UNIVERSITY OF LUSAKA

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Title of the Research Project: Identifying Effective Management and Leadership Styles to Optimize Institutional Performance and healthcare delivery at health facilities in Chipili District.

A DISSERTATION SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, UNIVERSITY OF LUSAKA IN PARTIAL FULFILLMENT OF THE AWARD OF MASTER OF SCIENCE IN PROJECT MANAGEMENT (MSCPM)

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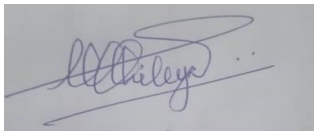
DECLARATION PAGE

I **MARTIN BAMBALA CHIPOSA** hereby verify that this scholarly thesis represents my original contribution, and all References, both published and unpublished, have been duly acknowledged in the designated reference section.

Authors Signature: _____ Date: 31st December 2024



Supervisor's Signature: _____ Date: December 2024

DEDICATION

This work is dedicated to the memory and legacy of my Dad (Michael Chiposa Snr).

ACKNOWLEGMENT

My thanks go to the Lord Almighty through his Son Jesus Christ who have guided me through the entirety of the study. I also express my profound gratitude to Mr. Charles Kapeleke Chileya, my dedicated and supportive supervisor from the University of Lusaka, School of Postgraduate Studies. His invaluable guidance, expertise, and constructive feedback have played a crucial role in shaping this thesis. His unwavering support and insightful suggestions have been instrumental in its completion.

I also express my gratitude to my family who continued to cheer me on throughout the journey of my study with their unwavering support.

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LIST OF ACRONYMS

SPSS:	Statistical Package for Social Sciences
MoH:	Ministry of Health
EBDM:	Evidence-based Decision-making model
UNZA:	University of Zambia
AHA:	American Hospital Association
CCL:	Centre for Creative Leadership
PCA	Principal Component Analysis
ANOVA	Analysis of Variance
SMAG	Safe Motherhood Action Group
CDE	Classified Daily Employee

ABSTRACT

This study explored the most effective management and leadership styles to optimize organizational performance at health facilities in Chipili District, Zambia. The district, being predominantly rural and remote, faced significant challenges such as resource constraints, inadequate infrastructure, limited staffing, and communication barriers, which hindered the provision of quality healthcare. The study aimed to identify leadership and management practices that could address these challenges, improve service delivery, and enhance organizational efficiency at health facilities in the region.

A mixed-methods approach was employed, combining quantitative correlation analysis and qualitative thematic analysis to explore the relationship between management approaches, leadership styles, and institutional performance in Chipili District health facilities. Data were collected through structured questionnaires and interviews with 102 healthcare staff (including both subordinates and managers), selected through stratified random sampling. Quantitative data were analyzed using SPSS version 22, while qualitative data were analyzed using Python (version 3.11.6). Validity and reliability were ensured through expert reviews and a Cronbach's alpha score of [insert value].

The findings revealed that adaptive leadership and participatory decision-making were strongly correlated with improved organizational performance ($r = 0.358$, $p < 0.001$). A linear regression analysis further confirmed that leadership effectiveness positively predicted service efficiency ($B = 0.247$, $p < 0.001$), although it accounted for only 12.8% of the variance, indicating the influence of other factors such as resource availability and staff training. Qualitative themes highlighted the importance of community engagement, staff motivation, and transformational leadership in overcoming resource constraints. Specifically, 75% of respondents reported improved morale under transformational leadership, which fostered collaboration, innovation, and local empowerment.

However, the study also found that transformational leadership did not significantly influence staff development ($r = 0.269$, $p = 0.453$) or inclusive environments ($R^2 =$

0.038, p = 0.587). Similarly, ethical leadership showed no statistically significant impact on service efficiency (F = 1.330, p = 0.259). Despite this, diversity inclusion leadership was strongly correlated with organizational culture ($\chi^2 = 62.585$, $p < 0.001$), suggesting that fostering inclusivity can enhance organizational performance.

In conclusion, this study demonstrates that adaptive and transformational leadership styles are critical for optimizing organizational performance in rural health facilities like those in Chipili District. By fostering participatory decision-making, community engagement, and staff empowerment, healthcare managers can overcome systemic challenges such as resource limitations and communication barriers. This study contributes to the growing body of knowledge on rural healthcare management by providing evidence-based recommendations for tailoring leadership practices to low-resource settings. Policymakers and healthcare managers should prioritize training programs, capacity-building initiatives, and inclusive decision-making processes to enhance service delivery. Future research should explore the long-term impact of these leadership styles on patient outcomes and healthcare equity in similar contexts.

Keywords: Healthcare Service Delivery,Chipili District ,Zambia, Transformational Leadership, Adaptive Leadership,Organizationa Performance.

CHAPTER ONE: BACKGROUND OF THE STUDY

The primary challenge facing the Healthcare Sector is cultivating a culture that consistently delivers high-quality, safe, and compassionate healthcare. Management and leadership are vital to the organizational culture thus hugely effective in developing effective management and leadership practices. Traditionally, management approaches and leadership styles though distinct, hugely complement each other. These were both broad and not tailored to specific sectors. However, as technology evolves rapidly, the “one size fits all” approach is no longer sufficient (Alloubani & Almatari, 2014). In some regions, formal education and specific qualifications are prerequisites for managing healthcare facilities, while in others particularly in developing countries or those with middle-income status, such expertise may be less developed. Despite these differences, there remains a collective responsibility to enhance patient care across all healthcare settings (Hahn & Gil Lapetra, 2019).

Research consistently highlights the importance of ethical standards, credibility, and trustworthiness in identifying effective leaders and creating management programs (Melynk, Bass, & Northouse, 2006). Educators in the healthcare field have long sought to define the ideal skill set for leaders, leading to a shift in management training programs targeting the healthcare profession by the late 20th century (White & Nayar, 2006). Today, the learning needs in this sector are shaped by audience profiles, academic methods, and effective communication of information.

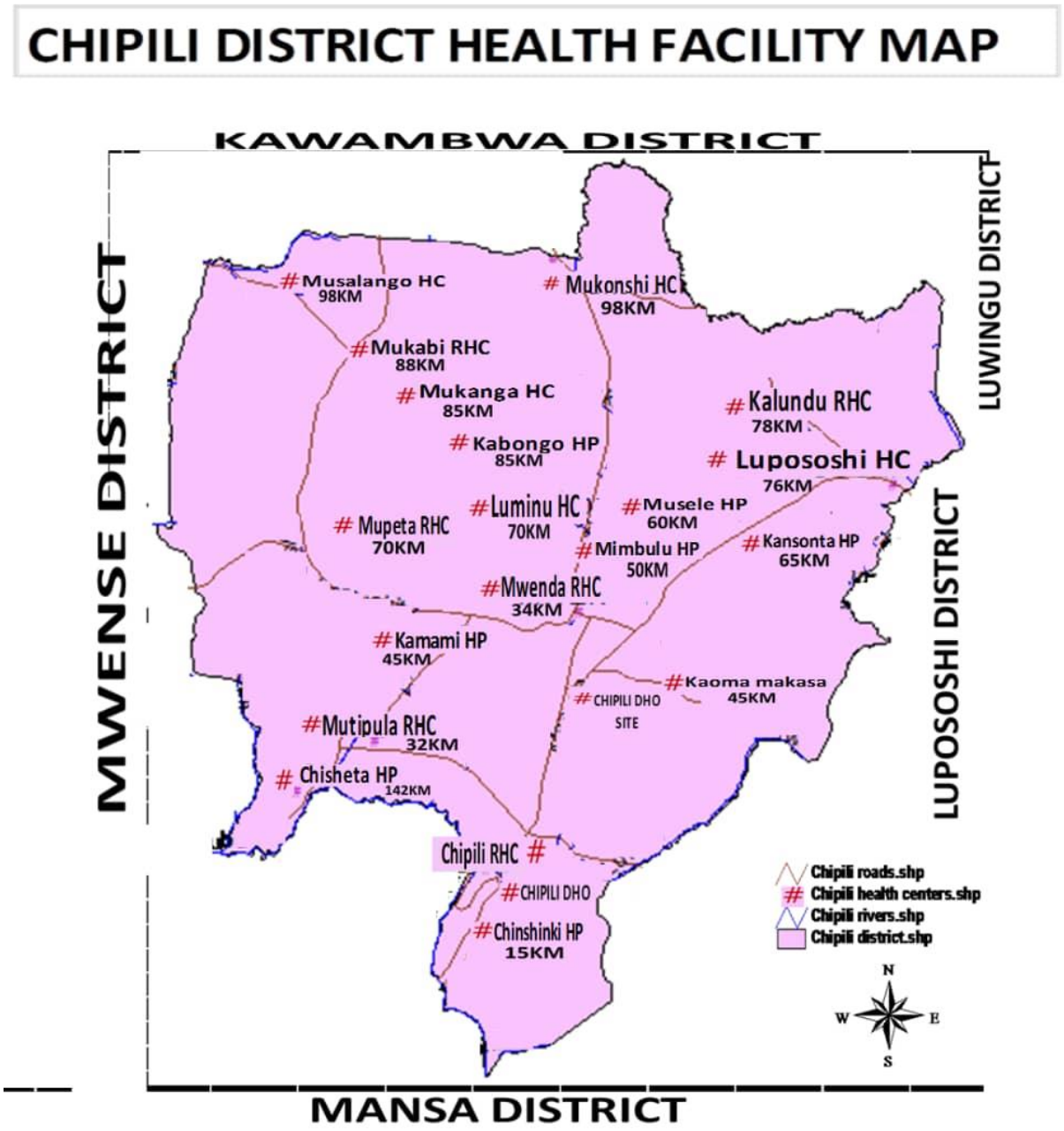
This evolution underscores the need for educational programs that align with the objectives of the Ministry of Health, focusing on patient care and the development of leadership qualities vital for effective hospital administration. A key aspect of Management in this context is the ability to foster collaboration and inspire healthcare teams. Effective leaders enhance team performance, ultimately leading to improved health outcomes.

This study aimed to explore how management approaches and leadership styles influenced positive change within facilities in Chipili District, thereby supporting initiatives that enhanced patient care. The unique challenges faced by the healthcare

industry necessitated effective management and leadership to improve patient outcomes, boost staff satisfaction, and achieve overall organizational success

Thus, this study seeks to identify the leadership style that best aligns with the specific demands of Chipili District. Chipili originated primarily from the Chipili Anglican Mission, established in 1918, which led to the formation of a settlement in the area.

It is located 1,040 kilometers from Lusaka, Zambia's capital, and 85 kilometers from Mansa, the provincial capital of Luapula Province. Additionally, the district has geographical coordinates on latitude 10 0 44 II South, longitude 29 0 5 II East. The late President Michael Chilufya Sata under Statutory Instrument No. 79 of 2012 declared Chipili in 2012. The district spans an area of 4,319 square kilometers and had a population of approximately 46,544 according to the 2022 census. Chipili is represented by one constituency (Chipili) and is divided into twelve wards. Being a recently created district in year 2012, Chipili district is not as developed socioeconomically as the neighboring districts such as Kawambwa, Chembe, and Mansa. Conversely, Chipili District includes two chiefdoms, Mwenda and Mutipula, both officially recognized, and is home to around Hundred and Eighty Nine (89) villages, (Who we are – Chipili Town Council (chipilicouncil.gov.zm)). The district constitutes of 20 health centres with a blend of Health Posts and Rural Health Centres, which are headed by A Facility In-Charge who is usually a Nurse or Midwife by profession. Other staff in the setup of rural Health Centres include Clinical Officers, Environmental health Technicians, Community Health Assistants, Midwives and Classified Daily Employees (CDE). The map below shows the geographic location of each facility;



Source: *Medium Term Expenditure Framework (2024-2026)*

The findings will be of high importance to Operations leaders, policymakers, and administrators, will offer a quantitative basis for optimizing staffing levels, improving resource allocation, and enhancing patient care outcomes in healthcare institutions.

1.1 INTRODUCTION

Because they offer vital medical services and advance public health, health facilities are vital to society. These institutions' efficacy is largely determined by a number of elements, one of which is leadership style. In healthcare companies, leadership affects not just operational effectiveness but also staff happiness, patient care quality, and overall organizational performance.

Different leadership philosophies have been used in healthcare settings over the years, and each has produced a different set of results in terms of patient care and institutional effectiveness. In the early 2000s, for instance, authoritative leadership was common in the western world, particularly in Europe and North America, according to Goleman (2000), who also remarked that it worked well in situations that called for decisive action and clear direction. Bass and Riggio (2006), on the other hand, backed transactional leadership's rise in the middle of the 2000s by stressing its function in controlling repetitive activities and preserving stability through rewards and penalties.

In North America, particularly the United States of America, Kouzes and Posner (2012) highlighted the significance of incorporating team members in decision-making to improve engagement and morale during the notable change towards participative leadership that occurred in the late 2000s and early 2010s. In the 2010s and 2020s, transformational leadership has become more popular, according to Northouse (2016), who also discussed how it may inspire and motivate employees to go above and beyond and promote innovation in patient care.

Each leadership style has specific qualities that influence decision-making, communication, employee motivation, and engagement. Identifying the most effective leadership style to improve organizational performance in healthcare settings like Chipili District is a hard task. Healthcare environments are distinct due to the combination of medical knowledge, interdisciplinary teamwork, ethical considerations, and a patient-centred approach. As a result, a thorough examination into the best Management Approach is required to ensure that health institutions in the Chipili District run smoothly while providing excellent treatment.

1.2 STATEMENT OF THE PROBLEM

Chipili District, a remote region, faces significant challenges in delivering quality healthcare due to limited resources, inadequate infrastructure, and poor

communication systems (World Health Organization, 2021; Bennett & Mills, 2009). Ineffective leadership and management practices, such as poor supervision, lack of decentralized decision-making, and weak staff motivation, further exacerbate these challenges (Smith et al., 2018; Mbindyo et al., 2009). While existing studies have highlighted general issues in rural healthcare, such as staff shortages and supply chain disruptions (Omaswa & Ogwal-Okeng, 2015; Gage & Nesbitt, 2017), there is a lack of research on context-specific solutions for Chipili District, particularly in the area of leadership and management.

Specifically, the interplay between leadership, management, and other factors such as infrastructure, communication, and resource allocation remains underexplored. Addressing these gaps is critical for improving healthcare outcomes in Chipili District Health Facilities, as current inefficiencies undermine service quality and community trust. This study aims to fill this knowledge gap by identifying sustainable, context-specific strategies to enhance healthcare delivery in rural settings like Chipili, with a particular focus on the role of leadership and management.

1.3 RESEARCH OBJECTIVES

1.3.1 General Objective

To identify the most effective Management and Leadership style to optimize organizational performance at health facilities in Chipili District

1.3.2 Specific Objectives

1) To identify and classify the predominant leadership styles practiced within health facilities in Chipili District.
2) To assess the impact of various leadership styles on the performance of health facilities in Chipili District, with a focus on patient outcomes and staff satisfaction.
3) To assess the relationship between the educational qualifications of management personnel and the effectiveness of management approaches in optimizing institutional performance and healthcare delivery at health facilities in Chipili District

4) To explore the relationship between Management and leadership styles and organizational culture within healthcare facilities, examining how leadership practices influence the values, norms, and behaviours within health facilities in Chipili District.

1.4. RESEARCH QUESTIONS

1. What are the predominant leadership styles practiced within health facilities in Chipili District?
2. How do different leadership styles influence patient outcomes (e.g., quality of care, patient satisfaction) and staff satisfaction such as job satisfaction, motivation in health facilities in Chipili District?
3. What is the relationship between the educational qualifications of management personnel and the effectiveness of their management approaches in improving healthcare delivery?
4. What is the relationship between leadership styles and organizational culture in health facilities in Chipili District, and how do leadership practices shape staff behaviours and workplace norms?

1.5 SIGNIFICANCE OF THE STUDY

The significance of this study lay in its potential to enhance healthcare delivery in Chipili District by examining the impact of various leadership styles on patient outcomes and overall service quality. This study specifically focused on health facilities within Chipili, aiming to identify which management approaches led to improved patient care. By exploring the relationship between leadership styles and healthcare performance, the study sought to provide valuable insights into how optimal resource utilization and streamlined operational workflows could address existing challenges faced by health facilities in the district.

The findings of this study offered evidence-based recommendations to healthcare leaders in Chipili District, enabling them to make more informed decisions regarding resource allocation. These insights were expected to enhance the capacity of healthcare facilities to meet their objectives, ultimately improving patient care and service delivery. Furthermore, this study contributed to the broader fields of

Management and healthcare, providing a foundation for future academic discussions and study on the intersection of leadership and healthcare outcomes. By emphasizing leadership styles that prioritized patient-centred care, the study aimed to improve patient satisfaction and overall well-being, thereby fostering more efficient and effective healthcare services in Chipili District.

1.6 SCOPE OF THE STUDY

This study aims to delve into the effects of various Management and leadership styles within staff from Rural Health facilities in the Chipili district. It seeks to understand how contextual factors such as organizational culture, local healthcare challenges, and resource availability shape the effectiveness of these leadership styles within this specific context.

The study involved a comprehensive review of relevant literature on leadership theories and styles, focusing on their practical application in health facilities in Chipili district. Additionally, the study intended to identify and classify various leadership styles exhibited within the organization, analysing their impact on organizational performance metrics.

1.7 DEFINITION OF KEY TERMS

For the purpose of this study, the following definitions are employed:

- **Management:** Management is a social and technical process which utilizes, resources, influences, human action and facilitates changes in order to accomplish organizational goals, (Theo Heiman and William Scott, 1978).
- **Leadership:** Leadership is the process of influencing and supporting others to work enthusiastically towards achieving objectives, (Keys, J. Bernard, Thomas L. Case. 1990).
- **Quantitative Study:** This is a study process that is systematic in nature focusing on quantifying data collection and data analysis.

- **Qualitative Study:** This is a study process that is utilized to explore and understand human behaviour, beliefs, experiences and attitudes.
- **Project Management:** According to Ekman, (1999), this is the application of the necessary knowledge, skills, tools and methods so as to plan, monitor and execute as well as control projects to achieve specific targets within a definitive timeframe, resource limitations and budgets.
- **Healthcare Worker:** This is any individual be it with varying qualifications with different capacities within a healthcare facility working.
- **Organizational Performance:** This is the economic outcomes ensuing from the interplay among an organization's attributes, actions, and environment" (Combs et al., 2005, p. 261).
- **Laissez-faire Leadership:** A leadership style characterized by non-interference, avoidance of decision-making, and allowing events to proceed without intervention.
- **Transformational Leadership:** A leadership style where leaders use their influence and enthusiasm to inspire followers toward organizational advancement (Robbins & Coulter, 2014).
- **Transactional Leadership:** A leadership style based on establishing predetermined objectives and using rewards and punishments to motivate followers.
- **Healthcare Provider:** This is a trained individual in the profession of healthcare who delivers healthcare services.
- **Healthcare Services:** These are services that healthcare providers render to patients aiming to maintain and improve their health in general.

1.8 ORGANIZATION OF THE REPORT

The report is divided into six chapters. Chapter 1 presents the study's background, problem statement, research objectives, and research questions, scope of the study as well as the definition of key terms. It also explains the study's significance, scope, and essential phrase definitions. Chapter 2 conducts a thorough literature review, with an evaluation of the Zambian, continental as well as global viewpoint on Management and Leadership in Healthcare settings. It dives deeper into the theoretical framework, specifically the evidence-based decision-making model that serves as the foundation for the study.

Chapter 3 focuses on the technique used in the research, including the research approach, design, study population, sample size, data collection instruments, and data processing processes, as well as the ethical considerations. The fourth chapter focusses on the presentation of the research analysis as well as the findings from the analysis that was obtained with the aid of statistical software.

It includes an examination of respondents' sociodemographic characteristics, the identification and classification of leadership styles within health facilities in the Chipili District, and an evaluation of the impact of these leadership styles on healthcare performance, with a focus on patient outcomes and staff satisfaction. It also looks at the relationship between leadership styles, management personnel's educational backgrounds, and company culture.

Chapter 5 excavates into connecting the findings with the research questions and research objectives so as to discuss the findings from chapter 5 of the analysis. Finally, Chapter 6 summarized the report as well as focus on recommendations that can be able to bolster Management and leadership practices in Chipili District Health facilities.

CHAPTER TWO: LITERATURE REVIEW

2.0 INTRODUCTION

Leadership is a multifaceted concept that has been defined in various ways. Koontz (2010) describes it as the ability of a manager to inspire and motivate employees to approach their work with confidence and enthusiasm. Similarly, Sanford (1973) emphasizes that without leadership, organizations are merely collections of individuals, underscoring the role of leaders in guiding behavior toward achieving organizational goals. Armstrong (2002) adds that leadership involves motivating and supporting others to pursue shared objectives, while Huber (2013) defines it as the process of influencing others to accomplish goals. These definitions collectively highlight the central role of leadership in shaping employee performance and organizational outcomes.

In the context of healthcare, leadership takes on added significance due to the complexity of health systems and the critical nature of service delivery. Effective leadership in healthcare is essential for addressing challenges such as resource constraints, workforce shortages, and evolving patient needs. This chapter reviews existing literature on leadership in healthcare, with a focus on global, continental, and Zambian perspectives. It also identifies gaps in the literature and justifies the theoretical framework adopted for this study.

2.1.1 Global Perspective

The concept of “global health” has evolved significantly over the past two decades, emerging as a complex and interconnected field that addresses health challenges across national borders and even planetary health (Rosa, 2017). The COVID-19 pandemic has further underscored the importance of global health leadership, highlighting how health systems are interconnected and how events in one part of the world can have far-reaching consequences (World Health Organization, 2020). As the environmental slogan “Think globally, act locally” suggests, effective leadership in healthcare requires a global perspective that considers both local and international contexts.

In high-income countries, significant efforts have been made to strengthen healthcare leadership. For example, the UK’s National Health Service (NHS) introduced general management in the 1980s, followed by an internal market for healthcare in the 1990s,

aiming to create space for leadership and innovation (Goodwin, 2001). Similarly, in the USA, the American Hospital Association (AHA) has focused on identifying key issues affecting healthcare delivery, with studies such as the 2014 Health Research & Educational Trust report assessing the impact of leadership on health systems (Centre for Creative Leadership, 2011). These initiatives highlight the importance of leadership development in improving healthcare outcomes.

However, healthcare systems globally are becoming increasingly complex, with the integration of public and private services, primary and specialized care, and the need to respond to demographic, epidemiological, and technological changes (Senkubuge et al., 2014). This complexity has led to the rise of collaborative governance, where non-state actors work alongside health professionals to address population needs and drive innovation (World Health Organization, 2014). Despite these advancements, challenges such as workforce shortages, skill imbalances, and burnout persist, underscoring the need for effective leadership and workforce management (Waddington & Egger, 2007).

While these developments provide valuable insights, much of the literature focuses on high-income countries, leaving a gap in understanding leadership challenges and strategies in low- and middle-income countries (LMICs). This study seeks to address this gap by exploring leadership in the Zambian context, contributing to the global discourse on healthcare leadership.

2.1.2 Continental Perspective

"Fragile and weak" are likely the two most common adjectives encountered while reading about African health systems. Doubt has grown with regards to African management and leadership in providing healthcare ever since the previous Ebola outbreak that plagued most parts of West Africa. Indeed, the absence of such leadership is frequently seen as contributing to the continent's health issues. Dr. Margaret Mungherera, a former President of the World Medical Association, said in The Economist last year that "Developing leadership capacity should therefore be the

main emphasis of any effort aiming to reduce Africa's disease burden." But what is leadership? Former US President John Quincy Adams is quoted as saying: "If your actions encourage others to dream more, learn more, achieve more, and become more, you are a leader".

That statement accurately describes the health leaders that contributed to Francis Omaswa and Nigel Crisp's book African Health Leaders: Making Change and Claiming the Future. The book includes authoritative first-hand accounts from leaders such as Peter Mugyenyi, Uche Amazigo, Pascoal Mocumbi, Miriam Were, Hannah Faal, and Agnes Binagwaho, among others, who, despite working in difficult circumstances, have led real transformations in African health by inspiring others to do more and become more. Furthermore, the book provides a compelling historical account of the development of health systems in postcolonial Africa, emphasizing the contrast between western medical practice and traditional African health systems following independence, as well as the ongoing unresolved tensions between the two.

As a result of the economic and structural adjustments that took place in the 1980s, the HIV/AIDS epidemic that began in the early 1990s, and the massive inflow of development assistance, which created what the contributors describe as a culture of dependency that robbed Africans of their "self-confidence, self-respect, and self-determination, and the humiliation of being forced to implement solutions they knew to be wrong," African Health Leaders documents how health systems in Africa have been confronted with these repeated serious challenges.

These individuals worked under some of the same constraints that confront many health systems across sub-Saharan Africa today, including conflict and post-war contexts, inaccessibility of health facilities to most communities, limited human resources, absence of health facilities and equipment, insufficient finance, and weak supply chain management. Confronted by these same challenges, these health leaders implemented innovative approaches that greatly enhanced the impact of their work. Rather than being deterred by the challenges, they confronted them and drew on their knowledge, experiences, and existing research evidence. They built on a strong African sense of community and agency, *Ubunthu*, and showed, through their actions and the results they achieved, that much can be done with what is available to achieve better health outcomes in Africa.

The editors have done a skilful job of bringing together the disparate experiences of these leaders to reinforce a common message throughout the book: “working together, we can achieve more” the very essence of *Ubunthu*. The leaders recognised the importance of teamwork within and outside the health sector for achieving meaningful and sustainable health improvements. With a few exceptions, however, most of these important contributions have not received the attention they deserve. Consequently, the work of these leaders has not always informed efforts to advance an African perspective on health system strengthening and the search for home-grown solutions to the health challenges facing Africa (Alex. E, 2015).

African Health Leaders primarily focuses on health-service delivery with some attention to leadership in health policy but virtually nothing on leadership in health research. And although urbanization is recognized as a major process with important implications for health in Africa, the book largely acknowledges this within the context of the emerging burden of non-communicable diseases and the role of urbanization in weakening traditional family and community ties in Africa. However, emerging evidence from across the region suggests that health outcomes among the urban poor in various African countries are worse than those of rural residents, and calls for a rethinking of recommendations that largely see African populations in terms of a rural–urban dichotomy.

Importantly, the book highlights the views of a new generation of African health leaders. As the editors argue: “African leaders and leadership in health have an enormous role to play in a new Africa, where Africans recognize that the responsibility for making Africa an equal player in the global community rests primarily with Africans.” This book challenges Africans to step up to the plate and lead and non-Africans to support Africa's leadership in sustainably addressing its health challenges.

Furthermore, on the continental scale, a second generation of leaders has now assumed power in Africa, replacing those who inherited the colonial state following independence during the 1960s and 1970s and, in a few cases thereafter. Since independence, two or three governing trends have become clear on the continent. Foremost, it seems that, to the committed first group of leaders who inherited the colonial state, the most important goal was to eliminate ethnic divisions and create new nations, where the state was sacrosanct. To achieve this goal and emulating

somewhat the colonial governing model these first leaders, among whom stood out Kwame Nkrumah of Ghana, Julius Nyerere of Tanganyika, Ahmadou Ahidjo of Cameroon, Sekou Toure of Guinea, Nasser of Egypt (who governed already independent Egypt from 1956 to his death in 1970), Leopold Senghor of Senegal, Jomo Kenyatta of Kenya, Ben Bella of Algeria, Felix Houphouet-Boigny of Cote d'Ivoire, Francois Tombalbaye of Chad, Sylvanus Olympius of Togo, and Kenneth Kaunda of Zambia, did not hesitate to imprison their opponents and even, at times (but not often), eliminate them from the scene.

Regarding health, it appears that, there is scarcely any systematic administrative training for those who will serve as ministers of health or related jobs. Most learn the skills on the job, imbued with no principles of accountability based on hard data, which are scanty at present, for enlightened and wise decision-making, as many countries in Africa continue to show information gaps on annual health indices data requested by the WHO. On the point of information and data, so far, the best data have been collected by Gambia, Cote d'Ivoire, Nigeria, and Tanzania, countries that are also exemplary in storing, analysing, and using robust information. Many of the individuals who assume roles of responsibility have hardly been mentored or are exposed to meaningful supervision, letting the "one-eyed men lead the blind." Many in supervisory positions, as well, have little appreciation for investing in the future effectively and efficiently managing and enforcing the multisector prerequisites needed for an integrated approach to health underscored as important by anyone who understands or is sensitive to the nature of disease and its impact (Curry et al. 2012: 4).

African health systems are often described as "fragile and weak," a characterization that has been reinforced by challenges such as the Ebola outbreak in West Africa, which exposed significant gaps in leadership and management (Omaswa & Crisp, 2010). The absence of effective leadership is frequently cited as a contributing factor to the continent's health challenges. As Dr. Margaret Mungherera, former President of the World Medical Association, noted, "Developing leadership capacity should therefore be the main emphasis of any effort aiming to reduce Africa's disease burden" (The Economist, 2022). Leadership, as defined by former US President John Quincy Adams, is about inspiring others to "dream more, learn more, achieve more, and become more." This definition aptly captures the essence of the leaders profiled in

African Health Leaders: Making Change and Claiming the Future by Omaswa and Crisp (2010).

The book highlights the contributions of African health leaders such as Peter Mugyenyi, Uche Amazigo, Pascoal Mocumbi, Miriam Were, Hannah Faal, and Agnes Binagwaho, who, despite working in challenging environments, have driven transformative changes in healthcare delivery. These leaders exemplify the power of resilience, innovation, and community-driven approaches in addressing Africa's health challenges. The book also provides a historical account of health systems in postcolonial Africa, emphasizing the tension between Western medical practices and traditional African health systems, a dynamic that continues to shape healthcare delivery on the continent.

African health systems have faced repeated challenges, including economic and structural adjustments in the 1980s, the HIV/AIDS epidemic in the 1990s, and the influx of development assistance, which, while well-intentioned, often created a culture of dependency (Omaswa & Crisp, 2010). This dependency undermined local self-confidence and self-determination, forcing African leaders to implement solutions that were often misaligned with local contexts. Today, health systems across sub-Saharan Africa grapple with issues such as conflict, inadequate infrastructure, limited human resources, and weak supply chain management (Curry et al., 2012). Despite these challenges, African health leaders have demonstrated remarkable ingenuity, leveraging the African concept of Ubuntu the idea that "I am because we are" to foster collaboration and achieve better health outcomes.

The leaders profiled in African Health Leaders adopted innovative approaches to overcome systemic challenges. For example, they emphasized community engagement, inter-sectoral collaboration, and the use of existing resources to maximize impact. Their efforts underscore the importance of teamwork and shared responsibility, encapsulated in the book's central message: "Working together, we can achieve more" (Omaswa & Crisp, 2010). However, despite their achievements, many of these leaders' contributions have not received the recognition they deserve, limiting their influence on broader efforts to strengthen health systems in Africa (Alex, 2015).

Conversely, while African Health Leaders provides valuable insights into health service delivery and policy leadership, it largely overlooks leadership in health

research. Additionally, although urbanization is acknowledged as a significant factor affecting health in Africa, the book primarily frames it in terms of the rising burden of non-communicable diseases and the erosion of traditional community ties. Emerging evidence, however, suggests that the urban poor often experience worse health outcomes than rural populations, challenging the rural-urban dichotomy that has historically shaped health policies in Africa (WHO, 2016).

The book also highlights the emergence of a new generation of African health leaders who are redefining leadership on the continent. As the editors argue, "African leaders and leadership in health have an enormous role to play in a new Africa, where Africans recognize that the responsibility for making Africa an equal player in the global community rests primarily with Africans" (Omaswa & Crisp, 2010). This call to action challenges African leaders to take ownership of their health systems and for the international community to support these efforts in a way that respects local agency and priorities.

Notably, since independence, African leadership has evolved through distinct phases. The first generation of postcolonial leaders, including Kwame Nkrumah of Ghana, Julius Nyerere of Tanzania, and Kenneth Kaunda of Zambia, focused on nation-building and eliminating ethnic divisions, often adopting centralized governance models reminiscent of colonial administrations (Curry et al., 2012). While these leaders made significant strides in unifying their nations, their approaches often stifled dissent and limited accountability. In the health sector, this legacy is reflected in the lack of systematic training for health administrators and the absence of robust data for decision-making. Many health leaders learn on the job, with limited mentorship or supervision, leading to a situation where, as the saying goes, "the one-eyed man leads the blind" (Curry et al., 2012).

Moving forward, to address these challenges, there is a need for targeted investments in leadership development, particularly in areas such as health research, data collection, and policy formulation. Countries like Gambia, Côte d'Ivoire, Nigeria, and Tanzania have made progress in collecting and utilizing health data, but much work remains to be done to close information gaps across the continent (WHO, 2016). Strengthening leadership capacity will require a multifaceted approach that includes

formal training, mentorship, and the creation of enabling environments for leaders to thrive.

2.1.3. Zambian Perspective

In Zambia, health leaders and managers are often trained health professionals such as doctors, nurses, and pharmacists promoted to managerial roles based on clinical expertise rather than leadership or management skills (Daire, 2014). This practice has created a leadership gap, as many new managers lack the necessary training to effectively oversee health systems. For example, district health teams are typically led by newly qualified medical doctors whose education emphasizes clinical skills, with minimal focus on management and leadership (MoH, 2012). This mismatch between skills and responsibilities often results in inefficiencies and suboptimal health outcomes.

To address these challenges, the Zambian government has implemented several initiatives. The Ministry of Health (MoH) developed a five-year Governance and Management Capacity Strengthening Plan in 2012, aimed at improving systems, structures, and managerial practices across the health sector (MoH, 2012). This plan emphasizes transparency, accountability, and capacity building at all levels of the health system. Additionally, the government has partnered with tertiary institutions, such as the University of Zambia (UNZA) Schools of Public Health and Nursing Sciences, to integrate management and leadership courses into health training curricula (MoH, 2012). Furthermore, healthcare services administration has been introduced as a discipline, requiring hospital administrators to hold at least a first-degree qualification in a health-related field (MoH, 2012).

While formal training is essential, it is not sufficient on its own. The integration of leadership and management skills into daily practice is critical for sustainable change. This is often achieved through mentorship and coaching, which bridge the gap between theoretical knowledge and practical application (Judith & Gilson, 2014). In Zambia, the MoH has developed capacity-building plans for senior and middle-level managers, focusing on both in-service and pre-service training (MoH, 2012). These programs aim to foster a culture of continuous learning and professional development, enabling health leaders to adapt to the evolving demands of the health sector.

Despite these efforts, significant gaps remain. There is limited evidence on the effectiveness of current leadership training programs in improving health outcomes. Additionally, the focus on formal qualifications may overlook the importance of soft skills, such as emotional intelligence and communication, which are critical for effective leadership. Furthermore, the rural-urban divide in healthcare access and quality persists, highlighting the need for context-specific leadership strategies. Addressing these gaps will require a more holistic approach that combines formal training with mentorship, coaching, and context-specific strategies.

2.2 THEORETICAL FRAMEWORK

The healthcare sector is dedicated to providing a spectrum of care, ranging from preventive to rehabilitative and palliative services. One of the noteworthy challenges faced by healthcare facilities is the dearth of leadership development initiatives targeting potential senior staff, consequently contributing to an uneven distribution of leadership roles. In the ever-evolving landscape of contemporary business, effective leadership stands as a cornerstone, influencing organizational culture, fostering employee engagement, and ultimately shaping overall performance (Ngozi E, 2024).

In the contemporary era, marked by a heightened emphasis on social skills and patient-centric care, leaders seek guidance to effectively manage their organizations and mitigate disparities within healthcare. As underscored by Dotson and Nuru-Jeter (2012), the emergence of patient care teams embracing interdisciplinary collaboration underscores the necessity of grooming senior executives capable of resonating with the diverse spectrum of employees. This shift accentuates the significance of cultivating leadership skills that align with the evolving landscape of healthcare and its workforce.

2.2.1 Evidence-based Decision-making model

From the perspective of healthcare managers, the utilization of the Evidence-Based Decision-Making (EBDM) model assumes paramount importance in overseeing physicians' decisions regarding patient care. A study conducted by Rousseau (2008)

in Carnegie Mellon University revealed that merely 15% of physicians in a tested hospital based their patient care decisions on past evidence. This statistic underscores the notion that not everyone possesses the acumen to be a healthcare manager, and physicians might not excel in making administrative decisions. Hospitals that boast a positive rapport with proficient administration managers tend to reap benefits such as reduced mortality rates, enhanced performance metrics, and an overall improvement in staff well-being (Agarwal, Green, Agarwal, & Randhawa, 2016).

The conceptual framework of the EBDM model, which emerged in the 1990s (Barends, Villenueva, Briner, & ten Have, 2015), introduced an innovative perspective to the realms of leadership and management. This framework advocates for the process of healthcare managers developing the capability to critically evaluate evidence derived from specific research as a pivotal aspect of hospital functioning. Implementing an EBDM cycle encompasses various crucial factors. In the initial phase, roles within the system are classified into categories of facilitators, barriers, and predictors. This phase mandates that the leadership style factors in the available facilities, potential procedural complexities within the hospital, and adheres to Healthcare Leadership Alliance (HLA) specifications for healthcare management.

The second phase of the EBDM cycle involves devising management strategies that incorporate insights from experiences and align decisions with evidence-based contexts (Janati et al., 2018). In the face of numerous challenges that require attention, it can indeed be daunting and complex to identify a starting point. A forward-thinking leader, however, recognizes that the most effective approach is to begin with evidence. Extensive study findings emphasize that healthcare quality, population health outcomes, cost management, and clinician engagement and satisfaction collectively known as the Quadruple Aim in healthcare (Bodenheimer & Sinsky, 2014) are all enhanced when decisions and care are grounded in robust evidence, rather than relying on tradition or outdated policies ("that is the way we do it here; that is the way the outdated policy says it needs to be done").

Despite the evident positive impact of EBP, which was initially defined in medicine as the thoughtful utilization of the best available evidence to inform decisions about patient care such as evidence-based decision-making; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000), consistent implementation of EBP remains lacking

among clinicians and healthcare leaders worldwide. Since its initial definition, EBP has evolved to encompass a lifelong problem-solving approach to healthcare delivery. This approach integrates the highest quality evidence from well-conducted studies with clinical expertise and the preferences and values of patients (Melnyk & Fineout-Overholt, 2019). Within a clinician's expertise lie components such as clinical judgment, internal evidence drawn from a patient's history and physical examination, and data derived from EBP, evidence-based quality improvement, or outcomes management initiatives (Melnyk & Fineout-Overholt, 2019).

Evidence-based leadership follows a similar problem-solving methodology, aiming to lead and guide organizations or groups toward shared goals. This approach integrates the conscientious use of the best available evidence with leadership acumen and the preferences and values of stakeholders (Gallagher-Ford, Buck, & Melnyk, 2019). As healthcare navigates its challenges, embracing evidence-based practices in both clinical and leadership domains emerges as a pivotal strategy to drive positive change and achieve the *Quadruple Aim* objectives.

The path-goal theory operates on the premise that leaders possess adaptability and can adjust their leadership style in accordance with the demands of the situation. Intervening variables, such as the leader's age, educational qualifications, training, the environment, and the characteristics of followers, play a role in this theory. Effective leaders under this framework are responsible for illuminating the path that aids their followers in achieving their objectives. They simplify the journey by minimizing obstacles and challenges (Northhouse, 2007).

2.4 CONCEPTUAL FRAMEWORK

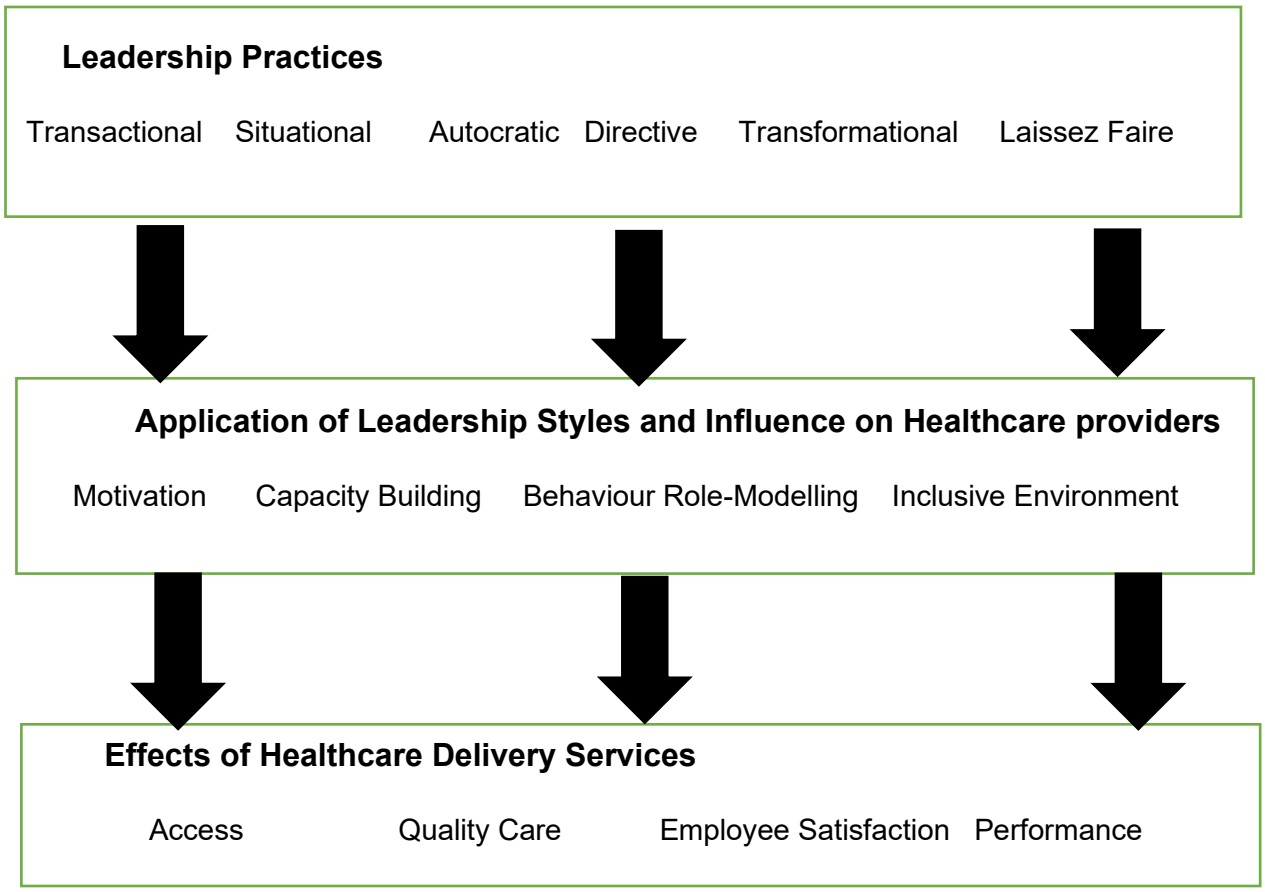
A conceptual framework is a set of interrelated concepts or abstracts that are assembled together in some rational scheme by virtue of their relevance to a common theme; sometimes referred to as a conceptual scheme (Polit and Hungler, 1989).

The path-goal theory will be used to concoct a conceptual framework for this paper.

Figure 2.4.1 Path-Goal theory model of leadership influence on healthcare Organizations and optimization of their performance by Northouse (2006)

Figure 2.4.1

Derived: Northouse, (2006)



2.4.1 Operationalization of the Conceptual Framework

This section explains the operationalization of the independent variables (leadership practices) and dependent variables (healthcare performance and organizational outcomes) in the study. The conceptual framework is informed by the Path-Goal Theory and the Evidence-Based Decision-Making (EBDM) model, which provide the theoretical foundation for understanding how leadership practices influence healthcare organizations.

The independent variables in this study were leadership practices, which are categorized into five key dimensions based on the Path-Goal Theory and the EBDM model. Each dimension is defined, and its operationalization is explained as follows;

Directive Leadership Practices involve providing clear instructions, setting expectations, and guiding employees on how to achieve organizational goals. These practices ensure that employees have a clear understanding of their roles and responsibilities, helping to streamline the process of reaching organizational objectives. To measure these practices, survey items such as, “My supervisor provides clear instructions on how to perform tasks,” will be used, with responses recorded on a Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Data was collected through structured surveys and interviews with healthcare staff and managers.

In contrast, Supportive Leadership Practices focus on showing concern for employees' well-being, fostering a positive work environment, and providing emotional support. These practices create a supportive and nurturing atmosphere that enhances employee morale and job satisfaction. To assess these practices, survey items like, “My supervisor shows concern for my well-being,” will be utilized, with responses recorded on a Likert scale. Supportive leadership has been shown to improve employee morale and job satisfaction, particularly in high-stress environments such as healthcare (Laschinger, Finegan, & Wilk, 2009).

Participative Leadership Practices, on the other hand, encourage employee involvement in decision-making processes, promoting collaboration and shared responsibility. Participative leadership fosters collaboration and shared responsibility, which are critical for innovation and problem-solving in teams (Somech, 2006).

Additionally, by involving employees in decisions, leaders can create a sense of ownership and collective responsibility toward organizational goals. These practices will be measured using survey items such as, “My supervisor involves me in decision-making,” with responses recorded on a Likert scale. Similarly, data was collected through surveys and interviews, enabling a comprehensive understanding of how collaboration influences team dynamics and leadership effectiveness.

Achievement-Oriented Leadership Practices are designed to set challenging goals, encourage high performance, and motivate employees to excel. Achievement-oriented leadership is associated with higher employee motivation and performance, particularly when goals are specific and challenging (Locke & Latham, 2002). Survey items such as, “My supervisor sets challenging goals for our team,” will be used to measure these practices, with responses recorded on a Likert scale. Data was collected through surveys and interviews, helping to gauge how goal-setting and performance expectations influence employee motivation and outcomes.

On the other hand, the dependent variables in this study were access, quality care, employee satisfaction as well as employee performance which are influenced by leadership practices, and each is defined and operationalized with specific indicators supported by relevant literature.

Access refers to the availability and affordability of healthcare services to patients, encompassing the ability of individuals to obtain timely and appropriate care when needed (World Health Organization [WHO], 2010). As a critical determinant of healthcare system performance, access is often measured through indicators such as service availability, geographic proximity, and financial affordability (Levesque, Harris, & Russell, 2013). In this study, access will be operationalized using indicators such as the percentage of patients able to access healthcare services within a reasonable time frame (e.g., within 24 hours for urgent care) and the affordability of services, measured by out-of-pocket expenses as a percentage of household income (WHO, 2010). Data for these measures will be sourced from hospital records, patient surveys, and government or organizational reports.

Quality care refers to the degree to which healthcare services meet established standards and improve patient outcomes. It encompasses dimensions such as effectiveness, safety, patient-centeredness, and equity (Institute of Medicine [IOM],

2001). High-quality care ensures that patients receive evidence-based treatments that lead to improved health outcomes. This study will measure quality care through indicators such as patient outcomes, including recovery rates and mortality rates (Donabedian, 1988), adherence to clinical guidelines and best practices, assessed through clinical audits, and patient satisfaction scores, which will be obtained through surveys. For instance, patients will be asked whether they are satisfied with the quality of care received. Data will be drawn from hospital records, patient surveys, and clinical audits to assess these dimensions.

Employee satisfaction refers to the level of satisfaction and engagement among healthcare staff and is closely linked to employee retention, productivity, and patient outcomes (Kovner, Brewer, Wu, Cheng, & Suzuki, 2006). Satisfied employees are more likely to provide high-quality care and remain committed to their organizations. To operationalize employee satisfaction, this study will use indicators such as employee engagement survey scores, including items like "I feel motivated to perform my duties," as well as turnover rates and absenteeism, which serve as indirect indicators of employee dissatisfaction (Hayes et al., 2012). These data will be collected through employee surveys and HR records.

Conversely, Performance refers to the overall effectiveness and efficiency of the healthcare organization, encompassing clinical and administrative outcomes such as cost efficiency, productivity, and innovation (Kaplan & Norton, 1996). High-performing organizations deliver quality care while optimizing resource utilization. In this study, performance will be measured through indicators such as cost efficiency, including budget adherence and resource utilization rates (Peters et al., 2009), organizational productivity, which will be assessed by the number of patients served per month or the volume of services provided, and innovation, evaluated through the number of new initiatives or improvements implemented within the organization (West & Farr, 1990). Data for these measures will be sourced from organizational financial reports, performance reviews, and interviews.

CHAPTER THREE: METHODOLOGY

3.0 INTRODUCTION

This chapter outlines the research methodology adopted to conduct the study, elucidating the systematic approach employed to gather, analyse, and interpret data in order to address the research objectives effectively. The research methodology serves as the blueprint guiding the entire research process, ensuring its rigor, validity, and reliability. The chapter outlines the research design, population and sample selection procedures, data collection methods, validity and reliability, data analysis techniques and ethical considerations adhered to throughout the study.

3.1 RESEARCH APPROACH

A mixed-methods research approach, combining both quantitative and qualitative methodologies, was used in this study. The quantitative approach, such as the correlation coefficient, was employed to quantify the relationships between variables (Creswell, 2003). This approach is particularly useful for determining the direction and strength of relationships between independent and dependent variables.

The qualitative approach, which has been widely used in fields such as anthropology and education, was employed to investigate complex social and cultural phenomena (Creswell, 2005). In this study, the qualitative approach was used to identify, characterize, and understand the various management approaches and leadership styles prevalent in Chipili District health facilities, as well as their impact on institutional performance and healthcare delivery.

The specific mixed-methods design used in this study is the triangulation design, where both quantitative and qualitative data were collected simultaneously and analysed independently before being integrated to provide a comprehensive understanding of the research problem. This design was chosen because it allows for the convergence of data from different sources, enhancing the validity and depth of the finding.

3.2 RESEARCH DESIGN

The research design for this study is a mixed-methods design, which integrates both quantitative and qualitative approaches to address the research questions. According to Ikmund (2000), the research design is a master plan specifying the methods and procedures for collecting and analyzing the needed information. In this study, the quantitative component employed a correlational research design to examine the relationship between management and leadership styles (independent variables) and institutional performance and healthcare delivery (dependent variables). The correlation coefficient was used to quantify the direction and strength of these relationships (Creswell, 2003).

The specific mixed-methods design used in this study is the triangulation design, where both quantitative and qualitative data were collected simultaneously and analysed independently before being integrated. This design was chosen because it allows for the convergence of data from different sources, enhancing the validity and depth of the findings. By combining the strengths of both quantitative and qualitative approaches, this design provided a more robust understanding of the research problem

3.3 STUDY POPULATION

The selection of participants for the study will be intentional to ensure a broad range of diversity. The study population will include Chipili District Health Facility staff, such as, Facility Managers such as Nursing officers and Facility In-Charges, Facility Departmental In-Charges as well as other health facility staff among others. These individuals are primary leaders who directly supervise healthcare providers using various leadership approaches. Additionally, this will involve other facility staff such as nurses, Community health assistants, Office orderly, clinical officers and Midwives among others.

3.4 SAMPLE SIZE

The total sample size was determined from the One Twenty (120) healthcare facility staff using Yamane's (1967) formula for sample size computation, which is represented by the following formula:

$$n = \frac{N}{1 + N(e)^2}$$

Where: N is the population size, n is the corrected sample size (in this case, 120 employees of the 19 Health facilities), and e is the error margin, which in this case is 5%.

In which: Population size is ascertained by **N**, whilst sample size is denoted by the letter **n** (in this particular case where 120 employees of 19 healthcare facilities in Chipili District) and **e** denotes the margin of error which in this case is 5%.

The sample size was 92 employees from the 19 Health facilities with a margin of error of 5%. The total population size (**N**) for this study was 120 employees. This is due to the fact that, depending on the target population and the amount of available funding, the Yamane formula from 1967, which determines sample size, permits the margin of error to be either 10% (0.10) or 5% (0.05).

$$\boldsymbol{n} = \frac{N}{1 + N\ (e)2}$$

$$\boldsymbol{n} = \frac{120}{1\ +\ 120(0.05)\ 2}$$

$$\boldsymbol{n} = \frac{120}{(1)\ +\ 0.3}$$

$$n = \frac{120}{1.3}$$

$$n = \mathbf{92}$$

3.5 SAMPLING TECHNIQUES

To obtain precise generalizations about the larger population, sampling was employed to collect a subset of the total population (Bless and Achola, 1998). Simple random sampling is a probability sampling method that ensures every member of the population has an equal opportunity to participate in the study. Thus, 92 staff members from health facilities in the Chipili district were chosen for this inquiry using simple random sampling. The sample size of 92 was determined using a sampling formula that ensured a representative subset of the population, which had a total size of 120.

The sampling frame employed in this study consisted of lists containing all 120 employees from the health facilities in Chipili District. An identifying number (e.g., 1, 2, 3, and 4, and so on to 120) was randomly assigned to each employee in the population. One employee at a time was chosen from a box containing the identities of all 120 employees after they had been thoroughly mixed and shuffled. This procedure was repeated until the desired sample size of 92 people was reached. With this technique, there was an equal probability for every member of the population to be selected for the sample.

3.6 DATA COLLECTION/ INSTRUMENTS

According to Gupta & Gupta, (2014), there are two types of data namely primary data and secondary data. Primary data is original in trait as it is information collected for the first time (Gupta & Gupta 2014, Kombo & Tromp 2014). On the other hand, Secondary data comes from two major sources that are external and internal (Gupta & Gupta (2014:69). Internal data stems from the documents that are maintained by an

institution while external data is obtained from other sources other than the archives of the institution.

With consideration that respondents required being interviewed, self-administered questionnaires and interviews both structured and unstructured, had to be used with questions prepared in such a way so as to address the research questions of the study. There were a series of written questions that a participant was required to answer in the questionnaire. The format of the questionnaire was in a way that it solicited short answers that included where a respondent had to strongly agree, agree, neither agree nor disagree, disagree or strongly disagree.

For qualitative data collection, semi-structured interviews were conducted with key informants, including Facility Managers, Departmental In-Charges, and other staff. The interviews were designed to explore leadership styles, management practices, and their impact on institutional performance. Data collection continued until saturation was reached, with iterative analysis ensuring that no new themes emerged in subsequent interviews.

3.7 DATA ANALYSIS

The data collected from the questionnaires and interviews were analysed both quantitatively and qualitatively to address the research objectives. Prior to analysis, the data underwent a rigorous process of cleaning and validation to ensure completeness, accuracy, and uniformity. Missing or inconsistent responses were addressed through inference, recalls, or revisiting respondents where feasible. This process ensured that the data were reliable and ready for analysis.

Quantitative data were derived from structured questionnaires administered to two groups: managers and subordinates. The responses were inputted and analysed using the Statistical Package for Social Sciences (SPSS) Version 22. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize the sociodemographic characteristics of respondents and baseline variables.

To examine relationships between variables, Pearson correlation analysis was conducted to assess the strength and direction of linear relationships, such as the

association between leadership effectiveness and service efficiency. Linear regression analysis was employed to predict the impact of leadership styles on outcomes like service efficiency and staff satisfaction. Additionally, one-way ANOVA was used to compare group means for variables such as ethical leadership and service efficiency impact.

For more advanced analysis, principal component analysis (PCA) was conducted to identify underlying factors and reduce dimensionality in variables related to organizational culture and leadership practices. The Kaiser Criterion (Eigenvalues > 1) was applied to extract significant components, and the results were interpreted using component matrices and communalities.

Conversely, qualitative data from interviews were analysed using Python software for content analysis. Thematic analysis was employed to identify recurring patterns and themes relevant to the research questions. The process involved iterative coding, categorization, and validation of themes to ensure reliability and consistency. Saturation was achieved when no new themes emerged in the final interviews, indicating that the data were sufficiently comprehensive.

3.8 VALIDITY AND RELIABILITY

In this mixed methods study exploring the effective Management and Leadership Styles to Optimize Institutional Performance and healthcare delivery at health facilities in Chipili District., it was cardinal to ensure that validity and reliability were established. Validity pertains to the accuracy and appropriateness of the research instruments and procedures in measuring what they intend to measure, while reliability concerns the consistency and stability of the research findings over repeated measurements or under varied conditions (Bryman, 2016).

To address validity concerns, rigorous measures were undertaken. Expert reviews from the supervisor to refine the questionnaire, ensuring clarity, relevance, and extensiveness were done.

Reliability was ensured through internal consistency, the questionnaire items were assessed using measures like Cronbach's alpha coefficient, indicating the degree to which items within each scale consistently measure the same construct. By upholding

both validity and reliability standards throughout the research process, this study aimed to produce robust findings that accurately reflect the dynamics Management and Leadership in Chipili District.

3.9 ETHICAL CONSIDERATIONS

Since this study engaged human participants and investigated Management approaches and leadership styles in the Health Facilities in Chipili district, certain issues were addressed. It was necessary to ensure the privacy as well as the security of the participants. These issues were identified to them in advance so as prevent future problems that could have arisen during the research process. The significant issues that were considered included consent, confidentiality and data protection.

Permission to conduct the study was obtained from The University of Lusaka through an ethical clearance letter as well as an introductory Letter introduced to the Chipili district health office as well as facilities to conduct the research.

In the conduct of the study, the interview forms were drafted in a simplified and concise manner to prevent conflicts or misunderstanding among the respondents. People who participated in the study were given ample time to respond to the questions posed to them to avoid errors and inaccuracies in their answers. The respondents were given a waiver regarding the confidentiality of their identity and the information that they did not wish to disclose. The respondents' cooperation was eagerly sought after, and they were assured that the data gathered from them would be treated with the strictest confidence, so that they would be more open. This was done with the hope that this would promote trust between the researcher and the respondents.

CHAPTER FOUR: PRESENTATION AND ANALYSIS OF RESULTS

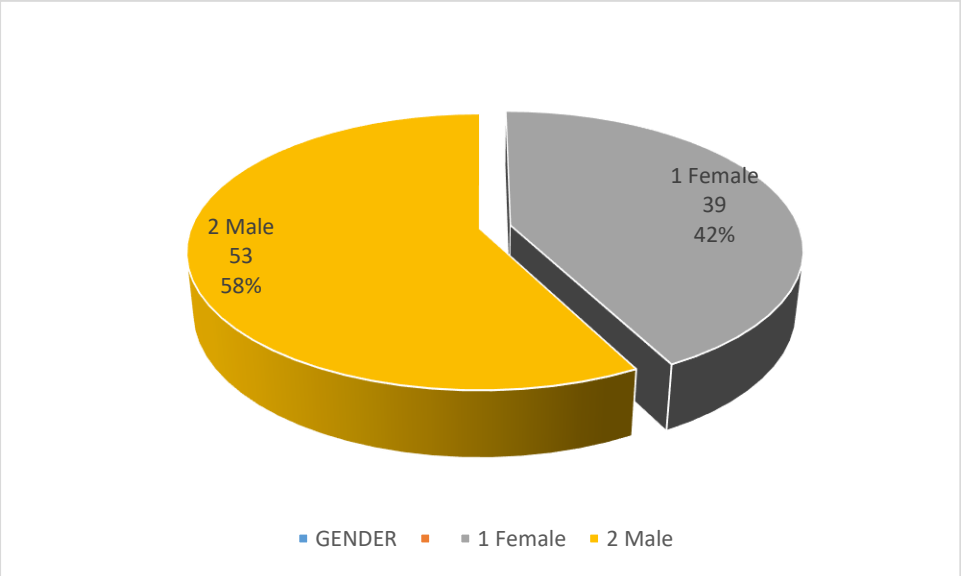
4.0 INTRODUCTION

The information obtained from the healthcare workers both subordinates and managers in the Nineteen (19) Health Facilities in Chipili District is presented and examined in this chapter. The current surveys were cited by the researcher as the source of data for this analysis. The quantitative information gathered by the questionnaire was examined using SPSS version 22 of the Statistical Package for the Social Sciences. Additionally, Python (3.11.6) was used for qualitative data analysis. The chapter simultaneously offered a thorough analysis while also describing the interpretation.

4.1 SOCIODEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

4.1.1 Gender

Figure 1 Respondent distribution by gender

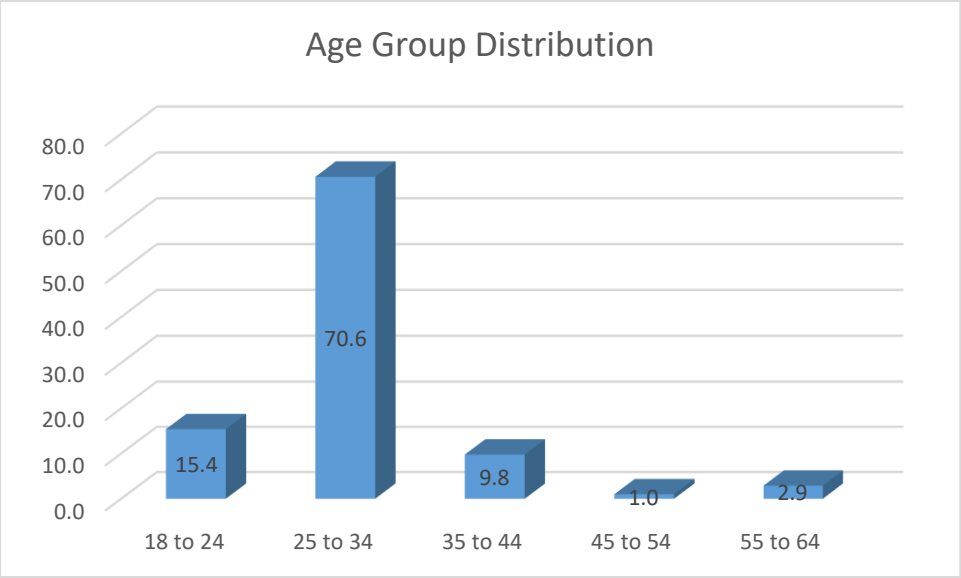


Source (Field Data, 2024)

The pie chart illustrates the gender distribution of respondents. Males constitutes the majority accounting 53 respondents (58%), while female represents 39 respondents (42%). This indicates that the sample has a higher proportion of male participants than female

4.1.2 Age Group Distribution

Figure 2 Respondents by Age distribution

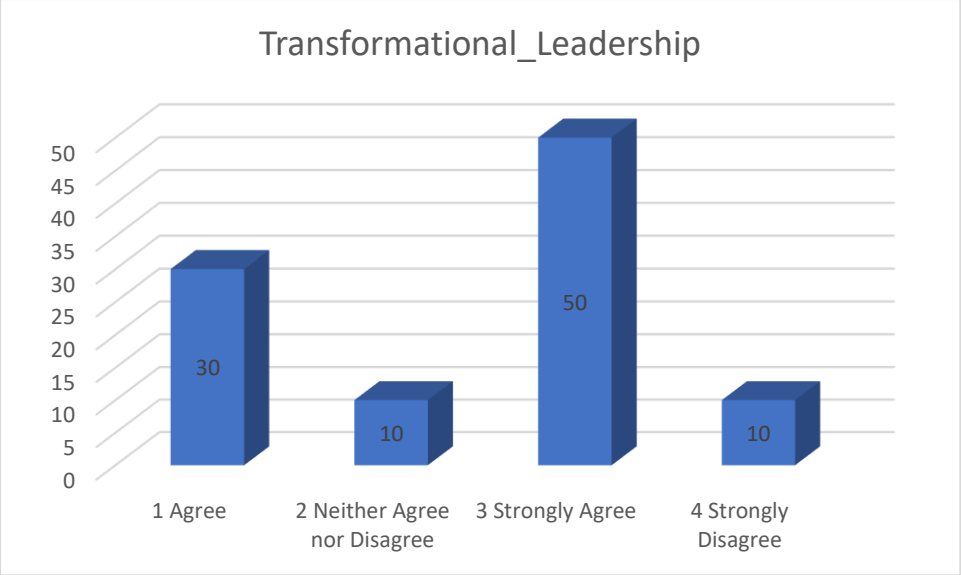


Source (Field Data, 2024)

The age distribution of respondents of figure 1 shows that the majority fall within the 25 to 34 years' age group, accounting for 71.6% of the sample. The second largest group is 18 to 24 years (14.7%), followed by 35 to 44 year (9.8%), older age groups such as 45 to 54 years (1%) and 55 to 64 years (2.9%), are minimally represented. This indicates that most participants are young adults representing the largest proportion of the workforce. Conversely, the respondent number has increased to 102 instead of the sample size of 92 due to an inclusion of the Leaders responses from the Managers questionnaire.

4.1.3 To identify and classify the predominant leadership styles practiced within health facilities in Chipili District

Figure 4: Leaders responses on transformational Leadership

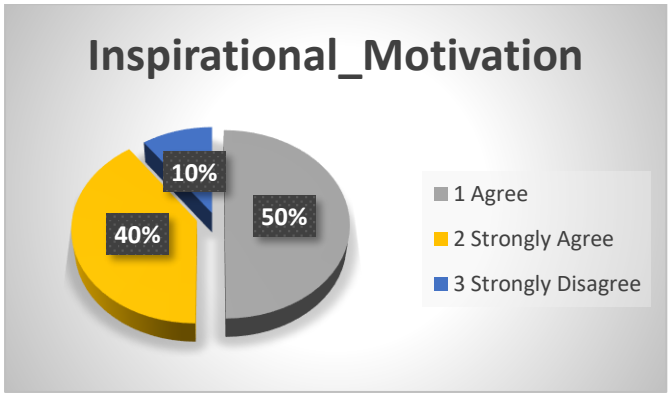


Source (Field Data, 2024)

The analysis revealed that transformational leadership is the predominant leadership style practiced within health facilities in Chipili District. As illustrated in Figure 4, approximately 80% of respondents (both leaders and subordinates) expressed agreement or strong agreement with the traits associated with transformational leadership, such as inspirational motivation, intellectual stimulation, and individualized consideration. This high level of endorsement suggests that transformational leadership is widely recognized and valued in the district's healthcare settings.

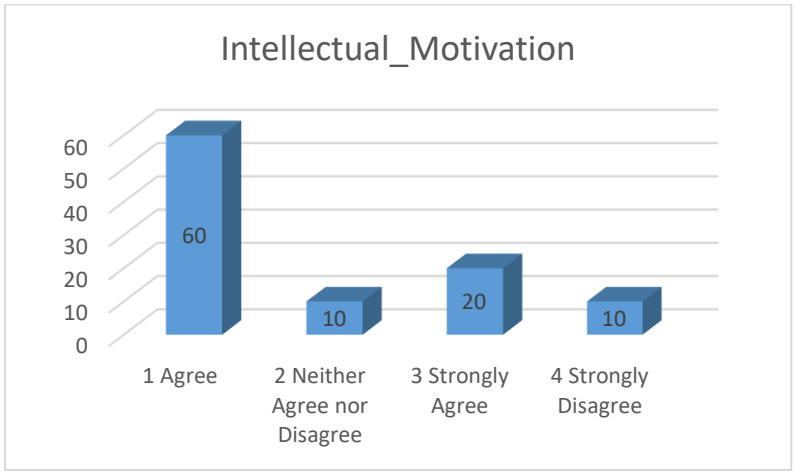
However, the remaining 20% of responses (neutral, disagree, or strongly disagree) indicate that some healthcare workers may not fully experience or understand the principles of transformational leadership. This could be attributed to factors such as limited training opportunities, resource constraints, or variations in leadership practices across facilities. These findings align with existing literature, which highlights the effectiveness of transformational leadership in fostering employee motivation and organizational performance (Author, Year). Nonetheless, the presence of neutral and disagree responses underscores the need for targeted leadership development programs to ensure consistent application of transformational leadership principles across all health facilities in Chipili District

Figure 5: Response of Leaders on Inspirational Motivation



Source (Field Data, 2024)

Figure 6: Response of leaders on intellectual motivation

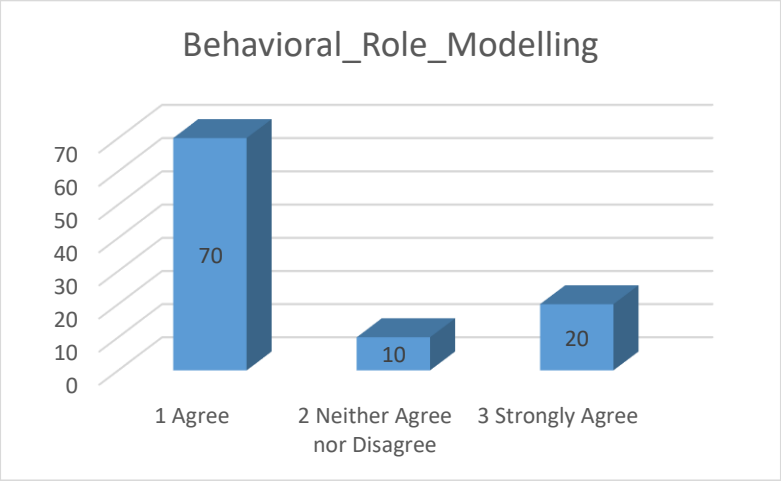


Source (Field Data, 2024)

The figure highlights leaders' perceptions of intellectual motivation as a component of transformational leadership. While the majority of respondents acknowledged its benefits such as enhanced creativity, problem-solving skills, and overall well-being neutral and disagree responses were also observed. These responses may reflect a lack of exposure to intellectual stimulation or practical challenges in implementing such practices. For instance, some leaders may prioritize immediate operational needs over

long-term intellectual development. Addressing these barriers through training programs and resource allocation could help foster a culture of intellectual motivation within health facilities.

Figure 7: Response of Leaders on Behavioral Role Modelling



Source (Field Data, 2024)

The figure demonstrates leaders' perceptions of behavioural role modelling as a leadership practice. The high level of agreement suggests that most respondents recognize its effectiveness in promoting positive behaviours and fostering a culture of learning. However, neutral responses indicate that some leaders may lack exposure to or understanding of behavioural role modelling principles. This could be due to limited opportunities for mentorship or inconsistent implementation across facilities. To address this, healthcare organizations could introduce structured mentorship programs and leadership workshops to enhance role-modelling practices.

In a nutshell, transformational leadership was deemed the predominant leadership style in Chipili District's health facilities, with strong support for its key components inspirational motivation, intellectual stimulation, and behavioural role modelling. However, the presence of neutral and disagree responses highlights the need for

targeted interventions to address gaps in leadership practices and ensure consistent application across all facilities. These findings address the research objective of identifying and classifying leadership styles by demonstrating the prevalence of transformational leadership in Chipili District's health facilities.

4.2 TO ASSESS THE IMPACT OF VARIOUS LEADERSHIP STYLES ON THE PERFORMANCE OF HEALTH FACILITIES IN CHIPILI DISTRICT, WITH A FOCUS ON PATIENT OUTCOMES AND STAFF SATISFACTION

Table 1 Correlation analysis between leadership effectiveness and impact on service efficiency from Subordinates.

The table presents the results of a Pearson correlation analysis examining the relationship between leadership effectiveness and service efficiency. The analysis revealed a weak to moderate positive correlation ($r = 0.358$, $p < .001$), indicating that higher leadership effectiveness is associated with improved service efficiency.

Correlations			
		Leadership_Effectiveness	Impact_on_Service_Effeciency
Leadership_Effectiveness	Pearson Correlation Sig	1	.358 .000
Impact_on_Service_Effeciency	Pearson Correlation Sig	.358 .000	1
**. Correlation is significant at the 0.01 level (2-tailed).			

Source (Field Data, 2024)

The correlation analysis revealed a weak to moderate positive relationship between leadership effectiveness and service delivery efficiency ($r = 0.358$, $p < .001$). This statistically significant correlation indicates that enhanced leadership effectiveness is associated with improvements in service efficiency within Chipili District's health facilities. While the positive relationship suggests that effective leadership contributes to better service delivery, the moderate strength of the correlation ($r = 0.358$) implies that other factors such as resource availability, staff training, and infrastructure also play a significant role in determining service efficiency.

To further explore this relationship, a linear regression analysis was conducted. The model was statistically significant ($F = 13.397$, $p < .001$), with leadership effectiveness explaining 12.8% of the variance in service efficiency ($R^2 = 0.128$). The positive unstandardized coefficient ($B = 0.247$, $p < .001$) confirms that leadership effectiveness positively predicts service efficiency: for every one-unit increase in leadership effectiveness, service efficiency is expected to increase by 0.247 units. However, the relatively low R^2 value (0.128) indicates that leadership effectiveness, while a contributing factor, accounts for only a small portion of the variation in service efficiency. This finding underscores the importance of considering other variables such as organizational policies, staff motivation, and patient load that may influence service delivery. Future research should explore these factors to gain a more comprehensive understanding of the determinants of service efficiency in Chipili District.

Table 2: Responses by leaders in the health facilities

Correlation analysis

Correlations			
		Transformational_ Leadership	Staff Development
Transformational Leadership	Pearson Correlation	1	.269
	Sig.		.453

Staff Development	Pearson Correlation	.269	1
	Sig.	.453	

Source (Field Data, 2024)

A Pearson correlation analysis was conducted to examine the relationship between transformational leadership and staff development. The results revealed a weak positive correlation (r = 0.269), indicating that as transformational leadership increases, there is a slight tendency for staff development to improve. However, the relationship was not statistically significant (p = 0.453), suggesting that transformational leadership does not have a meaningful impact on staff development in Chipili District's health facilities.

To further investigate this relationship, a linear regression analysis was performed. The results showed a weak positive correlation (R = 0.269) and a low explanatory power (R^2 = 7.2%). The overall model was not statistically significant (F = 0.622, p = 0.453), and the effect of transformational leadership on staff development was not significant (B = 0.288, p = 0.453). These findings suggest that other factors such as training opportunities, resource availability, and organizational support may play a more significant role in staff development than transformational leadership alone. Future research should explore these factors to identify effective strategies for enhancing staff development in healthcare settings.

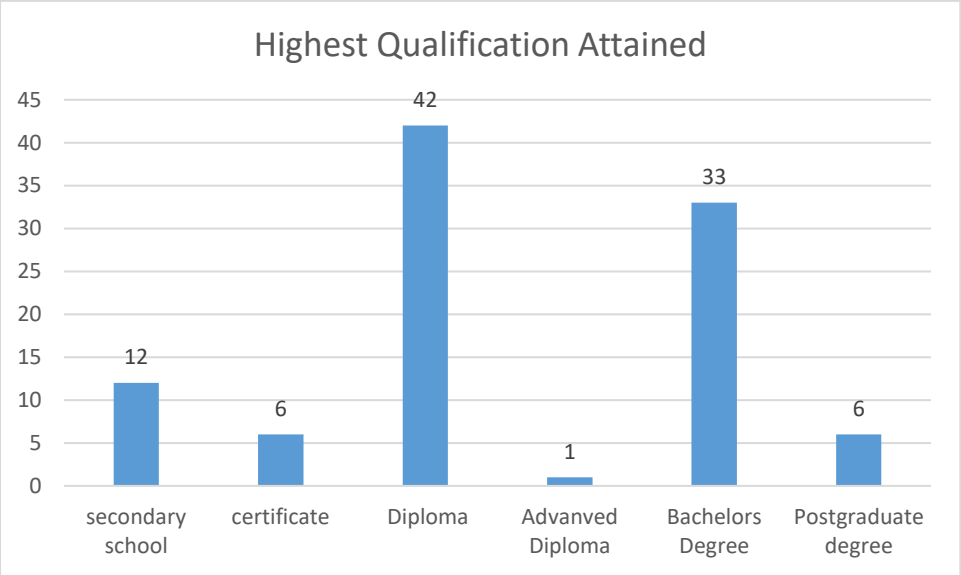
4.3 TO ASSESS THE RELATIONSHIP BETWEEN THE EDUCATIONAL QUALIFICATIONS OF MANAGEMENT PERSONNEL AND THE EFFECTIVENESS OF MANAGEMENT APPROACHES IN OPTIMIZING INSTITUTIONAL PERFORMANCE AND HEALTHCARE DELIVERY AT HEALTH FACILITIES IN CHIPILI DISTRICT

4.3.1 Highest Qualification Attained

Figure 3 Respondents distribution by Educational Qualification

The figure illustrates the distribution of respondents' highest academic qualifications. The majority hold a diploma, followed by a bachelor's degree, while postgraduate qualifications and secondary school education are less common. This distribution

reflects the educational profile of management personnel in Chipili District's health facilities.



Source (Field Data, 2024)

The analysis of educational qualifications among management personnel revealed that the majority of respondents hold a diploma (42 respondents), followed by those with a bachelor's degree (33 respondents). A smaller proportion of respondents reported postgraduate qualifications (6 respondents) or secondary school as their highest qualification (12 respondents). Only one respondent held an advanced diploma, making this the least represented group. Overall, the findings suggest that the workforce in Chipili District's health facilities is reasonably educated, with most personnel possessing mid- to higher-level qualifications.

However, the inclusion of leaders' responses increased the total number of respondents to 102, exceeding the initial sample size of 92. This discrepancy should be noted when interpreting the results, as it may introduce bias or affect the generalizability of the findings. Despite this, the data highlights the need for targeted training programs to bridge gaps in advanced qualifications and ensure that management personnel are equipped with the skills necessary to optimize institutional performance and healthcare delivery.

4.4 TO EXPLORE THE RELATIONSHIP BETWEEN LEADERSHIP STYLES AND ORGANIZATIONAL CULTURE WITHIN HEALTH FACILITIES, EXAMINING HOW LEADERSHIP PRACTICES INFLUENCE THE VALUES, NORMS, AND BEHAVIORS WITHIN HEALTH FACILITIES IN CHIPILI DISTRICT

Table 3 Responses by subordinates on Ethical Leadership and Service Impact/Support

The table presents the results of a one-way ANOVA analysis examining the relationship between ethical leadership and service efficiency impact/support. The analysis revealed no statistically significant differences, suggesting that ethical leadership does not significantly influence service efficiency in Chipili District's health facilities.

One way ANOVA Analysis between Ethical leadership and service efficiency impact /support						
		Sum of Squares	df	Mean Square	F	Sig.
Service_effeciency_impact	Between Groups	14.464	5	2.893	3.052	.014
Service_Effecienc y_support	Between Groups	14.431	5	2.886	1.330	.259

Source (Field Data, 2024)

The analysis revealed no statistically significant difference in service efficiency impact across groups when comparing ethical leadership ($F = 3.052$, $p = 0.14$). This suggests that ethical leadership does not have a significant effect on service efficiency impact in Chipili District's health facilities. Similarly, there was no statistically significant difference in service efficiency support between groups when comparing ethical leadership ($F = 1.330$, $p = 0.259$). These findings indicate that ethical leadership, while important for fostering trust and integrity, may not directly influence service efficiency in this context.

However, the analysis did reveal a statistically significant difference in service efficiency impact when comparing leadership effectiveness (F = 3.650, p = 0.005). This suggests that effective leadership practices such as clear communication, decision-making, and resource allocation play a more significant role in influencing service efficiency than ethical leadership alone. These findings highlight the need for a balanced approach to leadership development, incorporating both ethical principles and practical leadership skills to optimize healthcare delivery.

Table 4 Relationship between leadership effectiveness and service delivery impact/support

One way ANOVA Analysis between leadership effectiveness and service efficiency impact /support						
		Sum of Squares	df	Mean Square	F	Sig.
Service_effeciency_impact	Between Groups	16.805	5	3.361	3.650	.005
Service_Effecienc y_support	Between Groups	203.247	5	40.649		

Source (Field Data, 2024)

In contrast, to the table above, this analysis revealed that there a statistical significant difference found in service efficiency impact between groups when comparing leadership effectiveness (F=3.650, P=0.005). This indicates that leadership effectiveness pay a significant role in influencing service efficiency impact in the healthcare facilities.

Table 5 Responses by leaders on ethical decision making and Inclusive Environment

One way Anova analysis between ethical decision making and Inclusive Environment/ Diversity Promotion						
		Sum of Squares	df	Mean Square	F	Sig.
Inclusive Environment	Between Groups	.600	2	.300	.280	.764

Diversity Promotion	Between Groups	.100	2	.050	.175	.843

Source (Field Data, 2024)

The results indicate no statistically significant differences in Ethical Decision Making scores across the three levels of Inclusive Environment. The p-value (F= 0.280 p=0.764) exceeds the commonly accepted threshold of 0.05, suggesting that group means are not significantly different.

Similarly, there are no statistically significant differences in Ethical Decision Making scores across the three levels of Diversity Promotion. The high p-value (F=0.175, P=0.843) indicates that variations in Diversity Promotion levels do not significantly impact Ethical Decision Making.

The findings suggest that neither Inclusive Environment nor Diversity Promotion significantly influences Ethical Decision Making. This implies that the leadership styles or management practices associated with creating an inclusive environment or promoting diversity do not have a measurable impact on ethical decision-making scores.

4.4.1 PRINCIPAL COMPONENT ANALYSIS

4.4.1.1 Response by subordinates on diversity inclusion Leadership

Table 6 Cross tabulation analysis

	Diversity_Inclusion_Leadership				
	Agree	Disagree	Neither Agree nor Disagree	Strongly Disagree	Strongly Agree
Negative	1	0	1	0	0
Neither Negative nor Positive	3	1	1	1	1
Positive	40	0	5	1	6

Very Negative	0	0	2	1	0
Very Positive	17	0	3	0	6

Source (Field Data, 2024)

Table 7 Chi-square Tests for Organizational culture and Inclusive environment

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	62.585[a]	25	.000
Likelihood Ratio	32.449	25	.145
Linear-by-Linear Association	1.653	1	.199
N of Valid Cases	93		

SUBORDINATE RESPONSE

Source (Field Data, 2024)

The chi-square statistic of 62.585 is relatively large. This indicates that there is a significant difference between the observed and the expected frequencies in the contingency table for the relationship between organizational culture and diversity inclusion leadership. Significance p value=0.000 is less than p=0.05 this means that the result is statistically significant. This indicates that there is a very strong likelihood that the relationship between organizational culture and diversity inclusion leadership is not due to chance. (There is a significant relationship between organizational culture and diversity inclusion leadership).

Table 8 Responses on Factors analysis by subordinates

Communalities

	Initial	Extraction
Team_Recognition	1.000	.716
Inclusive_Environment	1.000	.955
Diversity_Promotion	1.000	.879
Extraction Method: Principal Component Analysis.		

Source (Field Data, 2024)

The results indicate that 71.6% of the variance in Team Recognition is explained by the extracted factors. This indicates a strong representation of this variable within the factor solution. While 95.5% of the variance in Inclusive Environment is explained by the extracted factors. This is an excellent representation and shows that the variable is closely aligned with the factor structure. 87.9% of the variance in Diversity Promotion is explained by the extracted factors. This is also a very strong representation.

Table 9 analysis of an underlying structure of Team Recognition, Inclusive environment and Diversity Promotion

Total Variance Explained						
Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	2.549	84.978	84.978	2.549	84.978	84.978
2	.411	13.698	98.676			
3	.040	1.324	100.000			
Extraction Method: Principal Component Analysis.						

Source (Field Data, 2024)

A Principal Component Analysis (PCA) was conducted to explore the underlying structure of three variables: Team Recognition, Inclusive Environment, and Diversity Promotion. The Kaiser Criterion (Eigenvalues > 1) was applied, and one dominant factor was extracted, explaining 84.978% of the total variance. This single factor highlights a consistent relationship among the variables. The second and third

components explained 13.698% and 1.324% of the variance, respectively, and were excluded due to Eigenvalues below the threshold of 1.0. These findings demonstrate that the three variables are highly interrelated and can be summarized by one latent factor.

Table 10 Factor Analysis for Inclusive Environment

Component Matrix[a]	
	Component
	1
Team Recognition	.846
Inclusive Environment	.977
Diversity Promotion	.937

Extraction Method: Principal Component Analysis.

Source (Field Data, 2024)

The component matrix results shows inclusive Environment (0.977) has the strongest alignment with the factor, highlighting its central role. Diversity Promotion (0.937) is significantly correlated, emphasizing the importance of promoting diversity as part of the factor. Team Recognition (0.846): is slightly lower, however remains a strong contributor to the factor.

After factor analysis, regression analysis was also carried out.

Table 11 Regression analysis between Transformational Leadership and Team Recognition

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.561[a]	.315	.229	.873

Source (Field Data, 2024)

The model table above shows that R= 0.561 Indicates a moderate positive correlation between Transformational Leadership and Team Recognition. R squared of 31.5% of the variance in Team Recognition is explained by Transformational Leadership. This suggests a moderate effect size.

Table 12 Responses between transformational Leadership and team recognition

ANOVA[a]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2.804	1	2.804	3.679	.091[b]
	Residual	6.096	8	.762		
	Total	8.900	9			
a. Dependent Variable: Team Recognition						
b. Predictors: (Constant), Transformational Leadership						

Source (Field Data, 2024)

A linear regression was conducted to assess the relationship between transformational leadership and team recognition at health care facilities in chipili district. The results showed F-statistic (3.679) that evaluates the overall significance of the model. A p-value (Sig. = 0.091) which slightly exceeds the common threshold of 0.05, indicating that the relationship between Transformational Leadership and Team Recognition is not statistically significant.

Table 13 Standardized and Unstandardized coefficients on Team Recognition

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.346	.706		4.741	.001
	Transformational Leadership	-.519	.271	-.561	-1.918	.091

Source (Field Data, 2024)

The results above show that when Transformational Leadership is zero, the predicted level of Team Recognition is 3.346 (Constant). For every one-unit increase in Transformational Leadership, Team Recognition decreases by 0.519 units. While Standardized Beta (-0.561) Indicates a moderate negative relationship between the variables. The effect of Transformational Leadership on Team Recognition is not statistically significant (t-value =-1.918 and p-value =0.091)

Table 14 Regression analysis between Transformational Leadership and inclusive environment

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.196[a]	.038	-.082	.987
a. Predictors: (Constant), Transformational Leadership				

Source (Field Data, 2024)

The table above Indicates a (R=0.196) weak positive correlation between Transformational Leadership and Inclusive Environment. Only 3.8% of the variance in

Inclusive Environment is explained by Transformational Leadership. The adjusted R Square value (-0.082) confirms that the model has no meaningful predictive power.

ANOVA[a]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.312	1	.312	.320	.587[b]
	Residual	7.788	8	.974		
	Total	8.100	9			

a. Dependent Variable: Inclusive Environment b. Predictors: (Constant), Transformational Leadership

Source (Field Data, 2024)

The results above show the p-value (0.587) which is much greater than the threshold of 0.05, indicating that the relationship between transformational leadership and inclusive environment is not statistically significant.

Table 15 Inclusive environment and Transformational Leadership

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.115	.798		2.651	.029
	Transformational Leadership	-.173	.306	-.196	-.566	.587
a. Dependent Variable: Inclusive Environment						

Source (Field Data, 2024)

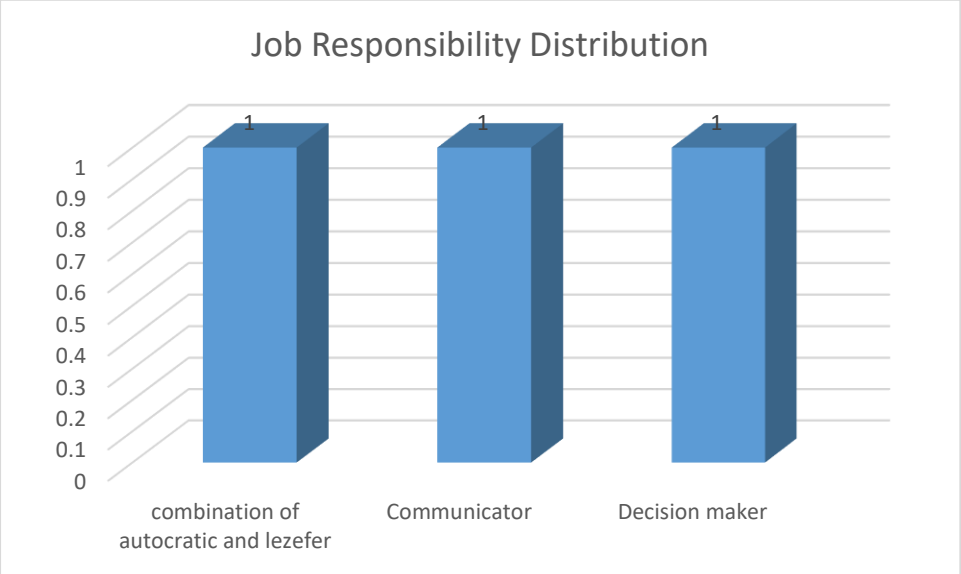
The predicted level of inclusive environment is at 2.115 when transformational leadership is at zero according to the table above. The transformational leadership coefficient (0.173) suggest a weak negative relationship which entails that for every one-unit increase in Transformational Leadership, the predicted value of Inclusive Environment decreases by 0.173 units. Standardized Beta (-0.196) shows that the effect of Transformational Leadership on Inclusive Environment is small and negative. There is lack of statistical significant (t-value -0.566 and p-value 0.587) of which the lack of statistical may suggest that the relationship may be by chance.

The findings that follow presents the findings from the analysis of the healthcare delivery data collected from facility In-charges and Departmental leads. The aim was to identify key themes and insights regarding job responsibilities, support strategies, and leadership styles in healthcare delivery in the district.

4.5 QUALITATIVE ANALYSIS OF LEADERSHIP PRACTICES, SUPPORT STRATEGIES AND JOB RESPONSIBILITIES AND SERVICE DELIVERY IN HEALTHCARE FACILITIES IN CHIPILI DISTRICT.

This analysis involved qualitative data, focusing on responses related to job responsibilities, strategies for supporting healthcare providers, and leadership practices. Visualizations were created to illustrate the distribution of these responses.

Figure 8 Job Responsibility Distribution



The graph shows the distribution of job responsibilities among the respondents in district. The roles identified include In- charge, General management of the facility and Manage HIV and TB programs, this indicates a diverse range of responsibilities among respondents in the district. The distribution highlights the most common role such as nurse in charge which may suggest a need for targeted training or resources for those individuals.

Figure 9 Support Strategies for Healthcare Providers

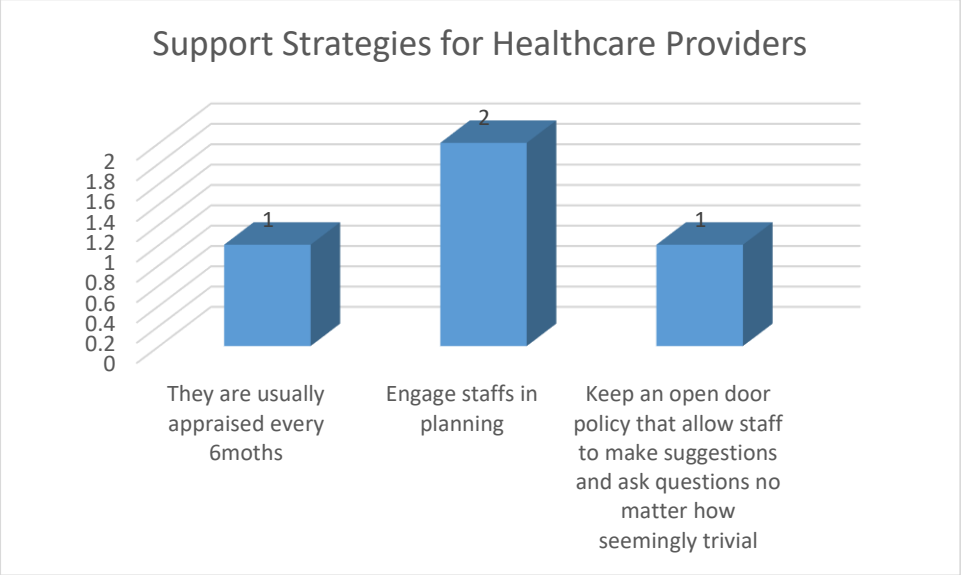


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Figure 9 illustrates the various strategies implemented to support healthcare providers. The Common strategies include engaging staff in planning, appraisal and marinating an open door policy for suggestions. The frequency of each strategy indicates which methods are most commonly used, in this case engaging staffs in planning is the most commonly used strategy. The frequencies provide an insight into the effectiveness of support systems and potential areas for improvement.

Figure 10 Leadership Styles Practices

The leadership styles practiced within the healthcare facility are depicted in this graph above. The leadership styles noted include communicative decision making and situational leadership reflecting a blend of approaches. The findings suggest that healthcare leaders employ a blend of leadership styles rather than relying on a singular approach, this indicates an emphasis on flexibility and responsiveness to dynamic healthcare challenges. The dominance of certain styles such as communicator and situational leadership highlights the importance of collaboration and adaptability in improving healthcare delivery and staff performance. Understanding the leadership styles can help in assessing the impact of leadership on organizational performance, healthcare delivery and staff performance/development.

Leadership implementation.

Leaders emphasize the use of multi-sector approaches and regular data review meetings to monitor and implement healthcare services effectively. These strategies reflect a commitment to evidence based decision making and fostering collaboration to improve service outcomes

Effective service delivery.

Responses highlight the importance of self-assessment and consistent division of staff to ensure effective healthcare delivery. These findings emphasize the critical role of self-assessment and the systematic allocation of responsibilities among staff to

enhance healthcare delivery by ensuring clear and consistent division of labor healthcare facilities can optimize service efficiency and maintain high standards of patient care.

Performance maximization policies.

Key strategies for enhancing performance include weekly performance reports and annual staff appraisal. These practices provide structured opportunities for monitoring progress, identifying gaps, and reinforcing accountability, and ultimately contributing to improved organizational performance and service delivery.

CHAPTER FIVE: DISCUSSION OF FINDINGS

5.1 WHAT ARE THE PREDOMINANT LEADERSHIP STYLES PRACTICED WITHIN HEALTH FACILITIES IN CHIPILI DISTRICT?

The analysis reveals a strong preference for transformational leadership among health facility leaders in Chipili District. Most leaders expressed agreement with its core principles, such as inspiring and motivating teams, fostering a positive work climate, and challenging existing practices (Figure 4). This is further supported by the strong endorsement of inspirational motivation (Figure 5), indicating that leaders prioritize instilling a shared sense of purpose and direction, which is critical for employee engagement and commitment.

However, responses regarding intellectual stimulation (Figure 6) were mixed. While many leaders recognized its importance, a significant proportion expressed indifference or disagreement, suggesting a gap in understanding its role in transformational leadership. This divergence may reflect varying organizational cultures or resource constraints within the district. The strong consensus on behavioural role modelling as stipulated in Figure 7 highlights leaders' awareness of the importance of leading by example to promote desired organizational values.

While transformational leadership is prevalent, the mixed responses on intellectual stimulation indicate a need for targeted training to enhance leaders' understanding of its role in fostering innovation. This finding aligns with the study's objective of identifying and classifying leadership styles, providing new insights into the challenges of implementing transformational leadership in resource-constrained settings.

5.2 HOW DO DIFFERENT LEADERSHIP STYLES INFLUENCE PATIENT OUTCOMES (E.G., QUALITY OF CARE, PATIENT SATISFACTION) AND STAFF SATISFACTION SUCH AS JOB SATISFACTION, MOTIVATION IN HEALTH FACILITIES IN CHIPILI DISTRICT?

The correlation analysis shows a moderate positive relationship between leadership effectiveness and service efficiency, suggesting that effective leadership enhances

healthcare delivery. However, the moderate strength of this relationship implies that other factors, such as resource availability or staff training, also play a role. Transformational leadership showed a weak, non-significant relationship with staff development, indicating that it may not be a primary driver of employee growth in this context.

Ethical leadership, while important for organizational culture, did not significantly impact service efficiency, as revealed by ANOVA analysis. Similarly, inclusive environments and diversity promotion had no direct effect on ethical decision-making. These findings suggest that while ethical and inclusive practices are valuable, their impact on operational outcomes may be indirect or context-dependent.

The study highlights the importance of effective leadership in improving service efficiency, addressing the objective of assessing leadership impact on patient outcomes and staff satisfaction. The findings suggest that leaders should complement transformational practices with targeted staff development initiatives and consider contextual factors that influence healthcare delivery.

5.3 WHAT IS THE RELATIONSHIP BETWEEN THE EDUCATIONAL QUALIFICATIONS OF MANAGEMENT PERSONNEL AND THE EFFECTIVENESS OF THEIR MANAGEMENT APPROACHES IN IMPROVING HEALTHCARE DELIVERY?

The findings indicate that most management personnel in Chipili District hold diplomas or degrees, reflecting a workforce with intermediate to higher educational qualifications as shown in figure 3. This suggests that such qualifications are beneficial for roles requiring specialized skills and management capabilities. However, a small proportion of staff with only secondary education may require further training to enhance their skills and career prospects.

The study fulfils its objective of exploring the relationship between educational qualifications and management effectiveness. The findings suggest that while the current workforce is well-suited for mid- to high-level roles, institutions should invest in professional development programs, such as tuition reimbursement or bursaries, to support staff in pursuing higher qualifications.

5.4 WHAT IS THE RELATIONSHIP BETWEEN LEADERSHIP STYLES AND ORGANIZATIONAL CULTURE IN HEALTH FACILITIES IN CHIPILI DISTRICT, AND HOW DO LEADERSHIP PRACTICES SHAPE STAFF BEHAVIOURS AND WORKPLACE NORMS?

The Chi-square test revealed a significant association between diversity-inclusive leadership and organizational culture ($\chi^2 = 62.585$, $p < .001$), indicating that leaders who prioritize diversity foster a more inclusive and collaborative work environment. Principal Component Analysis (PCA) further confirmed the strong interrelationship between team recognition, inclusive environments, and diversity promotion, with a single dominant factor explaining 84.978% of the variance.

However, the relationship between transformational leadership and specific cultural elements, such as team recognition and inclusivity, was more nuanced. While a moderate positive correlation was observed with team recognition ($R = 0.561$), it was not statistically significant ($p = .091$). Similarly, the correlation with inclusivity was weak and non-significant ($R = 0.196$, $p = .587$), suggesting that transformational leadership alone may be insufficient to foster a truly inclusive environment.

The study addresses its objective of exploring the relationship between leadership styles and organizational culture. The findings highlight the importance of diversity-inclusive leadership in shaping organizational culture but suggest that additional interventions, such as targeted policies and structural changes, are needed to enhance inclusivity and team recognition.

5.5 EXPLORING LEADERSHIP, SUPPORT STRATEGIES, AND PERFORMANCE OPTIMIZATION IN HEALTHCARE DELIVERY: INSIGHTS FROM KEY INFORMANTS IN CHIPILI DISTRICT.

Analysis of job responsibilities within Chipili District's healthcare facilities (Figure 8) reveals a clear division of labour, with several key roles emerging as central to facility

operations. The most prevalent positions include facility In-charges, general facility managers, and those responsible for overseeing specialized programs, notably HIV and TB care. This distribution suggests a structured organizational framework within the district's healthcare system, designed to address diverse healthcare needs

Key informants shared their perspectives on the diverse responsibilities they manage

One In-charge nurse described the dual nature of their role: "As the nurse in charge, my responsibilities extend beyond managing patient care to overseeing administrative tasks at the clinic. The duality of my responsibility tends to lead to being stretched thin thus find myself in need of more support most especially with regards to administrative tasks." This quote highlights a critical challenge: the burden of administrative duties on clinical staff. This conflation of clinical and administrative responsibilities may detract from patient care and contribute to staff burnout. This suggests a potential need for dedicated administrative support within these facilities to allow clinical staff to focus on their core competencies."

HIV/TB Program Manager: "*Managing both HIV and TB programs requires constant coordination with both staff and external partners. The significance of the burden with regards to administration in the aforementioned programs can be jarring hence it would be more useful to have more hands with regards to assistance*."

The prominence of the nurse in charge role in the district reflects the critical role these professionals play in day-to-day operations. The widespread involvement of nurses and healthcare providers in managerial and administrative tasks underlines a need for targeted training to balance clinical and managerial responsibilities effectively.

The qualitative data also provides insights into the various strategies used to support healthcare providers, as depicted in Figure 9. Maintaining an open door policy, staff appraisals as well as the inclusivity of staff in planning are some of the highlighted strategies.

A common theme was the importance of staff involvement in decision-making, as expressed by several respondents:

Departmental Lead: "Engaging the staff in planning and decision-making has been crucial. It helps them feel valued and more invested in the success of the facility. We can gather their feedback and ensure we're meeting their needs as well."

Facility In-charge: *"I always encourage an open-door policy where my team can come to me with any concerns or suggestions. This creates a transparent work environment and helps build trust*."

Staff engagement and the open door policy were responses of high frequency which evidently showcases their essentiality towards fostering a collaborative and positive work environment. The aforementioned strategy likely contributes towards staff morale and could be better expanded via formal training programs to provide a continual professional development.

Figure 10 illustrates as to how the leadership strategies are adaptive with leaders using different approaches dependent on the context and challenges faced in the district. Furthermore, the leadership styles observed within the district are diverse, reflecting a blend of communicative decision-making and situational leadership

Several key informants emphasized their leadership approaches:

Facility In-charge: "*I tend to adopt a communicative decision-making approach, involving the team in discussions about changes or challenges we are facing. It's important to ensure that everyone is on the same page and feels heard.*"

Departmental Lead: "*Situational leadership is key here. I try to adapt my approach based on what each situation requires whether it's offering direct guidance or empowering the team to take charge of certain decisions*."

The responses from some of the managers highlight an emphasis on flexibility in management and leadership within the district. Adaption management and leadership styles to the specific needs of the moment usually is particularly vital in healthcare settings, where emergency situations and staff dynamics can diverge greatly. The combination of communicative decision-making and situational leadership provides a strong foundation for collaboration, staff development, and improved patient care.

Leadership within the district focuses heavily on multi-sector approaches and the use of data-driven strategies to ensure effective service delivery. Key informants elaborated on the role of data reviews and collaborative approaches in guiding decision-making:

Facility In-charge: "*We hold regular data review meetings where we analyse our performance and discuss any gaps in service delivery. This helps us to be proactive rather than reactive in our approach*."

Departmental Lead: "*A multi-sector approach allows us to integrate feedback from different departments. It's a powerful way to ensure that we address the broader needs of our healthcare delivery model*."

The emphasis on data-driven decision-making and multi-sector collaboration underscores the importance of evidence-based management. This enables facility leaders to address performance gaps and optimize healthcare services by bringing together insights from various sectors and making informed decisions based on regular data assessments.

Key findings from the qualitative data highlighted the importance of self-assessment and a clear division of responsibilities in ensuring effective service delivery. Informants stressed the role of both structured performance reviews and the systematic allocation of duties among staff:

Facility In-charge: "*We conduct self-assessments regularly to evaluate our services and identify areas for improvement. Ensuring that everyone has clear responsibilities is also crucial to avoid overlaps and ensure tasks are completed efficiently*."

Departmental Lead: *"I think the systematic division of labour is important to prevent confusion. Each staff member must know their role and what they're responsible for to maintain smooth operations*."

These findings suggest that clear role definitions and self-assessment are vital for ensuring that healthcare facilities operate efficiently, delivering high-quality care consistently.

Chipili District's healthcare system implements essential performance maximization measures such as weekly performance reports and annual staff reviews, which respondents consistently identified as critical instruments for increasing organizational performance. The frequency of performance evaluations ensures that both employees and leaders receive regular feedback, fostering accountability and ongoing growth.

Departmental Lead: "*The weekly reports help us stay on track. It's an opportunity for us to evaluate performance and make adjustments before issues escalate*."

Facility In-charge: "*Annual staff appraisals are essential to assess individual progress and set goals for the future. They help keep everyone focused and accountable*."

The use of regular performance reviews emphasizes the need of establishing a structured feedback loop in the healthcare system. These assessments provide vital insights into employee development, identify areas for improvement, and ensure that everyone is on the same page with the organization's goals.

In a nutshell, the findings emphasize the necessity of a diverse workforce and effective support mechanisms in improving healthcare delivery. Healthcare providers' performance is heavily influenced by their leadership styles. The analysis provides important insights into the dynamics of healthcare delivery.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

This study analysed leadership and management practices in healthcare facilities in Chipili District and their impact on service delivery. Findings revealed a mix of leadership styles such as transformational, transactional, and situational being used across the district. However, their effectiveness in achieving key outcomes, such as staff development and service efficiency, was inconsistent. For example, while transformational leadership showed potential for improving organizational culture, its impact on staff development and overall performance was limited. This highlights the need for targeted leadership interventions tailored to Chipili District's specific context.

The study also identified gaps in applying leadership principles, particularly in ethical decision-making, diversity inclusion, and staff development. These gaps underscore the importance of adopting a more holistic approach to leadership that addresses both organizational and human resource challenges. For instance, the lack of robust staff development programs hindered the potential benefits of transformational leadership, suggesting that leadership effectiveness is closely tied to training and career advancement opportunities.

In conclusion, while healthcare management and leadership in Chipili District align with some best practices, significant improvements are needed. Strengthening leadership through targeted training, inclusive policies, data-driven decision-making, and staff development could enhance service delivery, foster a positive organizational culture, and improve patient outcomes.

6.2 RECOMMENDATIONS

6.2.1 Enhance Leadership Development Programs

Given the limited impact of transformational leadership on staff development, healthcare managers in Chipili District should undergo continuous leadership training. Programs should adapt transformational leadership models to the local context, emphasizing individualized consideration, intellectual stimulation, and inspirational motivation. For example, workshops could help leaders apply these principles in resource-constrained settings.

6.2.2 Improve Staff Development and Training Initiatives

The reliance on non-qualified personnel, such as Safe Motherhood Action Groups (SMAGs) and Community Daily Employees (CDEs), highlights the need for robust staff development programs. Leadership should prioritize formal training for these groups in basic medical procedures, administrative tasks, and patient care. Additionally, mentorship programs and career advancement opportunities should be established to retain qualified staff and reduce turnover.

6.2.3 Strengthen Diversity and Inclusion Leadership

To create a more inclusive work environment, healthcare leaders should implement policies promoting diversity and cultural competence. Workshops and training sessions could address biases related to gender, ethnicity, and background. For example, diversity committees could ensure all employees feel valued and respected, improving morale and collaboration. With regards to policies could result to creation of an environment in which each employee feels valued and respected irrespective of their gender, ethnicity or background. Workshops and trainings targeting the aforementioned could help promote cultural competence among healthcare staff.

6.2.4 Focus on Ethical Decision-Making and Transparency

Gaps in ethical decision-making undermine trust and morale. Leaders should undergo training in ethical decision-making frameworks and conflict resolution. Clear protocols for ethical decision-making and transparency should be established, such as regular audits and open forums, to ensure decisions align with patient and system interests.

6.2.5 Communication Improvement and Staff Engagement

Effective communication is essential for a positive organizational culture. Managers should adopt strategies like regular team meetings, anonymous feedback systems, and leadership training in active listening. These measures would ensure all staff, regardless of position or education, feel valued and heard, improving morale and service delivery.

6.3 STUDY LIMITATIONS

While the study investigating the management and leadership styles that are predominant in improving patient care and service delivery, there were certain hurdles that made it challenging to go beyond actualization of the study.

Geographical Location

The lack of tarred roads in Chipili District made accessing some facilities difficult, causing delays in distributing and collecting questionnaires. This may have limited the sample's representativeness and the findings' generalizability, as remote facilities may face unique leadership challenges not fully captured.

Language Barrier

Despite respondents having middle to higher education levels, some struggled with the questionnaire due to language barriers. Additional explanations may have introduced bias or misinterpretation, potentially compromising data accuracy on leadership styles and their impact.

Limited Scope of Independent variables

The study focused on specific variables, such as staff motivation and capacity building, but did not explore others like technological support, workload, and employee autonomy. This limited scope may have restricted the analysis's depth and broader applicability.

6.4 SUGESSTIONS FOR FURTHER STUDY

Future studies could be to;

1. Adapt leadership models to local contexts, addressing cultural and resource constraints in rural healthcare.
2. Explore additional variables, such as technological support and workload, to better understand leadership effectiveness.
3. Develop innovative data collection methods, like mobile-based surveys in local languages, to overcome geographical and language barriers.

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APPENDIX I: INFORMATION SHEET

Hello. My name Martin Bambala Chiposa. I am a student at the University of Lusaka pursuing a Master of Science in Project Management. I am currently working on a research project aimed at Identifying Effective Management and Leadership Styles to Optimize Institutional Performance and Healthcare delivery in healthcare Facilities in Chipili District, Luapula Province, Zambia.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information, and I will take time to explain. If you have questions later, you can ask them to me. Please also be informed that there is no direct benefit to your participation in the study. However, the information you will provide insights and experiences that are essential for assessing how these leadership approaches impact organizational culture, staff satisfaction, and service delivery

Confidentiality:

The information collected will be used purely for academic purposes and it will be kept confidential. The study will only link you individually to what you will say if you give consent.

Additional information

If you have any questions about the study please feel free to contact me at 0976313090 or 0956960196 or email: chiposamartin@gmail.com

Consent

Participation in the study is voluntary. Please take your time to decide whether or not you would like to participate. If you decide to participate, please note that you are free to withdraw at any time.

Do you wish to participate in the study?

Yes [ ] **No [ ]**

Respondent's Signature **Date**

UNIVERSITY OF LUSAKA

SCHOOL OF POSTGRADUATE STUDIES

Plot No. 37413, Off Alick Nkhata Mass Media. P. O Box 36711, Lusaka.

Phone: +260211258505, 258409 Fax +260211233409; Cell +260976075850,961917862,

E-mail:unilus@zamnet.zm,ictar@zamnet.zm

UNILUS-RESEARCH ETHICS COMMITTEE

Ref no: FWA00033228-4210/24
Date: 25th October 2024

STUDENT NAME: Martin bambala chiposa

Identifying Effective Leadership Styles to Optimize Organizational Performance and healthcare delivery at health facilities in Chipili District

The above research was submitted to the research ethics committee for review. The study has no major ethical problems and is approved subject to the following:

1. The study cannot be changed without express permission of the UNILUS research ethics committee.
2. Approval from the necessary authority should be sought.

The committee wishes you success in your work.

Professor Kasonde Bowa

MSc(Glasgow),M.Med(UNZA),FRCS(Glasgow),FACS,FCS,DPH(LSTMH),MPH(UCL)

Chairman- UNILUS REC
Professor of Urology and Consultant Urologist

UNIVERSITY of LUSAKA
Passion for Quality Education: Our Driving Force

Plot No. 37413, Off Alick Nkhata Mass Media, P.O. Box 36711, Lusaka, Zambia.
Phone: **+260211258505 / +26021126994** | Email: **info@unilus.ac.zm** | Website: **www.unilus.ac.zm**

All correspondence should be addressed to the Vice Chancellor

Monday, October 14, 2024.

To whom it may concern,

Dear Sir/Madam,

RE: DATA COLLECTION-MARTIN BAMBALA CHIPOSA

This serves to confirm that **Mr. Martin Bambala Chiposa** student number **MSCPM23119834** is a registered student of the University of Lusaka pursuing a **Master of Science in Project Management** two Year Masters program currently in his **4th semester** of study.

The student is seeking data to enable him write a mandatory dissertation for the award of his degree. Kindly assist with the data he needs in line with his research title to enable him finish in time for submission. A copy of the full dissertation can be availed to you at your request.

Any assistance rendered to him will be highly appreciated.
Yours faithfully,

Mwamba Chanda (Mr.)

DEPUTY REGISTRAR

UNIVERSITY OF LUSAKA
REGISTRAR POSTGRADUATE
14 OCT 2024
P.O. BOX 36711,
LUSAKA.

APPENDIX 2: CONSENT FORM FOR PARTICIPATION IN RESEARCH

TITLE: IDENTIFYING EFFECTIVE MANAGEMENT AND LEADERSHIP STYLES TO OPTIMIZE INSATITUTIONAL PERFORMANCE AND HEALTHCARE DELIVERY AT HEALTH FACILITIES IN CHIPILI DISTRICT.

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

1. Details of procedures and any risks have been explained to my satisfaction.
2. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

I understand that:

- I may not directly benefit from taking part in this research and I am free to withdraw from the project at any time.
- While the information gained in this study will be published, I will not be identified, and individual information will remain confidential.
- Whether I participate or not, or withdraw after participating, will have no effect on my execution of duties.
- I may ask that the recording/observation be stopped at any time, and I may withdraw at any time from the session or the research without disadvantage.
- I agree to the tape recording being made available only to the research team.

What does your signature on this consent form mean?

Your signature on this consent form means:

- You have been informed about this study and the ethical conditions under which you will take part.

- You have agreed to participate in this study voluntarily and will provide the required information adequately.

Participant's Statement of Informed Consent:

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

_____

Print name of participant

_____

Print name of person obtaining consent

Date: _____

Signature of participant: _____

Date: _____

Signature of Person Obtaining Consent: _____

I certify that I have explained the study to the volunteer and consider that they understand what is involved and freely consent to participation.

Researcher's name: _____

Signature: _____

RESEARCH TOOLS

IDENTIFYING EFFECTIVE MANAGEMENT AND LEADERSHIP STYLES TO OPTIMIZE INSATITUTIONAL PERFORMANCE AND HEALTHCARE DELIVERY AT HEALTH FACILITIES IN CHIPILI DISTRICT.

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

INSTRUCTIONS;

1. Please do not write your name on this questionnaire

2. The questionnaire is divided into parts;

Part 1 is on the demographic information for participants and the Second Part that focuses on the objectives of the research that will consist of four (4) sections.

3. You are required to rate yourself on how frequently each statement fits you

4. All questions may be answered.

5. Tick or circle the most appropriate answer from the options provided

PART 1 - DEMOGRAPHIC INFORMATION

1. What is your gender?

o Female

o Male

2. What is your age?

o 18 to 24

o 25 to 34

o 35 to 44

o 45 to 54

o 55 to 64

o Above 65

3. What is the highest level of school you have completed?

o Secondary school

o Some college with a certificate

o Diploma

o Bachelor degree

o Post graduate degree

o Other (specify)

Objective 1: Identify and classify the predominant Management and leadership styles practiced within health facilities in Chipili District.

1. I make others feel good to be around me.
   - Strongly Disagree
   - Disagree
   - Neither Agree nor Disagree
   - Agree
   - Strongly Agree

2. I enable others to look at existing problems in new ways
   - Strongly Disagree
   - Disagree
   - Neither Agree nor Disagree

- Agree
- Strongly Agree

3. I help others develop themselves.
   - Strongly Disagree
   - Disagree
   - Neither Agree nor Disagree
   - Agree
   - Strongly Agree
4. I talk optimistically about the future of the Health Facility.
   - Strongly Disagree
   - Disagree
   - Neither Agree nor Disagree
   - Agree
   - Strongly Agree
5. My subordinates have complete faith in me.
   - Strongly Disagree
   - Disagree
   - Neither Agree nor Disagree
   - Agree
   - Strongly Agree
6. I model what should be done.
   - Strongly Disagree
   - Disagree
   - Neither Agree nor Disagree

- Agree
- Strongly Agree

7. I help others find meaning in their work.
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
8. I adapt my leadership style to meet the needs of my team.
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
9. I actively seek feedback to improve my leadership approach
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree

Objective 2: Assess the impact of various Management and Leadership styles on the performance of health facilities, focusing on patient outcomes and staff satisfaction.

10. I provide rewards for workers who work hard toward institutional goals

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

11. I demonstrate a high degree of confidence in subordinates' ability to achieve challenging goals

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

12. I increase others' willingness to try harder.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

13. I motivate others to exceed their own expectations.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

14. I recognize and celebrate the achievements of my team.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

15. I prioritize the professional development of my team.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

16. I encourage innovative solutions to improve healthcare delivery.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

Objective 3: Ascertain how the identified Management and Leadership practices affect service delivery in health facilities in Chipili District.

17. I consider the moral and ethical consequences of decisions made at my Health Facility.

- Strongly Disagree
- Disagree

- Neither Agree nor Disagree
- Agree
- Strongly Agree

18. I ensure workers maintain high standards in their work.
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
19. I articulate a vision for the future development of the Health Facility.
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
20. I work with others in a satisfactory way.

Strongly Disagree

- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

21. I help others rethink ideas they had never questioned before.
    - Strongly Disagree
    - Disagree

- Neither Agree nor Disagree
- Agree
- Strongly Agree

22. I help others to enjoy their work.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

Objective 4: Explore the relationship between Management and Leadership styles and organizational culture within health facilities

23. I create an inclusive environment where everyone's voice is heard.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

24. I go beyond self-interest for the good of the institution

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

25. I recognize and celebrate achievements of my team.

- Strongly Disagree

- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

26. I often interact with employees at the Health Facility
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
27. I increase others' willingness to try harder
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
28. I promote a culture of accountability among team members
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
29. I prioritize ethical behaviour in all decisions made at the Health Facility.
    - Strongly Disagree

- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

30. I create an inclusive environment where everyone’s voice is heard.
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
31. I actively promote diversity and inclusion in my team.
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree

IDENTIFYING EFFECTIVE MANAGEMENT AND LEADERSHIP STYLES TO OPTIMIZE INSATITUTIONAL PERFORMANCE AND HEALTHCARE DELIVERY AT HEALTH FACILITIES IN CHIPILI DISTRICT.

MULTIFACTOR LEADERSHIP QUESTIONNAIRE (MLQ) (Bernard M. Bass & Bruce J. Avolio (1996, 2002) QUESTIONNAIRE FOR HEALTHCARE PROVIDERS INSTRUCTIONS;

1. Please do not write your name on this questionnaire

2. This questionnaire is divided in two parts;

Part 1 is on the demographic information for participants and the Second Part that focuses on the objectives of the study that will consist of four (4) sections.

Leadership rating information.

3. You are required to rate yourself on how frequently each statement fits you

4. All questions may be answered.

5. Tick or circle the most appropriate answer from the options provided

PART 1 - DEMOGRAPHIC INFORMATION

1. What is your gender?

o Female

o Male

2. What is your age?

o 18 to 24

o 25 to 34

o 35 to 44

o 45 to 54

o 55 to 64

o Above 65

4. What is the highest level of school you have completed?

o Secondary school

o Some college with a certificate

o Diploma

o Bachelor degree

o Post graduate degree

o Other (specify)

Objective 1: Identify and classify the predominant Management and Leadership styles practiced within health facilities in Chipili District.

4. Talks optimistically about the future.

- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

5. Articulates a vision of future opportunities.

- o Strongly Disagree

- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

6. Serves as a role model
   - Strongly Disagree
   - Disagree
   - Neither Agree nor Disagree
   - Agree
   - Strongly Agree

7. Demonstrates strong conviction in beliefs and values
   - Strongly Disagree
   - Disagree
   - Neither Agree nor Disagree
   - Agree
   - Strongly Agree

5. My subordinates have complete faith in me.
   - Strongly Disagree
   - Disagree
   - Neither Agree nor Disagree
   - Agree
   - Strongly Agree

6. I model what should be done.
   - Strongly Disagree

- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

7. Demonstrates strong conviction in beliefs and values
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree

Objective 2: Assess the impact of various Management and Leadership styles on the performance of health facilities, focusing on patient outcomes and staff satisfaction.

8. Treats me as an individual rather than just a member of the group
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree

9. Listens to my concerns
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree

- Agree
- Strongly Agree

10. Offers special rewards for good work.
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
11. Helps others to develop their strengths.
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
12. Gets others to do more than they expected to do.
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
13. Instils pride in being associated with him/her
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree

- Agree
- Strongly Agree

Objective 3: Ascertain how the identified Management and Leadership practices affect service delivery in health facilities in Chipili District.

14. Is alert for failure to meet standards
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
15. Demonstrates how to look at problems from new angles
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree
16. Engages in actions that enhance the image of competence
    - Strongly Disagree
    - Disagree
    - Neither Agree nor Disagree
    - Agree
    - Strongly Agree

17. My leader is very effective when it comes to providing support for service delivery to patients

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

18. To what extent do you agree that leadership directly impacts the efficiency of service delivery?

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

Objective 4: Explore the relationship between Management and Leadership styles and organizational culture within health facilities

19. Considers the moral and ethical consequences of decisions

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

20. Displays extraordinary talents and competence.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

21. How would you describe the culture of your health facility?

- Very Negative
- Negative
- Neither Negative nor Positive
- Very Positive
- Positive

22. My leader fosters an environment that values diversity and inclusion.

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

KEY INFORMANT INTERVIEW SCHEDULE FOR THE FACILITY IN-CHARGES AND DEPARTMENTAL LEADS

Facilitator Introduction: I am Martin Chiposa, I am a student at the University of Lusaka. I am currently pursuing a Master's degree in Project Management. This questionnaire is intending to gather information on the presence identification of Management and Leadership styles that influence healthcare and service delivery in Healthcare Facilities in Chipili District. The information being gathered will be treated as confidential and used solely for academic purposes and not otherwise. Please respond correctly to enable the researcher to attain the intended objectives. Your assistance is highly appreciated for the success of this research study.

Do not write your name since identity is not required. Communicate to phone number 0976313090 or 0956960196 if you have doubts/ would like to get further clarification. Please kindly provide a prompt explanation applicable to the empty spaces provided.

SECTION A: GENERAL INFORMATION

1. Position held ……

2. Job responsibility …….

3. Length in service …….

SECTION B: EXPERIENCE

4. What strategies have you put in place to ensure that :

a. The healthcare providers receive the support

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b. There are effective healthcare delivery services in your Healthcare Facility

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5. Who is involved in strategizing the Healthcare Facility plans?

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6. How do you as a leader ensure that healthcare delivery services are well implemented in your Healthcare Facility?

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7. From your experience, what things if any make it difficult for you not to ensure healthcare providers receive the needed support in the delivery of services in wards and other departments?

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8. What things if any enable you to ensure healthcare delivery services are well done in wards and other departments?

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SECTION C: PRACTICE

9. Who do you directly supervise among your subordinates?

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10. How is this supervision done?

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11. What local policies (if any) have you come up with at your hospital to prevent poor healthcare delivery services?

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12. What policies have you put in place to maximize performance by the Healthcare Providers?

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13. What leadership role do you play in the day to day healthcare delivery service at your Healthcare Facility?

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SECTION D: AWARENESS

14. What type of leadership do you think you particularly practice at your Healthcare Facility?

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15. In what ways do you think your leadership influences the way healthcare providers perform in their day to day delivery of healthcare services?

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16. What comments (if any) do you get on your leadership style from your subordinates?

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SECTION E; OPINION

17. a. In your own view, does your Management and leadership at various levels in your Healthcare Facility influence healthcare providers and how delivery services are implemented?

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b. Give reasons for your answer pointing out specific practices that influence healthcare providers in their healthcare delivery services?

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Report #24476225

School of Postgraduate Studies Title of the Research Project: Identifying Effective Management and Leadership Styles to Optimize Institutional Performance and healthcare delivery at health facilities in Chipili District.

3 6 7 18 22 A DISSERTATION SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, UNIVERSITY OF LUSAKA IN PARTIAL FULFILLMENT OF THE AWARD OF MASTER OF SCIENCE IN PROJECT MANAGEMENT (MSCPM) Student Name: MARTIN BAMABALA CHIPOSA Student number: MSCPM231198342024

@January 2025 DECLA

RATION PAGE I MARTIN BAMBALA CHIPOSA hereby verify that this scholarly thesi s represents my original contribution, and all References, both published and unpublished, have been duly acknowledged in the designated reference section.

Au thors Signature: _____ Date: 31 st December 2024

Supervisor's Signature: _____ Date: December 2 024 i ii DEDICATION Th

is work is dedicated to the memory and legacy of my Da d (Michael Chiposa Snr). iii iv ACKNOWLEGMENT My thanks go to the Lord Almighty through his Son Jesus Christ who have guided me through the entirety of the study. I also express my profound gratitude to Mr. Charles Kapeleke Chileya, my dedicated and supportive supervisor from the University of Lusaka, School of Postgraduate Studies. Hi