003), "*Rough Notes*". Journal of Applied Psychology, Vol.2 No. 1 pp. 17-24.

Hume, D. A.(*1993). Remuneration and Performance of Employees in the United Kingdom Food Industry*. Unpublished Doctor of philosophy in business management thesis, Glasgow University-United Kingdom.

Hunt, J.W. (1986). *Managing people at Work. (2nd Ed), London: McGraw-Hill.*

Huselid, M. A. (1995). *The Impact of Human Resource Management Practices on Turnover, Productivity and Corporate Financial Performance; Academy of Management Journal, Volume 38* No.3 pp 635-672.

Ivancevich. M. John (2001). *Human Resource Management* (8thedition), New York: McGraw Hill Series USA.

Iyengar, K and Iyengar S.D. (2009). *Emergency Obstetric Care and Referral: Experience of two Midwife-led Health Centers in Rural Rajasthan, India*. Reproductive Health Matter, 17(33):9-20.

Jacob, R. and Washington, C (2003) *Employee development and Organization*: A review of literature and direction for future research. Roultege, part of the Taylor and Francis Group.

Jamal, K. and Adwan, A. (2008). *The reality of workforce planning in the health sector hospitals the non-governmental sector in the Provinces of Gaza.*

Jeppsson, A. and S. A. Okuonzi (2000). *Vertical or Holistic Decentralization of the Health Sector? Experiences from Zambia and Uganda. International Journal of Health Planning and Management* 15: 273–289.

Jitta , Kawesa, and Kisitu (1996). *Evaluation of Health Financing Reforms in Uganda: A document review of user fees.* A paper presented to the World Health Organization Child Health and Development Center, Makerere University Kampala, Uganda.

Johnson, D. W., and Johnson, R. T.(1995*). Social Interdependence – Cooperative Learning in Education.* In Bunker and J. Z. Rubin (Eds.), Conflict, Cooperation, and Justice (pp. 205-251). San Francisco Jossey-Bass Publishers.

Johnson, D. W., and Johnson, R.T. (1999). *Learning Together and Alone: Cooperative, competitive, and individualistic learning*

(5th ed.). Needham Heights: Massachusetts: Allyn and Bacon.

Joint Learning Initiative, (JLI). (2004). *Human Resources for Health: Overcoming the Crisis*. Cambridge: Global Equity Initiative, Harvard University Press.

Kampala Capital City Authority Act (2010*), Uganda Government Printery*

Kaplan, S. and Atkinson, A.(1998). Advanced Management Accounting. Third edition. Prentice Hall Inc, Upper Saddle River, New Jersey.

Kavuma, R.M.(2009). *Uganda's Health Care System Explained. The Guardian News and Media Limited*, Wednesday 1st April 2009.

Ketchard, A. A.,and Strawser,J. R. (2001). *Multiple dimensions of Organizational commitment: Implications for future accounting Research*. Behavioral Research in Accounting, 13 (1), 221-251.

Khurram,S., Sajid, B and Muhammad, I.R (2008*). Impact of HR Practices on Perceived Performance of University Teachers in Pakistan.* International Review of Business Research Papers Vol.4 No.2, PP.302-315

Kleynhans, R, Markham, L, Meyer, W, Van Aswegen, S and Pilbean, E. (2007). *Human Resource Management: A fresh Perspective*. Cape Town: Pearson Education South Africa.

Kirton, G., and Greene, A.(2000). *The dynamics of managing diversity: A critical approach*, Oxford: Butterworth Heinemann

Knippenberg, Rudolf, Agnes Soucat, Kayode Oyegbite, Maria Calivis, Ian Hopwood, Reiko Niimi, Mamadou Pathe Diallo, Mamadou Conde, and Samuel Ofosu-Amaah.(1997)."Bamako Initiative Programmes in West Africa: An Assessment of 5 Years Field Experience in Benin and Guinea." *International Journal of Health Planning and Management* 12 (Suppl. 1): 29–47.

Kramar, R. (1986) *The Personnel Practitioner and Affirmative Action, Human Resource Management.* Australia, 24: pp38-44.

Kithinji (2002*). Improving Service Delivery through Public Service Reform: Lessons of experience from select Sub-Saharan Africa Countries.* A Paper for presentation and discussion at the Second Meeting of the DAC Network on Good Governance and Capacity Development held at the OECD Headquarters, February 14-15, 2002. Nairobi: KK Consulting Associates

Koch, M. J. and R. G. McGrath (1996). *Improving Labour Productivity: Human Resource Management Policies do Matter.* Strategic Management Journal, 17. Pp 335-354

Koontz, H. and Weinrich, H. (2002). *Management: A global perspective.* (10th Ed), New Delhi: Wishwa Prakashan.

Kotler, P and Keller, KL (2006). *Marketing Management*. 12th edition. Upper Saddle, NJ: Prentice-Hall International

Kramer, M. and Schmalenberg, C. (2004*). Essentials of a Magnetic Work Environment Part 1*. Nursing. 34(6): 50-54.

Kreitner, R. (1995). *Management* (6th Ed), Boston: Houghton Mifflin Co.

Kreitner, R. and Kinicki, A. (2008). Organizational Behaviour. 8th (edn), McGraw-Hill: New York.

Kurowski, C., Wyss, K., Abdulla, S and Mills, A.(2007). *Scaling up Priority Health Interventions in Tanzania: The Human Resource Challenge. Health Policy and Planning*, 22:113-127.

Lawler, E., MOHrman, S. A., and Ledford, G. E.(1998). *Strategies for High performance organizations-The CEO Report*. San Francisco, CA: Jossey-Bass Publishers.

Lepak, D. P. and Scott A. Snell. (1999).*The Human Resource Architecture: Towards a theory of Human Capital allocation and Development. Academy of Management Review*, 24(1): 31-48.

Liao, H. and A. Chuang, (2004). *A Multilevel Investigation of Factors Influencing Employee Service Performance and Customer Outcomes*. Academy of Management Journal, 47(1): 41-58.

Linda, M. (2001). *Introduction to Human Resource Management.* Theory and Practice. Great Britain: Palgrave Publishers Ltd.

Lirkert. R. (1932). *A Technique for the Measurement of Attitudes*. New York: Archives of Psychology.

Liu, Y., Zhao, Y and Liu Y., (2006). "*The Relationship between HRM, Technology Innovation and Performance in China".* International Journal of Manpower, Vol. 27 No. 7, pp. 679-697

Liu, Y, Combs, J. G, Ketchen (Jr), D.J and Ireland, R.D. (2007). *The Value of Human Resource Management for Organizational Performance. Business Horizon*, 50:503-511

Luca,J.,and Tarricone, P. (2001). *Does Emotional Intelligence affect Successful Teamwork?* Proceedings of the 18th Annual Conference of the Australasian Society for Computers in Learning in Tertiary Education at the ASCILITE, p. 367 – 376, Melbourne: University of Melbourne

Luecke, R.B. J. (2006). *Performance Management*. Measure and Improve the Effectiveness of Your Employees, Harvard Business School Publishing Corporation, Boston: Harvard University Press.

Lutwama,G.W.(2011).The *Performance of Health Workers in Decentralized Services in Uganda*. Thesis, University of South Africa.

MacDuffie, J. P. (1995). *Human Resource Bundles and Manufacturing Performance: Flexible Production Systems in the World Auto Industry*. Industrial Relations and Labour Review.

MacDuffie, J.P. and Krafcik, J.F. (1992) *'Integrating Technology and Human Resources for satisfactory Performance Manufacturing: Evidence from the International Auto Industry'*. In Kochan, T. A. and Useem, M. (eds) Transforming Organizations. New York: Oxford University Press.

Malhotra, N., Budhwar, P., and Prowse, P.(2007*). Linking Rewards to Commitment: A Empirical Investigation of Four UK call Centers*. In International Journal of Human Resource Management. pp. 2095-2127. Routledge: Taylor & Francis Group

Maicibi, N.A. (2003).*Pertinent Issues in Employees Management.* Kampala: MPK Graphics (U) Ltd.

Maicibi, N. A. (2007). *Human Resource Management Success*: The tips for HRM Theorists and Practitioners. Kampala: Makerere University Printery.

Manion, J. (2005). *From Management to Leadership*. San Francisco: Jossey-Bass.

Manuwa-Olumide, A.(2009).*Addressing the Human Resource in Primary Health Care in Nigeria: Evidence-Based Approaches for Improving Health Workforce Performance.* An invited paper presented on the 9th June at the National Health Conference on Primary Health Care in Nigeria 30 years after Alma-Ata, in Uyo, Akwa-Ibom State, Nigeria.

Markovits, Y., Davis, A.J., and Dick, R. v. (2007). *Organizational Commitment Profiles and Job Satisfaction among Greek Private and Public Sector Employees*. International Journal of Cross Cultural Management, 7, 1, 56-70.

Mathauer, I and Imhoff, I.(2006). *Health Worker Motivation in Africa: The Role of Non Financial Incentives and Human Resources Management Tools*. Human Resources for Health,4(24):1-17

Marthis, R.I. and Jackson, J. H. (2000). *Human Resources Management.* New Jersey: Prentice Hall.

Maslow, A. H. (1954). *Motivation and Personality*. New York: Harpe and Row.

McMahan, G.C, Bell, M.P and Virck, K. (1998).*Strategic Human Resource Management*: Employee Involvement, *Diversity and International Issues'*, Human Resource Management Review,6 193-214.

McNamara, C. (2005). *Human Resource Management and Talent Management*. Authenticity Consulting LLC.

McPake. B, Asiimwe.D, Mwesigye .F, Ofumbi. M, Ortenblad. P, Turinde.A, (1999). *Informal Economic Activities of Public HealthWorkers in Uganda: Implications for Quality and Accessibility of Care.* Social Science and Medicine. 49, pp. 849-865.

Mendelson, M.B., N.Turner and J. Barling, 2001. *Perceptions of the Presence and Work Systems and their Relationship to Employee Attitudes: A Test of Competing Models*. Personnel Review, 40(1): 45-69

Mercer, H and Dal Poz, M. (2002). *Human Resources for Health: Developing Policy Options for Change*. Geneva: WHO.

Meyer, J. P. and Allen, N.J. (1997). *Commitment in the workplace,* Thousand Oaks, CA: Sage Publications.

Mike, A. (2010). *Visual Workplace: How you see Performance in the Planet and in the Office.* International Trade Journal, 11(3), 250-260.

Miles, E. W.,Hatfield, J. D., and Huseman, R. C. (1989). *The Equity Sensitivity Construct: Potential Implications for Worker Performance*. Journal of Management, 15, 581–588.

Ministry of Finance Planning and Economic Development (2002) *Deeping the Understanding of Poverty: 2nd Participatory Poverty Assessment Report*. Kampala, Uganda.

Ministry of Finance Planning and Economic Development, (2002) *Deeping the Understanding of Poverty: 2nd Participatory Poverty Assessment Report*. Kampala, Uganda.

Ministry of Health (2002). *Uganda Pharmaceutical Sector Baseline Survey*. Kampala: Government of Uganda.

Ministry of Health Uganda ,(2006). *Human Resources for Health Policy*. Kampala: Government of Uganda.

Ministry of Health Uganda (2008). *Annual Health Sector Performance Report: Financial Year 2007/2008*. Kampala: Government of Uganda.

Ministry of Health,(2009b). *The Draft National Health Policy II: Reducing Poverty through promoting People's Health*. Government of Uganda.

Ministry of health.(2009a). *Health Sector Strategic Plan*. Government of Uganda.

Ministry of health.(2010a). *Health Sector Strategic Plan II.* Government of Uganda.

Ministry of Health (2010b) *National Policy on Public Private Partnership in Health.* Kampala.

Ministry of Health (2011a). *Annual Health Sector Performance Report Financial Year 2010/2011.* Kampala: Ministry of Health.

Ministry of Health (2011b*). Medicines and Health Services Monitoring Unit.* Annual Report *2011*. Kampala.

Ministry of health.(2011c). *Health Sector Strategic Investment Plan.* Government of Uganda.

Ministry of Public Service (1989) *Public Service Review and Reorganisation Kampala Commission, Uganda.*

Mor Barak, M., Cherin, D. A., and Berkman, S. (1998). *Organizational and Personal Dimensions in Diversity Climate. Journal of Applied Behavioral Science*, 34(1), 82-104.

Mowday, R., Porter, L., and Steers, R. (1979). *The Measurement of Organizational Commitment.* Journal of Vocational Behavior, 14, 2, 224-247.

Nakkazi Esther (2010). *The East African; Uganda Health Service Delivery Poor despite Funds Allocations.*

Nankinga, Y. (2006*). Motivation and Performance of Teachers in Secondary Schools of Makindye urban council;a case study of Kakungulu Memorial School.* Unpublished Master' Dissertation, Kampala International University.

Nayeri, N.D, Nazari, A.A., Salsali, M and Ahmadi, F.(2005). *Iranian Staff Nurses' Views of their Productivity and Human Resource Factors Improving and Impeding it: A Qualitative Study. Human Resource for Health*, 3(9):[1-11].

Nayyab, H., Hamid, M., Naseer, F. and Iqbal .M., (2011), "*The Impact of HRM Practices on the Organizational Performance :The Study of Banking Sector in Okara, Punjab Paki stan)".* Interdisciplinary Journal Of Contemporary Research In Business, Vol. 3, NO.3, pp.661-672.

Newstrom, W.J. and Davis, K.(2001).*Organizational behavior, Human behaviour at work, Tate McGraw-Hill publishing Company Limited, p.256.*

Noe, L., Hollenbeck, H., Gerhart, A. and Wright, O.(2007*). Relationship between HR Practices and Perceived Employees' Performance of Bankers in NWFP,* Pakistan, European Journal of Social Sciences Volume 18, Number 2.

Ntoburi, S, Wagai, J, Irimu, G and English, M.(2008). *Debating the Quality and Performance of Health Systems at a Global level, Is not enough, National Debates are Essential for Progress.* Tropical Medicine an International Health, 13(4):444-47.

Okuonzi, SA. (2004). *Learning from the failed Reforms in Uganda.* BMJ, 329(7475):1173-1175.

Okwero, P. (2010). *Fiscal Space for Health in Uganda.* World Bank Working Paper No. 186. Washington DC: World Bank.

Olum, Yasin. (2003). *Public Service Reform in Uganda (1989 - 2002): A Critical Appraisal.* Makerere University Department of Political Science and Public Administration.

Osman, I., Ho,F. and Galang, M. C (2011). *The Relationship between Human Resource Practices and Firm Performance: An Empirical Assessment of Firms in Malaysia".* Business Strategy Series, Vol.12 No. 1, pp. 41-48

Padarath, A, Chamberlain, C, McCoy, A, Ntuli, A, Rowson, MandLoewenson, R.(2003). *Health Personnel in Southern Africa: Confronting misdistribution and brain drain.* Equinet discussion Paper Number 3. Regional Network for Equity in Health in Southern Africa (Equinet) Health Systems: Trust (South Africa and Medact (UK).

Panayotopoulou, L and Papalexandris, N. (2004), *"Examining the Link between Human Resource Management Orientation and Firm Performance".* Personnel Review, Vol.33, No.5,pp. 499-520.

Paré, G. and M. Tremblay (2007). *The Influence of High-Involvement Human Resource Practices, Procedural Justice, Commitment and Citizenship Behaviors on Information Technology Professionals' Turnover Intentions.* Group and Organization Management, 32(3): 326-357.

Park, H. J, Mitsuhashi, H., Fey, C. F. and Bjorkman, I. (2003). *The Effect of Human Resource Management Practices on Japanese MNC Subsidiary Performance: A Practical Mediating Model,* International *Journal of Human Resource Management,* 14(8), 1391-1406.

Pathak, R. D., Budhwar, P. S., Singh, V. and Hannas, P. (2005). *Best HRM Practices and Employees" Psychological Outcomes: A Study of Shipping Companies in Cyprus.* South Asian Journal of Management,12(4), 7.

Paul, A.K and Anantharaman, R.N. (2003), *'Impact of People Management Practices on Organizational Performance: Analysis of A causal Model', International Journal of Human Resource Management,* Vol.14, No.7, pp.1249.

Peck, S.R. (1994), '*Explaining the Link between Organizational Strategy and the Employment Relationship: The Role of Human Resources Policies', Journal of Management Studies,* Vol. 31,pp. 715–736.

Pei,Y.L. (2007). *Correlation between Management and Employee Motivation in Sasol polypropylene in south Africa.* Unpublished Masters of business administration management dissertation, University of Pretoria, Pretoria South Africa.

Pfeffer, J. (2005). *Producing Sustainable Competitive Advantage through the Effective Management of People.* Academy of Management Executive 19(4): 95-106.

Pfeffer J. (2007) *Human Resources from an Organizational Behavior Perspective: Some Paradoxes Explained.* Journal of Economic Perspective, 21(4), 115-134.

Pinder, C. (1998). *Work Motivation in Organizational Behavior.* New Jersey: Prentice Hall.

Polit, D. F. and Beck, C.T. (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice.* 8th edition. Philadelphia: Lippincott Williams and Wilkins

Public Service Reform Commission in Uganda (1989-2002): Kampala, Uganda

Ramsay (2000). *Employees and High performance systems: Testing Inside the box.* British Journal Industrial Relations. 38(4):501- 531.

Rao. S.P.(2001). *Essentials of Human Resource Management and Industrial Relations*: Himalaya's publishing company

Research Report 1, (2010).*Governing Health Service Delivery in Uganda: A Tracking Study of Drug delivery mechanisms Research Report.* Economic Policy Research Centre. Kampala, Uganda.

Robbins, D. (2001). *Fundament of Management*. (3rd edn), Prentice Hill.

Rowe, A.R., De Savingny, D., Lanata, C.F., Victoria.C (2005). *How can we Achieve and Maintain High Quality Performance of Health Workers in Fair Resource Settings*? The Lancet, 366:1026-1035.

Robbins, S.P., Odendaal. A., Roodt, G. (2007). *Organizational Behaviour.* Global and Southern African Perspectives. CapeTown: Maskew Miller Longman.

Ruwan, A. (2007). *The Impact of Human Resource Practices on Marketing Executive Turnover of Leasing Companies in Sri Lanka.* Contemp. Management. Res., 3(3): 63-76.

Saunders, M, Lewis, P and Thornhill, A. (2009). *Research Methods for Business Students.* 5th edition. Harlow: FT Prentice Hall.

Senyucel, Z. (2009). *Managing Human Resources in the 21st Century.*

Scarnati, J.T. (2001). *On becoming a Team Player.* Team Performance Management: An International Journal,7 (1/2), 5-10.

Schuler, R. S.(1989). *'Strategic Human Resource Management and Industrial Relations'.* Human Relations, 42; 157-84

Schuler, R. S. and Jackson, S.(1998). "*Linking Competitive Strategies and Human Resource Management Practices.*" Academy of Management Executive 1(3): 207-29

Schuler, R. and MacMillan, I. (1984).*Gaining Competitive Advantage through Human Resource Management practices.* Human Resource Management, 23 (3), 241-255.

Schuler,R. S.(1989). Strategic Human Resource Management and Industrial Relations. Journal of Management.

Screenland, P. (2005). *Public Health Care under Pressure in Sub-Saharan Africa.* Health Policy, 71,(3), pp;375-82.

Shanks, N.H. (2003). *Management and Motivation.* Jones and Bartlett Publishers.

Shanks, N. H.(2007).*Management and Motivation.* In Introduction to Healthcare Management. Jones and Bartlett Learning. United States

Sharma, J. P. and Bajpai, N. (2010) *Organizational Commitment and its Impact on Job Satisfaction of Employees: A Comparative Study in Public and Private Sector in India.* International Bulletin of Business Administration, 9, 7-19.

Shikdar, A. A. (2002*). Identification of Ergonomic issues that affect Workers in Oilrigs in Desert Environment.* International Journal of Occupational Safety and Ergonomic, 10(8), 169-177

Shims, D. (2001) *Recent Human Resource Developments in OECD Member Countries.* Public Personnel Management, 30:3 pp 323-47

Silbert, L.T. (2005). *The effect of Tangible Rewards on Perceived Organizational Support.* Management Sciences,Website. *uwaterloo.ca/bitstream/10012/872/1/lsilbert2005.*

Simon, M. K.,and Francis, J. B. (2001). *The Dissertation and Research Cookbook.* Dubuque, IA: Kendall/Hunt Publishing Company.

Sims, R. R. (2007). *Human resource management: contemporary issues, challenges, and opportunities.* International Age Publishing, Inc.

Smerek, R. and Peterson, M. (2007). *Examining Herzberg's theory: Improving Job Satisfaction among non-academic Employees at a University. Research in higher Education, 48*(2), 229-250.

Smith, D.G. (2011). *Work environment more important to employees.* Retrieved November 25, 2011 from http://www.business know how.com.

Snell, S. A. and Youndt, M. A. (1996). "*Human Resource Management and Firm Performance*: Testing a contingency model of executive controls." Journal of Management. 21(4).

Soomro, R. B, Gilal, R .G, Jatoi. M. M. (2011), "*Examing the Impact of Human Resources Management (HRM) Practices on Employees Performance; A Case Study of Pakistani Commercial Banking Sector."* Interdisciplinary Journal of Contemporary Research in Business, Vol.3, No.1,pp 865-878.

Ssengooba, F, Rutebemberwa, E and Hongoro, C. (2005). *Human Resources for Health in Decentralized Uganda: Developments and Implications for Health Systems Research.* Mumbai, India: Forum 9 Conference presentation, 12-16 September.

Ssengooba, F., Rahman, S.A., Hongoro, C, Rutebemberwa, E., Mustafa, A., Kielmann, T. and McPake, B. (2007*). Health Sector Reforms and Human Resources for Health in Uganda and Bangladesh: Mechanisms of Effect.* Human Resources for Health 5(1): 3.

Ssewanyana, S., Bategeka, L., Mugisha, F., and Muwanika, F., (2010), *Governing Health Service Delivery in Uganda.* A tracking study of drug delivery mechanisms .Economic Policy Research Center. Research Report No.1

Stavrou, E. T. (2005), *The Configurational Approach to Linking Strategic Human Resource Management Bundles with Business Performance:* Myth or Reality? *Management Revue*, Vol.16, No.2, pp.186-201.

Stello, C. M.(2014). *Herzberg's Motivation Factors*. Mindstools.com. University of Minnesota

Stone, F. M. (2003). The Manager's Question and Answer Book. USA. AMACOM.

Storey, J. (2001). "*Human Resource Management Today: An Assessment.*" In John Storey (ed.). *Human Resource Management: A Critical Text*. 2nd edn. London: Thomson Learning, 3-20.

Strober, M.(1990). *Human Capital Theory:* Implications for HR Managers", Industrial Relations 29 (2) 214-29.

Tang, T.W. and Y.Y. Tang,(2012). *Promoting Service Oriented Organizational Citizenship in Hotels.* The role of High-performance human resource practices and Organizational Social Climates. International Journal of

Hospitality Management, 31(3): 885-895.

Tawfik-Shukor, A. R, Klazinga, N.S and Arah, O.A. 2007. *Comparing Health System Performance Assessment and Management Approaches in the Netherlands and Ontario, Canada.* BMC Health Services Research, 7(25):[1-12].

Tessema, M. and Soeters, J.(2006). *Challenges and Prospects of HRM in Developing Countries*: Testing the HRM-performance link in Eritrean civil service, International Journal of Human Resource Management, 17(1), 86-105.

Thomas, K. W. (2002). *Intrinsic Motivation at Work: Building Energy and Commitment.* San Francisco. Berrett-Koehler Publishers, Inc.

Tornow, W.W.(1988).*Contract Redesign. Personnel Administrator*, October, 97-101.

Treece, E.W., and Treece, J. W. (1986). *Elements in Research in Nursing.* St. Louis: C. V. Mosby.

Tsaur S.H., Lin, Y.C. (2004)," *Promoting Service Quality in Tourist Hotels: the Role of HRM Practices and Service Behavior*" Tourist Management 25 (2004) 471–481.

Uganda Bureau of Statistics (2010). *Uganda National Household Survey 2009/2010; Social-Economic Report* . Kampala, Uganda.

Uganda Bureau of Statistics (2011). *District Population Profile*. Kampala, Uganda.

Ulrich, D. (2013). *Human Resource Champion*: The Next Agenda for adding Value and Delivering *Results*. University of Michigan. Harvard Business press.

Usman, A. (2O11), *Statistical Methods for Biometric and Medical Research*. Kaduna, Nigeria. Millennium Printing and Publishing Company Limited Vroom, V (1964) *Work and Motivation*, Wiley, New York

Velnampy, T.(2006) .*Satisfaction and Organizational Commitment on the Impact of Performance, 10th annual international Symposium; Growth and challenges for 21st Century; p. 338.*

Velnampy,T.(2007) *Job Attitude and Employees Performance of Public Sector Organizations in Jaffna District*, Sri Lanka

Vogus, T.(2006). *What is it about Relationships? A behavioral theory of Social capital and performance*. Labor Emp. Rel. Proc. 58 164–173.

Wagner, W.G., Pfeffer, J. and O'Reilly, C (1984). *Organizational Demography and Turnover In Top-Management Groups. Administrative Science Quarterly.*

Wahba, M. A. and L. G. Bridwell (1987). *Maslow Reconsidered: A Review of Research on the Need Hierarchy Theory.* In Motivation and Work Behavior. R. M. Steers and L. W. Porter, eds. New York: McGraw-Hill Book Company, 51-58.

Wang, M.L., (2010). *Does Organizational Support Promote Citizenship Behavior: The moderating Role of Market-Focused HRM.* The Service Industries Journal, 30(7): 1077-1095.

Way, S.A. (2002). *Satisfactory Performance Work Systems and Intermediate Indicators of Firm Performance within the U.S. Small Business Sector.* Journal of Management, 28: p. 765-785.

Way, S.A., and Thacker, J.W. (2001). *The Successful Implementation of Strategic Human Resource Management: A Canadian Survey.* International Journal of Management, 18 p. 25-32.

Wei, Y.C.,T.S. Han and I.C. Hsu, (2010*). High-Performance Human Resource Practices and OCB: A Cross-Level Investigation of a Causal Path.* The International Journal of Human Resource Management 21(10): 1631-1648.

Weihrich, H and Koontz, H. (2002). Management: A Global Perspective. 10th edn, McGraw Hill. New York.

Wireman, M. F. and Bantel, K. A. (1992). *Top Management Team Demography and Corporate Strategic Change. Academy of Management Journal*, 35(1), 91-108

World Bank ,(1993). *World Development Report: Investing in Health.* New York: Oxford University Press.

World Health Organization, (2001). *Report of the Scientific Peer Group on Health System Performance Assessment.* Geneva

World Health Report,(2000). *Health System: Improving Performance.* Geneva: World health organization.

World Health Organization,(2005). *Regional Data Base:* Human Resources for Health. Brazzaville: Word Health Organization. Geneva

World Health Organization,(2006). *Report on Working together for Health.* Geneva.

World Health Organization, (2007). *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes, WHO's Framework for Action.* Geneva.

Wright, P. M., Garden, T. M. and Moynihan, L. M.(2003). *The Impact of HR Practices on the Performance of Business Units,* Human Resource Management Journal, 13(3), 21-36.

Yang, Y.C.,(2011). *High-Involvement Human Resource Practices, Affective Commitment and Organizational Citizenship Behaviors in Service Setting.* The Service Industries Journal, 32(8): 1209-1227.

Youndt, M. A. (1996). *Human Resource Management, Manufacturing Strategy and Firm Performance*. Academy of Management Journal, 39(4): 836-866.

Zerbe, W.J., Dobni, D. and Harel, G.H.(1998). *Promoting Employee Service Behaviour: The Role of Perceptions of Human Resource Management.* Canadian Journal of Administrative Sciences,15 (2): 165-179.

APPENDICES

APPENDIX 1

SAMPLE TRANSMITTAL LETTER

OFFICE OF THE DEPUTY VICE CHANCELLOR (DVC)

COLLEGE OF HIGHER DEGREES AND RESEARCH (CHDR)

Dear Sir/Madam,

RE: INTRODUCTION LETTER FOR Mr. Wandiba Augustine

REG.NO. Ph.D /36515/71/DU, TO CONDUCT RESEARCH IN

YOU INSTITUTION.

The above mentioned candidate is a bonafide student of Kampala International University pursuing a Ph.D. in public Management

He is currently conducting a field research for his dissertation entitled, Human Resource Management Practices and Health Service Delivery in Kampala, Uganda.

Your institution has been identified as a valuable source of information pertaining to his research project. The purpose of this letter then is to request you to avail him with the pertinent information he may need.

Any data shared with him will be used for academic purposes only and shall be kept with utmost confidentiality.

Any assistance rendered to him will be highly appreciated.

Yours truly,

Novembrieta R. Sumil, Ph.D.

Deputy Vice Chancellor, CHDR

APPENDIX II

TRANSMITTAL LETTER FOR THE RESPONDENTS

Dear Sir/ Madam,

Greetings!

I am a Ph.D. candidate in Public Management of Kampala International University. Part of the requirements for the award is a dissertation. My study is entitled, Human Resource Management Practices and Service Delivery in Kampala, Uganda. Within this context, may I request you to participate in this study by answering the questionnaires. Kindly do not leave any option unanswered. Any data you will provide shall be for academic purposes only and no information of such kind shall be disclosed to others.

May I retrieve the questionnaire within 5 days.

Thank you very much in advance.

Yours faithfully,

Mr. Wandiba Augustine

APPENDIX III

INFORMED CONSENT

I am giving my consent to be part of the research study of Mr. Wandiba Augustine that will focus on human resource management practices and service delivery.

I shall be assured of privacy, anonymity and confidentiality and that I will be given the option to refuse participation and right to withdraw my participation anytime.

I have been informed that the research is voluntary and that the results will be given to me if I request for it.

Initials:_____

Date_____

APPENDIX IV

PROFILE OF RESPONDENTS

1. Urban council/Division _____
2. Name of Health Center_____
3. Level of Health Center. II_____ ,III___, IV_____
4. Gender : Male_____, Female_____
5. Age (years)_____
6. Educational level: Certificate_____ Diploma _____Degree _____Postgraduate_____
7. Length of service _____

APPENDIX V

TOOL TO DETERMINE PERCEIVED FAIRNESS OF HUMAN RESOURCE MANAGEMENT PRACTICES

Direction: Please respond to the options on human resource management practices in terms of reward and development management practices in your urban council. Kindly be guided with the scoring system below. Write your scoring for each item in the space provided before each number.

Score	Rating Mode	Description
4	Strongly Agree	You agree with no doubt at all
3	Agree	You agree with some doubt
2	Disagree	You disagree with some doubt
1	Strongly Disagree	You disagree with no doubt at all

Reward Management Practices

__1 Salary and Wages are generally satisfactory to you.

__2 Allowances and bonuses are fair to employees.

__3 Recognitions and promotions are fairly done based on merit.

__4 All our payment and rewards come in time.

__5 Payment and promotion structures are properly communicated

__6 Salary I receive is equitable to my efforts.

__7 Payment system is reviewed frequently to accommodate changes in cost of living.

__8 Payment days are timely communicated to all employees.

__9 Payments, recognitions and promotions are well balanced with workloads and competences of employees.

__10 Allowances given always influences my work output.

__11 In our organization, salary and other benefits are comparable to

the market.

Development Management Practices

__12 Provision of priority to seniority in promotion decision.

__13 This organization has well structured training and development programs for all the employees to benefit from.

__14 The selection for staff training and development are conducted according to needs assessment center and therefore free and fair.

__15 Training needs are identified through a formal performance appraisal mechanism.

__16 There are equal opportunities for development of all staff in this organization.

__17 There are regular on job and off job training programs in this organization.

__18 Training needs identified are realistic, useful and based health strategy of the organization.

__19 There are formal training programs to teach new employees the skills they need to perform their jobs.

__20 Our organization conducts extensive training programs for its employees in all aspects of quality.

__21 Innovation and creativity are encouraged in the organization.

Thank you

APPENDIX VI

TOOL TO DETERMINE PERCEIVED EFFECTIVENESS OF HEALTH SERVICE DELIVERY

Direction: Please respond to the options on effectiveness of service delivery in terms of setting service standards, responsiveness, productivity and availability of health workers in your urban council. Kindly be guided with the scoring system below. Write your scoring for each item in the space provided before each number.

Score	Rating Mode	Description
4	Strongly Agree	You agree with no doubt at all
3	Agree	You agree with some doubt
2	Disagree	You disagree with some doubt
1	Strongly Disagree	You disagree with no doubt at all

Setting Service Standards

___1 I always try to give my clients the best quality of health services I can afford

___ 2 I always research for new insights and innovative solutions to health problems

___3 I always ensure there is enough drugs and equipments in my unit

___4 I am always transparent in serving all patients

___5 I always give equal treatment to all patients irrespective of their status

___6 I always ensure good sanitation in my unit

Responsiveness of Health Worker

___7 I always try to identify health problems to clients.

___8 I always try to ensure safety of my patients.

___9 I always give clear directions to my clients where they can get what they want.

___10 I always assist my clients to understand drug prescriptions.

___11 I always make proper diagnosis before I give medical services to my clients

___12I always try to get feedback from clients on health issues and respond to them

___13 I always serve patients quickly and timely

___14 I always communicate to patients consistently

Productivity of Health Worker

___15 I always educate clients about the available health services in my unit.

___16 I always give enough counseling to my clients.

___17 I always make follow-up on my patients.

___18 I always serve a big number of patients as expected

___ 19 I always take care to ensure that patients are given Standard and genuine drugs

___20 I never bark at or abuse my patient's even if am annoyed

___21 I always serve my patients on basis of first come first Served

___22 I do not make people I know jump lines

Availability of health worker

___23 I am always easily accessible to all clients who come around my unit

___24 I always available for patients for all, my scheduled periods

___25 I always give enough drugs and attention to my clients

___26 I am always committed to give health care to my patients whenever am at job

___27 I am available to my clients whenever they need me

Source: Modified from Public health report 2008 volume 118.

Appendix VII

INTERVIEW GUIDE FOR PATIENTS

1. What is your view of availability of health workers at the center?
2. Health workers' are seen to be committed to their work in Kampala. What is your comment on this?
3. Health centers have enough drugs and equipment. What is your view on this?
4. Health workers' counsel and make follow- up to patients after treatment.
5. Do health workers serve you quickly as arrive at center?
6. What should be done to improve health services at the center?

Thank you

APPENDIX VIII

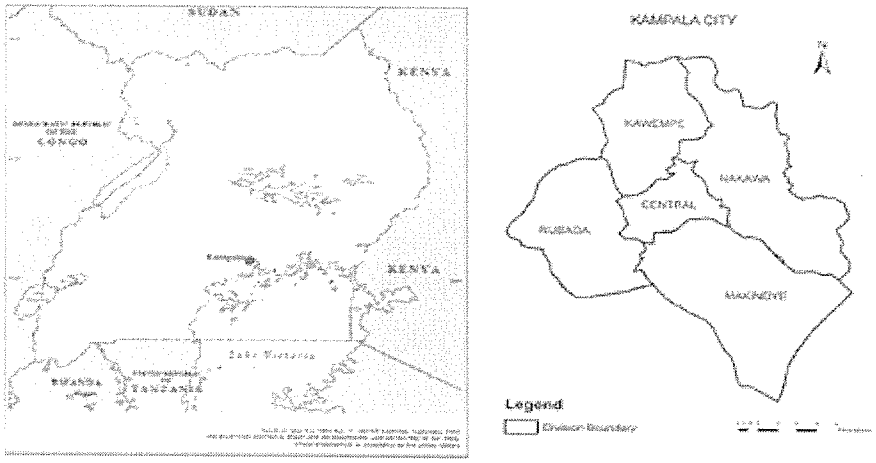
INTERVIEW GUIDE ADMINISTRATORS

1. You are satisfied with your salary? Yes or No, explain.
2. What is your view on the health staff salary?
3. Do salaries/allowances come in time?
4. If you are paid well, would you do the effectively?
5. What are other forms of benefits that your institutions give you?
6. What is your view on such benefits given to workers?
7. What are mechanisms that are used for developing human resources?
8. What is your view on this human resource development mechanisms?
9. Rewarding and development of health workers seems to be a major challenge facing health centers in Kampala. In your view;
10. What are the most important aspects that enhance rewarding and development of health workers in your health center?
11. What are the most important aspects that hinder the rewarding and development of health workers in your health center?
12. Health workers have been seen as not being committed to their work in Kampala.
13. What is your comment on this view?

Thank you

APPENDIX IX

Location of Kampala



Source: UN-Habitat (2009)

APPENDIX X (A)

VALIDITY TESTING

The Content validity ratio (Lawshe, 1975) can be used to gauge the content validity of questions on empirical measures:

$$CVI = \left(\frac{2n_r}{N}\right) - 1$$

Where n_r = number of subject matter experts, who believe the item is relevant and N = the total number of subject matter experts Using five subject matter experts ratings, the following computations were made possible on the research construct validity:

Human Resource Management Practices

Item No	No of experts rating item as 'Relevant'	Total No of experts	CVR
1	5	5	1
2	3	5	0.2
3	3	5	0.2
4	4	5	0.6
5	5	5	1
6	5	5	1
7	5	5	1
8	5	5	1
9	5	5	1
10	5	5	1
11	5	5	1
12	5	5	1
13	5	5	1
14	5	5	1
15	5	5	1
16	5	5	1
17	5	5	1
18	5	5	1
19	5	5	1
20	5	5	1
21	5	5	1
Total			0.904762

Health Service Delivery

Item No	No of experts rating item as 'Relevant'	Total No of experts	CVR
1	3	5	0.2
2	5	5	1
3	5	5	1
4	5	5	1
5	5	5	1
6	5	5	1
7	5	5	1
8	5	5	1
9	5	5	1
10	5	5	1
11	5	5	1
12	3	5	0.2
13	4	5	0.6
14	5	5	1
15	5	5	1
16	5	5	1
17	5	5	1
18	5	5	1
19	5	5	1
20	5	5	1
21	5	5	1
22	5	5	1
23	5	5	1
24	5	5	1
25	5	5	1
26	5	5	1
27	5	5	1
Total			0.957447

SUMMARY

CVR for Research Instruments	
Mean CRV-HRMP	0.905
Mean CRV-HSD	0.957
TOTAL Mean CRV	**0.931**

APPENDIX X(B)

RELIABILITY TESTING

(Cronbach's alpha Coefficient)

Items	No. of Items	Cronbach's alpha
Reward management practices	11	0.864
Employee development management services	10	0.864
Health worker's services	27	0.907
	Overall Mean	**0.875**

Source: Cronbach (1951).

APPENDIX XI

CALCULATIONS OF SAMPLE SIZE IN PUBLIC HEALTH CENTERS IN URBAN COUNCILS IN KAMPALA

No	Urban Council	Health center	Target Population	Sample size
1	Central	Kisenyi	96	43
2	Nakawa	Kiswa	50	23
3	Makindye	Kiruddu	58	26
		Kisugu	52	24
4	Kawempe	Kawempe	54	24
		Komamboga	56	25
5	Rubaga	Kitebi	59	27
		Kawaala	63	28
		Total	**488**	**220**

Source: Health Workers Register at Health Centers (2013)

The calculation are done using Slovene's formula, $n=\frac{N}{1+N(e^2)}$, Where n=the required sample size; N = the known population size; and e= the level of significance, which is = 0.05.

Kisenyi Health Center

n=?, N=96, e=0.05

$n= \frac{N}{1+N(e^2)}$

$$n=\frac{96}{1+96(0.05^2)}$$

n=43

Kiswa Health Center

n=?, N=50, e=0.05

$$n=\frac{N}{1+N(e^2)}$$

$$n=\frac{50}{1+50(0.05^2)}$$

n=23

Kiruddu Health Center

n=?, N=58, e=0.05

$$n=\frac{N}{1+N(e^2)}$$

$$n=\frac{58}{1+58(0.05^2)}$$

n=26

Kisugu Health Center

n=?, N=52, e=0.05

$$n=\frac{N}{1+N(e^2)}$$

$$n=\frac{52}{1+52(0.05^2)}$$

APPENDIX XII

AVAILABILITY OF HEALTH FACILITIES WITHIN COMMUNITIES BY REGION (%)

Health facility	Kampala	Central	Eastern	Northern	Western
Health unit Government	6.0	8.7	23.2	12.9	14.1
Hospital Government	0.9	2.0	0.0	0.7	0.9
Health unit NGO	7.6	18.9	9.9	1.6	4.9
Hospital NGO	1.3	3.3	1.3	0.3	2.0
Private clinic	72.6	56.5	38.9	33.5	22.3
Pharmacy	45.9	29.8	35.7	2.7	4.8
Traditional healer	71.4	70.6	74.3	49.0	51.4
Traditional birth attendant	33.4	48.3	72.5	87.1	69.8

Source: UBOS, 2010

KCCA
CAPITAL CITY AUTHORITY
For a better City

DIRECTORATE OF PUBLIC HEALTH AND ENVIRONMENT

REF: PHD/KCCA/600/201

31st July, 2013

Mr. Wandiba Augustine,
Kampala International University,
P. O. Box 20000,
Kampala.

RE: PERMISSION TO CARRY OUT RESEARCH ENTITLED "HUMAN RESOURCE MANAGEMENT PRACTICES AND HEALTH SERVICES DELIVERY IN KAMPALA, UGANDA"

I refer to Dr. Sofia Sol T. Gaite's letter dated 11th June, 2013 requesting for permission to allow you to carry out the above research in KCCA Health Centres.

This is to inform you that permission has been granted to you to carry out the above mentioned research at Kawempe, Kiswa, Komamboga, Kitebi, Kawaala, Kisugu, Kiruddu and Kisenyi Health Centres from 1st to 31st August, 2013.

The above permission is granted to you on the following conditions:

1) Data collection from the relevant urban health facility is further subject to obtaining permission from the administration of that Health Centre.

2) Provision of report to our office after your final data analysis.

I wish you success.

By copy of this letter, the Division Medical Officers and the In-charges of the Health Centres are requested to offer you all the necessary assistance.

(Dr. Okello Ayen Daniel)
AG. DIRECTOR PUBLIC HEALTH SERVICES AND ENVIRONMENT

c.c. All Division Medical Officers

c.c All In-charges, KCCA Health Centres.

P. O. Box 7010 Kampala - Uganda
Plot 1-3 Apollo Kaggwa Road
Tel: 0414 231 446 / 0204 660 000
Web: www.kcca.go.ug, Email: info@kcca.go.ug
f: facebook.com/kccaug, t: @KCCAUG