

**WORKERS PARTICIPATION ON QUALITY SERVICE  
DELIVERY IN GOVERNMENT HOSPITALS:  
THE CASE OF DODOMA REGIONAL REFERRAL HOSPITAL**

**MZUMBE UNIVERSITY**  
**RESEARCH REPORT ON**  
**WORKERS PARTICIPATION ON QUALITY SERVICE**  
**DELIVERY IN GOVERNMENT HOSPITALS:**  
**THE CASE OF DODOMA REGIONAL REFERRAL HOSPITAL**

**By**  
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**A Dissertation Submitted in Partial Fulfillment of the Requirements for the**  
**Master of Business Administration (MBA-CM) of Mzumbe University**

**2013**

**CERTIFICATION**

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled **Workers Participation on Quality Service Delivery in Government Hospitals: The Case of Dodoma Regional Referral Hospital**, in partial fulfillment of the requirements for the award of the degree of Master of Business Administration (Corporate Management) of Mzumbe University.

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## **DEDICATION**

This study is dedicated to my daughters, Charity and Careen.

## **ABBREVIATIONS AND ACRONYMS**

AMO	Assistant Medical Officer
ANOVA	Analysis of Variance
CHAS	College of Health and Allied Sciences
CO	Clinical Officer
CT	Care and Treatment
CTC	Care and Treatment Center
DRRH	Dodoma Regional Referral Hospital
ENT	Ears, Nose and Throat
FGDs	Focus Group Discussions
FIG	Figure
HAB	Hospital Advisory Board
HIV	Human Immune Virus
HMIS	Health Management Information Systems
HMT	Health Management Team
HOD	Heads of Department
HS	Hospital Secretary
ICU	Intensive Care Unit
IMD	Internal Medicine Department
IPC	Infection, Prevention and Control
IT	Information Technology
KPIs	Key Performance Indicators
MNRH	Muhimbili National Referral Hospital
MOHSW	Ministry of Health and Social Welfare
MOI	Medical Officer In charge
MSD	Medical Stores Department
MU	Mzumbe University
OPD	Out Patient Department
RRHMT	Regional Referral Health Management Team
SPSS	Statistical Package for Social Sciences
STI	Sexual Transmitted Infections
TB	Tuberculosis
TQM	Total Quality Management
UDOM	University of Dodoma
USA	United States of America
WIT	Work Improvement Team

## **ABSTRACT**

The purpose of this study was to explore the extent to which workers participation influence quality service delivery in different departments or sections of Dodoma regional referral hospital. The study adopted a case study design which enabled the study to triangulate the data and information. In this study, four methods of data collection were used, namely: questionnaires, semi structured interview, focus group discussions and documentary review from a sample of 150 respondents.

SPSS from software version 16 was used to analyze data that were collected. The data analysis includes the use of simple description of percentages, tables and graphs. Generally, performance or staff appraisal is the one which determines the level of performance of section or department and eventually the hospital as a whole. As the staff performs well, the whole section performance becomes valid.

On participation of workers, the study found that workers' frequency of involvement was high (42.3%) and they participated in making duty rosters. There is a strong relationship between workers participation and quality service delivery. The more they participate the more quality service delivery becomes. The study also revealed that several strategies were used by the management to improve quality service delivery such as team spirit, availability of quality working facilities, good and conducive working environment.

The study recommends that DRRH should strive to maintain the high standard it has in order to keep patients satisfied with the services they receive; should encourage the staff to treat patients with courtesy and respect in line with the health sector reforms and patient centered quality assurance; and should review the working arrangements and procedures at different service delivery stations in order to improve efficiency, minimize patient waiting times and provide for patient comfort.

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## **DEFINITION OF TERMS**

### **1. Worker**

Is the one who works at a particular occupation or activity; an office worker. She/he can be a person who does manual or industrial labor. In other words, a worker is anyone you employ in your business under a contract of service or apprenticeship. In this relationship, you, for example, set the nature and place of work, when it is performed, and how it is performed.

### **2. Hospital**

Is a health care institution providing patient treatment by specialized staff and equipments. Hospitals often but not always provide for inpatient care or long term patients' stays. They are largely staffed by professional physicians and surgeons.

### **3. Hospital or Health Workers**

Health workers are members of a community who are chosen by community members or organizations to provide basic health and medical care to their community. Hospital workers typically work in a hospital, and work with patients and their families in need of psychosocial help. They typically work on an interdisciplinary team with professionals of other disciplines (such as medicine, nursing, physical, occupational, speech and recreational therapy, etc.)

### **4. Workers' Participation**

Is a process by which subordinate employees, either individually or collectively, become involved in one or more aspects of organizational decision making within the enterprises in which they work.

### **5. Quality Service**

This is defined as the customers' perception of how well a service meets or exceeds their expectations.

**6. Customer Satisfaction**

It is a customer condition where experience with a product or service equals or exceeds expectations.

**7. Patient**

A patient is any recipient of healthcare services. The patient is most often ill or injured and is in need of treatment by a physician. A patient is a person with a unique problem; is a person who is suffering and needs help.

## **CHAPTER ONE**

### **1.0 Introduction**

This chapter covers the key aspects (research problem, objectives and research questions) from which the other chapters proceed. The chapter starts with background information of the study on workers' participation. After the background information, the chapter proceeds to highlighting the statement of the problem, objectives of the study and research questions, significance of the study, scope and delimitation of the study.

### **1.1 Background Information**

This study was born out of ever increasing concerns about the role of workers participation on quality service delivery in an organization. Quality service delivery is about goals, organizations, processes, and people to ensure that the right things are done at the right time. Quality service delivery is often termed as a process not an end in itself. It is believed that the benefits of higher customer satisfaction, better quality products and higher gain on the services often depend on the adoption of quality performance in service delivery. It requires a complete cooperation between management and employees. Nel (2002) argues that management's objective with workers participation is not to give away any part of its control but to link it to management's goal of improving efficiency and effectiveness of the organization. He further maintains that workers' participation has an economic objective in that it brings about improvement of productivity and consequently higher profits for the organization. This implies that, from the management side, workers' participation will result in improving efficiency and effectiveness of the organization.

It is important that an organization develops a friendly and pleasant environment that is conducive for the organization's personnel to achieve at their best levels; such an environment will ensure that personnel are motivated to reach their highest productivity achievements (Rossouw *et al.*, 2003). Employees may be offered an opportunity to make suggestions about ideas on how to increase work efficiency and

productivity. Involving them will entail interaction in an attempt to reach an agreement on an action to be taken in order to achieve the organization's objectives.

Workers participation has been the focus of many organizations which provide services to people. According to Rummler (1995), the significance of quality service delivery is client centered. Workers are quality service providers' practitioners. They find the organization model useful because it enables them and their clients to understand the variables that influence quality service and to adjust the variables so that quality of service is improved on a sustained basis. In the health sector, clients/patients need respect accuracy and fairness; hence, the ministry of health needs reforms that will set modality in managing the health sector so as to meet clients' needs. The general purpose of this study was to determine the extent to which workers participation influence quality service delivery in Dodoma Regional Referral Hospital. The study offers some general insights on quality service delivery. More specifically, the study investigated the extent of workers participation in decision making on issues of their departments and related to their participation and quality service delivery in each department.

The concept of workers participation represents a popular theme in the analysis of the world of work among scholars in the fields of industrial sociology, industrial relations as well as management (Yesufu, 1984). It refers to any arrangement which is designed to involve employees (workers) in the important decision making within the workplace. This implies that rather than selecting only a group within the enterprise with the responsibility of making decisions, all those who are to be affected by these decisions would be involved in its formulation and implementation. In recent time, scholars have directed increasing attention to the issues of workers participation and its broader effects in organization performance (Mankidy, 1984).

The need to create a nation of healthy citizens has been one of the major preoccupations of Tanzania's government. As early as the immediate years of independence in 1961, diseases had been singled out as one of the three major enemies (the other two being, ignorance and poverty) that demanded serious government interventions. In recent years, the Tanzania development vision 2025

identified health as one of the priority sectors. Among the targets of the vision is attainment of high quality livelihood for all Tanzanians (URT, 2000). Following this, the government through the ministry of health and social welfare (MOHSW), has embarked on various reforms in the public health sector which aimed at expanding delivery of quality health services in the country. In this reform, regional hospitals will be reformed in order to competently perform their referral role of handling cases requiring specialized care, rather than providing primary health care. Furthermore, health workers will be sensitized to follow available standard treatment guidelines (URT, 2008). However, reforms without strategies on workers participation cannot work effectively. Workers participation is the process whereby workers are involved in the decision making process rather than simply acting on orders. In any organization including health organizations, workers participation is used as a strategy to improve performance and encourage individual employees to take responsibility for quality in health service delivery in terms of carrying out activities which meet the requirements of their customers.

According to Awases (2006), workers participation is key a driving performance in organization to achieve good performance. Hence, workers participation and performance are both bounded to each other and cannot be separated. This is particularly important in the health sector because human resources are the most important assets of health systems. Thus, performance of health organization depends on knowledge, skills and motivation of individuals. It is therefore important for employers to provide suitable working conditions to ensure that the performance of employees meets the desired standard. African countries are trying to improve the functioning of health care delivery systems to ensure that the populations they serve receive timely quality care. Health care is labour intensive, making human resources one of the most important inputs in health care delivery (WHO, 2000). The challenge of Dodoma general hospital is to adopt and implement quality service delivery in the health sector according to the reforms made by the ministry of health and social welfare (MOHSW).

In Tanzania like other developing countries, the health sector is facing various problems including shortage of health workers and increased work loads of health workers due to immigration of health personnel (Awases, 2006). This problem is serious in the newly upgraded referral hospitals like Dodoma Regional Referral Hospital (DRRH). One way to reduce the impact of this is through workers participation. However, researches in this area are scant. Thus, against this backdrop, this research was conducted to explore the participation of workers towards quality service delivery in the health sector particularly in Dodoma Regional Referral Hospital.

Dodoma regional referral hospital operates in line with the National Health Policy. Legally, the hospital is administratively under Dodoma regional secretariat social services cluster. In adherence to the health sector reforms, the hospital is level II health institution; hence, serving as a referral hospital of level I health institution. Hospital layout of Dodoma regional referral hospital (DRRH) is presented by appendix 7 (seven).

### **1.2 Statement of the Problem**

In the light of the background of the study, it is therefore logical to state that workers are the frontline individuals in quality service delivery of any organization. In health organization like hospital, workers (doctors, nurses, and pharmacist and lab technicians) are charged with the duty of delivering quality health service to the patients. Successful attainment of this goal is hinged on their participation in decision making about service delivery. This is so because as workers are involved in work practice, they demonstrate improvement in performance. Thus, their participation ascertains the extent to which they offer themselves for the achievement of goals of better health services. It is argued that if the workers participate in decision making, then the potential benefits of their participation in decision making will result into better quality service delivery. It is even more logical when the context is explored in some of the newly upgraded referral hospitals like Dodoma Regional referral Hospital.

Dodoma Regional Referral Hospital is divided into departments and sections which are sources of quality service delivery to patients. Workers (employees) are posted to these departments and assigned duties according to their professions. The participation of workers in these departments has led to quality service delivery in the hospital; hence, patients' satisfaction. However, researches on workers participation have been done in several organizations like Flour mills Nigeria plc and Niger Insurance Plc in Nigeria (Yusuf, 1984) and in Zimbabwe by Mangiza (1991), but little has been done to show the effects of workers participation on quality service delivery in public hospitals in Tanzania.

Thus, on the basis of this argument, the major problem addressed in this study was to explore workers participation on quality service delivery in government hospitals in Tanzania particularly in Dodoma Regional Referral Hospital. How participation affects quality service delivery in the hospital was the question to be answered.

### **1.3 Research Objectives**

#### **1.3.1 Main Objective of the Study**

The purpose of this study was to explore the extent to which workers participation influence quality service delivery in different departments or sections of Dodoma Regional Referral Hospital.

#### **1.3.2 Specific Objectives of the Study**

Among the specific objectives of the study were to:

- (i) Determine the performance level of service delivery for each department or section in Dodoma Regional Referral Hospital.
- (ii) Explore the extent to which workers participate in the decision making on matters pertaining to their departments or sections on service delivery.
- (iii) Relate workers participation and performance of sections towards quality improvement in the hospital.
- (iv) Identify a strategy (s) for improving quality service delivery in the hospital.

#### **1.4 Research Questions**

The following research questions were formulated to guide the study:

- (i) What is the level of performance of service delivery in the sections of Dodoma Regional Referral Hospital?
- (ii) To what extent do workers participate in decision making on matters pertaining to the quality service delivery in their sections or departments?
- (iii) To what extent does workers participation influence quality service delivery in the hospital?
- (iv) What strategy (s) can be adopted to improve quality service delivery in Dodoma Regional Referral Hospital?

#### **1.5 Significance of the Study**

It was expected that the findings of this study would be important in different ways: Firstly, the findings of the study would form a basis for the need to raise quality service delivery of workers through appropriate motivational techniques. The involvement of workers in management decision making acts as a means for inducing motivation in the workers leading to positive work attitude and high quality service delivery. Secondly, it was assumed that the findings were desirable in view of the benefits of workers participation to the hospital and the society at large. The findings are capable of providing workers conducive work environment, opportunity to exercise their innate potentials and willingness to pursue corporate goal of Dodoma Regional Referral Hospital. Lastly, the results of the study were equally expected to enable decision makers to take the appropriate actions to boost all practices that are critical to quality improvement towards better health service delivery in Dodoma regional referral hospital. The findings are also important for building the capabilities of researchers on the related topics.

## **1.6 Limitations of the Study**

Generally, the fieldwork had been successful; however, that does not mean that the data collection process had not encountered any limitations. To a certain extent the study was conducted under the following limitations as far as data collection was concerned. Availability of funds and time was a big problem. This is because the researcher is private sponsored and research usually needs large amounts of fund for stationeries, allowance for research assistants, data collection and analysis as well as report writing. Although the research permit was granted to allow the conduct of this study, the members of the hospital administration were reluctant to allow the photocopying of the documents. They only allowed the review of the documents to be conducted in the hospital premises. This restriction imposed on the use of the documents actually consumed most of the time planned for other activities such as interviews and focus group discussions. Also, note taking from the documents did not provide the researcher with the opportunity to study thoroughly the contents of the documents at some other times.

Moreover, because the questionnaires were self administered, some respondents were not willing to give information. Thus, some questionnaires were not returned. Also, some questions were not filled up by respondents and some were writing meaningless answers. Another limitation has come from the interview appointments which were frequently not honored. As a result, frequent follow-ups for the appointments were essential to ensure that data were collected especially from the hospital management team. Uncompleted interview sessions were the common phenomena in the heads of department offices, since sometimes at the middle of the interview session the doctors or MOI could leave for emergence cases or other official duties or interruptions happened and the interviews were required to end prematurely. Such situations did not only mean rescheduling the interviews for another day but also revisiting the whole plan adopted for the fieldwork. This meant that the fieldwork and data collection was a time consuming exercise.

### **1.7 Scope and Delimitation of the Study**

The study was conducted in Dodoma urban in Tanzania and was confined to Dodoma Regional Referral Hospital. The hospital was selected on the criteria that, in recent years, Dodoma region has undergone significance increase in population due to the establishment of higher educational institutions. Also, being among the newly upgraded referral hospitals, it receives cases from the surrounding district hospitals which cause challenges in service delivery. However, to make the study manageable and to complete within the available time and resources, the study was conducted in Dodoma Regional Referral Hospital and restricted itself to the investigation of workers participation in quality service delivery in the hospital.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.0 Introduction**

This chapter reviews foreign and local related literature of interest to the present study. It addresses theoretical framework on workers participation in quality service delivery. It also presents empirical studies conducted previously on the effect of workers participation in quality service delivery in government hospitals. The human relations and participatory democratic theories have been presented. Lastly, the section presents the conceptual framework of the study.

### **2.1 Theoretical Framework of the Study**

The theoretical approach is considered as an important starting point for research on human behavior. This is because theories simplify the complex phenomenon under the study by suggesting which factors should be studied in particular. In this study, two relevant theories have been adopted to explain the effects of workers participation in quality service delivery. The human relations and participatory democratic theories guided the study on workers participation in quality service delivery.

#### **2.1.1 The Human Relations Theory**

The human relations theory stems from the understanding that the co-operation of workers is desirable for the attainment of the objectives of high productivity and industrial peace. It contends that workers would be better motivated if they are treated like human beings rather than as rational objects. For instance, by making them have a feeling that the organization accords them recognition by involving them in the decision making process. In the light of the theory, the worker is to be perceived in terms of his membership of a social group rather than as an individual. Consequently, his behavior is seen as a response to group norms rather than simply being directed by financial consideration. Workers should then be expected to react to group norms so that when they are given the opportunity to take part in management decision making, they are likely to respond positively to organizational issues.

### **2.1.2 Democratic Participatory Theory**

The democratic participatory theory emphasizes on conditions which are necessary for effective participation and function performed by participation to the individuals and society. For instance, Rosseau (1956) contended that through participation in decision making, individual sense of freedom is increased since it gives him a very real degree of control over the course of his life and structure of his environment. Again, it serves to increase the value of individual freedom by enabling him to be his own master. Mills (1965) sees industry as an area where the individual could gain experience in the management of the collective just as he could in government. The theory views the political arena as a kind of a market place in which individuals constantly attempt to maximize the benefits and minimize losses they could secure from the political process. It assumes that man is selfish in the sense that each participant would be motivated by the desire to protect or enhance his own personal interest. The theory assumes that the increase of participation is likely to increase the feeling of political efficiency that ordinary citizens possess. This helps to increase the potential so that their actions can have effect on public policy and lead to greater sense of control over their communal lives. In essence, greater participation in one sense of life leads to greater participation in other spheres, that is, the work place (Pateman, 1970)

## **2.2 Empirical Review**

### **2.2.1 The Concept of Participation**

Participation is not a new concept; it has been talked and written about it during the 50s or even before (Vettivel, 1999). Despite more than five decades of practicing participation, still there is no common understanding of what participation really means. The term 'participation' presents a number of difficulties in terms of its definition. Participation is about people's interaction determined by the behaviors of the interacting individuals or organizations.

According to Hyman (2005), participation can be categorized as individual versus collective. Individualized forms of participation may clash with the existing collective arrangements and fail to induce a harmonious climate. Concerns have also been expressed over individualized financial participation, and a fall in share prices could make it harder to attract high-quality staff. Collective participation, on the other hand, can work with the existing labour-relations channels and attitudes in a productive way.

Giddens (2001) posits that human behavior is complicated and many-sided, and it is very unlikely that a single theoretical outlook could cover all its aspects. Participation is a management response to increased workers resistance to change and build team spirit. Consequently, team working is suggested to have a positive impact on employees, especially in improving relation, avoiding conflict, handling, changing employees' attitude and behaviors, building trust and improving communications. Thus, all of which are critical elements along the participation-perception-performance causal path. ([www.jrf.org.uk](http://www.jrf.org.uk)).

According to Juliette (2005), participatory measures such as team working and high involvement work practices demonstrate improvements in performance, but also can have less positive outcomes for employees and social well being. Performance changes may occur because participation leads to changed attitudes which lead to higher performance. Alternatively, changes to behavior and performance may be achieved not through attitude changes but through fear and an insecure or intensified work environment. Dejourney (1985) found that the productivity enhancement results in cooperation were strongest in converted firms and less so in organizations founded as cooperatives. This may suggest that the relative increase in employee influences and participation is an important explanatory factor.

A crucial assumption in the management literature is that, participation can affect changes in employees' attitudes and behaviours; thus, improving organization performance. There are a number of contended areas along this casual path, the

association between participation and attitude change, the association between attitude change and changes in employee behavior and the association between attitude change and organization performance. Nevertheless, if participation fails to produce attitude changes in employees, it may also fail to induce behavioral changes associated with organization performance ([www.jrf.org.uk](http://www.jrf.org.uk)). It is perhaps not surprising therefore that research indicates that employees in the sections are to be coordinated and linked together rather than focusing on just one part. Example changes in staff skills and knowledge through training will only yield improvement to the extent that the lack of training was the major cause of poor performance of the organization. If problems in process are not addressed in the departmental meetings and majority consensus are reached, then even trained staff will not be able to accomplish their work to the best of their abilities.

The three main rationales for introducing employee participation are based upon different economic, social and political assumptions: Economically: changes in employees' attitudes and behavior are achieved through financial participation, by offering employees a stake in the firm. Employees' association with management values and goals has increased, and they are more motivated and committed to achieving those goals. Socially: by catering for employees' social needs, through improved job security and satisfaction and quality of working life, higher performance is achieved. Alternatively, satisfying social needs can be treated as an end in itself. Governmental: current policy is to improve national economic efficiency while also improving the experience of work for employees. Not all the literature agrees on the universal, positive effects of participation. Some suggest that participation may have no effect or even negative effects on performance. However, it is difficult to discern a definitive pattern. Lack of consistency in the outcomes of participatory measures suggests that schemes are not isolated from the effects of the external economic, political and social environment (Juliette, 2005).

According to Hyman (2005), the degree of influence accorded to employees is also important. Low levels of participation with little employee autonomy have been identified as a reason for disappointing results. Where employees' expectations have

been raised by introducing participation, but there is little real improvement in employee influence, workers may express resentment and dissatisfaction. Where participation is only from the top down, workers may feel that they are being lectured and not listened to. Even where participation is from the bottom up, workers may feel that management is using their ideas, with no return seen by employees. High levels of participation also have their own problems. Some authors claim that employees do not make hard decisions, opting for outcomes that maximize income, not profit. Others claim that employees are not able to discipline co-workers, and that decision-making takes too long. From the management perspective, high degrees of employee influence may mean that managers' input in decision-making is reduced.

### **2.2.2 Workers' Participation**

Workers' participation has been explained as a plank of industrial democracy (Adewumi, 1991). Similarly, Mills (1977) described the spread of industrial democracy to Western Europe in the 1970s a story of capitalism in transition. In his words, in countries where it is occurring, industrial democracy, *affects the nature, control and even ownership of private enterprise; the nature control, power and bargaining areas of the labour unions...and the roles and contributions and rights of the individual worker in contemporary and future industrial society* (Heisler and Houck (eds.) (1977)

The description above shows that industrial democracy affects many aspects of lives of different people in modern society. This reason may explain the wide clamor for the introduction of worker participation arrangement in most countries. Mills (1977) identified four basic forces underlying the clamor for industrial democracy. The first one was political in nature, pushed primarily by socialists and moderate labour and political leaders. The second was an industrial or economic force championed by innovative and socially-oriented management and at times, by unions. The third was an intellectual and theoretical force pushed by MacGregor (1960) Maslow (1964) and Emery, Thosrud and Trist (1964).

This fervor explains rising workers demand for increasing influence in management decision making. The increasing interest in worker participation has been traced to a number of factors. First, is the real or anticipated political pressure which was designed to extend the popular democratic dispensation in the larger society to the economic sphere. Second, is the growing pressure on the collective bargaining system arising from continuing difficulties from negotiating in the context of high inflation and in some instances increasing disenchantment with the dialogue of confrontation. More importantly, is the endemic problem within the modern industrial system which may tend to encourage employers to consider experimenting with different forms of participation. Lastly, the growing interest in participation was encouraged by the problem associated with denying powerful groups (for example, shop stewards and work groups) formal and legal means of exercising their rights. When such situation arises, the workers concerned will employ informal bargaining methods and illegitimate facts to achieve their goals. To forestall these negative trends, management is forced to introduce certain participation schemes (Mills, 1997).

With respect to the status of workers participation in the developing world, Mankidy (1984) Kester and Schiphorst (1986) have argued that in these countries, labour relations are characterized by a break-up of the existing patterns. In most of these countries, there is an increasing awareness that the labour relations produced in these countries are grossly defective. Trade unions are also seen as very weak in many of them. Lastly, on the ideological ground, collective bargaining is rejected because of its emphasis on the dependent wage labour position of the worker. Kester and Thomas (1981) have demonstrated that there is a fast growing interest in the development of workers participation in developing countries. In their studies, they found one form of workers participation or the other in these countries. In some cases, workers participation was introduced an essential part of development strategy. For instance, in Tanzania, the idea of workers participation formed an important aspect of her socialist ideology. This is anchored on the notion of man centered development strategy.

### **2.2.3 The Concept of Quality**

A theoretical framework of quality is deeply discussed by the four quality gurus to total quality management (TQM), namely W. Edward Deming, Joseph M. Juran, Philip B. Crosby and Kaoru Ishikawa. Guru J.M. Juran defined quality as fitness for purpose. This criterion of fitness for purpose is perfectly suitable only at a particular stage of production. Total quality control is an effective system for integrating the quality development, quality maintenance and quality improvement efforts of the various groups in an organization. Philip Crosby defined quality as conformance to specifications. Quality should first be perceived from customer's point of view. This is because it is the customer who decides whether or not to buy a product or service according to his or her perception of quality (Kanishka Bedi, 2007).

Quality improvement is an art of management that has originated from Japan industry in 1950s and became popular in the Western Countries especially USA and Great Britain since 1980s. Quality improvement is about goals, organizations, processes and people to ensure that the right things are done at the right time. Quality improvement is often termed as a journey; not a destination. It is believed that the benefits of higher customer satisfaction, better quality products, and higher gain on the services are often obtained following the adoption of quality performance in service provision. It requires a complete turnaround in corporate culture and management approach as compared to the traditional way of top management giving orders and employees merely obeying them.

Quality of service provision and workers participation has been the focus of many organizations which provide services to people. With today's increasing demand for quality health services, it has become increasingly important for the organizations to know and apply quality improvement in providing quality services to people. Organizations continually search for ways to increase quality services. The importance of quality improvement is client centered. In health care provision, clients always everywhere want respect, understanding their illness, fairness, accuracy, competence, convenience and results. The best care helps clients achieve

their own expectations. The health sector reform process has to look modality of managing health services to meet the clients' satisfaction.

Participative management has become a key word in implementing quality improvement in the organization. There is a positive link between participation and satisfaction, and motivation and performance (Juran, 1992). Employees' involvement team, which consists of small groups of employees who work on solving specific problems related to quality and productivity, represent one way of participative management. Such teams have proved effective in solving problems related to productivity and quality as well as improved employee morale and job satisfaction (kanji, 1996). It was argued that employee participation can be a means of improving company performance, particularly by changing employees' attitudes and improving the work environment. There is some evidence from the literature that participation can have a positive effect on organizations' performance and the working environment. [www.irgo.com.uk](http://www.irgo.com.uk).

Work group involvements promote quality services and increase performance of the organization. It does this by fostering trust and a shared commitment to an organization's objectives demonstrating respect for individual employees and enabling employees to get maximum job satisfaction. Stevens (1993) suggests that the ultimate success of quality improvement is based on its ownership by employees and their empowerment to make changes. Naturally, workers directly involved in a process know best how to improve it.

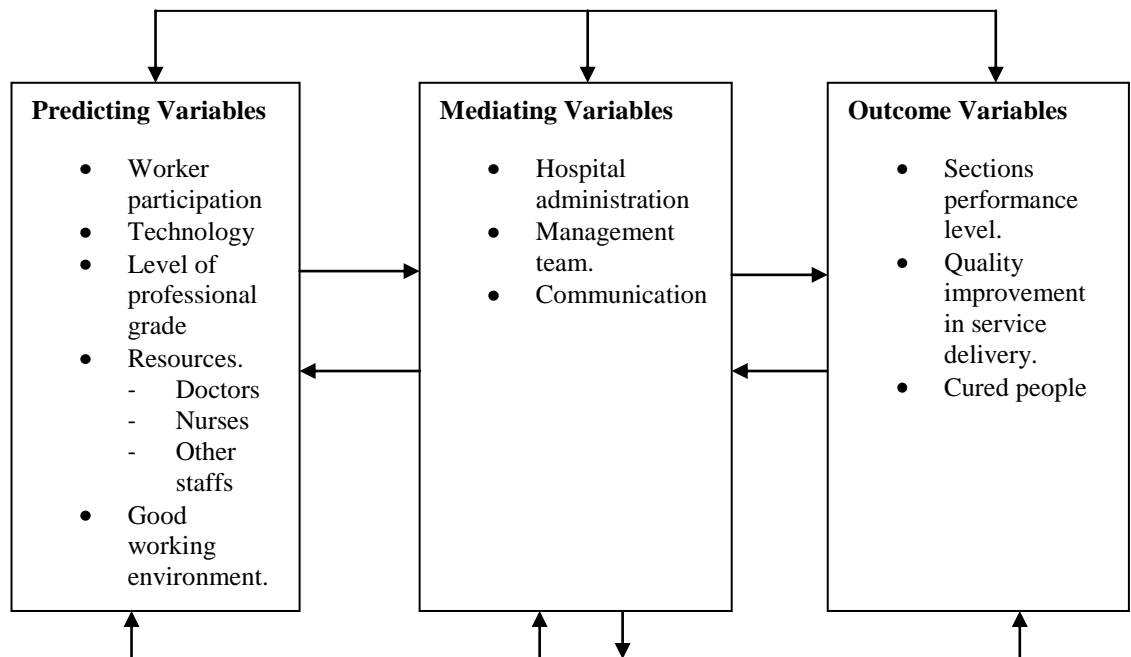
### **2.3 Conceptual Framework of the Study**

A conceptual framework explains, either graphically or in a narrative form, the main things to be studied, including the key factors that are constructs or variables and the presumed relationship among them (Miles and Huberman, 1994). This study adopted the conceptual framework which covers three dimensions: the predicting variables, mediating variables and outcome variables. A predictor variable is the one whose values are used to determine the values of the outcome variables. It is analogous to the independent variables. Outcome variable is the one whose values are to be

modeled and predicted by the other variables. Mediating variables describe how, rather than when effects will occur by accounting for the relationship between the independent and dependent variables (Miles and Huberman, 1994).

In this study, predicting variables comprised of workers participation, technology, resources (both human and capital) and the level of professional grade. The mediating variables included hospital administration and communication. The outcome variables were section performance on quality service delivery in the hospital. The predicting variables can directly influence outcome variables, but sometimes the same predicting variables can further be influenced by the mediating variables before their influence become vivid to the outcome variables. In this case, the mediating variables can intervene the influence of predicting variables on the outcome variables. Consequently, there could be interplay of both predicting variables and mediating variables on the outcome variables. Relationship of independent variables and dependent variables is shown in figure 1 below as far as quality improvement is concerned.

**Figure 2.1: Conceptual Framework for the Study**



**Source:** Adopted and modified from Stufflebeam’s model, 2000.

One could exemplify the model by taking resources (doctors ) as a predicting variable that could directly influence patients at sections in the hospital in terms of quality service delivery if a doctor(key surgeon) departures, or introduction of new technology like CT Scan in the hospital may change service delivery dramatically and rapidly.

## **CHAPTER THREE: RESEARCH METHODOLOGY**

### **3.0 Introduction**

After reviewing different literature in the previous chapter, this chapter addresses the key methodological issues of the study. It presents the study area, rationale for selecting the study area, research design and study population. It also discusses sampling techniques and sample size. The chapter further highlights the semi-structured interview, structured questionnaire; focus group discussion and documentary analysis that were used to collect data for the study. The efforts that were made to check the validity and reliability of the research instruments are also discussed. The SPSS version 16.0 computer program was also used to analyze most of the collected data.

### **3.1 Research Design and Approach**

Research design refers to the structure of an inquiry: it is a logical matter rather than a logistical one (Yin, 1989). Kothari (2004) defines it as the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure. A research design is needed to facilitate the smooth sailing of the various research operations, thereby making research efficient as possible yielding maximal information with minimum expenditure of effort, time and money.

Considering the influence of workers participation on quality service delivery, a case study approach was considered useful in guiding this research. In particular, the explanatory case study approach seemed to fit the main objective of this research which aims at understanding and explaining the phenomenon being studied (Yin, 2003). The rationale of the case study approach in this research was to facilitate the in-depth study of workers participation in quality service delivery in government hospitals. The benefits, which this research has obtained from employing case studies, include the opportunity to rely on multiple sources of evidence such as interviews, documentary reviews, questionnaires, and focus group discussions. Hence, the approach has enabled the study to triangulate the data and information.

There are two basic approaches to research, namely quantitative approach and the qualitative approach. According to Kothari (2004), quantitative approach involves the generation of data in quantitative form which can be subjected to rigorous quantitative analysis in a formal and rigid fashion. Alternatively, Qualitative approach to research is concerned with subjective assessment of attitudes, opinions and behavior. Research in such a situation is a function of researcher's insights and impressions. Such an approach to research generates results either in non-quantitative form or in the forms which are not subjected to rigorous quantitative analysis. Generally, the techniques of focus group interviews, projective techniques and depth interviews were used.

This study used a mixed research approach, which is a combination of quantitative and qualitative approaches where qualitative approach dominated the study, with less use of quantitative approach. Qualitative approach enabled the researcher to obtain purposive and objective information on opinions of doctors, nurses and administrators, effectiveness and challenges of workers participation. The quantitative data were particularly needed to assess the relationship between workers participation and quality of service delivery in the hospital. Multiple approaches were used in attempting to answer the research questions. The data gathered through different sources were complimentary and helped to provide explanation of the issues explored. The methods included semi-structured interview, structured questionnaire, focus group discussions and documentary review. The use of the two approaches led to the production of a rich, robust, holistic description and understanding of the extent to which workers participation influence quality service delivery in Government hospitals particularly Dodoma regional referral hospital.

### **3.2 Study Area and Rationale for selecting it**

The study was conducted in Dodoma regional referral Hospital. The hospital was purposively selected for three reasons: firstly, in recent years Dodoma region has undergone significant increase in population due to the establishment of higher educational institutions such as the University of Dodoma (UDOM) and Saint John's

University which has significant implications on the quantity and quality of service delivery in all sectors and health sector in particular. Secondly, being among the newly upgraded referral hospitals, Dodoma regional referral hospital receives referral cases from the surrounding district hospitals and from neighboring regional hospitals which is expected to cause challenges in service delivery. Lastly, the hospital was selected due to the researcher's knowledge on the institution as the researcher is dwelling in Dodoma region.

### **3.3 Population of the Study**

According to Best and Kahn (1998), population is a group of individuals who have one or more characteristics in common. Target population, entails a group of persons, objects or instructions that define the object of the investigation (Shulman, 1988). The target population of the study must be explicitly and equivocally defined. On this basis, the population of this study was made up of five categories of respondents (doctors, nurses, supporting staff, patients, and administrators). The groups were obtained from sections and 13 departments of the hospital. The aim was to ensure that the data that are collected provide view points from the main respondents because every department and section provides specialized health services that are different from other departments. The researcher assumed that the selected subjects of the study had useful information on the study questions and they were considered the key stakeholders who were directly involved in delivery of quality services in the hospital.

### **3.4 Sample Size and Sampling Techniques**

#### **3.4.1 The Sample Size**

A study sample refers to a selected portion of the population that represents the aggregate of the target population for the study (Neuman, 2003). Drawing sample from a population is necessary because in many cases a complete coverage of the population is not possible due to resource constraints such as time and money. Therefore, sampling is conducted for the purpose of measuring the elements of

population characteristics and drawing conclusions regarding the entire population (Miles and Huberman, 1994).

The sample of this study was drawn from Dodoma regional referral Hospital. One hundred and fifty (150) respondents out of four hundred and twenty (420) employees were selected for the study. These include eighty seven (87) workers from different departments and sections in the hospital (doctors, nurses and supporting staff), thirteen (13) administrators and heads of departments and fifty (50) patients. This sample was considered representative since it formed more than one third (1/3) of the total population.

### **3.4.2 Sampling Techniques /Procedures**

Stratified sampling and purposeful sampling procedures were employed in this study. The study employed these types of sampling procedures because the researcher believed that one sampling procedure working in isolation might cause biasness or distort the whole picture of reality that the researcher was investigating (Cohen, Manion, and Morrison, 2000).

#### **3.4.2.1 Purposive Sampling Technique**

Purposive sampling entails deliberately selecting cases on the basis of specific qualities which they illustrate (Neuman, 2003). Similarly, it involves selection of participants through the researcher's own opinion and relevance to the research topic. In purposive sampling, the selected respondents are the individuals who are conversant with the research phenomenon. They must be knowledgeable enough to provide relevant information for the study. In this case, thirteen (13) participants were selected through purposive sampling.

Purposeful sampling technique was employed in the present study due to the fact that it was possible to obtain the types of respondents (management team and heads of department) who had specific information which was relevant for the study. For

example, heads of departments were sampled purposively to provide relevant statistics such as the number of employees in their sections or departments.

### 3.4.2.2 Stratified Random Sampling Technique

A stratified sampling technique was used because the population from which a sample was to be drawn did not constitute a homogeneous group. Stratified sampling technique was applied to obtain a representative sample. The researcher grouped employees into their departments. 13 departments were selected for sampling. This was done by grouping the sample in each sub-group of respondents to get participants from each selected department. Respondents were further sub-grouped according to gender, and after that systematic random sampling were conducted to get equal representation according to their composition in each department or section. The idea of stratified sampling was to ensure that every department got better representation because the departments had different health services. In sum, then, the number of respondents involved in the present study and their respective instrument(s) administered have been presented in Table 3.1 below.

**Table 3.1: Profile of Respondents and Respective Instrument(s) Administered**

S/N	Respondents	Number of respondents		
		Expected	Responded/Actual	Instrument(s)
1	Management Team	10	13	Interview guides
2	Doctors	50	11	FGD and questionnaires
3	Nurses	40	34	FGD and questionnaires
4	Supporting Staff	30	26	Questionnaires
5	Patients	20	48	Questionnaires
	<b>Total</b>	<b>150</b>	<b>132</b>	

**Source:** Field Data, (2013)

### 3.5 Data Collection Tools

Data collection tools allow the researcher to systematically collect information about the objectives of the study and about the settings in which they occur. In the collection of data, the researcher has to be systematic. In this study, four methods of data collection were used, namely: questionnaires, interviews, documentary review and focus group discussions.

### **3.5.1 Questionnaires**

According to Creswell (2005), a questionnaire is defined as a form used in survey design that participants in a study complete and return to the researcher, and that the participants choose answers to questions and supplies basic personal or demographic information about themselves. Questionnaires were employed as a data collection tool because of its ability to collect large amount of data in a short period of time, and that it is relatively cheap to administer. On questionnaires the researcher asked some questions that were close ended and some that were open ended. There were questionnaires for each category of respondents: 71 employees (doctors, nurses, and supporting staff) and 48 patients. Each set of questionnaires had both closed ended and open ended questions. This helped the researcher to easy response, quicker to administer, record responses and code prior to data analysis (Refer to appendices 1 and 2).

### **3.5.2 Interview**

On the other hand, data were collected through interviews. Kombo and Tromp (2006) defined interview as questions of various forms that are asked orally. Cohen, Manion, and Morrison (2000) explained that interview allows subjects to provide their interpretations of the world in which they live, and to express how they regard the situation from their own point of view. One-to-one semi-structured interview was conducted to the management team and heads of departments. One-to-one semi-structured interview is a data collection process in which the researcher asks questions to and records the answers from only one participant in the study at a time. The researcher used interview guide to collect information from 13 heads of departments (see interview guide in appendix 3). The use of interview with the pre-determined questions to this category of respondents facilitated the data collection process. The reason was based on the fact that the targeted participants had busy schedules during the official working hours.

It should be noted that the interviews could only be conducted during those times. Therefore, interview guide enabled the study to adapt to the situation; and hence, the

collection of data and information in such an environment. The interview was conducted to the management team and heads of departments to capture their reaction and perceptions on workers participation on quality service delivery in the hospital. This type of interview allowed considerable flexibility in the dialog and allowed the researcher to ask follow-up questions to gain deeper understanding of interviewees' experiences, feelings and perspectives about workers participation. The interview guides were made using rating and checklist questions simplifying the task of quantifying some of the qualitative data on the respondents' opinions; therefore, permitting general analysis of the data.

### **3.5.3 Focus Group Discussions**

Along with other methods of data collection, the researcher obtained data through focus group discussions (FGDs). According to Bryman (2004), FGD is a small and a homogeneous group of six to ten or twelve people meant for gathering data for a particular research topic through discussion. In this study, FGD was used to collect data from doctors, nurses and laboratory technicians. Through FGD, data including people's feelings, perceptions and general comments about workers participation on quality service delivery were captured. FGD offered an excellent way to get people talk and allowed for cross checking. Group members were able to correct if somebody did not remember or else did not provide arguments or answers in a way that would not satisfy the group. The topic guide was used to direct the discussion (See Appendix 4).

### **3.5.4 Documentary Review**

Documents consist of public and private records that researchers obtain about a site or participants in a study, and they can include newspapers, minutes of meetings, personal journals and letters (Creswell, 2005). They are records kept and written by actual participants in, or witnesses of an event (Best and Khan, 1998). The researcher used documentary review guide to visit the documents as per appendix 5.

Various relevant pieces of hospital strategic plan, budget books, hospital monthly and annual reports, patients' attendances, hospital meeting proceedings and agenda had been reviewed. These documents provided the avenue to corroborate the evidence from other methods of data collection employed in this study. In other words, the documents were useful for making inference about events which took place in the hospital departments; and hence, the triangulation of evidence was possible. The consultation of these documents was used to crosscheck the data that were obtained from interviews, focus group discussions and questionnaires.

### **3.6 Validity and Reliability of the Instruments**

While validity means the quality that an instrument used in research is accurate, correct, true, meaningful and right (Guba and Lincoln, 1998); reliability refers to the degree of consistence within which instances are assigned to the same category by different observers or by the same observer but in different occasions (Hamersley, 1990). Silverman argues that one must show his or her audience that the procedures used in a particular study were both reliable and valid before thinking about concluding his or her research dissertation (Silverman, 2000).

To enhance validity of the instruments, the researcher employed various strategies. First, multiple sources of data strategy (triangulation of methods and persons) was employed. This method increased the depth of exploring as well as accuracy. On the other hand, triangulation of persons was used to ensure that data on a particular issue were obtained from different people. The ultimate goal was to minimize biasness.

Second, the researcher ensured that, all instruments prepared were checked by her research supervisor and fellow master's students. Their comments helped the researcher to refine the instruments by adding, removing or maintaining some items. Trochim (2001) states that reliability is the degree to which a measure is consistent or dependable; the degree to which it would give you the same result over and over again, assuming the underlying phenomenon is not changing. Hence, in order to ensure internal consistency of the questionnaires, reliability analysis was employed

using statistical package for social sciences (SPSS) analysis. The main objective of this method was to estimate the degree to which the same results can be obtained with a repeated measure of accuracy of the same concept.

### **3.7 Ethical Considerations**

Much as the social science research involves collecting data from and about people; it has to adhere to ethical and professional codes of conduct to safeguard the rights of the participants and enhance trustworthiness of the findings. According to Kvale and Brinkman (2009), ethical issues may arise in the process of soliciting, recording and using data from respondents. Following this, attention was paid to rules and regulations during process of preparation and conducting the research in the field. The work ensured ethical issues to participants, which involved obtaining permission to access the organization that one intended to research, ensuring voluntary participation, informed consent, confidentiality and anonymity.

**Obtaining Permission:** With regard to obtaining permission to access the area of study, the researcher obtained introduction letter from the Directorate of Graduate Studies from Mzumbe University and Hospital Secretary (HS) in Dodoma regional referral Hospital.

**Voluntary Participation:** During field work, respondents were asked to participate voluntarily and were given clear explanation as to why the study was conducted. This is important in establishing confidence to respondents.

**Confidentiality and Anonymity:** Cohen (2001) argued that a participant is considered anonymous when the researcher or any other person who reads the work cannot identify the participant named in the information given. Confidentiality and anonymity of respondents was highly taken care of to ensure that respondents were free to give their opinions and feelings.

**Informed Consent:** Is a procedure in which an individual chooses whether to participate in an investigation or not, after being informed of the facts that would likely to influence their decisions. To ensure an informed consent, the researcher provided fair explanations of the objectives and purpose of the study to the participants of the study. The participants were provided with full information of the purpose of the study and the permission was asked from them. This allowed them to be free to participate in the research in answering the questions.

### **3.8 Data Analysis**

According to Bogdan & Bicklen (1992), data analysis is a process of systematically working with data or applying statistical and logical techniques to describe, organize, summarize and compare the data collected and divide them into manageable portions. In this study, the data collected from the field were processed and analyzed quantitatively and qualitatively according to the research questions investigated.

As suggested by Creswell (2003) specifically for the analysis of qualitative data, thematic analysis of data was employed. Creswell (2003) states that thematic analysis is carried out by designing detailed descriptions of the study and using coding to put themes into categories. Thus, data collected from interviews and documents were subjected to statistical package for social sciences (SPSS) program whereby they were coded and categorized according to the research questions. In addition, some of the respondents' views and opinions were presented as quotations.

On the other hand, quantitative data from questionnaires were subjected to statistical package for social sciences (SPSS) from software version 16. Using SPSS, the measures involved analysis of variance (ANOVA) and mean values. Descriptive statistical analysis gave out frequencies, means and percentages. Lastly, the data were presented in figures, graphs, tables and pie charts.

## **CHAPTER FOUR: FINDINGS AND DISCUSSION**

### **4.0 Overview**

In this chapter, the results of the study are presented and discussed relevant to the research problem in chapter one. More specifically, the findings of the study are presented in relation to the research questions. In this case, the presentation of data is done by using tables and figures where necessary. The main purpose of this chapter is to provide detailed information on workers' participation on quality service delivery in government hospitals particularly Dodoma regional referral hospital (DRRH).

### **4.1 Context of the Study**

#### **4.1.1 Capacity of Dodoma Regional Referral Hospital**

Dodoma regional referral hospital is a Government hospital located in central Tanzania within Dodoma Municipality. It serves a population of 2.4 million. Its history goes far back to 1930 when it started officially as a hospital. Before that and most precisely during the First World War the now Dodoma regional referral hospital was just a health camp which offered health services to casualties of the First World War. It has bed capacity of 420 and outpatient department which has 35 rooms including specialized clinics. On average, 350 outpatients are attended per day in this department. Due to the fact that the TB and isolation wards are not fully occupied, the average bed occupancy rate is 83%. The length of hospital stay ranges between 4 to 5 days and about 3,275 operations are performed in a year. The number of deliveries is between 30 and 40 days with a cesarean section rate of 19%.

Dodoma regional referral hospital serves as a referral center for district hospitals of Kondoa, Kongwa, Mpwapwa and Chamwino as well as other neighboring districts of Kiteto (Manyara Region), Manyoni (Singida Region) and Gairo (Morogoro Region). It also serves as a district hospital for Bahi District as this district has no hospital of its own. Moreover, it serves those who refer themselves directly from home.

#### **4.1.2 Functional Departments and Sections**

The hospital has the following functional departments and sections demonstrated by appendix 6. The departments include: administration, pharmacy, medical, surgical, OBS and gynal, paediatrics, trauma, ophthalmology, radiology, laboratory, oral and dental, and preventive service. With reference to the organization structure and after the introduction of hospital reform, the hospital management is led by MOI, Hospital Secretary and Hospital Matron under the umbrella of HAB (Hospital Advisory Board). All departments should be led by the Heads of Department (HOD). MOI is the chief executive and spokesman of the hospital; he is responsible and accountable for all matters arising in the hospital. Moreover, he is responsible for quality of health services available in the hospital.

#### **4.1.3 The Hospital Profile**

The hospital offers services such as outpatient, emergencies, internal medicine, surgical, pediatric, gyneco-obstetrics, laboratory and mortuary services, medical records, radio diagnostic and imaging, physiotherapy and orthopedic workshop. These services are the backbone of the hospital in providing quality health care services. Refer to Table 4.1 below.

**Table 4.1: Main Hospital Services**

<b>Department</b>	<b>Services</b>
Out- Patient Department	Primary care consultations, Specialized care consultations (medical, diabetes, ophthalmology, ENT, CTC, surgery), Reproductive Health consultations
Emergencies	24/7 emergencies, Intensive Care Unit, EPRU
Internal Medicine Department	Admission, Treatment and procedures
Surgical Department	Admission, General surgery, Anesthesia, Minor surgery and Central sterilization and supplies
Pediatrics	Admission, Treatment and procedures
Gyneco- Obstetrics	Admission, Normal deliveries, C/section, Complicated deliveries and Gynecological surgeries
Laboratory	Hematology, chemistry and parasitology
E-Ray and Imaging	Standard X-rays, X-ray with contrast and Ultrasound
Ophthalmology	Ophthalmic surgery, admissions and optometry
Orthopedic/ Traumatology	Physiotherapy, orthopedics workshop, admissions, orthopedic surgery
Preventive Services	Sanitation and hygiene, inspection, data management, record and reports, surveillance, disaster management.
Pharmacy	Drugs and medical supplies, medical equipments
Administration	Transport, procurement and supplies, accounts, human resources, HMIS
Oral Dental	Dentures, admission, surgery, dental X-rays.

**Source:** Field Data, (2013)

These departments should be strengthened with modern equipments and skilled personnel in order to provide quality health care services. All these departments operate under the head of department who is a specialist in that particular field. For example, surgical is headed by a surgeon.

#### **4.1.4 Source of Funds**

In the financial year 2011/2012, the hospital budgeted to use a total of Tanzanian shillings 4,771,881,170 as shown below:

Salaries	2,922,703,000/=
Other charges	448,421,000/=
Basket fund	108,987,670/=
User fee charges	355,569,500/=
Drug revolving fund	136,200,000/=
Development project	800,000,000/=
<b>Total</b>	<b>4,296,025,950/=</b>

The budget for the procurement of drugs and medical supplies from the Medical Stores Department (MSD) is deposited directly by the Ministry of Health and Social Welfare (MOHSW) and is not given to the regional hospital.

**Table 4.2: Source of Funds**

Source	Spent for medicines and supplies last year
MSD	313,567,934.30
Cost sharing	64,783,500.00
Basket Fund	8,881,000.00
<b>Total</b>	<b>387,232,434.30</b>

**Source:** Field Data, (2012)

Stakeholders are very important in providing quality of health care services because everyone has its own role to play.

## 4.2 Demographic Characteristics

Presented in this section is the information relating to respondents' socio-demographic parameters, namely gender, marital status, department, occupation, age, education qualification and work experience.

### 4.2.1 Gender

The respondents were asked to indicate their respective gender and the findings were categorized as indicated in Table 4.3 below:

**Table 4.3: Frequency and Percentage Distribution of Respondents According to Gender**

Respondents	Frequency	Percent	Valid Percent	Cumulative Percent
male	28	39.4	39.4	39.4
female	43	60.6	60.6	100.00
<b>Total</b>	<b>71</b>	<b>100.00</b>		

**Source:** Field data, (2013)

The results from Table 4.3 above shows that majority of the respondents were females (60.6%) as compared to males who were only 39.4%. Sex of the respondents makes the strongest unique contribution to explaining research objectives. Females were noted to be more responsive than males. The difference might be related to a

greater willingness on the part of women to be more participatory than men. Furthermore, this can be contributed by a large number of female employees who are nurses in the hospital.

#### 4.2.2 Marital Status

There were three categories of marital status among the respondents: single, married and widowed. With regard to the distribution of respondents according to marital status, majority of the respondents were married (63.4%), 35.2% were single and there were very few widows (1.4%). In relation to age distribution, this indicates that most of workers in Dodoma regional referral hospital had families because most of them were above 20 years of age.

#### 4.2.3 Department

**Table 4.4: Frequency and Percentage Distribution of the Respondents According to Departments**

S/N	Department	Frequency	Percent	Valid Percent	Cumulative Percent
1	Surgical	15	21.1	21.1	21.1
2	Medical	21	29.6	29.6	50.7
3	Obstetrics & gynecology	5	7.0	7.0	57.7
4	OPD	1	1.4	1.4	59.2
5	Laboratory	14	19.7	19.7	78.9
6	Administration	10	14.1	14.1	93.0
7	Dental	1	1.4	1.4	94.4
8	Pediatrics	2	2.8	2.8	97.2
9	Ophthalmology	2	2.8	2.8	100.00
Total		71	100.00	100.00	

**Source:** Field data, (2013)

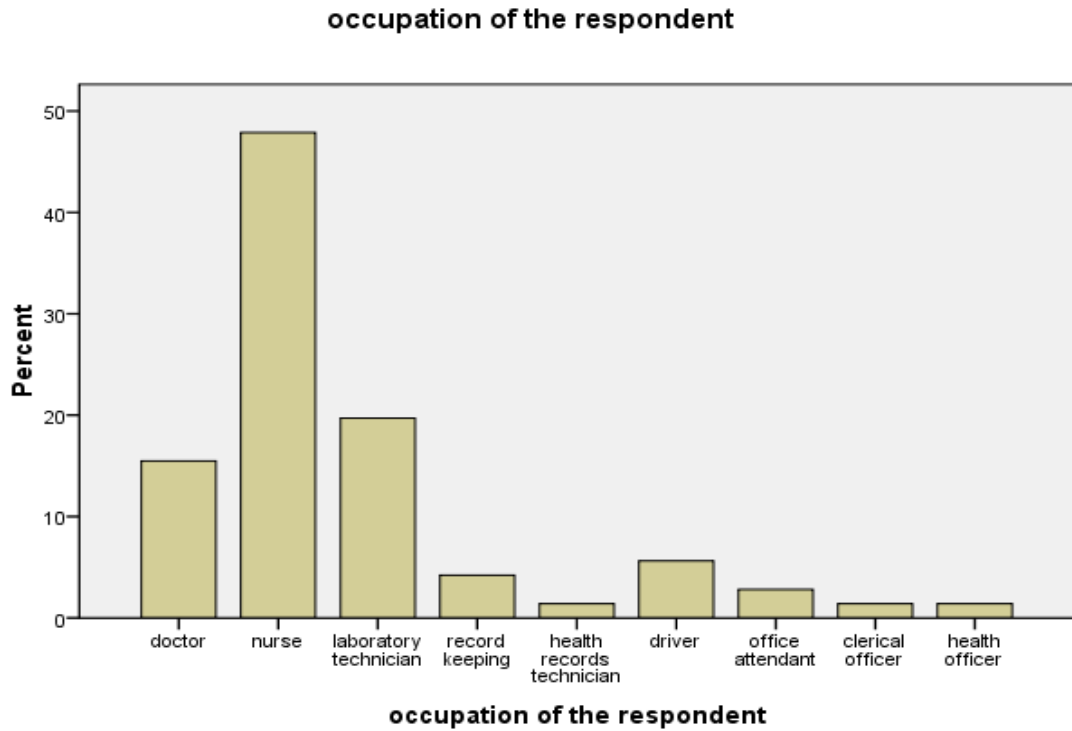
There were 13 categories of departments where the respondents came from. These were: medical, surgery, pediatrics, orthopedic, ophthalmology, OBS and gynecology, laboratory, pharmacy, administration, oral and dental, OPD, preventive services and radiology. Table 4.4 above demonstrates that majority of the respondents were from medical department (29.6%) with a total number of 21 respondents while very few were from dental (1.4%), OPD (1.4%), pediatrics (2.8%) and ophthalmology (2.8%). Data also showed that 21.1 % of the respondents were from surgical, 19.7% from laboratory, 14.1% from administration, while 7.0% of them were from obstetric and

gynecology. Majority of the respondents were from medical department because of the number of employees available amounting to sixty (60) with four (4) sections. The sections include OPD clinic with five employees, male ward with twenty employees, female ward with twenty eight employees and psychiatric ward with seven employees. The department manages patients with common diseases including respiratory infections (ARI), pneumonia, diarrhea, sexually transmitted infections, asthma and the like. The number of patients attended in the year 2012 was 6,975.

This is comparable to the study done at Muhimbili National Hospital (MNH) which showed that the medical directorate was among the major eight (8) directorates in the hospital. The directorate of medical services has six departments, namely: Internal medicine, pediatric and child health, emergence Medicine department, outpatient department, rehabilitative medicine and psychiatry. The medical department is among the major 12 clinical departments at Muhimbili National Hospital (MNH) which is a tertiary referral and teaching hospital situated in Dar es Salaam city. The hospital serves patients referred from the three municipal hospitals (Temeke, Kinondoni and Ilala) as well as patients from other regional hospitals in the country. MNH has bed capacity of about 1500 and it serves 1,500 outpatients per day. Forty percent of the admissions per week are admitted in the medical ward. The medical department has bed capacity of 210 beds; total admission per day is about 40 patients. The number of the wards within the department are ward 3, 4, 5, 6, 7, 8 TB ward and ward 1 which is high dependence ward. The department runs clinic including general medical OPD and 12 subunits which are Respiratory, Cardiology, Diabetic, Neurology, Dermatology, Gastroenterology, Nephrology, Rheumatology, Geriatric, Hematology, Oncology, Infectious clinic, (HIV and STI clinic and TB clinic which is conducted at IDC). The department also offers private services including inpatient and out-patients.

#### 4.2.4 Occupation

**Figure 4.1: Frequency Distribution of the Respondents According to Occupation**

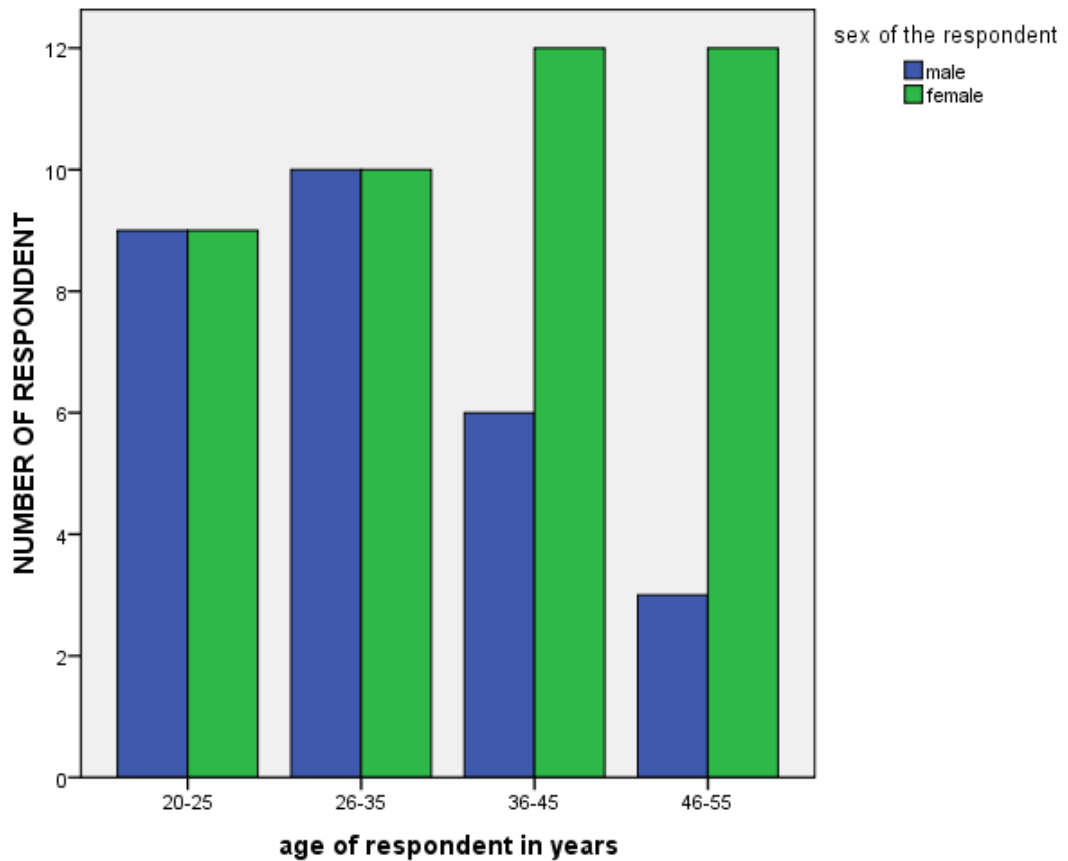


**Source:** Field data, (2013).

Workers were also asked about their occupation. The purpose was to determine a wide range of jobs that people can perform in the hospital and different cadres which are found in the hospital. In this study, occupations were divided into several categories, namely: doctors, nurses, laboratory technicians, pharmacists, accountants, drivers, office attendants, clerical officers, health officers, records keeping, and health records technicians. The results from figure 5 above indicate that overall 48% of the respondents were nurses followed by 20% laboratory technicians, 17% were doctors and the rest 15% were drivers, record keepers, office attendants, health record technicians and clerical officers. The nurses were many because nearly half of the hospital employees were nurses and they showed a greater participation in this study.

#### 4.2.5. Age

**Figure 4.2: Frequency and Percentage Distribution of Respondents According to Age**



**Source:** Field data, (2013).

The age of the respondents is an important aspect during interpretation of results. The respondents were asked to indicate their age. The age distribution of the respondents is presented in five major groups. The minimum age was 20 years and the maximum age was 56 years. The mean age was 25 years. Results indicate that 25.4% of the respondents were in the age category between 20 to 25 years. 28.2% of the respondents were in the age category between 26 to 35 and years. About 25.4% of the respondents were in the age category of 36 to 45 years, the age category of 46 to 55 years was only 21.1% and unfortunately the researcher did not obtain a respondent of age above 56 years. These results justify that the hospital employees

were too young and few were older; hence, employment cost are low for the time being because employees who are about to retire are few.

Trends in the above figure clearly show that majority of the respondents' age ranged between 26 to 35 years (28.2%) while only 21.1% ranged between 46 to 55 years and was the least record among the five categories. This indicates clearly that majority of the workers in the hospital were very young and energetic and few of them were towards retirement age and the hospital would have to employ few workers to replace their position.

#### **4.2.6 Education Qualification Analysis**

The results indicate that majority of the respondents are certificate and diploma holders (39.4%) and (38%) respectively and only 1.4% had attained a master's degree. These results may be due to the fact that health workers professionals undertake science subjects which are somehow difficult to attain. Furthermore, in relation to the age of the respondents, in the past most health staff preferred to undertake certificate courses but nowadays for a health provider to undertake those subjects he must have passed "O" level science subjects and today it becomes difficult for those who attained certificate in the past to go for further studies because they have to repeat "O" level subjects. That is why only few respondents have attained a master's degree and many have attained certificate and diploma courses.

#### **4.2.7 Work Experience Analysis**

Presented in Table 4.5 below are the work experiences of respondents. For simplification of the presentation of these data, three categories were established.

**Table 4.5: Frequency and Percentage Distribution of Respondents According to Work Experience**

Working experience of respondents in health care				
Years	Frequency	Percent	Valid Percent	Cumulative Percent
more than 10	23	32.4	32.4	32.4
5-10	26	36.6	36.6	69.0
less than 5	22	31.0	31.0	100.0
<b>Total</b>	<b>71</b>	<b>100.0</b>	<b>100.0</b>	

**Source:** Field data, (2013).

From the analysis in Table 4.5 above, it is evident that majority of the respondents had a work experience in health care of 5 to 10 years (36.6%), (32%) among them had a working experience of more than ten years and only 31% had an experience of less than 5 years.

**Table 4.6: Frequency and Percentage Distribution of Respondents According to Work Experience**

Working duration of respondents in DRRH				
Years	Frequency	Percent	Valid Percent	Cumulative Percent
more than 10	23	32.4	32.4	32.4
5-10	23	32.4	32.4	64.8
less than 5	25	35.2	35.2	100.0
<b>Total</b>	<b>71</b>	<b>100.0</b>	<b>100.0</b>	

**Source:** Field data, (2013).

In relation to Dodoma regional referral hospital, majority of the respondents had a work experience of less than 5 years (35.2%) but some workers had 5 to 10 (32.4%) years and others had more than 10 years (32.4%). The results indicate that DRRH had qualified and experienced staff to deliver quality service to its clients/ patients and it deserved to be a referral hospital for such number of experienced staff. If we compare the two tables above, there is no great difference between workers' experience in health care and in Dodoma regional referral hospital.

### 4.3 Discussion of Findings by Research Questions

#### 4.3.1 What is the level of performance of service delivery in the sections or departments of Dodoma regional referral hospital?

The Oxford English Dictionary defines performance as the accomplishment, execution, carrying out, and working out of anything ordered or undertaken. This refers to the outputs/outcomes (accomplishment), but also states that performance is about doing the work as well as about the results achieved. Performance could therefore be regarded as, behavior - the way in which organizations, teams and individuals get work done.

**Table 4.7: Hospital Key Performance Indicators (KPIs)  
MAIN PRIMARY INDICATORS, 2012**

INDICATOR	LAST YEAR
Total population	2,004,544
Number of beds	420
Number of doctors	27
Number of nurses	214
Total admissions	14,961
Total inpatient day	41
<b>Total OPD</b>	<b>99,970</b>
<b>Total major surgery</b>	<b>3,956</b>
Staffing level	Dodoma Regional Referral Hospital has a total of 430 staff of different cadres against the required 1163 staff which is 36.9% staffing level available. These include 3 specialists, 19 medical doctors, 14 AMO, 6 CO, 212 nurses, 1 pharmacist, 1 hospital secretary and 2 dental surgeons.

**Source:** Field Data, hospital strategic plan 2012-2013.

Table 4.7 above shows hospital key performance indicators which only apply to all referral hospitals including Dodoma regional referral hospital. The researcher wanted to assess the performance of Dodoma regional referral hospital departments or sections. This was done by distributing questionnaires to patients who gave out their views on how the sections were delivering services. Quality was used as a measure to assess whether the work was done correctly, though this depended on the perception of patients or clients. Other criteria used to assess the level of performance was

consultation waiting time, meeting patient expectations, patient satisfaction, acceptable communication by service providers and understanding of patients the explanation of their illness from health providers.

#### 4.3.1.1 Consultation Waiting Time

This study wanted to examine waiting time used by patients before receiving the service in sections or departments. This was done to outpatient clinics only. Most patients had to wait up to one hour to be called into the consultation room. 14.6% of the patients reported that they waited for less than or thirty minutes, while 25% of the respondents waited between sixty minutes and above, but 29.2% received services between half to one hour. Another 31.2% reported that they had not observed at all. The results indicated that consultation waiting time to see the intended doctor ranged between thirty minutes to one hour.

**Table 4.8: Consultation Waiting Time**

Time	Frequency	Percent	Valid Percent	Cumulative Percent
0-30 min	7	14.6	14.6	14.6
30-60 min	14	29.2	29.2	43.8
60 min and above	12	25.0	25.0	68.8
I have not observed	15	31.2	31.2	100.0
<b>Total</b>	<b>48</b>	<b>100.0</b>	<b>100.0</b>	

**Source:** Field data, (2013).

#### 4.3.1.2 Received Expected Service

The study wanted to know if services delivered in the hospital departments and sections met customers' satisfaction despite the waiting time.

**Table 4.9: Services Received by Patients despite Waiting Time**

	Frequency	Percent	Valid Percent	Cumulative Percent
always	20	41.7	41.7	41.7
sometimes	18	37.5	37.5	79.2
rarely	5	10.4	10.4	89.6
never	5	10.4	10.4	100.0
<b>Total</b>	<b>48</b>	<b>100.0</b>	<b>100.0</b>	

**Source:** Field data, (2013).

From Table 4.9 above, it shows that most of the patients received expected service despite the waiting time. The majority of patients (41.7%) reported that they were able to see their doctor of choice but 10.4% reported that it was rare and sometimes never did they receive the expected service despite the long waiting times. However, as Dodoma regional referral hospital serves as a teaching hospital for the University of Dodoma (UDOM) at the College of Health and Allied Sciences (CHAS) and Interns attend to patients along with consultants as part of their training; therefore, it may not always be possible for a patient to be seen by a particular consultant. This is often a cause for concern for the patients, who fear that they may not be receiving the best care possible.

#### **4.3.1.3 Fast Track**

As described in the descriptive statistics section, majority of the patients involved in this study were females (64.6%). This is because most cases relate to women. For example, women attend in the hospital for cases like maternity and other gynaecological diseases. Patients came from different parts of Dodoma; some of them came from outside Dodoma to seek medical and surgical care at Dodoma regional referral hospital but were staying with relatives and friends. Most of them used public transport to get to the hospital. Dodoma regional referral hospital operates a preferential treatment system called “Fast Track”. For an additional fee, a patient is taken through the service delivery station more quickly than usual. Most of the patients involved in this study could not afford to get on the “Fast Track” system; indeed, some of them were exempted from paying the statutory cost sharing fees. In other words, the patients attending Dodoma regional referral hospital were ordinary Tanzanians who could not afford to go to the private hospitals in the town. This has implications for patient–service provider relations at the hospital. There was a tendency for health care providers to treat patients of low socio-economic status poorly.

#### 4.3.1.4 Patient Satisfaction

**Table 4.2: Frequency and Percentage Distribution of Patient Satisfaction**

Range	Frequency	Percent	Valid Percent	Cumulative Percent
much satisfied	17	35.4	35.4	35.4
satisfied	12	25.0	25.0	60.4
a bit satisfied	13	27.1	27.1	87.5
not satisfied	6	12.5	12.5	100.0
<b>Total</b>	<b>48</b>	<b>100.0</b>	<b>100.0</b>	

**Source:** Field data, (2013).

Table 4.10 above shows that, 35.4% of the respondents were much satisfied with service delivery in the hospital and those with 12.5% were dissatisfied with service delivery. Patients are the primary beneficiaries of the services and care that hospitals provide. The patient satisfaction study examined the extent to which patients at Dodoma regional referral hospital were satisfied with the services and care they received. This was part of a baseline study that sought to determine the level of performance of the hospital after the reform.

Questionnaires were distributed to patients at the OPD clinics, laboratory, X-ray, pharmacy and inpatient wards. The study found that most patients were satisfied with the services and care they received. This high level of satisfaction must be viewed within the context of a hierarchical public health care delivery system, with Dodoma regional referral hospital at the apex. The services and care Dodoma regional referral hospital provides can only be excellent compared to those provided by lower level health facilities. Indeed, patients covered by this study perceived the services provided by the hospital as superior, and this was reflected in the high level of satisfaction they reported. Some patients expressed dissatisfaction with specific aspects of the services that they received. They were particularly dissatisfied with long waiting times before receiving services, the high costs of treatment and investigations charged at the hospital in the fast track system, poor levels of hygiene in the wards, and negative attitudes of staff towards patients. Although only a small proportion of patients expressed dissatisfaction with these aspects of the services delivered, they are significant in that they constitute a call for action by the Dodoma

regional referral hospital management to encourage the health personnel to embrace a new staff patient relationship ethos, in which the patient is viewed as a customer.

The patient satisfaction aspect of hospital care has been highlighted in a study undertaken in a Nigerian hospital, which found that patients were most satisfied with staff patient relationships. However, patients were dissatisfied with the amount of time they were able to spend with their doctors. Two studies of patient satisfaction with primary health care in provincial hospitals in South Africa done in 1999 and 2002 are particularly relevant for this study at Dodoma regional referral hospital. The studies measured the expectations and perceived performance of patients regarding the quality of primary health care and to determine the problem areas that still exist, and to suggest how these could be addressed. The researchers argue that quality control is not only relevant in the private sector, and that the Government must also strive to provide satisfactory care within the resources available. They posit that patient satisfaction is a fundamental indicator of the success.

Results of one-to-one semi-structured interview conducted with management team and heads of departments attest to our findings. When asked about the level of performance in the hospital, the Medical Officer In charge explained that, most patients were referred to Dodoma regional referral hospital from lower level hospitals such as Makole hospital, St.Gemma hospital and other health facilities surrounding the region. For some patients, attending Dodoma regional referral hospital was the end of a long journey through health facilities that offered less-than-optimal quality service of care. This must be kept in mind when appraising their opinions about quality service delivery received at Dodoma regional referral hospital and their satisfaction with the care they received, as these patients will invariably compare this with the care they received in lower level health facilities. This hospital has great relevance to public hospitals in Tanzania and it values the importance of developing mechanisms for assessing the overall performance of the hospital, and patient satisfaction with this performance, as Tanzania and other countries strive to implement health sector reforms.

#### **4.3.1.5 Working Conditions and Safety of Working Environment**

Working environment refers to characteristics of the environment which a person is expected to work. It includes physical, social environment, employment conditions and benefits. According to Bezuldenhout (1994), working conditions refer to the interaction of an employee with the physical working environment. Working condition in Dodoma regional referral hospital includes physical conditions such as working tools, equipment materials and schedules. Psychological conditions include work pressure and stress; and physical layout refers to a clean and comfortable environment. All these contribute a lot to the performance of any service organization like Dodoma regional referral hospital.

Work pressures and safety are some of the issues affecting workers' working environment at Dodoma regional referral hospital due to a huge number of patients flowing to the hospital from and outside Dodoma region. At the same time, the continuous understaffing results in overburdening available staff with heavy workloads especially in the female wards particularly maternity and children wards. Regarding workplace safety, the report shows a relationship between staff shortages, heavy workload, stress and injuries such as low back pain, musculoskeletal injuries and injuries from sharp objects.

Despite the above shortcomings in the hospital, 29 respondents (40.8%) agreed that the working environment was safe to the extent of 51% to 75% but 11 (15.5%) disagreed that the environment safety was only 0-25%. This result generally shows that the overall hospital working environment was safe for health providers to provide quality service to its clients and eventually increased the level of performance in the departments and sections of the hospital. There were some sections in the hospital where or whose environment of service was not safe to provide service. To some extent, it might cause harm to patients or to the employees. The findings suggest that there are risky sections for service delivery for patients and employees. There is a need to identify the areas and rectify.

#### **4.3.1.6 Facilities for Service Provision**

Working tools is one of the most strategies used in the service organizations to provide quality service and improve the performance level. Hence, for the hospital to provide standard service, facilities need to be good and up-to-date. The researcher wanted to know if Dodoma regional referral hospital had enough facilities for service delivery. 67.6% of the respondents said that there were no enough facilities for service delivery in the hospital, while 32.4% supported that working facilities were available. The results also showed 70.4% of the available facilities were not in a good condition and the hospital was in need of all required medical facilities by 66.2% so that it could be able to deliver quality services. Basing on the above results, the hospital management needs to look for enough and quality working tools for its service providers so that they can be able to provide quality service and at last increase the performance level.

#### **4.3.1.7 Response from Management Team and Heads of Departments**

A total of 13 respondents interviewed, 10 (77%) were males and 3 (23%) were females. When interviewed about the level of performance in the hospital, they responded that, performance management is one of the most important and critical functions of the hospital human resource. It is seen as a way of establishing mechanisms for reviewing the performance of staff and helping them to effectively contribute towards the achievement of the hospital objectives. Performance or staff appraisal is the one which determines the level of performance of the sections or department and eventually the hospital as a whole. As the staff performs well, then the whole section performance becomes valid. Performance appraisal is an approach used mostly in the hospital where an individual in the section or department is assessed by an immediate supervisor on his or her ability to deliver services on time, punctuality at work station, meeting customer expectations, satisfaction and the ability to give clear explanation of the patient's illness. Employees' performance appraisal form is attached for reference. (See appendix 8).

The hospital secretary, Mr. Isack Kaneno, insisted that performance assessment of the hospital is done to identify excellent performers with the aim of rewarding people who are ready for promotion. Moreover, it is done to determine whether the set of targets have been achieved and whether the laid down standards have been adhered to. He insisted that hospital assessment for the last year started on 7<sup>th</sup> September, 2012 to 8<sup>th</sup> September, 2012. After the assessment, the assessors met and analyzed the findings according to functional areas using given format as shown in appendix 9. Despite the above results, the researcher reviewed various documents in the hospital and found that, the public service management and employment policy of 1999 explains performance management system, which emphasizes promotion procedures based on open performance and appraisal system (promotion on merit). Nevertheless, the standing orders (1994) stipulated that employee shall be paid to and from once in every two years travel expenses while proceeding on annual leave, and training for carrier development of employee should be paid by employer.

Cost sharing policy is also implemented in the hospital; it is among hospital the sources of income. Consequently, the collection of fund depends mainly on the participation of employees for the fact that documents used for collection have to be filled properly by the employees and patients need clear information on price of services and money collection points and procedures. Furthermore, the researcher found that there was a poster at the out-patient department which explained the price of ultra- sound services, admission and surgery services, laboratory investigation and x-ray expenses. These findings suggest that there are clear guidelines and regulations of necessary benefit of employees from employer. Also, the price of services is clearly communicated to clients attending for different services in Dodoma regional referral hospital; thus, making the performance level to be high.

### 4.3.2 To what extent do workers participate in decision making on matters pertaining to quality service delivery in their sections or departments?

Participation of workers in the decision-making process has resulted in successful value creation in Dodoma regional referral hospital. Though the extent to which employees should participate in organizational decision making is still a matter of debate. Some say that workers' union should participate with management as equal partners while some believe in restricted or bounded participation, that is, participation of employees or workers to a limited extent. However, there are a number of ways through which employees can participate in the decision-making process in any organization.

Employees of Dodoma regional referral hospital participate in organizational decision making through various levels: information, consultation, deciding, acting together and supporting. The findings on respondents' frequency of involvement in the decision making process of the hospital showed that respondents in the case study demonstrated generally high frequency of involvement (42.3%). This result could be explained by higher educational status of respondents with their professions who are more willing to seize the opportunity of participation in management decision making. However, workers are not involved in every aspect which needs decision making. There are some aspects which management team makes decision on behalf of workers so as to fasten decision and take actions as fast as possible as shown by Table 4.11 below in decision making levels.

**Table 4.31: Levels of Participation in Dodoma Regional Referral Hospital**

Levels of participation	Frequency	Percent	Valid Percent	Cumulative Percent
Information	37	52.1	52.1	52.1
Consultation	3	4.2	4.2	56.3
Deciding together	13	18.3	18.3	74.6
Acting together	8	11.3	11.3	85.9
Supporting	10	14.1	14.1	100.0
<b>Total</b>	<b>71</b>	<b>100.0</b>	<b>100.0</b>	

**Source:** Field data, (2013).

From Table 4.11 above, it shows that the respondents' level of participation in decision making is information (52.1%) while consultation is only 3%. This finding would lead us to conclude that the hospital management was not favorably disposed towards granting workers significant measure of participation in decision making and it implies that a lot is needed to be done to change the current negative disposition of the hospital management towards workers' participation in decision making. Moreover, results of focus group discussion with health providers (doctors, nurses and laboratory technicians) support the study findings. When asked about the extent to which she was involved in the making of decisions in the hospital, a nurse attendant in the OPD section replied:

*“The management in this hospital does not consider; it as its duty to contact junior employees on how decisions are made”*

A surgical doctor in the major theater in Dodoma hospital had this to say on the similar question:

*“I am always busy in the theater from morning up to evening; may be this is why I don't think and know about decision making”*

It is possible to observe the obvious variation in reasons advanced by the two informants on why they demonstrated low involvement in decision making. While the nurse informant from OPD expressed that her low or lack of involvement was due to management unwillingness, the respondent from the surgical department indicated that he was not much involved in decision making because of his busy schedule of work. It is also interesting to know that a number of respondents indicated that they had no interest in participating in decision making of their sections or departments. This category of employees demonstrated a non-challant attitude towards their participation in decision making, as a lab technician respondent had this to say:

*“I am in this hospital to work and earn my salary. I have no business with decision making. I am not paid for such job.”*

An opinion like this reflects the instrumental orientation of some of the workers in the hospital. Being mostly junior workers, these respondents tend to demonstrate more interest in earning a living from work rather than to satisfy the higher order needs of self expression through participation. However, in spite of this tendency, the findings showed that a larger proportion of respondents in the hospital reported that they were involved either regularly or occasionally in the decision making process of their sections. The following are the words of a respondent in the hospital:

*“Management in this hospital does not hesitate to involve some of us in the decision making process whenever it is necessary”*

This opinion is similar to another expressed by a surgery head of department:

*“As a senior staff, I and other heads of departments in the various sections are made to contribute to the decisions in matter relevant to our departments”*

Views like the ones above show that respondents have some measures of participation in the decision making process of their organization. On the factors which could influence workers participation in decision making, it shows that there is a relationship between age, education, job position and respondents level of participation. There is a significant relationship between educational attainment and participation in decision making in different departments and sections of the hospital.

This finding demonstrated that the respondents’ measures of participation were related to their educational qualification in the hospital, while those who possessed low educational qualification exercised low measure of participation, those with higher education demonstrated the equivalent level of participation in decision making. It is evidenced from these findings that an individual’s educational qualification could influence the level of participation he/she could exercise. This finding is not surprising since those with higher educational qualification tend to have more knowledge about management decision making and are also more likely to seize the opportunity to be involved in the affairs of their organizations.

#### **4.3.2.1 Participation in Decision Making on Quality Service Improvements**

When asked about their participation in hospital decision-making processes on quality service improvements, most of the study respondents (42.3%) reported that they were always involved in discussions regarding ways to improve work output. Almost a good number of the doctors and nursing staff gave this response. In addition, 29.6% of other respondents revealed that meetings to discuss work-related issues with management hospital were rare. Moreover, in such meetings, always respondents were free to ask different questions and 32.4% of the meeting suggestions were sometimes put into practice.

The researcher reviewed documents of 13 departments for the purpose of self satisfaction of departments which conducted meetings as per given schedule. Results showed that the medical department had four minutes of the meetings, the surgery department had seven minutes of meetings, pediatrics showed eight minutes of meetings, obstetrics and gynecology had nine minutes of meetings, out-patients department had six minutes, laboratory had four and administration department had ten minutes of meetings. The rest of the departments did not present any minute of the meeting. These findings from 13 departments showed that six (46.2%) out of 13 departments conducted meetings and seven departments (53.8%) did not do so as per given schedule. This was confirmed by the presence of minutes of meetings in six out of 13 departments which showed the highest number was ten and the lowest was four. Therefore, this suggests that meetings were conducted though were few compared to 12 meetings which were to be conducted per year. The findings had two implications:

First, departments did not follow instructions proposed by the hospital management that each department should conduct meetings monthly for twelve months to discuss issues pertaining to each department. Second, employees had little time to discuss matters arising in the department. These meetings had influence in performance of departments. Most literatures suggest that the most common methods for the firm to increase performance are employees' orientation and regular meetings at department

or work as a group. Furthermore, the researcher found a document which showed and explained the time table for RRHMT as shown in Table 13 below.

**Table 4.4: Meeting Schedule for RRHMT Dodoma Year 2011/2012**

MONTH	DATE OF THE MEETING
JULY 2011	20 JULY 2011
AUGUST 2011	17 AUGUST 2011
SEPTEMBER 2011	21 SEPTEMBER 2011
OCTOBER 2011	19 OCTOBER 2011
NOVEMBER 2011	16 NOVEMBER 2011
DECEMBER 2011	21 DECEMBER 2011
JANUARY 2012	18 JANUARY 2012
FEBRUARY 2012	22 FEBRUARY 2012
MARCH 2012	21 MARCH 2012
APRIL 2012	18 APRIL 2012
MAY 2012	23 MAY 2012
JUNE 2012	20 JUNE 2012

**Source:** Field data, (2013)

Given the importance of interaction between different work units, management and between workers in maintaining and improving patient services, respondents were asked to comment on the opportunity for such meetings; the responses are summarized in Table 4.13 below.

**Table 4.53: Frequency of Attending Meetings between Different Departments**

Meeting Frequency	Frequency	Percent	Valid Percent	Cumulative Percent
very often	19	26.8	26.8	26.8
often	22	31.0	31.0	57.7
rarely	23	32.4	32.4	90.1
not at all	7	9.9	9.9	100.0
<b>Total</b>	71	100.0	100.0	

**Source:** Field data, (2013).

Generally, such meetings within or between departments were often (31%) or rarely (32.4) held. Some respondents revealed that these meetings were held very often (26.8%). This was particularly the case among doctors and supporting staff of the hospital. For example, doctors from different departments and specialties would be expected to meet to resolve clinical care problems, and regular communication

between clinical and supporting staff would be similarly necessary to maintain the smooth delivery of services. This finding was therefore somewhat surprising given the complex nature of a hospital working community and the need for effective communication across the board to improve patient care and to minimize workers dissatisfaction. The lack thereof suggests that many problems requiring joint discussion remained largely unresolved, providing a major source of frustration for staff and inefficiency in the expected outputs.

To make sure that workers participated in decision making on matters pertaining to their sections or departments for the purpose of improving quality service delivery in the hospital, health providers participated in making duty schedules. The research results indicated that 47.9% of the respondents participated in making rosters. This result implies that some employees participated and others did not and some heads of departments or sections enhanced employees' participation in preparing duty rosters. Also, some heads of departments had little emphasis on participation and communication. This might bring little change in employee relations. Of all respondents, 64.8% were satisfied with the duty roster prepared though 26.8% were a bit satisfied, and 8.5% of the respondents were not satisfied at all. This result had implications that even though there were employees who did not participate in preparing duty roster, but in-charges of sections were entrusted with the task and performed to the interest of the majority. Impliedly, the employees had willing and commitment with the task allocated to them.

#### **4.3.3 To what extent does workers participation influence quality service delivery in the hospital?**

In any organization including health organizations, workers' participation is used as a strategy to improve performance and encourage individual employees to take responsibility for quality in health service delivery in terms of carrying out activities which meet the requirements of their customers. Workers' participation may be an effective strategy to influence quality service delivery in a service organization like Dodoma regional referral hospital. The application of quality-management practices by manufacturers and service providers has become increasingly widespread.

Recognition of the differences between manufacturing and services through the dimensions of intangibility, inseparability, and heterogeneity of service products (Buttle, 1996; Berry and Parasuraman, 1991; Zeithaml *et al.*, 1990) has enabled quality-management practitioners to develop approaches that have proved effective in improving service quality.

The quality service, both technical and functional, is a key ingredient in the success of service organizations (Grönroos, 1984). Technical quality in health care is defined primarily on the basis of the technical accuracy of the diagnosis and procedures. Several techniques for measuring technical quality have been proposed and are currently in use in health-care organizations. Information relating to this is not generally available to the public, and remains within the purview of health-care professionals and administrators (Bopp, 1990). Functional quality, in contrast, relates to the manner of delivery of health-care services. Numerous studies have shown that provision of high-quality services is directly related to workers' participation. With competitive pressures and the increasing necessity to deliver patient satisfaction, the elements of quality control, quality service and effectiveness of medical treatment have become vitally important (Friedenberg, 1997).

Hence, there is a relationship between workers participation and quality service delivery. The more workers participate in any decision concerning work place the more the quality of service delivery increases. This can be justified by the fact that workers are the ones who are professionally in provision of such a service. That is why the results in Table 15 below reveal that the hospital practices participatory management in which a worker is involved in the policy from its formulation to implementation and not made to act on orders. If workers show a strong participation from one department to another, from lower level to higher level, then there must be high quality service delivery in the hospital. For example, if the OPD section does not perform well in receiving and directing patients to the respective sections, then the doctors will have nothing to do and therefore service delivery will be of low quality.

**Table 4.6: Types of Participation in Dodoma Regional Referral Hospital**

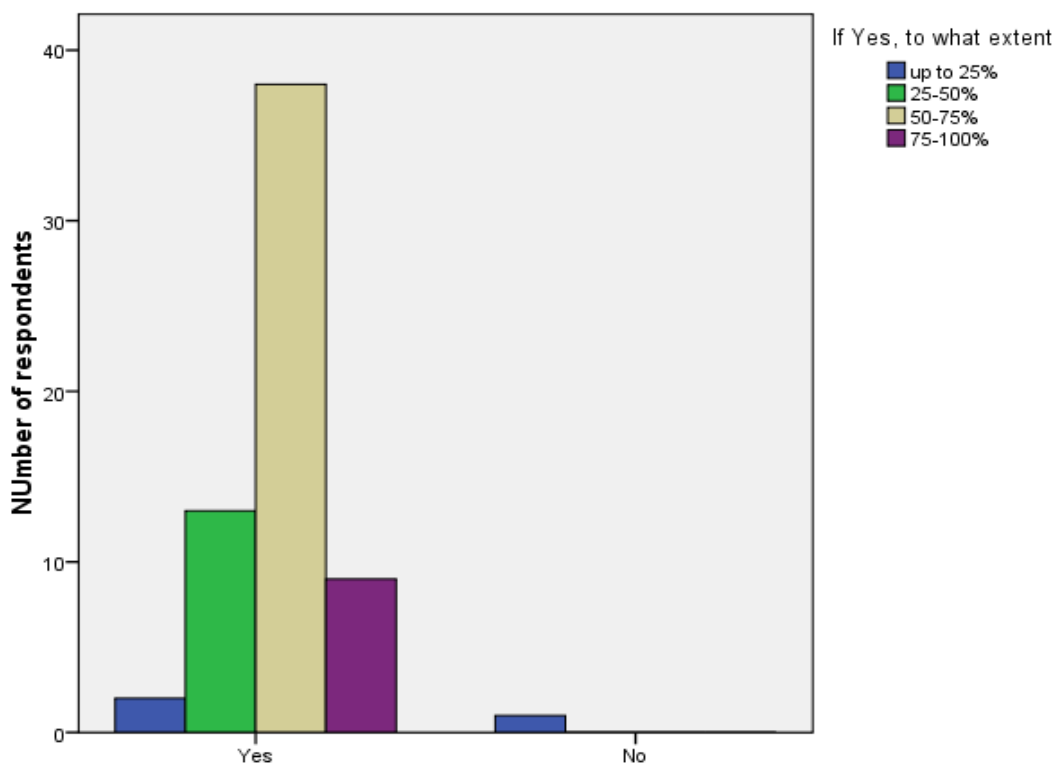
Types of Participation	Frequency	Percent	Valid Percent	Cumulative Percent
Participatory management	44	62.0	62.0	62.0
Non participatory	27	38.0	38.0	100.0
<b>Total</b>	71	100.0	100.0	

Source: Field data, (2013).

From Table 4.14 above, most of the respondents agreed that there was a strong relationship between workers participation and quality service delivery in the hospital. The more they participate the more the service delivery becomes. Most respondents (62%) supported that the hospital had participatory management and the rest (38%) agreed on non-participatory management.

#### 4.3.3.1 Workers' Participation Influence Quality Service Delivery

**Figure 4.3: Workers participation on quality service delivery**



Source: Field data, (2013).

From figure 4.3 above, the study shows that 62 respondents (87.3%) agreed that workers participation influenced quality service delivery to the extent of fifty to seventy five percent (50-75%) in contrary to those who supported that it was to the extent of seventy five to one hundred percent (75-100%). Only 9 respondents (12.7%) said that workers' participation was not the only factor to improve performance and influence quality service delivery, but there were other factors which influenced quality service delivery like motivation to workers, salary increase, night allowance, extra duty allowance and increase of work force.

Workers' participation is an important strategy in any service organization including Dodoma regional referral hospital. The hospital exercises workers' participation programs because evidence suggests that this has led to increased quality service through improved efficiency and organizational performance. Workers' participation has led to changing employees' attitudes, overcoming resistance to change and increase commitment. Moreover, there has been the experience of mutual advantage. The management has benefited from improved performance and for instance, reduced levels of turnover and absenteeism. Employees have enjoyed more secure employment, upgraded tasks, a large degree of workplace autonomy and incentives to take responsibility for quality service delivery.

#### 4.3.3.2 Outcomes of Workers Participation

**Table 4.7 Positive Outcomes of Workers Participation**

Outcomes	Frequency	Percent	Valid Percent	Cumulative Percent
High level of performance	16	22.5	22.5	22.5
Workers feelings of belonging to the organization	12	16.9	16.9	39.4
Minimal workers turnover	17	23.9	23.9	63.4
Good communication between management and workers	21	29.6	29.6	93.0
Readjustment of rules and regulations	5	7.0	7.0	100.0
<b>Total</b>	71	100.0	100.0	

**Source:** Field Data, (2013).

From Table 4.15 above, 29.6% of the respondents supported that workers participation influenced quality service delivery because there was a good

communication between management and workers, 23.9% said participation was good because workers did not think of exchanging jobs now and then and hence the rate of turnover was low, 22.5% supported that workers participation increased the level of performance in the hospital, while 16.9% felt themselves as part of the organization when they participated in different decisions of the hospital and only 7% of the respondents agreed that workers participation led to readjustments of rules and regulation because workers participated in all aspects of the hospital well being. Though this is in contrary to 46.5% of the respondents in the Table 4.16 below who said that workers participation had negative outcomes as management took longer time to make decision.

**Table 4.8: Negative outcomes of workers participation**

Outcomes	Frequency	Percent	Valid Percent	Cumulative Percent
Low level of performance	22	31.0	31.0	31.0
Longer time to make decision	33	46.5	46.5	77.5
Workers turnover	16	22.5	22.5	100.0
<b>Total</b>	71	100.0	100.0	

**Source:** Field data, (2013).

Table 4.16 above is in contrary to Table 4.15 which indicated positive outcomes of workers' participation. 46.5% of the respondents in the table said that workers' participation had negative outcomes as management took longer time to make decision. This is because the decision process will be longer from point of formulation to implementation as the idea will have to be discussed from lower to higher level so that every employee can make his or her contribution.

#### **4.3.4 What strategy (s) can be adopted to improve quality service delivery in Dodoma regional referral hospital?**

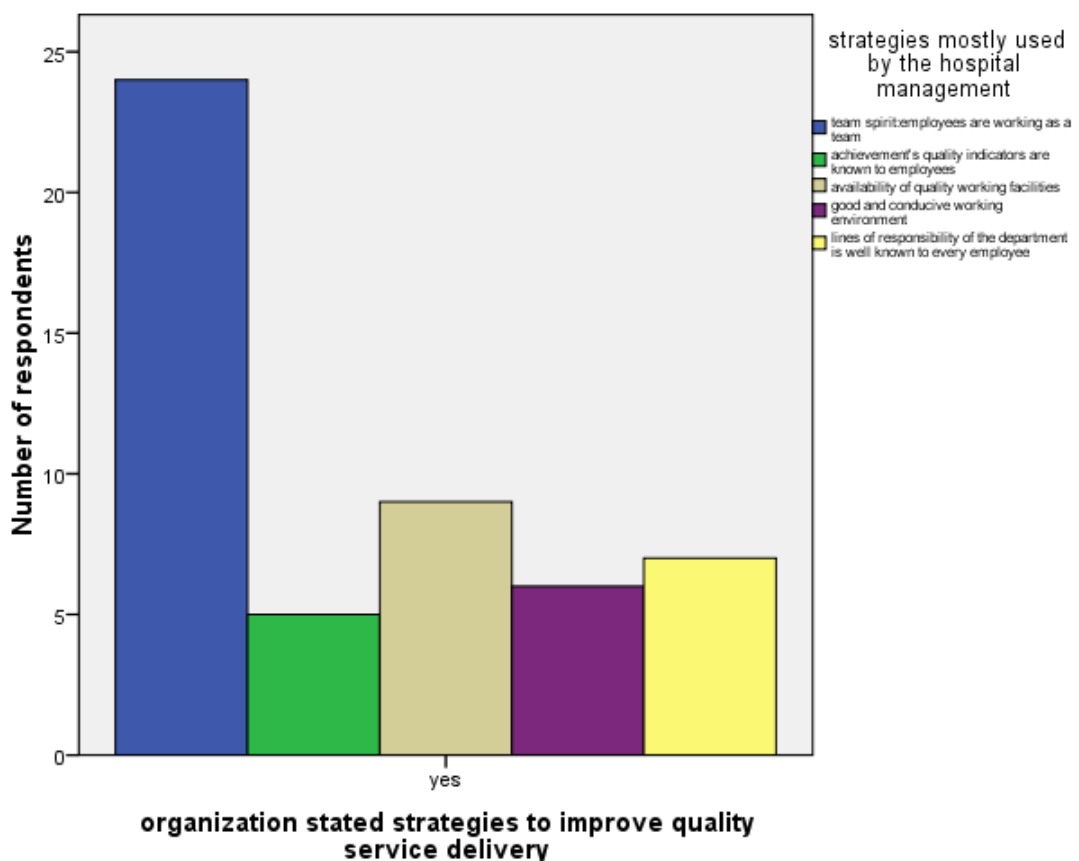
Hospitals are on a never-ending journey of quality improvement - employing new technologies and techniques and research on what works, as well as continuously training new workers and meeting the needs of patients. While hospitals are at different points on their quality path, all hospitals are committed to quality improvement. This commitment has helped hospitals make great strides in increasing adherence to treatment protocols and improving patient outcomes. Generally, quality

improvement efforts involve five steps: Identifying target areas for improvement; determining what processes can be modified to improve outcomes; developing and executing effective strategies to improve quality; tracking performance and outcomes; and disseminating results to spur broad quality improvement.

Dodoma regional referral hospital employs different approaches and strategies of quality improvement. Examples of these strategies include: team spirit, achievement's quality indicators are known to employees, availability of quality working facilities, good and conducive working environment, and lines of responsibility of the department are well known to every employee.

#### 4.3.5 Strategies Used by Management to Improve Quality Service Delivery

**Figure 4.4: Strategies Used by Management**



Source: Field Data, (2013).

Figure 4.4 above reveals that the management used team spirit strategy more (33%) followed by availability of quality working facilities (12%) and lines of responsibility of the department were well known to every employee (11.3%). On the other hand, good and conducive working environment (9.9%) and achievement's quality indicators (7%) were considered to be the least strategies used by hospital management to improve quality service delivery.

**4.3.5.1 Team Spirit:** We work together cooperatively believing that our efforts will reach the goals (together will make it).

**4.3.5.2 Achievement's Quality Indicators are Known to Employees:** Dodoma regional referral hospital quality indicators include hospital governance and management, number of qualified staff, and patient community perspective as described by Table 4.17 below.

**Table 4.9: Hospital Quality Indicators**

INDICATOR	DEFINITION	YEAR BEFORE LAST YEAR	LAST YEAR	TARGET
<b>HOSPITAL GOVERNANCE AND MANAGEMENT</b>				
Number of hospital board meetings in the year	With field minutes	0	0	4
Number of RRHMT meetings in the year	With field minutes	12	12	12
<b>QUALITY INDICATORS</b>				
Number of qualified surgeons	Number of qualified surgeons	0	0	1
Number of qualified obstetricians	Number of qualified obstetricians	1	1	1
Number of qualified pediatricians	Number of qualified pediatricians	0	0	1
Number of QIT meeting per year	With field minutes	37	43	56
<b>PATIENT COMMUNITY PERSPECTIVE</b>				
Number of feedback boxes in place in the hospital	Number of feedback boxes in place	1	1	3

**Source:** Field data, hospital strategic plan 2012-2013

**4.3.5.3 Good and Conducive Working Environment:** Remember, a good working environment is just one element to improve quality service delivery and creativity. Hospital management cannot motivate its employees but it can create an environment which is conducive to employees and remove the barriers to motivation that employees experience. Creating this favorable environment pays off in many practical ways: it reduces turnover (our employees like their jobs; hence, stay in it longer); saves time and money; lowers turnover (means the hospital spends less time and money hiring and training new employees); raises performance standards (the hospital develops experienced employees who have been with the organization for an extended time; hence, things are done faster and better); reduces absenteeism and tardiness (good working environment in the hospital motivates workers who come to work on time and they come in when scheduled).

**4.3.5.4 Availability of Quality Working Facilities:** Working tools is one of the most strategies used in the service organizations to provide quality service and improve the performance level. Hence, for the hospital to provide standard service facilities need to be good and up-to-date. The hospital management needs to look for enough and quality working tools for its service providers so that they can be able to provide quality service and at last increase the performance level. An inadequate facility for performing the expected tasks is a major factor in causing low morale at work. This problem was cited by respondents although details on this particular factor were not collected.

**4.3.5.5 Lines of Responsibility of Department are well Known to every**

**Employee:** After first employment, every employee is supplied with job description as a guideline of what is to be done in that particular job and department or section. Also, all heads of departments make sure that workers under their supervision are aware of the criteria used for evaluating their work performance and when the evaluation is to be done.

Interview conducted to management and heads of departments of the hospital revealed that strengthening service delivery was a key strategy to achieve the millennium development goals. This includes the delivery of interventions to reduce child mortality, maternal mortality, and the burden to HIV/AIDS, tuberculosis and malaria. Service provision or delivery is an immediate output of the inputs into the hospital system, such as health workforce, procurement and supplies and finances. Increased inputs should lead to improved service delivery and enhanced access to services. Ensuring availability and access to health services is one of the main functions of Dodoma regional referral hospital. Such services should meet a minimum quality standard. Hence, the management ensures availability, affordability and accessibility. Availability refers to the physical access or reachability of services that meet a minimum standard. This often requires specification in terms of the elements of service delivery such as basic equipments, drugs, health workforce and guidelines for treatment. Affordability refers to the ability of the client to pay for the services. Acceptability of the service depends on a socio-psychological dimension of the client.

Another strategy used by the hospital is facility reporting systems often referred to as health management information systems (HMIS). It is mostly used to monitor service delivery. These include supervisory or clinic-reported data on drug stock outs in a defined reference period (example in the last month), functioning of outreach services, and health worker availability. In general, facility reporting systems give only limited information on the status of service delivery and hospital statistics about performance related to in-patient activities including numbers of beds, admissions, discharges, deaths and duration of stay.

When asked about strategies which can be adopted to improve quality service delivery, the medical officer in-charge of the hospital replied:

*“Hospitals across the country are searching for ways to improve quality of care and promote effective quality improvement strategies”* Essential elements of a successful strategy, according to the study, include attracting and retaining the right people,

devising and updating the right in-house processes, and giving staff the right tools to do the job.

#### **4.3.6 Attracting and Retaining the Right People**

Dodoma regional referral hospital has high-quality doctors, nurses, administrators, and ancillary staff who are critical to producing high-quality outcomes and effective quality improvement. The hospital stressed the need for selective, hiring, credentialing, and re-credentialing. Successful recruitment and retention of nursing staff is tied to an absolute respect for and empowerment of nurses who must be treated as full partners in patient care and given opportunities for advancement. All are expected to be good team players, able to participate in multi-disciplinary teams for both quality improvement and patient care management.

#### **4.3.7 Developing Effective In-house Processes**

The hospital not only collects data on outcomes and cost, but also pulls apart the numbers on surgeries, tests, and other procedures to identify each step in the process where less-than optimal medicine is practiced. Quality improvement department is adequately staffed, has credibility with physicians and are trained to facilitate the problem solving process (example, the hospital has quality department headed by a physician to facilitate quality improvement in specific service lines). Deficiencies in outcomes are not hidden or ignored, but instead are used to inspire an iterative process of discovery followed by corrective actions and accountability. Effective problem solving leads to the development of evidence based protocols and critical paths, and enhanced efficiencies such as reduced turnaround time for test results and reduced errors related to standardization of supplies and procedures. Another important process involves team-based care management. A key to success involves making sure physicians and other caregivers accept the case manager's or team leader's role in coordinating and facilitating care.

#### **4.3.8 Providing the Right Tools to Do the Job**

Also, the hospital gives its doctors, nurses, and other staff the tools and support they need to practice high quality service delivery on a daily basis and to identify and investigate quality problems when they do surface. This includes investments in information technology (IT) and performance improvement departments with qualified staff who abstract medical records, analyze data, and facilitate the quality improvement. Other strategies involve external training, peer networking, and conferences. Information and data tools play a critical role. The research found that successful IT strategies employed by the hospital involved four main commitments: a willingness to invest in IT; working with doctors and others to customize an information system to meet specific needs and culture of the institution (example, the hospital has IT directors who are IT experts); nurturing and encouraging buy in so that new systems will be utilized and their benefits realized; and devising IT systems that provide real time feedback to providers (including access to patient history, test results, computerized reminders/alerts, etc.) as they are caring for patients.

## **CHAPTER FIVE: CONCLUSION AND POLICY IMPLICATIONS**

### **5.0 Introduction**

This chapter contains conclusions and recommendations. This study originated from the evidence and recognition that by far the most significant component of health systems is health personnel. Without a foundation of skilled human resources for health, health care systems cannot function adequately or effectively.

More specifically, the objectives of the study were to:

- i. Determine the performance level of service delivery for each department or section in Dodoma General Hospital.
- ii. Explore the extent to which workers participate in decision making on matters pertaining to their departments or sections on service delivery.
- iii. Relate workers' participation and performance of sections towards quality improvement in the hospital.
- iv. Identify a strategy (s) for improving quality service delivery in the hospital.

This chapter presents the conclusions obtained from the results of the study and the recommendations on workers' participation in quality service delivery in government hospitals, particularly DRRH.

### **5.1 Summary**

This dissertation is about workers' participation in quality service delivery in Government hospitals. The study is expected to form a basis for the need to raise quality service delivery of workers through appropriate motivational techniques thus leading to positive work attitude and high quality service delivery. Case study design was used including use of semi structured interview, focus group discussions, documentary review and questionnaires. Based on the findings, the study found that, participation of workers is important and there is a strong relationship between workers participation and quality service delivery. The more workers participate the more the quality service delivery becomes, but management need to use different strategies to improve quality service delivery like; team spirit, availability of good working facilities and conducive working environment.

## **5.2 Conclusion**

In the light of the research findings, the following conclusions were drawn:

Criteria used to assess hospital level of performance were consultation waiting time in which a patient used thirty minutes to one hour, meeting clients' expectations in which a patient was able to see the doctor of his/her choice, fast track service, clients' satisfaction, safety of the working environment and facilities for service provision. However, results from the management team revealed that performance or staff appraisal was the one which determined the level of performance of the sections or department and eventually the hospital as a whole. As the staff performs well, then the whole section performance becomes valid. In this approach, an individual in the section or department was assessed by an immediate supervisor on his or her ability to deliver services on time, punctuality at work station, meeting customer expectations and satisfaction and the ability to give clear explanation of the patient's illness. This was done to identify excellent performers with the aim of rewarding people who were ready for promotion.

Furthermore, documents reviewed in the hospital like public service management and employment policy of 1999 explains performance management system, which emphasizes promotion procedures based on open performance and appraisal system (promotion on merit). In responding to the second objective of the study, the extent to which workers participate in decision making and basing on the findings of the study, it could be concluded that workers in the hospital were generally much involved in the decision making process of the hospital. On the other hand, the workers generally demonstrated high interest and positive attitude towards participation in decision making. This implies that workers in the service sector are more involved in decision making whenever such opportunity arises. However, many hold the view that decision making is the preserve of the management. This implies that while the workers are willing to accept the responsibility of greater participation in decision making, they are not ready to challenge the management in this regard.

Finally, from the respondents' assessment of management attitude towards workers participation, it could be concluded that the hospital management was not favorably disposed towards granting workers significant measure of participation in decision making. This finding would lead the researcher to conclude that a lot is needed to be done to change the current negative disposition of the hospital management towards workers' participation in decision making. More importantly, the current obstacles against effective workers' participation in the hospital could be tackled through: enlightenment program for workers on their rights to seize the opportunity of participation in decision making; provision of monetary and other incentives for workers to encourage them sustain the current interest in participation; liberalizing management structure so as to allow for greater workers participation; and lastly, training programmes for workers in management functions as a way of properly equipping them on their decision making role.

With regard to the fourth objective of the study, strategies used by the hospital to improve quality service delivery, it could be concluded that Dodoma regional referral hospital is on a never-ending journey of quality improvement by employing new technologies and techniques as well as continuously training new workers for the purpose of meeting the needs of patients. Dodoma regional referral hospital employs different approaches and strategies of quality improvement. Examples of these strategies include: team spirit, achievement's quality indicators are known to employees, availability of quality working facilities, good and conducive working environment, and lines of responsibility of the department are well known to every employee. Strengthening service delivery is a key strategy to achieve the millennium development goals. Hence, the management ensures availability, affordability and accessibility of services that meet a minimum standard. Essential elements of a successful strategy, according to the study, include attracting and retaining the right people, devising and updating the right in-house processes, and giving staff the right tools to do the job.

### **5.3 Policy Implications**

The study recommends the following:

- i. The overall recommendation is that DRRH should strive to maintain the high standard it has in order to keep patients satisfied with the services they receive. As a regional referral hospital, DRRH is the final destination for most patients surrounding Dodoma Region. Very few are referred to hospitals outside the region like Muhimbili national referral hospital (MNRH). DRRH is equipped to provide the best and quality medical care and has highly trained health professionals to provide it. The patients who come to DRRH should be able to experience it as such.
- ii. A specific recommendation relates to the need to encourage the staff to treat patients with courtesy and respect in line with the Health Sector Reforms and patient centered quality assurance. Patients should not be expected to be grateful for whatever is done to/for them. They are customers whose concerns need to be taken into account, the indigent status of some of them being irrelevant.
- iii. Another specific recommendation is for DRRH to review the working arrangements and procedures at different service delivery stations. The fact that some patients expressed dissatisfaction with the services indicates that DRRH needs to do more in the drive towards improving service stations in order to improve efficiency, minimize patient waiting times and provide for patient comfort.

### **5.4 Areas for Further Research**

Based on the above limitations, the areas for further research are hereby suggested:

- i. Participants in this study were limited to those from Dodoma regional referral hospital. It is suggested that further studies be carried out to explore and make a comparison of workers' participation on quality service delivery from other district hospitals of Dodoma region that are not covered in this study. It will be made clear whether the importance of workers' participation noted in this study can be generalized to the whole of the region.

- ii. It has been revealed in this study that working facilities were not enough and were poor. There is a need to conduct an in-depth study to examine their effects on health service providers' performance.
- iii. Also, high cost paid on fast truck service in the hospital has been observed as a critical problem to some patients. A study could be conducted on how patients manage to pay the cost and obtain the service despite the high living cost existing in the region.

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## APPENDICES

### Appendix I(a): Patient's Questionnaire

Dear patient,

My name is Leonora R.Mruma. I am an assistant accountant at the Dodoma University. Currently, I am doing Masters of Business Administration (Corporate Management) at Mzumbe University in Morogoro. I am doing a study on workers participation in quality service delivery in Government Hospitals. Be free, answer freely, and individually, so that your answers reflect your true feelings and beliefs. Your responses will be useful for research purposes only and will always be kept confidential.

This questionnaire has two sections. Please respond to each item in all sections.

Insert a  $\checkmark$  in the box provided

#### Section One: Personal Particulars

1. Patient's sex:
  - 1) Male ( )
  - 2) Female ( )
2. Name of Department.....
3. Name of respondent (optional).....

#### Section Two: Measure of Quality Service Delivery

Tick  $\checkmark$  in the appropriate box.

4. What time do you spend in the queue or department to be attended?
  - 1) 0-30 minutes ( )
  - 2) 30-60 minutes ( )
  - 3) 60 minutes and above ( )
  - 4) I have never observed ( )
5. Despite the time you spend, do you get the service which you expected?
  - 1) Always ( )
  - 2) Sometimes ( )
  - 3) Rarely ( )
  - 4) Never ( )

6. Please give some reasons for the answer above:
- 1) .....
  - 2) .....
7. Are you satisfied with the way the service provider communicates to you?
- 1) Much satisfied ( )
  - 2) Satisfied ( )
  - 3) A bit satisfied ( )
  - 4) Not satisfied ( )
8. Give comments or opinions for the answer above?
- 1) .....
  - 2) .....
9. Are explanations given about your illness clear to you?
- 1) Very clear ( )
  - 2) Clear ( )
  - 3) A bit clear ( )
  - 4) Not clear at all ( )
10. Are you satisfied with the service?
- 1) Much satisfied ( )
  - 2) Satisfied ( )
  - 3) A bit satisfied ( )
  - 4) Not satisfied ( )
11. Is there a good process of obtaining health care services to everyone?
- 1) Very good ( )
  - 2) Good ( )
  - 3) Somehow good ( )
  - 4) Not good ( )
12. Is the process in question eleven (11) above well followed by the service providers?
- 1) Well followed ( )
  - 2) Sometimes followed ( )
  - 3) Followed ( )

4) Not followed ( )

13. In your own opinion, what ways do you think can help to improve the whole process of service delivery in the hospital?

1) .....

2) .....

3) .....

4) .....

14. Do you think the hospital has enough and quality drugs to enable service providers to deliver quality service in every section or department?

1) Quite enough

2) Enough

3) Very little

4) Nothing

## Appendix I(b): Dodoso Kwa Mgojwa

Habari,

Jina langu ni Leonora R.Mruma, mhasibu msaidizi Chuo Kikuu Dodoma. Kwa sasa, nachukua shahada ya uzamili ya uongozi Chuo Kikuu Mzumbe. Nafanya utafiti juu ya ushiriki wa mfanyakazi katika utoaji wa huduma bora za afya kwenye hospitali za serikali. Naomba ushirikiano wako. Taarifa utakazotoa ni siri na zitatumika kwa ajili ya utafiti si vinginevyo.

Dodoso hii ina sehemu mbili. Tafadhali jibu maswali yote.

### Sehemu ya Kwanza: Taarifa Binafsi

1. Jinsia:
  - 1) Mke ( )
  - 2) Mme ( )
2. Wodi namba au idara.....
3. Jina la mgonjwa (sio lazima).....

### Sehemu ya Pili: Kupima Ufanisi wa Huduma Bora

4. Unatumia wastani wa muda gani kwenye foleni hadi kupata huduma?
  - 1) Dakika 0 – 30 ( )
  - 2) Dakika 30- 60 ( )
  - 3) Dakika 60 na zaidi ( )
  - 4) Sijawahi kufuatilia kwa makini ( )
5. Pamoja na kukaa muda huo, ni kwa kiwango gani unaridhika na huduma unayoipata?
  - 1) sana ( )
  - 2) kidogo ( )
  - 3) sikuridhika ( )
  - 4) sikuridhika kabisa ( )
6. Toa sababu kuhusiana na jibu la swali la tano (5) hapo juu.
  - 1) .....
  - 2) .....
7. Je, unaridhika na mahojiano yanayofanywa kati yako na mtaalam wa afya?
  - 1) Naridhika sana ( )
  - 2) Naridhika kidogo ( )

- 3) Siridhiki ( )
- 4) Siridhiki kabisa ( )
8. Je, ushauri unaotolewa na mtaalam wa afya kuhusiana na ugojwa wako unaeleweka?
- 1) Unaeleweka sana ( )
- 2) Unaeleweka ( )
- 3) Unaeleweka kidogo ( )
- 4) Hauleweki kabisa ( )
9. Unaridhika na huduma zitolewazo hapa hospitalini kwa kiwango gani?
- 1) Naridhika sana ( )
- 2) Naridhika kiasi ( )
- 3) Siridhiki ( )
- 4) Siridhiki hata kidogo ( )
10. Mpangilio au utaratibu wa kupata huduma hapa hospitalini ni mzuri kwa kiwango gani?
- 1) Mzuri sana ( )
- 2) Mzuri ( )
- 3) Mzuri kiasi ( )
- 4) Sio mzuri kabisa ( )
11. Pendekeza njia za kuboresha utaratibu wa utoaji huduma hapa hospitalini.
- 1) .....
- 2) .....
12. Unadhani hospitali ina dawa nzuri na za kutosha kuwawezesha wataalamu wa afya kutoa huduma bora kwa wagojwa kwa kila kitengo na idara?
- 1) Zipo nyingi ( )
- 2) Zipo ( )
- 3) Zipo kidogo ( )
- 4) Hakuna kabisa ( )

## Appendix II: Questionnaire for the Hospital Employees

Dear Employee,

My name is Leonora R.Mruma. I am an assistant accountant at the Dodoma University. Currently, I am doing Masters of Business Administration (Corporate Management) at Mzumbe University in Morogoro. I am doing a study on workers participation on quality service delivery in Government Hospitals. Be free, answer freely, and individually, so that your answers reflect your true feelings and beliefs. Your responses will be useful for research purposes only and will always be kept confidential.

This questionnaire has six sections. Please respond to each item in all sections.

Insert a  $\surd$  in the box provided

### Section One: Personal Particulars

1. Respondent's sex :

1) Male ( )

2) Female ( )

2. Marital status: 1) Married ( )

2) Single ( )

3. Name of Department.....

4. Occupation (example, Doctor, Nurse, others) .....

5. Age:

1) 20 – 25 years ( )

2) 26 – 35 years ( )

3) 36 – 45 years ( )

4) 46 – 55 years ( )

5) 56 and above ( )

6. Area of specialization.....

7. What is your working experience in health care delivery?

1) More than 10 years ( )

2) 5 to 10 years ( )

3) Less than 5 years ( )

8. How long have you been working in Dodoma General Hospital?
- 1) More than 10 years ( )
  - 2) 5 to 10 years ( )
  - 3) Less than 5 years ( )
9. Level of professional qualification
- 1) Certificate ( )
  - 2) Diploma ( )
  - 3) Advanced diploma ( )
  - 4) Bachelor Degree ( )
  - 5) Postgraduate ( )
  - 6) Masters ( )
  - 7) PhD ( )
  - 8) Other (s) (specify): ( )
- .....
- .....

**Section Two: Measure of Participation**

Tick  $\checkmark$  in the appropriate box.

10. To what extent is the working environment safe for you to deliver quality service?
- 1) 0 to 25% ( )
  - 2) 26 to 50% ( )
  - 3) 51 to 75% ( )
  - 4) 76 to 100% ( )
11. Do you have enough facilities for service delivery?
- 1) YES ( )
  - 2) NO ( )
12. If yes, are the facilities in a good condition.....
13. If no, what kind of facilities do you need most?.....
- .....

14. Do you receive the necessary benefits from employer as per your civil servant regulation?

- 1) YES ( )
- 2) NO ( )

15. What kind of benefits do you think need to be improved?.....  
.....

16. Do you feel free to contribute or make suggestion on service improvement?

- 1) Always ( )
- 2) Sometimes ( )
- 3) Rarely ( )
- 4) Never ( )

17. How often do you attend meetings in your sections or departments?

- 1) Very often ( )
- 2) Often ( )
- 3) Rarely ( )
- 4) Not at all ( )

18. How much do you feel free to ask questions or to contribute ideas in the meetings?

- 1) Very free ( )
- 2) Free ( )
- 3) Somehow free ( )
- 4) Not free ( )
- 5) Not free at all ( )

19. Are all suggestions made in the meetings put into practice and taken care off?

- 1) Always ( )
- 2) Sometimes ( )
- 3) Rarely ( )
- 4) Never ( )

20. How often do you participate in making schedule of duties or time table in your section?

- 1) Very often ( )
- 2) Often ( )
- 3) Rarely ( )
- 4) Never ( )

21. Are you satisfied with the duty roster implemented in the sections/ department?

- 1) Much satisfied ( )
- 2) Satisfied ( )
- 3) A bit satisfied ( )
- 4) Not satisfied ( )

**Section Three: Types of Participation**

22. What types of participation exist in your organization?

- 1) Participatory management ( )
- 2) Non participatory ( )

**Section Four: Levels of Participation**

23. What are the common levels of participation that exist in your organization?

- 1) Information ( )
- 2) Consultation ( )
- 3) Deciding together ( )
- 4) Acting together ( )
- 5) Supporting ( )

**Section Five: Influence of Participation in Quality Service Delivery**

24. Does workers participation in your section or department improve quality of service delivery?

- 1) YES ( )
- 2) NO ( )

25. If yes, to what extent does workers participation improve quality service delivery?

- 1) Up to 25% ( )
- 2) 25 to 50% ( )
- 3) 50 to 75% ( )
- 4) 75 to 100% ( )

26. In your views, what positive outcomes of workers participation have you witnessed at your working place? Tick one of the most relevant outcomes.

- 1) High level of performance ( )
- 2) Workers feelings of belonging to the organization ( )
- 3) Minimal workers turnover ( )
- 4) Good communication between management and workers ( )
- 5) Readjustment of rules and regulations ( )

27. In your views, what negative outcomes of workers participation have you witnessed at your working place? Tick one of the most relevant outcomes.

- 1) low level of performance ( )
- 2) longer time to make decision ( )
- 3) workers turnover ( )
- 4) conflict with management ( )

**Section Six: Strategy (s) Used by Management to Improve Quality Service Delivery**

28. Does the organization have any stated strategies to improve quality service delivery?

- 1) Yes ( )
- 2) No ( )

29. If yes, please tick one of the most used strategy:

- 1) Team spirit: employees are working as a team ( )
- 2) Achievement's quality indicators are known to employees ( )
- 3) Availability of quality working facilities ( )
- 4) Good and conducive working environment ( )
- 5) Lines of responsibility of the department are well known to every employee ( )

### Appendix III: Interview Guide for Management

Dear Sir / Madam,

My name is Leonora R.Mruma. I am an assistant accountant at the University of Dodoma. Currently, I am doing Masters of Business Administration (Corporate Management) at Mzumbe University in Morogoro. I am doing a study entitled workers participation on quality service delivery in Government hospitals. Data collected during our discussion will be used for reference only and remain confidential. So feel free to disclose all the information you have concerning workers participation on quality service delivery in the hospital.

1. Respondent's sex:
  - 1) Male ( )
  - 2) Female ( )
1. Marital status:
  - 1) Married ( )
  - 2) Single ( )
2. Name of Department.....
3. Occupation (example, Doctor, Nurse, other) .....
4. Age:
  - 1) 20 -25 yrs ( )
  - 2) 26 – 35 ( )
  - 3) 36 – 45 ( )
  - 4) 46 – 55 ( )
  - 5) 56 and above ( )
5. Area of specialization.....
6. What is your working experience in health care delivery?
  - 1) More than 10 years ( )
  - 2) 5 to 10 years ( )
  - 3) Less than 5 years ( )
7. How long have you been working in Dodoma General Hospital?
  - 1) More than 10 years ( )
  - 2) 5 to 10 years ( )
  - 3) Less than 5 years ( )
8. Level of professional qualification.
  - 1) Certificate ( )
  - 2) Diploma ( )
  - 3) Advanced diploma ( )
  - 4) Bachelor Degree ( )

- 5) Postgraduate ( )
- 6) Masters ( )
- 7) PhD ( )
9. In their departments or sections, what aspects do workers participate in decision making?
10. How do you get your workers participate in matters mentioned above?
11. What aspects do you think workers are not supposed to participate in decision making to improve quality service delivery?
12. How do workers participate on quality service delivery?
13. What positive outcomes of workers participation have you witnessed in your organization?
14. What negative outcomes of workers participation have you witnessed in your organization?
15. How do you identify the level of performance of service delivery in the hospital?
16. How often do you conduct meetings with workers on matters pertaining to their sections or departments?
17. In such meetings, how do workers participate in giving out their views?
18. How do these meetings improve quality service delivery in the hospital?
19. Which strategies do you use to make sure that workers participate to improve quality service delivery in the hospital?
20. Please give out your views, opinions or comments on workers participation on quality service delivery in the hospital.

**Thank you very much for your cooperation.**

#### **Appendix IV: Employee's Focus Group Discussion Questions**

1. How often do you participate in making decision on matters pertaining to quality service delivery in your sections or departments?
2. In what aspects do you participate most?
3. What aspects you do not participate at all and why?
4. To what extent can workers participation in sections or departments improve quality service delivery?
5. Are you satisfied with the duty roster implemented in sections or departments?
6. How often do you attend departmental meetings?
7. How do you participate in such meetings?
8. How often are the suggestions of the meetings taken care off?
9. How do you measure the level of performance of each department in the hospital?
10. What are the positive and negative outcomes of workers participation in your sections or departments?
11. What are your views, opinions or comments on workers participation on quality service delivery in the hospital?

## Appendix V: Documentary Review Guide

### The documents reviewed were:

- i) Hospital strategic plan
- ii) Budget books
- iii) Meetings' agenda and reports
- iv) Hospital monthly and annual reports
- v) Patients attendances (both in and out patients)

### The purpose of review

*a) To determine performance level of service provision*

- Do annual and monthly reports determine the level of performance of each department?
- Do patients attendance records (both in and out patients) reflect the level of quality service provision?

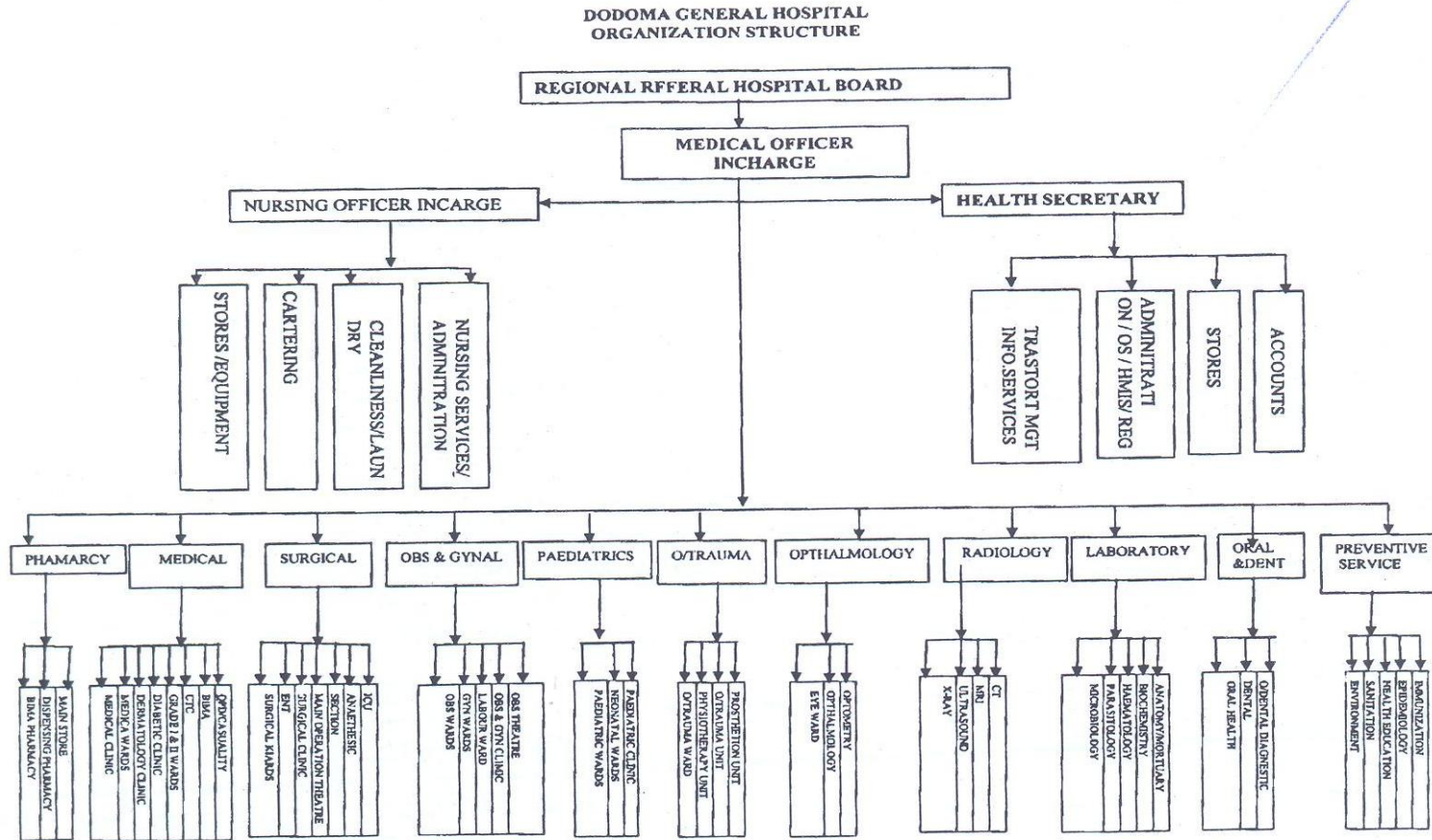
*b) To discover the relative importance of workers participation in decision making*

- Do meetings' agenda and reports show evidence of workers participation in decision making on matters pertaining to their departments?
- Does hospital strategic plan clearly indicate timetable of workers' meetings in a year?( departmental and general meetings)

*c) To discover workers participation towards quality service improvement in the hospital*

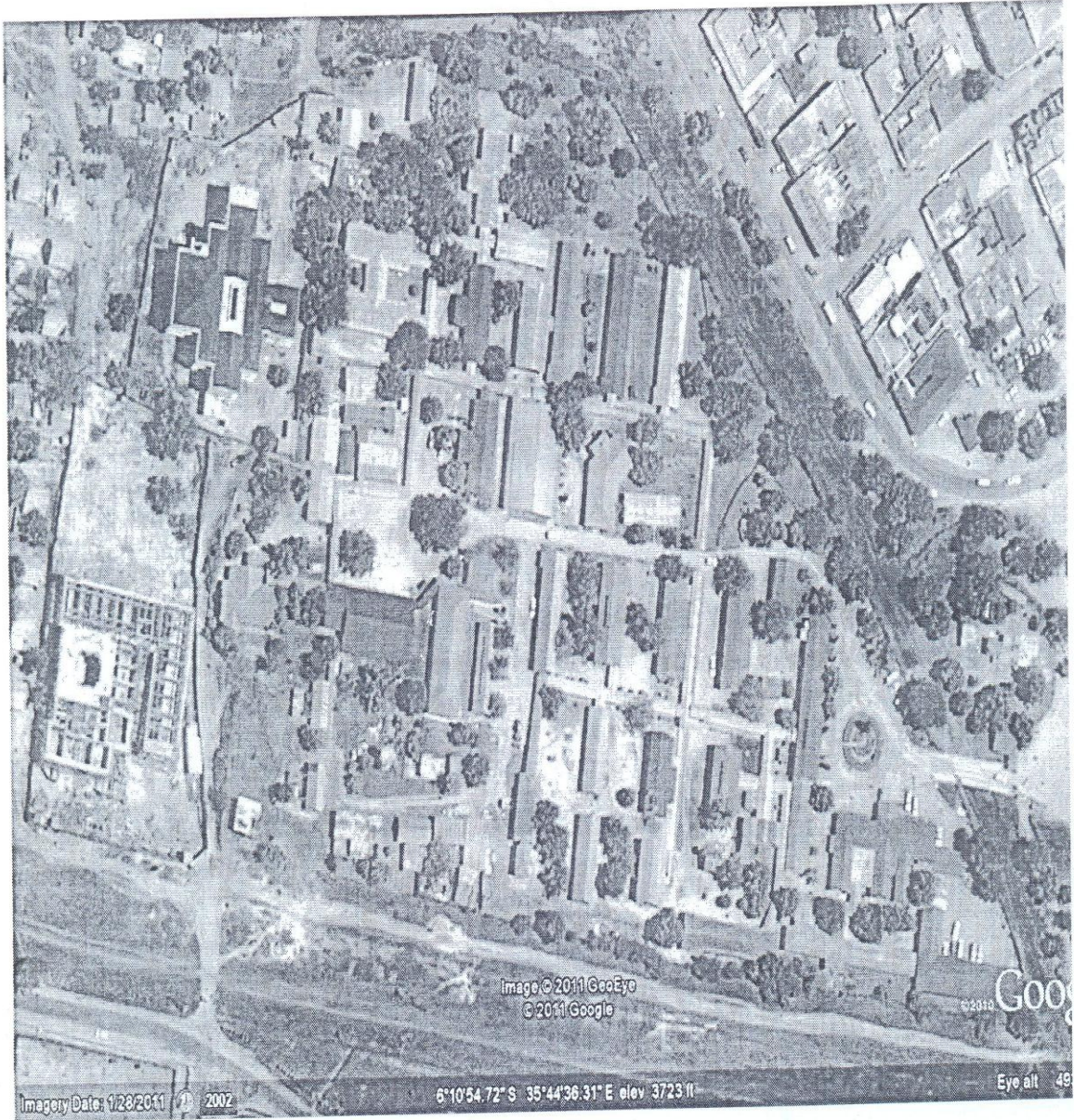
- Do hospital budget books indicate training costs to workers?
- Do annual reports indicate number of workers who will need further training?
- Do budget books and hospital strategic plan indicate purchase of up-to-date resources? (example, purchase of equipments and machines or hiring new and qualified employees)

## Appendix VI: DRRH Organization Structure



Source: Field data 2013( Hospital File Documents)

## Appendix VII: Hospital Layout



**Source:** Field data 2013 (Documentary Review)

## Appendix VIII: Open Performance Review and Appraisal Form



### UNITED REPUBLIC OF TANZANIA OPEN PERFORMANCE REVIEW AND APPRAISAL FORM

**TFN 832**

(To be filled in Triplicate)

From: **July 2011 to June 2012**

This Form replaces all other appraisal forms in the Public Service Institutions. It is intended to meet the requirements of the performance management system and development process.

#### **NOTES ON HOW TO FILL THIS FORM:**

1. This Form must be filled by all employees in the Public Service Institutions. For principal officers and above, at the end of the year, once fully completed, the original should be sent to the Permanent Secretary (Establishments), duplicate to the respective Head of organization and triplicate to the public servant concerned. All other employees (senior officers and below) original copy should be sent to the Chief Executive Officer of the organization, duplicate to the parent ministry of the specific cadre and the triplicate to the public servant concerned.
2. Where appropriate, each box shall carry only one letter or figure. Letters to be in capitals.
3. Personal/Agreed objectives are derived from the Organization's work plan (Strategic plan, Annual operating plans or Action plans) and are expected to be implemented in the current year.
4. Sections 2, 3 and 4 of this Form shall be filled by the Appraisee in consultation with the Supervisor and sections 5-6 in the presence of a third party if necessary.
5. Please note that appraisals that are rated as 1 are the best performers and appraisals rated as 5 are the worst performers. These should be brought to the attention of top management and usually to the attention of the Chief Executive Officer of their respective Organization.

**SECTION 1: PERSONAL INFORMATION**

Vote Code	<input type="text"/>	Check Number	<input type="text"/>
	Vote Description		

Sub Vote	<input type="text"/>	Present Station	<input type="text"/>
	Sub-vote description		

Name in Full	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Surname	First name	Middle name	Gender	

Academic Qualification

Duty Post	<input type="text"/>	Substantive Post	<input type="text"/>
-----------	----------------------	------------------	----------------------

Date of First Appointment	<input type="text"/>	Date of Appointment to present post	<input type="text"/>
	D D M M Y Y Y Y		D D M M Y Y Y Y

Salary Scale	<input type="text"/>	Period served under Present Supervisor	<input type="text"/>	Date of Birth	<input type="text"/>
			<i>Number of Months</i>		D D M M Y Y Y Y

Terms of Service

DD= Day, MM= Month, YYYY= Year, F= Female, Male= Male

**SECTION 2: MID-YEAR REVIEW (DECEMBER .....**)

*To be filled by the Appraisee in Consultation with the Supervisor*

<b>3.1 S/N</b>	<b>3.2 Agreed Objectives (As per Section 2)</b>	<b>3.3 Progress Towards Target</b>	<b>3.4 Factors Affecting Performance</b>

**SECTION 3: REVISED OBJECTIVES (if any)**

4.1 S/N	4.2 Agreed Revised Objective(s)	4.3 Agreed Performance Targets	4.4 Agreed Performance Criteria	4.5 Agreed Resources

4.6 Appraisee

4.7 Supervisor

.....  
.....

.....

.....

Name (in capital letters)

Signed

Name (in capital letters)

Signed

Date.....

Date.....

**SECTION 4: ANNUAL PERFORMANCE REVIEW & APPRAISAL (JUNE .....**)

*To be filled by the Appraisee and the Supervisor*

5.1 S/N	5.2 Agreed Objective(s)	5.3 Progress made	5.4 Rated Mark		
			App	Sup	Agree
<b>Overall Performance Mark:</b> <i>This should reflect the overall performance and achievement of agreed objectives in Section 5.</i>					

**Rating:**

1 = Outstanding performance      2 = Performance above average      3 = Average performance

4 = Poor performance      5 = Very poor performance

## SECTION 5: ATTRIBUTES OF GOOD PERFORMANCE

*To be filled by the Appraisee and the Supervisor*

6.1 S/N	6.2 MAIN FACTORS	6.3 QUALITY ATTRIBUTE	6.4 RATED MARK		
			Appraisee	Supervisor	Agreed Mark
1	WORKING RELATIONSHIPS	Ability to work in team			
		Ability to get on with other staff			
		Ability to gain respect from others			
2	COMMUNICATION AND LISTENING	Ability to express in writing			
		Ability to express orally			
		Ability to listen and comprehend			
		Ability to train and develop subordinates			
3	MANAGEMENT AND LEADERSHIP	Ability to plan and organize			
		Ability to lead, motivate and resolve conflicts			
		Ability to initiate and innovate			
4	PERFORMANCE IN TERMS OF QUALITY	Ability to deliver accurate and high quality output timely			
		Ability for resilience and persistence			
5	PERFORMANCE IN TERMS OF QUANTITY	Ability to meet demand			
		Ability to handle extra work			
6	RESPONSIBILITY AND JUDGEMENT	Ability to accept and fulfil responsibility			
		Ability to make right decisions			
7	CUSTOMER FOCUS	Ability to respond well to the customer			
8	LOYALTY	Ability to demonstrate follower ship skills			
		Ability to provide ongoing support to supervisor(s)			
		Ability to comply with lawful instructions of supervisors			
9	INTEGRITY	Ability to devote working time exclusively to work related duties			
		Ability to provide quality services without need for any inducements			
		Ability to apply knowledge abilities to benefit Government and not for personal gains			
<b>Overall Performance Section 6</b>					

**Rating:**

- 1 = Outstanding performance      2 = Performance above average      3 = Average performance  
 4 = Poor performance                5 = Very poor performance

## **SECTION 6: EMPLOYEE REWARDS/DEVELOPMENTAL MEASURES/SANCTIONS**

The supervisor will recommend the most appropriate reward, developmental measures or sanctions against the appraisee in accordance to the level of agreed performance targets.

## Appendix IX: Monitoring and Evaluation Sheet for the Progress of 5-Activities

Date: 7-8/ September/ 2012

HOSPITAL: Dodoma Regional Referral Hospital		DEPARTMENT:					
	DESCRIPTION	Very poor	Poorly	Fairly	well	Very well	AWARD MARKS
1	<b>5S LEADERSHIP OF HOSPITAL/ DEPARTMENT MANAGEMENT</b> Role & commitment of management, sustainability of 5s activity, training program for middle mgt, setting up 5s committees, 5s campaigns.						
1.1	5s commitment, knowledge, awareness of executive & supervisors	1	2	3	4	5	
1.2	5s progress meeting, evaluation, training conducted by patrol team and WIT minutes	1	2	3	4	5	
1.3	5s guideline is available and 5s manual developed with many relevant details	1	2	3	4	5	
1.4	Evidence of trainings conducted for managers and health workers	1	2	3	4	5	
	<b>TOTAL</b>	Full mark 20					0
		Acquired marks /20*100=					0
2	<b>SEIRI-(SORTING) “Sasambua”</b> Cluster free environment in premises, inside offices, work place,etc. evidence of removal of unwanted items should be evident all around						
2.1	Unwanted items removed from premises, offices, work place including drawers, cabinets and shelves	1	2	3	4	5	
2.2	Walls are free of old posters, calendars, pictures	1	2	3	4	5	
2.3	Notice boards-current notices with removal instructions	1	2	3	4	5	
2.4	Color coding for waste disposal maintained and standards followed	1	2	3	4	5	
	<b>TOTAL</b>	Full mark 20					0
		Acquired marks /20*100=					0
3	<b>SEITON-(SETTING/ORGANIZATION) “Seti”</b> Ability to find whatever is required with the least possible delay, evidence of eliminating the waste of time throughout the institute/ organization						
3.1	Photographic evidence of pre 5s implementation and afterwards	1	2	3	4	5	
3.2	Visual control methods adopted to prevent mix up of items (files, equipment, tools etc)	1	2	3	4	5	
3.3	Directional boards from hospital entrance to all facilities ( office, wards, laboratory etc) and corridors are clearly marked	1	2	3	4	5	
3.4	All machines/rooms/toilets/switches/fans regulators etc have identification labels	1	2	3	4	5	

3.5	All items are arranged according to 'can see', 'can take out' & 'can return' principle	1	2	3	4	5	
3.6	X-axis, Y-axis alignment is evident everywhere	1	2	3	4	5	
3.7	Maintenance methods of SETTING established and maintained	1	2	3	4	5	
	TOTAL	Full mark 35					0
		Acquired marks / 35*100=					0
4	<b>SEISO- (SHINING/CLEANLINESS) "Safisha"</b>						
	The cleanliness all around the institution should have been carried out according to the 5s concepts						
4.1	Flours, walls, windows, toilets, change rooms in working order & clean	1	2	3	4	5	
4.2	Daily self arrangement (3min/5min) is practiced	1	2	3	4	5	
4.3	Cleaning responsibility maps and schedules displayed	1	2	3	4	5	
4.4	Waste bin strategy is implemented	1	2	3	4	5	
4.5	Use of adequate cleaning tools is evident	1	2	3	4	5	
4.6	Storage of cleaning tools- brooms/maps/other equipment	1	2	3	4	5	
4.7	Machines/equipment/tools/furniture at a high level of cleanliness & maintenance schedules displayed	1	2	3	4	5	
	TOTAL	Full mark 35					0
		Acquired marks /35*100=					0
5	<b>SEIKETSU- (STANDARDIZATION) "Sanifisha"</b>						
	High level of standardization in all activities carried out in SEIRI, SEITON and SEISO and the evidence of standards being practiced all around						
5.1	Adopt 5s procedures & standardized on check list, labels corridors/isles & gangways	1	2	3	4	5	
5.2	Orderliness in the use of corridors/isles/gangways by pedestrians	1	2	3	4	5	
5.3	Innovative visual control methods implemented	1	2	3	4	5	
5.4	Standardization of maintenance/storage of files/records/orderliness in keeping furniture/equipment in offices/workplaces etc.	1	2	3	4	5	
5.5	Standardized check lists for common administrative procedures in hospital and department	1	2	3	4	5	
	TOTAL	Full mark 25					0
		Acquired marks /25*100					0
6	<b>SHITSUKE- (SUSTAIN/SELF DISCIPLINE) "Shikilia"</b>						
	Evidence of an disciplined approach to all 5s activities through proper training & development, which shows the sustainability in the long term						
6.1	Evidence of regular training program for all categories of employees in the section	1	2	3	4	5	

6.2	Evidence of 5s group activities & promotion of Kaizen schemes	1	2	3	4	5	
6.3	Evidence in carrying out internal audits by WIT	1	2	3	4	5	
6.4	Evidence of self discipline among visitors to the institution	1	2	3	4	5	
6.5	Evidence of self discipline in the overall institution	1	2	3	4	5	
	TOTAL	Full mark 25					0
		Acquired marks /25*100=					0
	GRAND TOTAL for 5S activities	Full mark 169					0
7	<b>Productivity/Services</b> Measures how efficiently inputs to output are used to produce goods & services with better management techniques and work methods						
7.1	Evidence of methods & systems adopted to improve productivity/employee	1	2	3	4	5	
7.2	Efficiency and effectiveness, use of innovative method to increase and sustain productivity	1	2	3	4	5	
7.3	Evidence in the use of 5s process to increase productivity	1	2	3	4	5	
	TOTAL	Full mark 15					0
		Acquired marks / 15*100=					0
8	<b>Quality</b> Goal is to create satisfied customers by doing 100% right work, responding speedily to requirements every time thus gaining trust & confidence						
8.1	Communication plans are evident for implementation of quality improvement	1	2	3	4	5	
8.2	Evidence of fewer rejects, less wastage, less rework through 5s process	1	2	3	4	5	
8.3	Evidence of direction & coordination to improve quality by 5s activity	1	2	3	4	5	
8.4	Sustainable quality in products or services evident through 5s process	1	2	3	4	5	
8.5	The quality in the process of the manufacture/service by 5s implementation	1	2	3	4	5	
	TOTAL	Full mark 25					0
		Acquired marks / 25*100=					0
9	<b>Cost</b> The intrinsic cost of providing products/services to declare standards by a given specified process right first time and every time						
9.1	Evidence in reduction in cost of materials, labor, energy, overheads lowering of defects etc by introducing 5s concept	1	2	3	4	5	
9.2	Tangible cost advantages through 5s methods in waste	1	2	3	4	5	

	control						
9.3	Evidence of lowering inventory cost by the use of 5s methods	1	2	3	4	5	
9.4	Lowering idle time of workers/machines by 5s activity	1	2	3	4	5	
	TOTAL	Full mark 20					0
		Acquired marks / 20*100=					0
10	<b>Safety</b> The overall safety to employees, visitors and property is evidently displayed by the use of 5s process						
10.1	Evidence of the effect of safety measured by less accidents occurred in the year	1	2	3	4	5	
10.2	Methods adopted in machinery & equipment on safety measures	1	2	3	4	5	
10.3	Methods adopted to protect the employees/visitors on accident	1	2	3	4	5	
10.4	Evidence of safety measures adopted in providing an excellent product/service	1	2	3	4	5	
10.5	Evidence knowledge and skills of employee on safety	1	2	3	4	5	
	TOTAL	Full mark 25					0
		Acquired marks /25*100=					0
11	<b>Delivery</b> Evidence in the reduction of the delivery time of the product/service by the implementation of 5s process						
11.1	Evidence of time delivery of products/services	1	2	3	4	5	
11.2	Overall effect to institution/organization by reducing delivery time	1	2	3	4	5	
11.3	Evidence of employees participation to reduce the delivery time	1	2	3	4	5	
11.4	Evidence of just in time in the hospital	1	2	3	4	5	
	TOTAL	Full mark 20					0
		Acquired marks /20*100=					0
12	<b>Morale</b> Evidence in the overall institution/organization in improving the morale by the implementation of 5s process						
12.1	Level of morale displayed by executive/staff & workers	1	2	3	4	5	
12.2	Innovative methods adopted to improve the morale of employees	1	2	3	4	5	
12.3	Evidence of projects carried out by the employees to display high level of morale	1	2	3	4	5	
12.4	Benefits extended by management to increase the morale of employees	1	2	3	4	5	
12.5	Evidence of 5s mindset, KAIZEN mindset or TQM culture	1	2	3	4	5	
	TOTAL	Full mark 25					0

	Acquired marks /25*100=						0
13	<b>5s organization, work improvement team (WIT)</b> Role & activities of WIT						
13.1	Number of actively working member of WIT	1	2	3	4	5	
13.2	Frequency of WIT activities	1	2	3	4	5	
13.3	Frequency of supervision by quality management team	1	2	3	4	5	
	TOTAL	Full mark 15					0
	Acquired marks /15*100=						0
14	<b>Empowerment of hospital staff through 5s, KAIZEN,TQM</b> Opportunity and environment for empowerment for hospital staff by themselves						
14.1	Learning opportunity for 5s, KAIZEN, TQM	1	2	3	4	5	
14.2	Frequency of conducting seminar for 5s, KAIZEN, TQM and training of WITs	1	2	3	4	5	
	TOTAL	Full mark 10					0
	Acquired marks /10*100=						0
	GRAND TOTAL for KAIZEN activities	Full mark 155					

**Source:** Hospital infection, prevention and control (IPC) assessment report year 2012