UNIVERSITY OF CAPE COAST

PERCEPTIONS OF FAIRNESS OF PERFORMANCE APPRAISAL AND ORGANIZATIONAL COMMITMENT AMONG EMPLOYEES OF GHANA HEALTH SERVICE IN CAPE COAST AND HO

BY

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Thesis submitted to the Department of Population and Health of the College of Humanities and Legal Studies, University of Cape Coast, in partial fulfillment of the requirements for the award of Doctor of Philosophy degree in Population and Health

MARCH, 2017

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DECLARATION

Candidate's declaration

I hereby declare that the thesis is the result of my original work and that no part of it has been presented for another degree in this university or elsewhere

Candidate's name: David Korku Kwamifoli

Signature……………………….Date………………………………….

Supervisors' declaration

We hereby declare that the preparation and presentation of this thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast

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ABSTRACT

In 2003, Ghana Health Service (GHS) introduced an appraisal system with the aim of improving performance of its employees and also link both individual and organizational performances to achieving critical health targets. Using performance indicators, this thesis assessed the perception of selected health workers on performance appraisal in GHS and its implications for organizational commitment and achievement of the three health related Millennium Development Goals (MDGs). Data were collected from 519 employees of Ghana Health Service (GHS) at the Cape Coast and Ho in Ghana. It involved those who had participated in performance appraisal and whose job performance directly or indirectly relate to the appraisal of other people.

The results indicated that when employees perceived their appraisal to be fair, it had positive consequences on perception of their commitment. Education and age could predict perception of fairness, while age and gross salary had the propensity to promote hard work and employee retention. Performance targets of some health workers were not linked to institutional goals on critical health targets including MDGs. Results revealed that appraisal was mainly for promotion to the neglect of personal and institutional development. The GHS may need to re-examine its appraisal system by involving peers, subordinates and supervisor as part of the evaluation process as well as ensuring that the performance targets of their employees are related to key organizational goals.

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KEY WORDS:

Organizational justice

Organizational commitment

Perception of fairness

Millennium Development Goals

Ghana Health Service

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DEDICATION

To my wife, Evelyn Nukunu and my chidren, Dela Kwamifoli, Selinam Kwamifoli and Etiam Kwamifoli

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BARS	Behaviourally Anchored Rating Scale
BOS	Behaviourally Observed Scale
CBR	Crude Birth Rate
CDR	Crude Death Rate
CFA	Confirmatory Factor Analysis
CSPIP	Civil Service Performance Improvement Programme
CSRP	Civil Service Reform Programme
CSU	Client Service Unit
FR	Fertility Rate
GDP	Gross Domestic Product
GDHS	Ghana Demographic Health Survey
GHS	Ghana Health Service
GOG	Government of Ghana
GSS	Ghana Statistical Service
HND	Higher National Diploma
HR	Human Resource
HIV	Human Immuno Virus
IGCME	Interagency Group Child Mortality Estimation
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPAT	Institutional Performance Assessment Tool
ITN	Insecticide Treated Net
JHS	Junior High School

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KMO	Kaiser-Meyer-Olklin
MBO	Management by Objective
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MSLC	Middle School Leaving Certificate
MSS	Mixed Standard Scale
MOH	Ministry of Health
MSS	Mixed Standard Scale
NDPC	National Development Planning Commission
NMR	Neonatal Mortality Rate
OECD	Organization for Economic Cooperation and Development
OHCS	Office of the Head of Civil Service
PIF	Performance Improvement Facility
PIP	Performance Improvement Plans
PNDC	Provisional National Defence Council
QHP	Quality Health Partners
SAP	Structural Adjustment Programme
SHS	Senior High School
SPSS	Statistical Product for Service Solution
SSCE	Senior Secondary Certificate Examination
TB	Tuberculosis
UCC	University of Cape Coast
UFMR	Under Five Mortality Rate
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

Background to the Study

The focus of every health care organisation is to prevent, cure or promote health in various combinations. Whichever way the focus is, managing performance is an important and critical activity that managers must undertake (Joinson, 2001). This is because the performance of employees can be directly linked to the performance of the organization (Dobre, 2013).

The sustainability of an organization can also be directly linked to continual improvement of individual and organizational performance (Coelho and Moy, 2003). As a result, organizations have developed systems meant to improve performance of employees and to ensure those employees achieve agreed objectives. Health care organizations, dedicated to ensuring employees are performing well on their jobs are found to be high performing organizations (Dobre, 2013).

Central to performance management of employees is appraisal, which is the systematic and a formal process through which an employee's job performance is assessed (Brown & Benson, 2010). This can be done through subordinates, supervisors, peers or even customers by means of effective monitoring and feedback (Gabris & Ihrke, 2001; Erdogan, 2002). The intention is to enable the employees develop their capabilities to enhance performance, form basis to distribute rewards and take developmental and administrative decisions (Murphy & Cleveland, 1991; Cardy & Dobbins, 1994; Lansbury & Bamber, 1998; Fletcher, 2001; Griffin & Ebert, 2002). It is also used to provide information relating to strengths and weaknesses of

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employees, which can be corrected through training and capacity development to improve individual and organizational performance (DeNisi, 2008).

According to Shearer (2006), appraisal system is effective when workers are motivated through appreciation and recognition, providing an enabling working environment, establishing cordial relationships and offering rewards (monetary and others) and feedback (Mucha, 2009). It also provides mechanisms for accountability, identification of roles of individuals and the process for analyzing and reviewing performance to enhance improvement. One of the most important factors in maintaining an effective performance appraisal is defining the purpose which may cover compensation, career planning, documentation of staffing changes, work load evaluation, counseling and development and training (Varma, Budwar & DiNisi, 2008).

It is argued that the effectiveness of any performance appraisal system depends largely on the attitudes and behaviours of individuals who are involved in the appraisal system (De Waal, 2003). These are classified into attitude and behaviour of employees on the job and the role of supervisors in communicating and providing feedback to subordinates when the job is being done. Evaluation of performance of employees is commonly done through rating or ranking using crireria-based measurement (Mondy, 2008). The criteria may be based on results or the behaviour of the employee. The behavioural criteria identifies a set of behaviours that are associated with an expected performance. On the other hand the results criteria predetermines specific outcomes that are expected to be achieved on the job (Milkovich & Newman, 2010).

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Performance appraisal was reported to have formally begun in the early 17th century when Robert Owen used silent monitors to evaluate the performance of employees in a cotton mill in Scotland (Wren, 1994). During the 1960s and 1970s, the focus of research of performance appraisal was on improving psychometric characteristic of the appraisal instrument and training for raters. This was to reduce subjectivity, rating errors and halo effect, thereby improving accuracy of the raters. This led to the development of a number of appraisal formats such as Behaviourally Observed Scale (BOS), Behaviourally Anchored Rating Scale (BARS) and Mixed Standard Scale (MSS) (Chakraborty, Hu & Cui, 2008).

Lardy and Farr (1980) set the tone in redirecting the interest of research to the role of the rater. This area dominated research in the 1980s and early 1990s and drew heavily on cognitive characteristics of the appraiser. However, it concentrated on the use of students as subjects in the laboratory setting such that there was a wide gap between research and practice. This, nonetheless, informed researchers and led to the shifting of attention to the field setting and built upon the body of knowledge already existing from laboratory setting.

In spite of the efforts in addressing accuracy and cognitive properties of the rater, the performance appraisal system consistently failed to ensure effectiveness and efficiency and contended that the ratee's input and acceptability of the system is equally important (DeNisi & Kluger, 2000; Atkins & Wood, 2002). The way employees perceived appraisal, for instance, should be considered more important for the sustainability of the appraisal

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system than the narrow psychometric factors like halo and leniency (Bernadin & Beatty, 1984).

One of the critical areas of performance appraisal is the reaction of subordinates towards an appraisal system. The reaction of employees to any appraisal system could be positive or negative, depending on their perceptions of fairness of the exercise (Kavanagh, Brown & Benson, 2007). This is because perception of fairness plays a role in ensuring identification with the appraisal system. Perception of fairness also has the ability to address issues relating to outcome, procedure or motive of employees as well as the kind of treatment they receive during the enactment of the appraisal process (Coetzee, 2005; Fullford, 2005). These have been found to have implications for job-related attitudes such as organizational commitment which is the attachment and loyalty employees have for their organizations. It is the force that binds the employee to the organization. It is also a psychological state of employees that enables them identify strongly with and get involved in the organizational activities, develop social networks and make side bets that will make them stay in the organization for a long time. Therefore, organizations seek ways to promote greater commitment among their employees as part of the process to meet organizational targets (Meyer & Allen, 1996).

In Ghana, performance appraisal was formally introduced into the civil service as part of a wider public sector reforms in 1993 as a way of making the service more effective and efficient in achieving its mandate (Ayee, 2001). However, there was no sector-wide participation and involvement in the design and implementation and therefore could not be institutionalized. Ghana Health Service introduced its performance appraisal system in 2003 (GHS,

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2003). The intention was to provide employees and managers with tools that were user friendly and effective to assess and improve both individual and organizational performance. In addition, it was meant to serve as a tool to identify training and developmental needs, link both individual and the organizational performances to achieving critical health targets and use an individual's performance output to determine promotion, pay raise and career progression. This process led to the construction of a new appraisal instrument which was piloted at Volta, Central, Eastern and Brong-Ahafo Regions of Ghana. This was followed by training of managers and supervisors (Quality Health Partners, 2005).

Statement of the Problem

The world adopted the eight Millennium Development Goals (MDGs) in 2000 in response to the need to create a world that will provide peace and decent living standards for everybody with special emphasis on children and women. Three out of the eight goals were directly health related and aimed at reducing child mortality, improving maternal health and combating HIV/ AIDS, malaria and other diseases by 2015 (WHO, 2000). In September 2000, Ghana adopted the MDGs and set specific targets and mechanisms to monitor progress in achieving the goals. Nonetheless, Ghana's MDG report for 2015 revealed that the progress in achieving a number of the targets was mixed (Republic of Ghana, 2015).

Although Under Five Mortality Rate (UFMR) declined from 111 deaths per 1,000 live births in 2003 to 60 deaths per 1,000 live births in 2014, and Infant Mortality Rate (IMR), during the same period, reduced from 64 deaths per 1,000 live births to 41 deaths per 1,000 live births (GSS, 2014), the

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targets of 21.5 deaths and 38.88 deaths per 1,000 live births for both IMR and UFMR respectively were not likely be achieved by 2015 (Republic of Ghana, 2015).

Maternal Mortality Rate (MMR) declined from 503 per 100,000 live births in 2005 to 319 deaths per 100,000 live births in 2014 (GSS, 2014). If the current trend of MMR rate continues, Ghana could not achieve the target of 185 per 100,000 live births by 2015. It will require extra efforts to accelerate the achievement of MMR. HIV prevalence rate fell from 3.2% in 2006 to 2.2% in 2008 but increased to 2.9% in 2009 and has again reduced to 1.6 in 2014 (GHS, 2014a). Improved efforts in the area of educational campaign and other programmes are required to promote behavioural change to sustain the current pace of decline (Republic of Ghana, 2015).

One area which seems to have been ignored in all attempts to achieve targets is the role of the health care provider. Little attention has been given to the performance and motivation of employees to enable them perform optimally on their jobs which has the potential of contributing to achieving the three health related MDGs. This can be achieved through an effective and efficient appraisal system. The available resources, the skills required on the job, and the enabling working environment are some of the essential ingredients of an effective and efficient performance appraisal system (Gruman & Saks, 2011). However, practitioners in the area of performance management are limited in the use of performance appraisal to improve organizational performance due to continuous failure of organizations to achieve their goals in spite of the existence of performance appraisal system (Grote, 2011). For instance, Ghana Health Service continues to miss its health

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targets on maternal and child health despite the available performance management system (GHS, 2014b). Meanwhile, researchers argue that perception of fairness of performance appraisal can influence commitment of employees to perform on their jobs and by inference the achievement of organizational targets (Colquitt et al, 2001; Cropanzano, Bowen & Gilliland, 2007). By implication, an unfair appraisal system is bound to fail and could lead to poor performance and low productivity (Long, Kowang, Ismail & Rasid, 2013). The low productivity and performance may reflect in poor attitude and commitment of employees to their work (Jaskiewicz & Tulenko, 2012). By inference, achieving organizational targets such as the three health related MDGs at both the individual and organizational levels could be affected negatively by low professional and organizational commitment if the appraisal system is perceived to be low. Recognizing the usefulness of fairness in an appraisal system, the Ghana Health Service introduced performance appraisal system in 2003. A study by Quality Health Partners (2005) reported that the appraisal system in GHS lacks ownership and commitment among employees. However, a study is yet to be conducted to assess the perception of fairness of its employees on the appraisal system and its possible implications for performance. The aim, therefore, is to understand the relationship between employees' perception of fairness of performance appraisal and its implications on the organizational commitment and by extension, the achievement of health goals, the MDG.

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Objectives of the study

The main objective of the study was to assess the perception of health workers about fairness of performance appraisal using four organizational justice constructs: distributive, procedural, interpersonal and informational and its effects on organizational commitment, using three constructs: affective, continuance and normative and their implications for performance.

The specific objectives of the study are to:

1. Assess the perception of employees on fairness of performance appraisal and their commitment to GHS,
2. Evaluate the perception of employees on the processes of the current appraisal system,
3. Explore the levels of awareness of health workers of health related MDGs and their performance and achievement of the health related MDGs.
4. Assess the categories (age, gender, staff categorisation, education, region and gross salary) of health workers and their perceptions of fairness of performance appraisal; and
5. Assess variability in organizational commitment by categories (age, gender, staff categorisation, education, region and gross salary) of health workers.

Hypotheses of the study

Conceptualising the study within the four and three constructs of organizational justice and commitments models, the available literature reports mixed findings on the relationship between perception of fairness of performance appraisal and organizational commitment (Rammmoorthy &

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Food, 2004; Robbins et al, 2005; Lambert et al, 2007; Ponu & Chuah, 2010; Okanbi & Ofoegbu & Eugene, 2013; Dartey-Baah, 2014), and for the patterns of variability of background variables (i.e. age, gender, education, staff categorization, and salary) in the perception of fairness and organizational commitment. These inconclusive findings thus create an opportunity for the testing of the under-listed hypotheses:

H1: There is no significant relationship between organizational justice constructs (distributive, procedural, informational and interpersonal) and organizational commitment constructs (affective, continuance and normative).

H2: There is no significant relationship between socio-demographic variables (age, gender, education, staff categorisation, region and gross salary) and appraisal ratings employees receive.

H3: There is no significant relationship between socio-demographic variables (age, gender, staff categorisation, region and gross salary) and organizational justice.

H4: There is no significant relationship between demographic variables (age, gender, staff categorisation, education, region and gross salary) and organizational commitment.

H5: There is no significant relationship between socio-demographic variables (age, gender, staff categorisation, education, region and gross salary) and awareness level of health workers on MDGs.

Significance of the study

Organizational justice is concerned with perception of fairness of employees in an organization. Its constructs have recently attracted considerable attention from researchers to understand how it affects

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employees work related attitudes and behaviours (Greenberg, 2009). Available evidence in the literature is inconclusive. For instance, some authors found positive relationship between organizational justice and commitment while others found no relationship between the two. Thus, to predict the effect of perception of fairness of appraisal on commitment of employees and their performance is unclear. In Ghana, the studies on perception of fairness are few. Among them are Acquaah and Padhye (2012), Badu and Asumeng (2013), Dartey-Baah (2014), and Abasimi, Atindanbila and Kwakye-Nuako (2014). Besides, they concentrated on the private sector organizations and are also not applied to the field of performance. For instance, Acquaah and Padhye (2012), in a comparative study of organizational justice and commitment in Ghana and India, found variations in commitment levels of employees in Ghana and India as well as in organizational justice, while Dartey-Baah (2014), in a study of organizational antecedents and perception of fairness in the banking sector in Ghana, found perception of fairness as a predictor of organizational commitment and variation in the commitment levels based on the position of the employee.

In the GHS, apart from a pilot study by Quality Health Partners (2005), there was no other study to assess the implementation of the appraisal system which was introduced in 2003. Though this is not an evaluative study, it has the potential of providing policy makers with insight into ways of improving the existing appraisal system to become effective in addressing work performance challenges. It is also expected to guide the design and implementation of performance appraisal system in the public sector.

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Organization of the thesis

The thesis is organized in eight chapters. Chapter one gives the introduction to the study. It entails the problem statement and the objectives to the study. This chapter also captures the hypotheses, and the significance of the study. Chapter two discusses concepts that are pertinent to performance appraisal system and how to achieve its effectiveness. It further deals with conceptual and theoretical issues about the various dimensions of organizational justice and commitment. The understanding of how performance appraisal system, particularly in the health sector, can increase productivity and achieve key health targets and organizational success is also discussed in this chapter. Chapter three provides an overview of performance management in Ghana. It outlines the historical development of performance management in public sector organizations in Ghana and the development and implementation of performance appraisal system in the Ghana Health Service. Chapter four presents and discusses the research methods employed in the study. It delineates methods of data collection and analysis. This comprises issues such as research design, measurements in instrument, pretesting, selection of respondents and administration of questionnaires. The statistical techniques adopted and the related tests performed are also discussed here. The results of the study are presented in chapters five, six and seven. Chapter five discusses the existing appraisal system and the perception of the health workers towards the appraisal process. It also discusses the role of the supervisor in the existing performance appraisal system as well as factors influencing appraisal ratings. Chapter six captures the issues relating to organizational justice and commitment constructs and how they relate to each

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other in the existing appraisal system. It also presents issues relating to the variability in organizational justice in performance appraisal and organizational commitment on empirical basis. It further discusses factors influencing organizational justice and commitment. Chapter seven deals with issues relating to the level of awareness of health related MDGs among employees of GHS and their implications for performance and the achievement of health targets. Chapter eight contains the summary and conclusion of the findings. It also presents limitations for the study, makes recommendations for performance appraisal policy in strengthening the health system to achieve key health targets, and suggest possible areas for further research.

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CHAPTER TWO

CONCEPTUALISING PERFORMANCE APPRAISAL, ORGANIZATIONAL JUSTICE AND COMMITMENT

Introduction

This chapter deals with the theoretical issues as well as the concepts and application of performance appraisal. It reviews studies on various theories, concepts and models of organizational justice and commitment. It also explores the various constructs of organizational justice and how they influence perception of fairness and in turn affect organizational commitment and overall performance in organizations. It further reviews the models on which the study is based and also relates issues on performance of health workers.

Performance appraisal

Organizations employ systematic ways of evaluating the performance of employees based on the standards established to make decisions. These are pay and promotions as well as identifying the training needs and factors that hinder effective job performance. An appraisal provides the opportunity to appreciate contributions and achievements of employees and to plan together to develop competencies and capabilities required for their performance in the future. It enables employees to know their capabilities and open communication channels about how their job contributes to achieving organizational goals and objectives (Duraisingam & Skinner, 2005).

The understanding of the concept in the definitions of performance appraisal would help us lay a solid foundation to demonstrate what

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performance appraisal is all about. Stone (2002) has indicated that performance appraisal is a term that was once associated with a rather basic process of a manager completing an annual report on a subordinate's performance. This involved giving ratings on a number of scales which focused on attitude and even personality. Performance appraisal, since then, has evolved to include a system for managing organizational performance, a system for managing the performance of the individual and a system for integrating the two (Erdogan, 2002).

Performance appraisal can also be described as the process of determining the extent to which an employee is performing a job effectively. This definition brings to the fore the role an employee plays in contributing to the achievement of the overall organizational goals. It also indicates that it is a process which suggests a continuous activity, and it projects series of activities that aimed at finding out how well the employee is doing on the job (Cole, 2002; DeNisi, 2008). The information available through appraisal is used to support planning and to improve products or services to increase profitability and customer satisfaction (Mucha, 2009).

Performance appraisal is again defined as the systematic and a formal process through which a job performance of an employee is assessed by supervisors or peers or even customers through effective monitoring and feedback to enable employees develop their capabilities to enhance performance (Gabris & Ihrke, 2001; Erdogan, 2002). This serves as the basis to distribute rewards and take developmental and administrative decisions. This definition emphasises the importance of performance appraisal in building employees' job capabilities to improve performance. The information

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available to managers during the appraisal cycle is used to identify performance weaknesses which can be corrected through training and capacity development to improve both individual and organizational performance (DeNisi, 2008). Where appraisal is used for administrative decisions, it is a mandatory requirement for supervisors to judge and rate individuals and group behaviours in an organization for a specific duration, and the results are kept for organizational use (Coens & Jenkins, 2000). This definition suggests that performance appraisal is about the judgement and the ratings supervisors place on their subordinates but does not emphasize the need to use the system to improve performance.

The purpose of performance appraisal

The main purpose of performance appraisal is to improve efficiency of an organization through mobilization of the efforts from the various employees in the organization (Atiomo, 2000). Performance Appraisal serves four main purposes: which are operational, strategic, developmental and administrative purposes.

Performance appraisal serves administrative purpose if it provides information for management decision making. In this regard, employees are evaluated in comparison to others to establish their relative contributions to enable managers take certain administrative decisions (Amba-Rao, Petrick, Gupta & Von der Embse, 2000; Gabris & Irke, 2001; Thite, 2004). This helps to clarify the expectations of employees and discuss the results of the performance to enable them accept the results and support the appraisal system (Havard, 2002; Farmer, 2004). It also promotes motivation of employees and favourable organizational outcomes such as job satisfaction

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and perception of fairness (Galang, 2004; Lilley & Hinduja, 2006). The results of the evaluation are used to review past performances of employees to reward acceptable performance and punish unacceptable performance (Shraeder, Self & Lindsey, 2006). The evaluation outputs help in conflict resolution and avoid the potential legal actions since there is evidence to support management decisions, thus emphasizing the importance of documentation in performance appraisal (Iqbal, 2012).

The appraisal results for administrative purpose are used to update employee records (Farmer, 2004), review job descriptions and transfer employees (Shen, 2004; Boyd & Kyle, 2004; Islam & Rasad, 2006), promote or demote employees (Roch, 2005; Payne, Horner, Boswell, Schroeder & Stine-Cheyne, 2009), determine pay raise and terminate employment of employees (Smigel, 2000; Nickols, 2007). The focus of this type of appraisal is for supervisors to evaluate the results of employees for administrative decisions. Notwithstanding, supervisors often ignore the need to provide feedback to improve on the weaknesses of employees, hence the emphasis on punishing poor performers based on past performance rather than helping them to improve upon their future performance.

The development purpose deals with the overall development of employees (Gabris & Irke, 2001; Nurse, 2005; Islam & Rasad, 2006). It helps to determine career path (Spinks, Well & Meche, 1999; Law & Tam, 2008) and provide the need for training, coaching and counseling (Islam & Rasad, 2006; Law, 2007) to enable employees meet their personal goals of self-development and acquire new competences to perform on the job (Odhiambo, 2005; Kuvaas, 2006). Through appraisal, supervisors are able to identify

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subordinates with great potentials and give them the needed exposure to develop them for a greater responsibility (Gabris & Irhke, 2001). This involves identifying, evaluating and developing the work performance of employees so that the organizational goals and objectives can be achieved.

This type of appraisal could help improve communication between the appraiser and the appraisee concerning each other's expectations (Noe, Hollenberk, Gerhart & Wright, 2006). The two-way communication helps to improve subordinates' understanding of what their supervisor's expectations about the job performance are. The supervisor also tries to understand what performance challenges of the employees are. It is believed that through this interaction, both subordinates and their supervisors would play complementary roles with a unity of purpose which will eventually lead to the achievement of the organizational goals (Brudan, 2010). The system emphasizes the importance of appraisal to the organization and the individual. Organizational goals are achieved while management focuses on staff development (Ovando & Ramirez Jr, 2007). There is evidence to show that overall development of employees improve their levels of commitment and satisfaction (Blackmore, 2005; Narcisse & Harcourt, 2008). Nonetheless, evidence suggests that performance appraisal is less important among older employees (i.e. 50+ years) compared to younger employees if it is used for developmental purposes. This is because the amortization period for investment in training for older employees declines with age (Brown & Heywood, 2005).

Performance appraisal serves a strategic purpose if it establishes a fit between the goals of the organization and the job targets of the individual

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employees (Aguinis, 2009). It refers to the extent to which performance standards of employees are related to the strategic goals of the organization. This is to support organizational goals and values and align individual efforts and performance to the organizational vision. It provides information for organizational planning and change (Walsh & Fisher, 2005) to increase organizational effectiveness and productivity (Herdlein, Kukemelk & Turk, 2008). It also requires the setting up of organizational, departmental, team and individual goals which are related to each other with appropriate reward strategies and schemes, training and development strategies and plans and mechanism for monitoring the effectiveness of the performance (Roberts, 2001; Holloway, 2009). This purpose helps to improve the individual employees while at the same time improve on the overall organizational effectiveness. Thus, organizations are able to meet their strategic objectives with focus on the future (Walsh & Fisher, 2005; Holloway, 2009). The focus on the future can be challenging if the events and activities do not unfold as anticipated; it may invalidate the individuals as well as the organizational strategies and goals.

Performance management serves operational purpose if it deals with the achievement of the department (Brudan, 2009) rather than the organizational goals (De Waal, 2007; Brudan, 2010). This is done through efficiency and effectiveness of employees in achieving departmental goals. It started with the use of accounting indicators such as profitability of the operations. As corporate environments became complex overtime; organizations began to consider nonfinancial indicators to measure efficiency and effectiveness of performance (Brudan, 2009).

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Performance appraisal process

An appraisal system is a process involving a series of sequential activities, leading to an outcome that could be used to achieve a purpose. It is made up of sequential activities that begin from one period of the year and end at the other. It also involves the system of tracking, gathering, analyzing and generating information on the progress of performance of employees (Pollit, 2008).

Performance appraisal process involves four steps, which are determining performance requirements, appraisal planning, monitoring and feedback, and performance review. The performance requirement stage involves meeting to determine the goals to be accomplished, the skills, knowledge and abilities required to carry out the job and how performance outputs would be assessed during the appraisal cycle (Pollit, 2008). These performance goals should be linked to the goals of the organization (ILO, 2003). The stage involves training of both supervisors and employees to ensure fair assessment (Pollit, 2008).

In the second stage of the appraisal process, supervisors meet subordinates to plan and discuss areas of performance to be evaluated and how the evaluation will be done (Pollit, 2008). The third stage is the monitoring and feedback. At this point, the supervisor tracks and gathers relevant information, interprets and communicates fairly to the appraisee. This is done by comparing what the employee has done with the job requirements specified in the appraisal objectives (Pollit, 2008). The final stage is the performance review where the evaluation of performance of employees is compared with the standards set at the beginning of the appraisal year. The result of the

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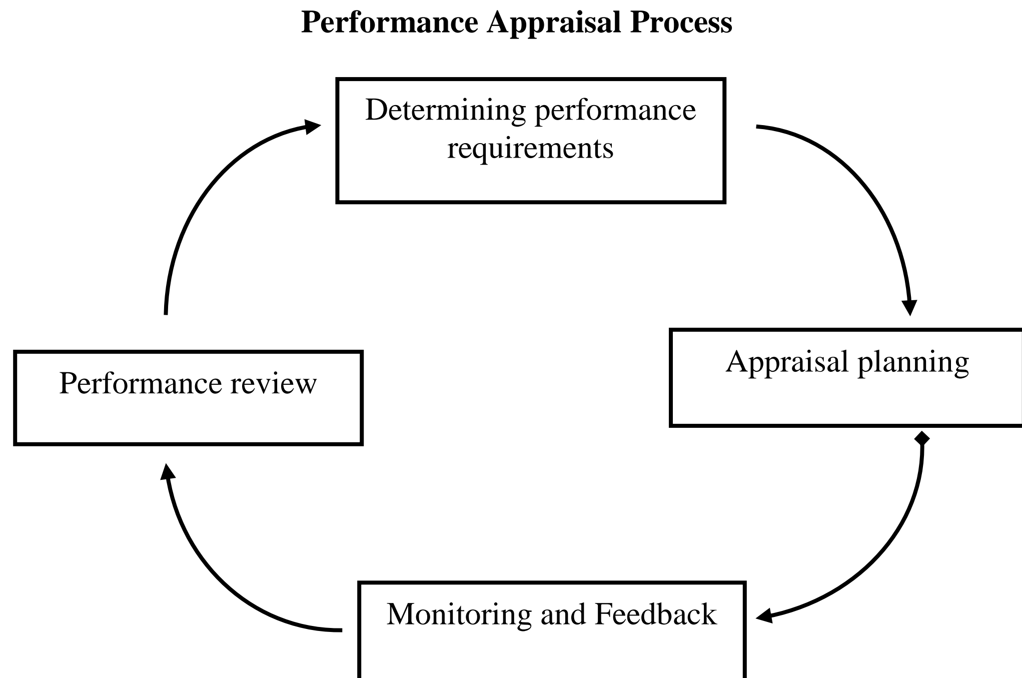
performance review feeds into the next planning stage and the process starts again (Bernheim & Daniel, 2003).

Performance Appraisal Process



Source: Performance Appraisal Process in (Pollit, 2008)

Performance appraisal methods

Appraisal method is the means by which performance of employees are measured. These can be classified into six groups, which are works standard, category graphic, critical incident, comparative, narrative and behavioural objective (Globler et al, 2006).

Work standard method compares the results of performance of employees to already established standards. In this case, management establishes goals against specific outputs for employees to achieve. In so doing, employees understand their job duties and know what is expected of them (Dessler, 2000). However, it is difficult to compare ratings of employees because standards for work may differ from job to job and from employee to employee (Mondy, 2008). It is mainly used to measure work of employees in the

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manufacturing or production sectors where the jobs are output based. In this regard, assessment is made on standards established on the production per day or per hour or over a period of time (Martinez, 2001; Bernardin, 2003). In this method, consideration is given to employees who serve as inputs'2 for other groups of employees since outputs of a group of employees may serve as inputs for others (Globler et al, 2006).

A graphic rating method lists a set of traits that an organization identifies to be valuable for effective performance, and the supervisor rates employees along a scale depending on how well they exhibited the trait. It allows for quantitative comparisons between the scores obtained by different employees on their personal traits or set of favourable behaviours or expected outcomes (Globler et al, 2006; Mondy, 2008). It is easy to design and use (Mondy, 2008). The rating is done on likert type of scale, ranging from 1 to 3 or 1 to 5. This type of scale is easy to fill, so it is common among supervisors but is prone to rating errors. Also, it does not describe in detail the meaning of the ratings employees are given, which leaves room for ambiguity. Managers are to be trained before the method is introduced. Even after the introduction, there is the need for regular training (Globler et al, 2006).

Critical incident method is when a supervisor prepares a list of statements of what is considered effective and ineffective behaviour of an employee for a job to be accomplished (Dessler, 2011). These represent the outstanding or poor behaviour of employees on the job. The supervisor maintains a log book or a sheet on each employee and records the events each time they exhibit any of these behaviours. These recorded incidents are collated at the end of the appraisal period and used to evaluate the employees.

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This method provides an objective basis for assessment of performance of employees. A high performing employee will receive more marks on the positive side of the list than low performing ones (Bogardus, 2007; Durai, 2010). Research shows that supervisors focus more on negative incidents than the positive ones (Durai, 2010). This method also requires close supervision in order to record consistently all the necessary events. Moreover, supervisors may be too busy to record the events consistently (Mondy, 2008).

Comparative method is a collection of techniques that compares results of performance outcome of employees to one another to create differentiation in their ratings. This is by ranking the employee from the best to the least performed employee on a certain attribute related to performance. It can also be achieved by rating employees in pairs (Mondy, 2008). This allows the manager to communicate areas employees over or under performed relative to others in similar positions. This can motivate employees to perform in a competitive work environment.

Nonetheless, the competition can potentially result in in-fighting and lack of harmony among employees in similar jobs (Aggarwal & Tharkur, 2013). This method is informed by a study on 7000 professional and managerial employees in the US that shows that 95 percent of employees were crowded in only 2 out of 6 rating categories (Globler et al, 2006). Two techniques are used in this method. These are paired comparison and forced distribution. In paired comparison, employees are compared with all others in pairs. The number of comparisons made in pairs are determined by the formula N(N-1)/2 where N is the number of employees (Mondy, 2008). Each

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employee is eventually given a positive comparison total to determine the best performers.

Pair comparison is not based on forced distribution; so it can bring out the real superior performers from the poor performers. The distribution in this case may not always assume a normal distribution. As an advantage, pair comparison is quick and easy to use if relatively few employees are being paired. It becomes tedious and cumbersome if there are several employees in a department that need to be paired (Bernardin, 2003). Forced distribution technique, on the other hand, spreads performance of employees on a pre-described distribution and places them into certain categories often in percentages. In this case, the employees are arranged from the best to the least performers. This has the advantage of eliminating rating error by forcing the distribution according to pre-determined percentages (Guerra-Lopez & Liegh, 2009). This technique cannot be used when the appraisal is used to take administrative decisions such as salaries. This is because the method does not measure actual performance based on job expectations, so least ranked employees would be demoralized, leading to low self-esteem and productivity (Dessler, 2012).

In narrative method, the supervisor observes and describes extraordinary job related good or bad behaviours of employees. In some cases, employees also describe some critical or important job related experiences they have had. In this case, only extraordinary behaviours are described, not the normal job activities or average work performance. Extraordinary good behaviours distinguish high performers from average performers and also

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extraordinary bad behaviours separate bad performers from others (Globler, et al, 2006).

In the essay method, the supervisor describes in a narrative form how employees perform on the job. It requires specifying instances where the subordinates exhibited their strengths and weaknesses. The manager is required to explain and give examples of specific performance, therefore minimizing the halo effect, central tendency and leniency biases (Mondy, 2008). This is useful if it is adopted for a developmental purpose. Nonetheless, it has a disadvantage of supervisors having to spend a lot of time describing examples of the performances of their employees. It also requires good writing skills, which some supervisors may lack (Guerra-Lopez & Leigh, 2009). Moreover, several narrative essays describing performance for several staff may be difficult to compare, so it may be difficult to use in taking administrative decisions (Bernardin, 2003).

Behaviourally Anchored Rating Scale (BARS) describes important job behaviours used to anchor a scale. In this case, the supervisor selects the description which best matches actual behaviour on a specific job dimension during the rating period. It makes use of critical incident technique and rating scales. This is done by spreading key or critical performances or indices on a scale (Dessler, 2012). BARS may cover six to eight defined performance dimensions in a form of prototypes. Steps involved in the development of BARS are generating critical incidents, developing performance dimensions, reallocating of incidents and scaling them, and developing of the instrument (Decenzo & Robbins, 2002). The critical incident is then spread along the

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scale to clarify and distinguish between different levels of performance (Decenzo & Robbins, 2002).

Organizations may combine two or more methods in performance appraisal programme. These are done in order to combine the advantages of the various methods while minimizing disadvantages associated with appraisal rating such as errors, halo effects and subjectivity (Michelman, 2007).

Use of objective in performance appraisal

The management by objective (MBO) involves goal setting. This starts with the setting of organizational strategic goals which is then cascaded down to departmental goals and finally to the individual goal (Locke & Latham, 2007). At the individual level, goals are set by all. The general consensus is that the involvement of employees in the goal setting will promote employee commitment and motivation (Bernardin, 2003). MBO is based on a principle that employees will achieve their goals if they are supported by management and are also provided with the needed resource;2es (Scholz et al, 2009).

One feature of MBO is that goals and objectives are determined before the commencement of the appraisal period (Ross, 2007; Seniwoliba, 2014). Studies have also shown that guidelines must be developed first before the implementation of the MBO programme (Roder, 2007). This must involve the setting up of appellate committee to review or arbitrate when there is disagreement between the subordinate and the superior concerning the achievement of the set goals. However, this can be time consuming because both the appraisee and the superior need to spend time on the appraisal system (Globler et al, 2006).

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Common rater errors in performance appraisal

Rater bias is the most common error in any appraisal system (Lunenburg, 2012). This may arise through conscious and unconscious means. It is often not based on actual job performance but on personal orientation related to sex, age, race, level of education, membership of the same group etc. A manager may give his personal secretary a higher rating than the other secretaries (Bellemare & Shearer, 2009). The bias model proposes that individual differences such as age, sex, marital status, race and education etc can influence the extent to which bias can occur (Esfahani et al, 2014). Affective supervisor-subordinate relationship is found to be associate'2d with higher appraisal ratings, less inclination to punish subordinates, greater halo and less accuracy (Lefkowitz, 2000). Demographic similarities relative to some members in the group can also lead to higher rating (Lardy, 1998). Gender biases in ratings are triggered by role incongruence. For instance, occupations that are masculine in nature tend to rate women lower than their male counterparts (Lyness & Heilman, 2006). Predictors of ratings are perceived to influence where and when rating errors are likely to occur (Lawrence, 1998). Fulford (2005) found a relationship between appraisal rating and level of education. Similarly, others also found age difference in the appraisal rating (Esfahani et al, 2014)

Various biases or errors may occur in appraisal ratings. These are halo, devil's horn, central tendency error, leniency bias, strictness bias, and recency error (Lunenburg, 2012). Halo occurs when only an aspect of subordinate's performance influences the supervisor to evaluate other aspects of his performance in a similar way. A halo may occur if a manager rates an

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employee high on quality and quantity of work done due to his/ her punctuality at work. This may be deceptive because such an employee may be an average performer in the actual performance in those aspects (Bol, 2011).

The opposite to halo effect is the devil's horn in which an employee performs poorly in one aspect of the work but is rated poorly not only in that aspect but also in the other aspects of the work. Both halo and negative halo effects can be eliminated through training (Moers, 2005). Central tendency error occurs when the supervisor rates every employee as an average performer. This may arise due to the difficulty of the supervisor to bring out differences in performance among subordinates. It may be because of lack of objectivity on the part of the manager or lack of understanding of the job requirements or failure to effectively supervise the work or fear of being blamed for individual low or high performance (Schleicher, Bull & Green, 2009).

Leniency bias is when managers give every employee high score. This may be due to inexperience or poor supervision. In this regard, the supervisor only tries to appease every employee to avoid being blamed for their poor performances. Nonetheless, high performing employees will complain about such a manager because everybody is rated the same. This will not encourage or motivate such employees to maintain or improve their performance (Ross, 2007). Strictness bias occurs when a manager, in a consistent manner, rates every employee not more than above average level. This is the opposite of leniency error. Organizations do not face much challenge with strictness error as they do to that of leniency bias. Managers are accused of being strict because they perceive none of the employees to be performing well enough to

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deserve an excellent rating. According to Dowling and Welch (2004) an inflated or lowered ratings given by superiors are intentional.

Recency error occurs when the superior uses the recent performance information to evaluate the employee for the entire period. This usually happens when the appraisal period is bi-annual or annual. In this case, the supervisor may not be able to remember everything about the employee's performance for the entire period. To minimize recency error, employee performance must be recorded and kept throughout the year. This can be achieved using log books and files to keep all critical incidences regarding the performance. The manager may then refer to them during the appraisal review. The opposite of recency error is the primary effect in which the information received first during the appraisal period receives the most weight (Bellemare & Shearer, 2009).

Raters of performance appraisal

Performance appraisal can be classified according to who does the rating. Supervisors, peers, customers and even an individual (self-appraisal) can conduct appraisal review or rating. It is a single rater if one of the groups indicated does the rating. It becomes multi-rater when more than two are involved in the rating (Schleicher, Bull & Green, 2009).

Supervisor, as a rater, is the most common form of appraisal system. It is assumed that the supervisor or the manager is in the best position to observe and supervise the job performance of subordinates and also evaluate the performance. Moreover, performance appraisal is seen as a component of a supervisory role of managers. Supervision in appraisal depends on the span of control, which is the number of employees a manager supervises. Bohte &

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Meier (2000) proposes that there is a limit to a span of control, beyond which supervision is ineffective or harmful. Gittell (2001) found that supervision with a range of span of control of less than 10 employees is associated with higher performance compared to those with employees ranging between 10 and 34. Supervisors also have control over resources that are required to carry out the job. They are also in the best position to determine the competencies required by the employee in order to perform the job well. However, supervisors may not be comfortable evaluating the job of their subordinates because of the confrontation that may arise out of the process (Michelman, 2007). Though supervisors have more at stake in monitoring and assessing the performance of their subordinates, they cannot be solely relied upon to establish standards for employees. Failure to involve the employees may lead to lack of commitment and the tendency to increase the perception of unfairness (Dessler, 2012).

Employees working closely with each other in a non-competitive work environment can evaluate each other's work. This is known as peer evaluation. Peers can provide useful information regarding the job performance which supervisors may not have. An employee has a much higher contact period with their peers than the supervisor. Objectivity on the part of peers during evaluation may be lacking due to possible retaliation. Studies show that peer bias may play a role when co-workers rate each other rather than their supervisors (Woodward, 2000; Schleicher, Bull & Green, 2009)

Multi-rater or 360 degrees appraisal system is a combined assessment of various stakeholders involving peers, supervisor, subordinates and clients. This approach which is gaining popularity in the recent times provides

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comprehensive picture of an employee's performance (Dowling & Welch, 2004). Self-rating could also be included in this process. 360 degrees appraisal system is considered the fairer and more objective than the other forms of the rating systems due to the number of people who are involved in the appraisal evaluation. Nonetheless, for the system to operate effectively, a number of issues ought to be addressed. The anonymity of the participants must be guaranteed and assured. However, the respondents must be held accountable for their assessment. This can be achieved by the supervisor ensuring that the scale is properly used by each rater. Quantitative methods must be used to rationalize the individual evaluations. To this end, the supervisor must be mindful in using subjective combinations of data from the evaluation process (Tung & Varml2a, 2008).

Self-rating is another type of rating process where an individual is made to assess his or her own performance. This is gaining popularity as part of overall employee evaluative system. It is believed that an effective self-rating is critical for white colour employees. It is also suggested that self-rating can affect a supervisor's evaluation (Grote, 2011). The tendency is that a lazy manager may depend solely on the information provided by the employee on the official appraisal form (Grote, 2011). The effect of self-rating on supervisor's evaluation is found to be positive (Globler, et al, 2006).

In a traditional appraisal system, supervisors are made to appraise their subordinates. However, the opposite is true in the reverse appraisal where subordinates are made to appraise their superiors. In recent times, some organizations allow subordinates to evaluate the work of their superiors. It is common among institutions of higher learning where students are made to

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evaluate the work of their teachers. This must be approached with caution since subordinates may not fully understand what their supervisor's job entails. The focus should be directed at evaluating specific strengths and weaknesses of the superior. This also requires high level of anonymity to reduce the fear of victimization (Ellsworth & Sherer, 2003).

Team appraisal is similar to 360 degrees appraisal but, in this case, the entire team members are made to appraise individual team members. In the health sector, in particular, teams have become t'2he fundamental unit of work. It is therefore prudent to measure the work of the team instead of the individual. In this vein, the team is under obligation to be concerned about how the individual performs in relation to the other team members (Ross, 2007). The evaluation is usually done at two levels: first there is internal evaluation. This involves the relationship between individual team members as well as the performance of the individuals in the team. At the second level, evaluation is done to ascertain whether the team has achieved its overall targets (Michelman, 2007).

Socio-demographic factors and job performance

Performance of employees in organizations is necessary to ensure competitive advantage, improve service delivery and productivity (Vermeeren, Kuipers & Steijn, 2009). Changes in demography are found to influence work performance of employees at various levels in an organization (Palakurthi & Parks, 2000). Differences in demography in performance can be explained by rational demography theory. The theory suggests that the degree of attraction among people of similar characteristics tend to be higher than those with different characteristics (Riordan, 2000). In the organizational context, the

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theory suggests that employees who have similar characteristics such as age, sex, race, tenure and profession are likely to have similar perceptions and attitudes that can impact on performance (Thoresen, Judge, Bono & Patton, 2001).

This theory has received theoretical; 2and empirical support. For instance, researchers have found that employees exhibit favourability bias towards employees of different characteristics. Empirically, Waldman & Saks (1998) found a fit between work performance between age, work experience and gross monthly salary. A study by Schultz and Adams (2007) also shows that there is a significant difference between age groups and work performance. This is in support of earlier finding by Smedley and Whitten (2006). McBey and Karakowsky (2001) have found a relationship between level of education and job performance, while other studies have shown that pay satisfaction drives job performance of employees (Dieleman et al, 2009).

Contrary to rational demography theory, other studies have found no relationship between gender and work performance (Igbaria & Shayo, 2007; Sharkey and Davis, 2008). For instance, Lee et al. (2010) found no significant differences among various professional groups. This may indicate that other factors could influence demographic factors in performance. These could be explained by studies that show that the initial negative effect of differences in demography may be counteracted with time as people learn about their similarities in value (Chatman & Flyn, 2001; Polzer, Milto & Swan, 2002). For instance, Polzer et al, (2002) found no effect of demography on the individual employees, suggesting that similarity in personality and values can moderate the effects of demographic difference.

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Concept of perception

Perception is defined as the process of acquiring, selecting, organizing and interpreting sensory information or events in order to give personal meaning to the situation (Pickens, 2005). Perception occurs when one is confronted with a situation or a stimulus which is interpreted into something meaningful based on prior experience. However, what an individual interprets or perceives may be substantially different from reality. A person's acceptance of a stimulus plays an important role in the perceptual process. On the other hand, receptiveness of the stimuli may be limited by a person's existing beliefs, attitudes, motivation and personality (Assael, 2005). Individuals will select stimuli that satisfy their immediate needs (perceptual vigilance) and ignore those that cause psychological anxiety (perceptual defence).

In performance appraisal, perception of fairness can be conceptualised through the concept of organizational justice. Managers are concerned about fairness because it plays a central role in providing equal opportunities for employment, fair labour practices and performance management. However, the varied goals and interest of employees and managers make it difficult to establish exactly what employees perceive as fair treatment (Coetzee, 2005). Perception of fairness is also considered multidimensional concept due to the disagreement people have about the definition and the varied answers they have about the questions on fairness. These answers depend on whether the perception is about the outcome, procedure, motive and treatment (Coetzee, 2005; Fullford, 2005).

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Organisational justice

Organizational justice is defined as a personal assessment by employees on ethical and moral standing of managerial conduct (Cropanzano, Bowen & Gilliland, 2007). It involves how decisions are made with the distribution of outcome and how those outcomes themselves are perceived (Greenberg & Baron, 2003). Greenberg (2001) argues that what people perceive to be fair depends on their experience based on their opinions regarding suitable ways to distributing outcomes and how to treat others. Constant exposure to these standards produces expectations that serve as the basis for assessment of fairness. Behaviour in compliance with these expectations is considered as acts of fairness, while breaches are translated as acts of unfairness (Greenberg, 2001).

Organizational justice was first derived to test for fairness in social interactions but not in organizational setting (Greenberg, 1990). In recent times, however, models have been proposed to measure fairness in organizations. Research on organizational justice has shown positive relationship between work place outcome such as organizational commitment (Materson, Lewis, Goldman & Taylor, 2000) and job satisfaction (Colquitt, 2001; Cohen-Charash & Spector, 2001). Organizational justice has the potential to provide powerful benefits to both employees and the organization, namely greater trust and commitment (Cropanzano, Bowen and Gilliland, 2007).

Researchers, for the last twenty years, have focused attention on two main dimensions of fairness perceptions. First is on how employees respond to the outcome they receive, and the second is the means by which the outcomes

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are distributed. The emphasis initially was placed on how rewards were distributed. Since then, issues about justice have been raised in the organizational setting in the areas of conflict resolution, personnel selection, performance appraisal, labour dispute resolution and wage negotiation, which subsequently led to varied approaches to justice.

Theories of organizational justice

Gilliland and Chan (2001) assert that there are no organizational justice theories; instead, there are a collection of constructs that are discussed under the broad area of organizational justice. These constructs (distributive, procedural, informational and interpersonal) form the basis on which research under organizational justice is undertaken.

Distributive justice

Distributive justice was based on equity theory, which was originally derived from Adams' social exchange framework. Equity theory states that people will consider the outcome they receive through social interaction to be fair if the ratio of their contribution is equivalent to the reward they receive in comparison to other employees (Adams, 1965). This involves the equitable distribution of resources and outcomes between employees and to seek a balance between what is put into the job and what is obtained from it (Greenberg & Baron, 2003). Employees will perceive a fair balance between inputs and outcomes by comparing their own situation with their co-workers. Inputs are what the employee perceives as their contributions to the work or the exchange from which they expect a just outcome. Outcomes are the

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rewards individuals receive as a form of exchange for their contribution (Adams, 1965).

People may not necessarily be concerned with the quantum of what they receive but how they are distributed in relation to what others receive. This stems from the fact that every human being is concerned about justice. Therefore, anytime resources are to be allocated individuals concerned will raise issues about equity (Greenberg, 2009; Sudin, 2011). The theory predicts that comparatively perceived low rewards will lead to dissatisfaction, which will compel the employee to take actions that will reduce the discrepancy between the employee and the co-worker. In a similar vein, an employee who is perceived to be overly rewarded will experience guilt, shame or remorse. These negative consequences will lead to the reduction of the imbalance (Cropanzano, 1993). Perceived fairness of outcome or reward eventually became known as distributive justice. To ensure fairness in the allocation of outcomes, Cropanzano et al. (2007) propose three (3) allocation criteria. They are distribution based on equality (that is the same reward to each person), need (rewards are given according to the needs of the individual) and equity (reward based on your contribution).

Perception of fairness in performance appraisal deals with ratings employees receive during the appraisal evaluation. Thus, when people perceive the ratings they receive as being commensurate with their contribution in terms of their job performance, distributive justice is purported to have been served (Erdogan, 2002). This is operationalized as the reaction of people towards their formal rating or pay raise (Folger & Cropanzano, 1998). When employees receive inflated or favourable ratings on their appraisal, then

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they perceive it as fair (Holbrook, 2002). Distributive justice plays an important role for employees to evaluate their organization (Lee, Lee & DanLum, 2007). They may be more loyal to their organization if they cannot obtain the same benefits in another organization (Lee et al, 2007). Employees may also rationalize their readiness to quit by finding and showing evidence of how the allocation was unfairly distributed (Dailey & Kirk, 1992)

Although this dimension of fairness perception was able to explain how employees react during the distribution of rewards, it failed to take into consideration the means through which the rewards are distributed (Bernerth, Feild, Giles & Cole, 2006). This prompted the shift of research to include procedural justice.

Procedural justice

Procedural justice is the perception of fairness of the processes that are involved in decision making or allocation of outcomes (Tyler, 2006). This stems from the argument that people are more concerned about the justice of procedure rather than the justice of the final outcome and further postulates that perception of fairness of procedure is an important determinant of attitude and behaviour (Lind & Tyler, 1998; Tyler, 1989). This has led to the development of two explanatory models. The extended self-interest model and the group value model.

The extended self-interest model is based on the extent to which individuals have control over the process to optimise their final outcome. This is based on assumption that people will try to maximize their personal benefits when they interact in a group. The theory further proposes that employees will not only choose outcomes and procedures that will inure to their benefits but

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also procedures that are generally fair to themselves within the social group, political system or work organization (Lind & Tyler, 1998; Tyler, 1989). Employees seek control over procedure in order to receive a favourable outcome. The ability to exercise voice over procedure is found to improve procedural justice because such control may lead to more favourable outcomes. High levels of perception of fairness were found when employees were made to have control and capable of influencing their goals (Tyler, 1989).

A similar concept was also put forward by Thibaut and Walker (1975) in the process control theory which states that fairness perceptions are driven by the level of control employees are able to exercise over processes that lead to the distribution of outcome (Thibaut & Walker, 1975). This theory also recognizes that employees cannot always maintain absolute control over their outcomes when interacting with others. When employees join and remain in the group, they begin to realise that their own desires must sometimes be delayed while the outcomes of other co-workers are sometimes accepted. This is because others may only remain in the group, knowing that their concerns are also sometimes addressed.

The group value model places emphasis on social interactions and group membership based on the assumption that procedures represent the norms and values of the group. The model identifies three non-control issues that affect procedural justice judgement. These are the neutrality of the decision making procedure, trust in the decision maker, and the evidence of the nature of the social interaction in terms of how group members are treated with respect and dignity (Lind & Tyler, 1998).

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In both models, self-interest and group value are found to have merits and have thus received empirical supports (Lind & Tyler, 1998). Procedural justice was found to be associated with delay in gratification (Reis, 1986). Tang and Sarsfield-Baldwin (1996) proposed five factors that can affect the procedural justice. They are trust in supervisor, clarity of expectations, two way communications, understanding the performance appraisal process and fairness. One area which has also received attention among researchers is how various dimensions of justice affect organizational attitudes and behaviours. While distributive justice has been established as a predictor of personal outcome such as satisfaction with pay, procedural justice is seen as an antecedent to organizational attitudes such as commitment and trust in the organization (Folger & Konovsky 1989; Lind & Tyler, 1998; Greenberg, 2001).

Review of studies on procedural fal2irness and how outcomes can be favourable to employees to support decisions and the decision makers to move the organization forward reveal that when the procedure is perceived to be fair, outcomes are also perceived to be favourable, likewise the support for decisions and the decision makers (Brockner, 2002). Procedural justice was found to enhance employees support and promote legitimacy to managerial and organizational decisions, and this legitimacy promotes commitment of their employees to the organization (Tallman, Phipps & Matheson, 2009). A reciprocal association was found between distributive justice and procedural justice with organizational commitment (Robbins et al, 2005). In a meta-analytical review of organizational justice, distributive justice and procedural justice were found to be significant predictors of organizational commitment

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(Colquitt, et al, 2013). Others also found distributive justice and procedural justice to be linked to higher level of organizational commitment (Aryee, Budhwar & Chen, 2002; Ramammoorthy, & Flood, 2004; Robbins et al, 2005; Lambert et al, 2007). Nonetheless, a study by Griffin and Hepburn (2005) reported that correctional officers in Arizona did not perceive any significant association between organizational justice and organizational commitment.

A study on private teachers in Pakistan conducted by Zaman, Ali and Ali (2010) shows that distributive justice and procedural justice have positive impact on organizational commitment. A study in Nigeria among employees of a food and beverage firm reports a significant relationship between distributive justice and organizational commitment (Okanbi et al, 2013). A study on employees working in diverse fields and organizations in Malaysia reports that there is a positive and significant relationship with procedural and distributive justice and organizational commitment (Ponu & Chuah, 2010). Another study on administrative and financial staff of a university hospital found a relationship between procedural and interactional justice positively significant with organizational commitment (Ravangard, Keshtkaran & Nickman, 2013). In another study with healthcare professionals (physicians and nurses), both procedural justice and distributive justice were found to be associated with organizational commitment (Seyfettin, Adna & Ramazan, 2010).

Informational and interpersonal justice

Some studies have also proposed additional justice constructs which are considered distinct from procedural and distributive justice (Lind & Tyler, 1998; Greenberg, 1990; Blader & Tyler, 2000). These constructs are referred

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to as informational and interpersonal justices. Interpersonal justice, according to Greenberg (1990), refers to the treatment employees receive during the appraisal cycle in terms of whether they are treated with respect or with sensitivity and dignity. On the other hand, informational justice refers to the explanations offered to employees by their supervisors as to why certain procedures or processes are carried out and how outcomes are distributed in a certain way. Interpersonal and informational justices together form the interactional justice concept and their relevance of justice lies in their ability to sustain human dignity and enhance self-esteem (Lind & Tyler, 1998).

The study of interactional justice is based on how the subjects in an organization perceive the treatment they receive from those in authority in the enactment of their actions and decisions (Lonsdale, 2013). This involves how superiors in an organization carryout procedures and also take decisions that affect the people they lead. The superiors are seen as the representatives of the organization so the subordinates may evaluate the organizational procedures by the treatment they receive from their supervisors (Lonsdale, 2013). At the high levels of interactional justice, both distributive and procedural justices are not significant. This means that when superiors show high levels of sensitivity, dignity and respect to employees, they seem to be somewhat tolerant to unfair distributive and procedural fairness (Starlicki & Folger, 1997). It has been suggested that procedural and interactional justices can serve as a substitute for each other (Starlicki & Folger, 1997; Bies, 2001).

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Overall organizational justice

Measurement of perception of fairness using separate constructs of organizational justice has dominated the literature over time. Interest in the measurement of the overall perception of fairness in recent time has begun to attract the attention of researchers (Greenberg, 2006). Ambrose and Arnaud (2005) indicate that the use of the constructs of organizational justice separately to measure the performance and other outcomes may come at a cost. In support of this view, Cropanzano and Ambrose (2001) suggested that the relative differences between the justice types may obscure the similarities among the constructs. Also use of different justice constructs to predict individual justice experience may not be accurate. For instance, it has been suggested that when individuals form an impression about justice, they are making a holistic judgment (Greenberg, 2001). Lind (2001) also indicates that individuals can indicate their source of justices but what drives their behaviour and attitudes is an overall sense of fairness. Shapiro (2001) suggests that victims of injustice are unlikely to be concerned about whether there are two, three or four types of justice but about their general experiences of injustice.

Gender and other demographic characteristics have also been found to influence overall justice in organizations. Empirical evidence from various studies found no significant difference in gender and perception of fairness (Coetzee, 2005; Esterhuizen, 2008; Owolabi, 2012; Khalili & Asmani, 2012). For instance, Cohen-Charash and Spector (2001), found no significant relationship between perception of fairness and gender and age. Similarly, Al Zubi (2010), in a study among employees of electrical companies in Jordan,

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found no significant relationship between the perceptions of fairness and gender.

On the other hand, Lee, Pollutla and Law (2000) argue that men and women should vary in their relative assessment of different dimensions of organizational justice, which is also supported by other studies that found a significant difference between males and females in their perception of fairness of performance appraisal (Van Zyl & Roodt, 2003; Duweke, 2004; Ozyer et al, 2014). According to Kirton & Greene (2005), gender differences exist because males and females play different roles within the social environment, which are judged against different expectations on how they ought to behave. It is therefore predictable that males and females will develop different skills, behave differently and perceive things differently.

On age, various studies show significant differences among employees with regard to perception of fairness (Van Zyl & Roodt, 2003; Duweke, 2004; Nasair, 2014; Ozyer et al, 2014), while Cohen-Charash and Spector (2001) found no significant differences between employees of various age groups. Coetzee (2005) found significant differences in various job levels and their perception of fairness similar to that of Owolabi (2012) in a study of the effect of organizational justice and turn-over intentions of health workers in Ekiti State in Nigeria. The effect of pay on perception of fairness is said to be driven by how the pay is determined, knowing how to maximize the pay and believing that pay is related to performance (Rasch & Szypko, 2013).

It was also suggested that understanding organizational justice in performance appraisal is important due to its impact on employees' job related attitudes and outcomes such as organizational commitment, job satisfaction

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and turnover rate (Colquitt et al, 2013; Cropanzano et al, 2007). It is therefore important to understand the concept of organizational commitment.

Organisational commitment

Organizational commitment is defined as a form of attachment and loyalty employees have for their organization (Meyer & Herscovitch, 2001). It is also perceived as an essential part of employees' psychological state because employees with high commitment engage themselves in more positive attitudes and behaviours that are beneficial to the organization (Jaros, 1997).

Organizational commitment can influence work in various forms, which can also affect the organization and the well-being of the employees (Meyer & Herscovitch, 2001). It is perceived as a force that binds employees to the organization. However, each concept of organizational commitment in the literature now represents each of the three constructs: affective, continuance and normative commitment which are separable both empirically and conceptually and are also equally important and useful (Meyer and Allen, 1987). It is therefore suggested that there is the need for researchers to evaluate all the three components of commitment in order to understand the relationship between employees and their organization (Meyer & Allen, 1991; Meyer et al, 2002 Cohen, 2003; Greenberg & Baron, 2003). The nature and the direction of the relationship between organizational commitment and other variables will depend on the type of commitment (Meyer & Allen, 1996).

Organizational commitment in large organizations is associated with low employees turnover and absenteeism (Camilleri, 2002; Gray, 2002) whereas organizational commitment among professional workers is less predictive of their intention to remain in the organization as compared to non-

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professionals (Shores & Martins, 1989). This is attributed to commitment of professionals towards their occupation rather than to their organization. Women are seen as less likely to be committed to their organization compared to men (Schwartz, 1989; Karrash, 2003).This is because women attach more importance to their roles in their families than in the organizational setting (Dodd-McCue & Wright, 1996). Others also suggested that women are more likely to be committed to their organization because they have to overcome barriers in order to secure employment and have less inter-organizational mobility as compare to men (Hrebiniak & Alutto, 1972; Loscocco, 1990; Grusky, 1996). Contrary to these assertions, some studies found gender difference in organizational commitment (Thorsteinson, 2003; Riketta, 2005; Steward, Bing, Gruys & Helford, 2007; Suki & Suki, 2011; Khalili & Asmawi, 2012).

The argument is that the development and maintenance of organizational commitment will vary across various age groups at various stages of career development (Rusbul & Farrel, 1983; Levinson et al, 1986). It was further predicted that an employee in the early stages of their career, will attempt to explore other jobs and will only remain if there are no alternatives. As a consequence, such employees will have a greater propensity to leave for other jobs than their older counterparts (Onstein, 1989; Onstein & Isabella, 1990). Thus, age is considered to be an important factor in organizational commitment in the early stages of career development of employees. Employees in the late stage of their career are more oriented to remain in their job and are considered to be more committed (Kumar & Giri, 2009; Dartey-

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Baah 2014). Studies also propose that that promotion through grades affect commitment rather than the age factor (Cohen, 1993; Beck & Wilson 2000).

For pay, Suma and Lesha (2013) found significant relationship between pay levels and organizational commitment in public institutions in Albania. Also, Gandhi and Hyde (2013), in a study in the public banks in India, found significant differences between pay and commitment levels among managerial and non-managerial levels and proposed that people who earn high salaries are not likely to leave their jobs.

Affective commitment

Affective commitment reflects the employee's ability to identify strongly with, involve in, and share in the vision of the organization to the extent that the employee becomes emotionally attached and feels he wants to be with and enjoy membership with the organization (Meyer et al, 2002). This aspect of commitment in the literature is the most prevalent. Individuals who are highly identified and involved in an organization have a stronger feeling of belongingness and are more psychologically attached to the organization (Lee et al, 2007). It therefore implies that individuals with high affective commitment continue to stay in the organization because they want to (Allen & Meyer, 1996). Psychological ownership associated with this type of commitment involves the entire aspects of the organizational life such as organizational culture and climate, organizational goals and vision, reputation of the organization, organizational policies and procedures and attitude of senior managers (Mayhew, Ashkanasy & dan Gardner, 2007).

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Continuance commitment

Continuance refers to the employee's perceived costs associated with losing the job that compels an employee to remain in the organization (Allen & Meyer, 1996). The continuance commitment is based on two factors, namely the extent and the number of investment an employee made in the organization, and the perceived availability or lack of alternatives (Meyer & Herscovitch, 2001). It is generally agreed that an employee will remain in an organization based on continuance commitment if the person's investment or side bets in the organization is likely to be lost if he/she leaves for another organization. Employees will have a stronger continuance commitment if they cannot obtain the same or better benefits in another organization (Lee et al, 2007).

Normative commitment

Normative commitment involves social factors that compel an employee to remain in the organization (Becker, 1960; Rusbult & Farrell, 1983; Meyer & Allen, 1987). This is considered the least common in the literature reviewed, yet it is very important because of its link to the employees' belief about their responsibility towards the organization (Meyer et al, 2002)

Models of organizational justice

A number of models have been proposed to explain the organizational justice structure. These are two structure models, three structure models and four structure models. The two factor model consists of distributive justice and procedural justice (Lind & Tyler, 1998; Folger & Konovsky, 1989: Greenberg,

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1990). Sweeney and McFarlin (1993), using structural equation modelling, showed that while distributive justice relates to outcomes at the personal level (e.g. rating, promotion and pay raise), procedural justice is related at the organizational level (e.g. organizational outcome). The validity of the two dimensions to measure organizational justice accurately was challenged by studies that proposed the third factor (Ambrose & Arnaud, 2005; Ambrose & Schminke, 2007).

Moag and Bies (1986) were the first to introduce the third factor known as interactional justice. They argue that this factor is distinct from both distributive and procedural justices. Whereas the interactional justice is the social exchange component of the interaction, procedural justice represents the process used to determine the outcome. There is a general agreement among researchers about the distinction between interactional and distributive justices, but the same cannot be said about interactional and procedural justices (Cohen-Charash and Spector, 2001). This stems from the view that interactional justice is about how procedures are enacted by supervisors but `subordinates perceive supervisors as the representatives of the organization so they may evaluate the organizational procedures by the type of interaction occuring between them and their supervisors (Lonsdale, 2013).

As a response to the above, Greenberg (1993) proposed a four factor model, arguing that interactional justice should be divided into two separate constructs, namely interpersonal justice and informational justice. He developed a taxonomy of justice perceptions by creating four distinct classes of justice. In support of this structure, Colquitt (2001) conducted two separate

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studies, one in the laboratory setting and the other in the field setting, to test for construct validity.

The four-factor model developed by Greenberg (1993) has the ability to integrate different views of the organizational justice concepts into four components in Table 1. These are systemic (structural-procedural), informational (social-procedural), configural (structural-distributive), and interpersonal (social-distributive).

Table 1: *Four Factor Model*

	Procedural Justice	Distributive Justice
Structural Determined	**Systemic** Procedural justice via structural means Concerns about procedures to assign rates, set criteria, communicate effectively, seek appeals, trust and understand the process.	**Configural** Distributive justice via structural means-decisions based on concerns about the norms that lead to ratings and accuracy of the rater.
Socially Determined	**Informational Justice** Procedural justice via social means : Concerns about the way raters communicate with their ratees and how raters offer explanations for their actions and inactions	**Interpersonal Justice** Distributive justice via social means. Concerns about the treatment that ratees' receive from their raters with sensitivity and respect.

Source: Greenberg's (1993) Taxonomy of Justice Perceptions Applied to Performance Appraisal (Thurston, 2001)

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The concept provides the basis for understanding organizational justice system through social and structural interactions. While the distributive justice perception in the four-factor model is about allocation of outcome, procedural justice is about how the allocation decisions are made. The structural components relate to the decision making in the course of the appraisal cycle and allocation of outcomes. The systemic component is derived from the procedural justice model developed by Thibaut and Walker (1975) and Lind and Tiler (1998) which are concerned with factors affecting perception of performance appraisal procedures. These are measured in terms of how employees are assigned responsibilities, set criteria, gather information, and seek appeals. It is also measured based on how subordinates perceive trust in their supervisors, clarify and understand the expectations of the appraisal process.

The configural component represents the distributive justice. It is based on the quality of work of an employee according to set performance standards and the norm of equity in the performance evaluation. This depends on decision norms and personal goals of the rater (Leventhal, 1980). Established social norms, feelings of the raters and political pressure may all affect the distributive justice. This is measured using accuracy of the rating and concern over the rating. These are based on acceptable ethical standards, lack of bias and how decisions and rules are applied consistently across employees and are also the representative of all concerned.

The social aspect of performance appraisal is described by the interpersonal and informational justices. Interpersonal justice involves how supervisors treat their subordinates with sensitivity during the appraisal cycle.

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This is assessed by two scales which are respect and sensitivity in treating subordinates during monitoring and supervision in the appraisal cycle (Thurston, 2001). Informational justice involves the social component of appraisal activities prior to the determination of the outcome. This entails the setting of performance appraisal goals and standards, routine feedbacks and explanations offered during the appraisal meetings. These are evaluated by the feedback supervisors provide for subordinates and the explanations offered when decisions are taken (Thurston, 2001).

The four factor organizational justice model appears to be the norm for a number of studies in organizational justice (Eib, 2015). The argument is that an appraisal system that promotes procedural, interpersonal, informational and distributive justice has the potential to meet individual and organizational goals (Ambrose & Schminke, 2007). There is evidence to suggest that perception of fairness in the ratings employees receive will increase their potential to perform effectively (Suliman & Kathairi, 2013). Fair treatment also has the potential to raise group spirit and when subordinates are made to participate in decision making process and are provided with the needed information, they are likely perform effectively on their jobs and be committed to the decisions, thereby remaining loyal to the organization (Colquit et al, 2013).

This study is based on the four factor organizational model because of its ability to explain the consequences of actions and inactions of employees and their supervisors in performance appraisal process which has the potential to influence the individual and the organizational performance.

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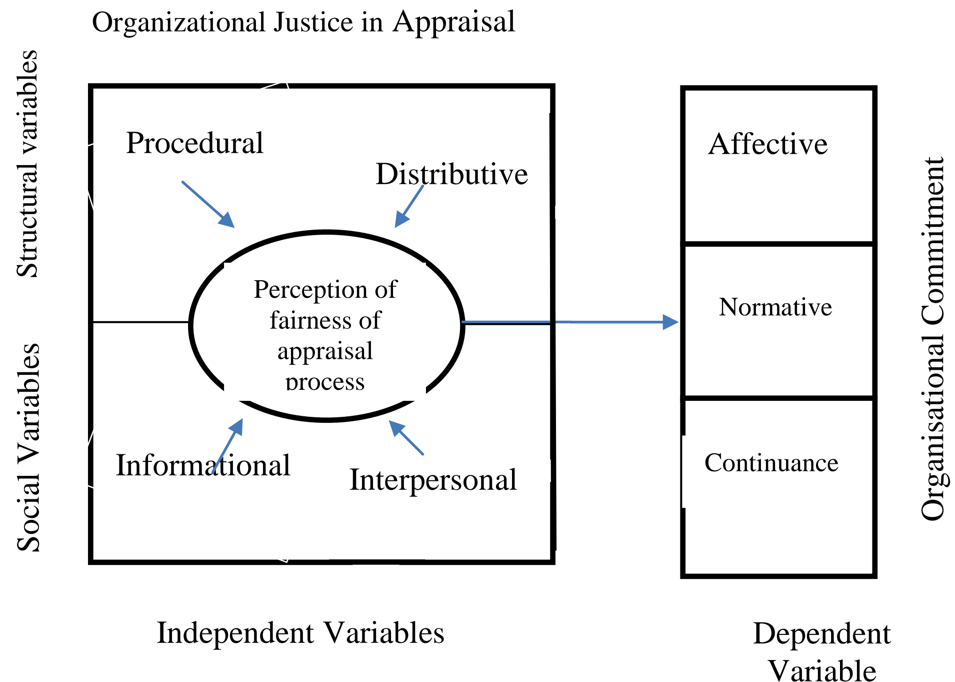
Conceptual framework for the study



Socio-structural Framework (Thurston, 2001; Meyer & Herscovitch, 2001).

The study argues that identifying, defining and measuring the context in which performance appraisal takes place will promote organizational commitment. Structurally (procedural and distributive justice), fairness can be perceived if appraisal process is clarified and the process made simple for employees to understand and provision is made for appeal. It is also perceived to be fair if the ratings employees received are seen to be equitable without any bias. On the social aspect (interpersonal and information), employees could perceive fairness if they are treated with respect and dignity and supervisors provide justification for their action and inactions (Greenberg, 1993; Thurston, 2001). The framework also points to the direction of relationship between perception of fairness and organizational justice that indicate that when employees perceived their appraisal system to be fair, they

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will reciprocate by showing commitment (Colquitt, 2001; Goldman, 2003; Greenberg, 2009). Organizational commitment represents the psychological state of the employees which are the affective, normative and continuance which promotes positive work related attitudes and behaviours among employees (Meyer & Herscovitch, 2001).

Performance of health workers

Performance of health workers is essential because it has influence on the type of services they render, which ultimately affects the health of the population (WHO, 2006b). High performing workers are the ones that are fair, efficient, and effective and are responsive to the needs of the population to achieve the outcome with the available resources under the prevailing circumstances (Omaswa, 2008).

Two elements have been identified to trigger performance at both individual and the corporate levels. These are job-related and enabling working environment (Rowe, De Savigny, Lanta & Victoria, 2005). The job related elements are availability of professional norms and code of conduct, clear job description and targets, proper matching of skills to the duties assigned, supervision and motivation (Rowe, et al, 2005; Mathauer & Imhoff, 2006). Job description will clearly specify job objectives, duties, responsibilities and the lines of authority and accountability and maintain standards. A study in Indonesia observed that the development of clear job description coupled with better in-service training and standards of nurses enhanced job satisfaction and compliance with standards (Franco, Bennett & Kafner, 2002), while other studies in Cape Verde indicated that health workers

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failed to maintain standards and pilfer materials meant for service provision due to poor remuneration (Ferrinho et al, 2004).

Performance can be affected if professionals are reassigned to duties other than those they are trained in (Global Health Partnership, 2005). A study in Tanzania estimated that 40% to 50% of district medical officer’s times were spent writing administrative reports, while in Uganda, district managers spent 70% to 80% of their time on planning, reporting and attending workshops (Omaswa, 2008). Supervision, monitoring and feedback have been found to enhance performance of health workers (Rowe et al, 2005; Egger, Travis, Dovlo & Hawken, 2005). An effective supervision makes the difference between staff motivation and performance between public hospitals and quasi government but autonomous hospitals (Marquez & Kean, 2002). In a study on effective supervision in both public and quasi-government hospitals in Ghana revealed that supervision seems to be more effective in quasi-government hospitals compared to the public ones (Dovlo, Sagoe, Ntow & Wellington, 1999). Staff relationships and teamwork are also essential elements that affect health worker performance. Evidence suggests that teams are more responsive to patient needs, are more cost effective and offer more job satisfaction to providers than employees working individually (Sims, 2003; Rafferty et al, 2005).

Enabling working environment refers to continuous education, people management, learning, responsibility and accountability (WHO, 2006a; Mathauer & Imhoff, 2006). In-service training has been found to change behaviour of workers when it is interactive, based on real-life problems and solutions. On-the-job training, especially at the work place through supportive

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supervision, clinical meetings or peer support is more cost effective than off-site training (Potter & Brough, 2004). This concept is an effective way of promoting an effective professional continuous development for health workers (O'Malley, Perdue & Petiacca, 2013). Team work approach and peer reviews are moderately successful in improving health workers performance (Clements, Dault & Priest, 2007).

Role of health workers in achieving health targets

The primary purpose of health workers is to promote health and deliver health services to improve the quality of life of the population (WHO, 2006a). These are of direct service providers such as medical doctors, dentists, nurses, midwives, pharmacists, community workers, allied health professionals, laboratory and other diagnostic workers as well as health management and administrators, finance officers, social workers and other support staff (WHO, 2006b).

WHO has recommended a minimum of 23 physicians, nurses and midwives per 1000 population in order to ensure coverage for essential maternal and child health services to achieve health related MDGs. This is because countries that fall below this threshold are unable to provide care at birth to significant number of pregnant women and emergency and specialized care to new born babies and young children (WHO, 2006a). Nonetheless, the target is not achievable in low income countries in Sub-Saharan Africa because of the funding gap in their national budget to support the health sector. The national income required to achieve the 23 physicians, nurses and midwives per 1000 population for Ethiopia, as calculated, shows that it would need to devote 53 per cent of its GDP to support health (Bossert & Ono,

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2010). To address this challenge, countries are making use of mid-level health workers and community health workers to diagnose and treat common health problems, to manage emergencies and refer appropriately the complicated condition beyond their competence. These categories of health workers, though not mentioned in the WHO's target, can provide a range of life-saving skills. Therefore, an effective workforce should be made up of a carefully planned professionals, paraprofessionals and community workers. The challenge here is the right mix of different categories of health workers and their individual skills combined to provide access of women and children to life-saving interventions (Bangdiwala et al, 2010).

A global approach in dealing with the challenge is focusing on health workers by using a "working lifespan" approach which deals with the various stages of working life of a health worker. This spans from the entry stage where the focus is on education and training to qualify to practice, followed by active performance stage, which deals with issues of supervision, system support, lifelong learning and motivation to improve performance. The final stage is the exit stage. Here, the emphasis is to avoid migration and attrition (Jimba et al., 2010).

Ensuring universal access to quality essential health services to achieve MDGs will require professionalism and team work (Gracia-Prado & Chawla, 2006). Hughes et al. (2002) suggested that poor performance is a product of health workers not providing care according to standards and organizational goals not meeting the needs of the serving population in a community. It is also as a result of unclear job expectations, lack of skills, resources, equipment and motivation. Causes such as low salaries, difficult working and living

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conditions and inappropriate training are part of failing health systems that are affecting the achievement of the MDGs.

Discussion and summary

The chapter argues that perception of fairness can be established using the concept of organizational justice. It distinguishes the constructs in a four factor organizational model which proposes justice as four separate concepts which provide the need to deal with various aspects of justice in the organization. This model appears to be the norm in recent times because it has the potential to meet individual and organizational goals. Nevertheless, some studies reviewed reported high correlation among the constructs. This suggests that, for some individuals, it is impossible to separate the various aspects of the justice. This may stem from the fact that those individuals may be more concerned about the overall perception of fairness influencing their attitudes and behaviours rather than any of the separate justice constructs (Ambrose & Arnaud, 2005). The review brought to the fore two approaches in assessing organizational justice. One is by measuring organizational justice as four different justice constructs and the other as an overall justice. This study adopts both approaches in order to broaden our understanding on the effects of the individual constructs in promoting justice as well as the overall effect of justice that drives behaviour in performance appraisal system.

Organizational commitment in the review was considered as an attitudinal outcome of the organizational justice in a three construct model. The constructs are normative, affective and continuance which are found to be separable conceptually and empirically and equally important and useful. It therefore means that when employees perceive an appraisal system to be fair,

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they will reciprocate through their levels of commitment to the organization (Cropanzano, Bowen and Gilliland, 2007).

Thus far, job related elements and enabling working environment can trigger performance. The job related elements refer to systems that workers need to carry out their jobs and those that shape and create enabling environment for the work to be done while enabling environment is the continuous education, management, learning responsibility and accountability. WHO (2006b) has recommended a minimum of 23 physicians, nurses and midwives per 1000 population in order to ensure coverage for essential maternal and child health services. Evidence available suggests that the availability of all categories of health workers in their right mix of skills is essential to ensure comprehensive health care (Bangdiwala et al, 2010). This can be achieved if the roles played by all health workers are seen as essential in providing the needed services required by population they serve.

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CHAPTER THREE

OVERVIEW OF PERFORMANCE MANAGEMENT SYSTEM IN GHANA

Introduction

Performance management in Ghana has undergone various stages of development from post independent era to the development of the new performance management system in 2007. In spite of the differences in the various approaches, the need to improve efficiency within the public service of Ghana has been an issue that cuts across the various periods. This chapter examines the performance management policy of 2007 in addressing performance in the public sector. It further outlines the performance appraisal system of Ghana Health Service, which is part of public service in Ghana. Performance of Ghana on health related MDGs is also discussed.

Historical perspective of performance management system in Ghana

Performance management in Ghana during post-independence era was based on reports and financial statements audited by Auditor General. Individual employee's performance was evaluated using annual confidential reporting system. This system of appraisal lacks transparency and accountability. The employee has no input in the process and the supervisor only determines what in his or her judgement the employee deserves. The system is subjected to abuse and thus makes its credibility questionable (Nkrumah, 1992; Ayee, 2001). This difficulty in measuring individual performance has culminated in the poor performance of the public institutions throughout the country (Ayee, 2001).

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In response to these institutional failures and poor performance at the individual levels, the Provisional National Defence Council (PNDC) embarked on World Bank and International Monetary Fund (IMF) prescribed Structural Adjustment Programme (SAP). The focus of the programme was on institutional reforms. The first phase was named a “stabilization phase” which was intended to reform public sector institutions to make them effective. This, however, was not achieved due to weaknesses in the public sector organizations which were expected to implement the programme (Hutchful, 2002).

The failures identified in the stabilization phase prompted the adoption of key reforms in the 2nd phase of the programme. The reform in the 2nd phase was based on the assumption that the public institutions would always continue to play a central role in the economy (GOG, 1985). This role was expected to be achieved through reforms and policies on employment and wages of the state enterprises. There were also institutional restructuring and management reforms. Some commercial enterprises were rehabilitated and their financial and social profitability were enhanced to improve their economic efficiency (GOG, 1985).

This was followed with the Civil Service Reform Programme (CSRP) from 1987 to 1993 as part of SAP. The objectives were to improve the motivation and the performance of the service through rationalisation of staffing levels, job analysis, classification and re-assignments and examine the overall salary structure of the service which had worsened over the years, leading to low morale and productivity (Dodoo, 1997). This low morale, affected the service’s ability to attract qualified and competent officers at the

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senior and policy management levels (Larbi, 2000; Hutchful, 2002; Fuseini, 2003). The programme failed to achieve its objectives due to the failure to recognize service as the primary function of the public sector and move away from command and control management approach to that of participatory approach, while focusing on the importance of service delivery to the public (Hutchful, 2002; Ohemeng, 2009).

The failure of CSRP to address the performance driven culture culminated in the government introducing yet another programme referred to as Civil Service Performance Improvement Programme (CSPIP). The goals of this reform were to drive service delivery at the public sector through results and performance orientation; promote value for money in all transactions; and achieve efficiency through cost effectiveness, innovation, market and customer sensitivity and accountability. It further aimed at the culture of good governance (Stevens & Teggemann, 2004; Antwi, Analoui & Nana-Agyekum, 2008; Ohemeng 2009). This reform was seen largely as the first serious attempt by the government to transform public service institutions by driving performance culture similar to those found in developed countries (Ohemeng, 2009). As part of the implementation of the programme, a number of laudable steps were taken. These were the development of service brochures, the establishment of Clients Service Units (CSU) to disseminate information and programmes to the public and other institutions and clients surveys to identify the service delivery challenges from the perspective of the public and appropriately address their concerns. An important component of the programme was to develop and sign performance management contracts between the government and the senior bureaucrats such as Chief Directors

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and the heads of various ministries and agencies (Larbi, 2000; Ohemeng 2009).

Notwithstanding the laudable objectives and the steps taken to improve the face of the public institutions under the CSPIP, it still failed to transform the culture of the public sector to any noticeable extent. Public sector institutions remained adamant to change and still held on to the old bureaucratic culture that affected their performance. The public did not get value for money and customer service (Ohemeng, 2009).

A number of reasons have been assigned to the inability of the CSPIP to improve the performance of the public institutions in any meaningful way. One of the reasons for the failure was attributed to the inherent weakness in the design and the implementation of the programme (Antwi et al, 2008). Another was linked to the unrealistic expectations associated with the signing of performance contracts and development of brochures on work ethics as well as expected standards of services were not enough to change the entrenched poor culture of work in the public sector (Adei & Boachie Danquah, 2002). Factors such as institutional fragmentation, lack of incentives and political will, lack of commitment and citizen's knowledge of and involvement in the programme were attributed to the reasons for the failure (Ohemeng, 2009). At the institutional level, the failure was linked to the inability of the system to enforce the laid down procedures at both the institutional and at the ministerial levels. This was basically attributed to the lack of institutional backing in terms of legislations that would compel civil and public servants to accept the programme and bring about the expected behavioural change that will improve the organizational performance (Adei & Boachie-Danquah, 2002). It was

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further indicated that the performance management embedded in legislation originating from cabinet, would compel ministers to remain committed to the programme. This would then call for doing things differently since failure to meet prescribed targets would lead to sanctions while those who met or exceeded their targets would be rewarded. In this way, resistance to change would be overcome (Ohemeng, 2009).

Performance management policies for the public sector of Ghana

The performance management system in the public sector is part of the human resource policy framework of the government intended to ensure professionalism in the management of human resources. It is meant to strengthen the capacity of the public service to ensure the use of accurate and reliable data for recruitment, training and other management functions. This is part of the general reform of the Central and Strategic Management Agencies which are made up of Public Services Commission, the State Enterprises Commission and the office of the Head of Civil Service (Public Services Commission, 2007). The policy framework is divided into three thematic areas. These are policy objectives, policy application and policy directives. These areas are fed into a number of important prescriptions meant to help in the overall achievement of the policy. These are made up of levels of assessment, performance planning, annual performance monitoring, performance improvement plans, development of performance assessment scales, conducting performance evaluation, incentives, sanctions, appeals and other processes (Public Services Commission, 2007).

There are two levels of assessment, namely the individual and institutional assessments. At the accountability section, the emphasis is on all

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levels within the organization from the chief directors and line directors through to the employees. In this case, each ministry or department is mandated to designate one senior officer as the performance management coordinator. The coordinator has the responsibility of ensuring annual performance planning, facilitate the execution of the plan, collect and analyse performance appraisal forms, and submit annual report to the chief director for the necessary action. The coordinator is also expected to serve as the principal liaison officer between the office of the civil service and the various ministries and departments (Public Services Commission, 2007).

A new Institutional Performance Assessment Tool (IPAT) was developed to enable the institutions to undertake bi-annual assessments. This defines the levels of assessment, how to develop plans, report and measure systems and performance. Details of performance planning should serve as an input for the overall annual plan of the institution. The institutions are expected to submit their annual performance reports through the office of the Head of Civil Service (OHCS) to the government and to the parliament for assessment on efficiency, effectiveness and economy. A key feature of the performance management system is the need for each institution to develop performance improvement plans (PIP) for their employees. This is to ensure that the individual level performances are properly linked to the institutional performance and the client's expectation. This stems from the fact that the public service institutions exist mainly to provide various range of services to the public. The quality of the service provided should therefore serve as indicators for performance assessment. The system also developed a performance assessment scale to be used by a panel to evaluate the

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performance of chief directors. It also addressed issues relating to incentives and sanctions. This was based on a clear process of assessment and rating of scores which vary according to levels of responsibilities, career dynamics and progression. In this case, chief directors were expected to receive a bonus in a form of a 13th month cheque or a one-off percentage pay based on the annual gross salary. This was then cascaded down to the lowest level in the organization. In a situation where an individual failed to meet the performance expectations, three levels of sanctions were proposed. First, failure would lead to written caution; second failure would result in reassignment; and third, failure would result in demotion or dismissal.

Rewards and sanction, though part of the previous performance management systems, were fraught with challenges because of lack of budgetary support (Ohemeng, 2009). To address this challenge, the OHCS designated a special fund referred to as the Performance Improvement Facility (PIF) to pay for the bonuses. Even though the PIF was to be managed by the HOSC, its overall management was to be based on guidelines and directives agreed upon by the Ministry of Finance and Economic Planning and the development partners such as World Bank and IMF (OHCS, 2007).

Performance management policy for Ghana Health Service

Ghana Health Service, as an outshoot of a civil service of Ghana, inherited the appraisal system of the Civil Service for evaluating the performance of its employees. However, in 2003, GHS developed its own performance appraisal policy due to the failure of the existing appraisal system, to address performance improvement challenges. The policy objectives were to streamline the use of performance appraisal as an effective

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tool for human resource management at all levels, measure performance output of employees, and identify their training needs to enhance effectiveness in the use of human resource. It also served to link performance output to career progression, promotion, pay and even institutional and national health targets (Quality Health Partners, 2005). The policy requires only supervisors to appraise their employees. When the new appraisal policy was introduced, it was piloted in four regions, namely Volta, Eastern, Western and Central Regions.

Performance appraisal process in Ghana Health Service

The performance appraisal process in GHS begins with the performance appraisal interview. This is a meeting between the supervisor and the employees. At this interview, both the supervisor and subordinates agree on the objectives to be achieved by the subordinates. This is followed by the establishment and the listing of the various activities required to be carried out to achieve each set objective or target. The employee is expected to fill the appraisal form in the presence of the supervisor by transferring the agreed objectives and activities onto the appropriate columns of the appraisal forms. Ghana Health Service has developed sample objectives to guide the setting up of good objectives that meet the Specific, Measurable, Achievable, and Realistic and Time Bound (SMART) criteria to be used during performance appraisal.

In order to ensure the performance appraisal system as a dynamic process, a mid-year review is required. This is a stage where supervisors are required to assess the employees on all the activities they set to be carried out within the period under review. This is based on the assumption that the

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achievement of the activities would lead to the achievement of the objectives. Thus, the review of activities would guide both the manager and the employee on how far the activities are being reached. It is important, at this stage, to identify performance challenges faced by the employee in the course of his or her activities and what can be done to surmount those challenges. It is also possible to assess the possibility of achieving the set objectives at this stage. Where the objectives are not achievable due to constraints that cannot easily be addressed by the subordinate or the supervisor, there may be the need to review them. These challenges may be due to lack of certain resources, or equipment or skills that may not be readily available. The mid-year review serves to provide feedback to both employees and their supervisors. Challenges that hinder effective performance are addressed at this stage. The challenges could be lack of skills, which can be addressed through training or lack of resources which could also be identified and made available. The interpersonal issues between the supervisor and the subordinates can also be addressed through training.

Apart from the official mid-year review, the supervisor is expected to monitor and keep track of the performance of each employees. The supervisor is expected to keep critical incidence file for his or her subordinates. The file contains critical incidence forms that record extraordinary positive or negative incidences which would guide the supervisor in the final evaluation. The filing of the form must be transparent in that, the subordinates must be aware of any incidence of theirs that is being recorded.

The final stage of the appraisal process in GHS is the performance evaluation. This is done after the appraisal year has elapsed. The process first

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involves the assessment of the objectives. This is determined by establishing whether the employees have achieved their targets or not. The second part is to rate the employee on certain behavioural but job related attributes. Every employee is assessed on five attributes, namely quality of work, job knowledge, initiative and resourcefulness, attendance and dependability and attitude towards work, patients, staff and public, which span from unsatisfactory to excellent. Each employee is then rated on a mean score which is determined by adding all the scores from the five attributes and the total score divided by five. The supervisor is expected to tick the appropriate column for the mean score obtained, which is classified in a range from 1 to 1.5 as unsatisfactory, 1.6 to 2.5 as marginal, 2.6 to 3.5 as good, 3.6 to 4.5 as very good and 4.6 to 5 as excellent. During the evaluation stage, strengths and weaknesses of the employees are established. This also feeds into the determination of the training needs of the employee.

The supervisor is expected to sign and comment, where necessary, on critical incidences that occurred during the appraisal year. The appraisee, on the other hand, must sign and comment whether he accepts the ratings and the comments of his or her supervisor. There is the need to state areas of disagreement if there are any. A higher authority or officer serves as a counter signing officer. Where there are disagreements, the counter signing officer initiates the process to resolve the issue.

An evaluative study on appraisal practices in GHS by Quality Health Partners (2005) revealed that employees were only appraised when they were due for promotion. They also indicated the appraisal system lacks ownership and commitment of employees to achieve institutional targets. They

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recommended that the appraisal system should be integrated into institutional, district, regional and national targets. It should also be made part of routine planning, budgeting, monitoring and evaluation. (Quality Health Partners, 2005) as suggested by Martinez (2001) to link appraisal system into the management system.

Performance management and the health related MDGs in Ghana

Ghana adopted three health related Millennium Development Goals in 2000 as part of a global effort to improve the health status of all people with emphasis on children and women. These were to reduce child mortality, improve maternal health and combat HIV/ AIDS, malaria and other diseases by 2015 (WHO, 2000). Ghana, since 2001, set specific targets and mechanisms to monitor progress in achieving the goals. Nonetheless, Ghana's MDG report for 2014 revealed that the progress in achieving a number of the targets was mixed as shown in Table 2 (Republic of Ghana, 2015).

Table 2: *Performance of Ghana on the Three Health Related MDGs*

MDG GOAL	Indicator	2014 Performance	Target
	UFMR (1,000 live births)	60	40
Reduce Infant Mortality	IMR (1,000 live births)	41	30
	NMR (1,000 live births)	29	20
Improve Maternal Health	MMR (100,000 live births)	319	185
	Supervised delivery (%)	74	100
Combat malaria, TB and other diseases	Malaria prevalence rate (%)	417 (2013)	<130
	TB prevalence rate (per 100,000)	286	<210
	HIV prevalence rate (%)	2.6	< 3.2

Source: Republic of Ghana (2015)

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Out of the eight indicators selected from the three MDGs in Table 2, Ghana is likely to achieve the target on one. HIV prevalence rate fell from 3.2 per cent in 2006 to 2.2 per cent in 2008 but increased to 2.9 per cent in 2009 and has again reduced to 1.6 per cent in 2014 (GHS, 2014a). Ghana is therefore likely to sustain the gains to reduce prevalence rate below the target of 3.2 by 2015. Improved efforts in the area of educational campaign and other programmes are required to promote behavioural change to sustain the current pace of decline. Under-Five Mortality Rate (UFMR), Infant Mortality Rate (IMR) and Neonatal Mortality Rate (NMR) indicators are used to assess target to reduce child mortality. Under Five Mortality Rate remains a public health concern because it measures more than 90 per cent of global mortality of children under the age of 18 (UNDP, 2003). Under Five Mortality Rate (UFMR) declined from 111 deaths per 1,000 live births in 2003 to 60 deaths per 1,000 live births in 2014. Infant Mortality rate (IMR), during the same period, reduced from 60 deaths to 41 deaths per 1,000 live births while NMR declined from 30 deaths per 1,000 live births in 2008 to 39 deaths per 1,000 live births (GSS, 2014; Republic of Ghana, 2015). The trend shows that the targets of 21.5 deaths, 38.88 deaths, and 20 deaths per 1,000 live births for both IMR, UFMR and NMR respectively are not likely be achieved by 2015 (Republic of Ghana, 2015).

The target of improving maternal mortality is assessed by Maternal Mortality Rate (MMR) and Supervised Deliveries (SD). Maternal Mortality Rate declined from 503 per 100,000 live births in 2005 to 319 deaths per 100,000 live births in 2014 (GSS, 2014). The trend indicates that Ghana is not likely to achieve the target of 185 per 100,000 live births by 2015. Evidence

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suggests that supervised delivery reduces the risk of complications and infections during childbirth and thereby reduces maternal mortality. Care provided by professionals during pregnancy and childbirth is an important intervention for safe motherhood. Supervised deliveries by skilled birth attendants increased from 59 per cent in 2008 to 74 per cent in 2014 (GSS, 2014). It appears there was an improvement in skilled deliveries in 2014 but there are disparities among the regional rates. In Greater Accra, for instance, 92 per cent of all live births were delivered by skilled birth attendants, while in the Northern Region, 34 per cent of live births were delivered by skilled attendants (Republic of Ghana, 2015). Therefore, the national target of having all deliveries in Ghana to be done by professional birth attendants by 2015 is not likely to be achieved.

Malaria continues to be the leading cause of morbidity and mortality in Ghana. It has become a public health concern because it is a major cause of poverty and low productivity (Republic of Ghana, 2015). It accounted for 32.5 per cent of all OPD attendances and 48.8 per cent of under-five admissions in the country (Republic of Ghana, 2015). Although over the past decade, there have been a number of interventions to reduce malaria through malaria control programme such as the promotion of insecticide treated nets (ITNs), the increasing incidence of malaria makes the attainment of this goal a challenge. From Table 2, malaria prevalence rate declined from 130 per 1,000 population in 2,000 and declined to 108 per 1,000 population in 2010, but increased to 417 per 1,000 population in 2013 (GHS,2013). TB prevalence rate also increased from 210 per 100,000 population in 2000 to 286 per 100,000

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population in 2014 (MOH, 2014). Therefore the target of halting and reversing the incidence of malaria and TB by 2015 is unattainable.

In all these, areas which could have contributed to the attainment of the targets are the knowledge, skills, motivation and deployment of health workers responsible for organizing and delivering the health services (WHO, 2009). Motivation, improvement and deployment of health workers was reported to have contributed to the gains made towards the achievement of maternal and child health targets of the MDGs in Ghana (Republic of Ghana, 2015). Performance management through appraisal system is seen as a way through which employees can be motivated to perform optimally on their jobs to achieve targets (Iqbal et al, 2013). Bevan and Hood (2006) found a link between motivation of health workers through performance appraisal and achievement of health related outcomes while Anand and Barnighausen (2004) found human resource as a determinant of achieving health targets.

Discussion and summary

Performance appraisal, not new to the public sector in Ghana, but has faced implementation challenges leading to the development of a number of appraisal policies to fill the gaps (Ohemeng, 2009). These challenges were inherent in the lack of sector wide participation and involvement in the design and implementation of the policies. In 2003, GHS developed a new performance appraisal system to address the already existing implementation challenges. The appraisal process provided for setting standards at the beginning of the year, assessing of mid-year activities and daily supervision, monitoring and providing feedback as well as reviewing the performance at the end of the year. These processes were geared towards ensuring that the

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individual and the organizational targets were met while performance outputs are used as the basis for administrative decisions such as promotion and developmental purposes like training and development. However some of the appraisal practices were found not to be in accordance with the policy. For instance, employees were said to be appraised only when they were due for promotion. Also, the employees lacked ownership and commitment to ensure achievement of their organizational goals (Quality Health Partners, 2005).

Millennium Development Goals four, five and six are to reduce infant mortality, improve maternal health and combat HIV/ Malaria/ TB and other diseases. MDG report of Ghana for 2014 indicated that seven out of eight indicators used in assessing the performance of the targets are not likely to be achieved by 2015. This could be attributed to the failure of health managers to address the job-related needs of health workers to perform optimally on their jobs to achieve the targets (Republic of Ghana, 2015).

A number of challenges inherent in the implementation of the appraisal system in GHS may have also reflected in the non achievement of targets in the health-related MDGs. For instance, the lack of commitment of the employees of GHS in the appraisal system (Quality Health Partners, 2005) could de-motivate the employees to focus on achieving their organizational goals. These implementation challenges provided the basis for this study to re-evaluate the entire appraisal process vis-à-vis the policy. The study therefore argues that if managers implement the performance management system in accordance with the processes set out in the policy, it could provide the needed impetus to achieve individual and organizational goals.

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CHAPTER FOUR

METHODS OF DATA COLLECTION AND ANALYSIS

Introduction

This chapter presents the methods of data collection and the profile of the study areas, study population, sampling procedures, instrument for data collection as well as pretesting of the instrument. The chapter also discusses the ethical issues, experiences from the field work and data analysis.

Profile of the study areas

The study is based on employees working in various health facilities in the Volta and Central regional capitals. Volta and Central Regions were randomly chosen from the four regions (Central, Volta, Brong-Ahafo and Eastern) where the current appraisal system was piloted. The regional capitals were selected on the basis that they represent all the units of health care delivery at the regional level. These are made up of sub-district facilities such as clinics, health centres and polyclinics. They also have district facilities such as district, municipal or metropolitan hospitals, district health directorates as well as regional level facilities such as regional hospitals and regional health directorates.

Ho and Cape Coast are the administrative capitals of Volta and Central Regions respectively. Cape Coast had 8 health facilities compared to 6 facilities at Ho (Table 4 and 5). The facilities at Ho and Cape Coast had 43 different health workers who are responsible for health service provision (Table 3).

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Table 3: *Categories of Staff at Cape Coast and Ho*

No.	Grade	No	Grade
1	Staff Nurses and Midwives	22	Health Research Officers
2	Nursing Officers	23	Auditors
3	Pharmacy Technicians	24	Architects
4	Nutrition Officers	25	Quantity Surveyors
5	Biostatistics Officers	26	Blood Donor Organizers
6	X-ray Officers	27	Human Resource Manager
7	Laboratory Officers	28	Health Educationist
8	Medical Superintendent	29	Medical Officers
9	Health Education Officers	30	Pharmacists
10	Supply Officers	31	Radiographers
11	Accounts Officers	32	Biomedical Scientists
12	Personnel Officers	33	District Directors
13	Records Officers	34	Physiotherapists
14	Executive Officers	35	Medical Assistants
15	Private Secretaries	36	Nurse Anaesthetists
16	Catering Officers	37	Community Oral Health Officers
17	Estate Officers	38	Dental Technologists
18	Transport Officers	39	Dieticians
19	Transport Manager	40	Occupational Therapists
20	Technologists (Mechanical and Clinical Engineering)	41	Accountant
		42	Regional Directors
21	Health Service Administrators	43	Deputy Regional Directors

Source: GHS (2012a)

These personnel were responsible for the health needs of the population of 169,897 in the Cape Coast Metropolis and 177,231 in the Ho Municipality. Males form 48.7 per cent of the population in Cape Coast while at Ho the males were 47.3 per cent. The children with ages 0-15 years accounted for 31 per cent of the population in Ho compared to 28.4 per cent in Cape Coast. Also, 40 per cent of the population in Cape Coast compared to 72.7 per cent at Ho were migrants. The Crude Birth Rate (CBR) and Crude Death Rate (CDR) for the population in Ho were 20.9 per 1,000 population and 8.3 per 1,000 population respectively. For Cape Coast, the CBR and CDR were 17.9 per 1,000 population and 5.2 per 1,000 population respectively.

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Fertility Rate (FR) in Cape Coast was 2.2 compared to 2.6 in Ho (GSS & Ho Municipal Assembly, 2014: GSS & Cape Coast Municipal Assembly, 2014).

Research design

The study used quantitative scales developed by Moorman (1991), validated by Tang and Sarsfield-Baldwin (1996) and another developed by Thurston (2001) to measure constructs of distributive, procedural, informational and interpersonal justices to assess perception of fairness and another developed by Meyer and Allen (1996) to measure affective, normative and continuance commitments in GHS. The Cronbach Alpha reliability test of .926 was obtained for the scales used for measuring organizational justice and commitment constructs during the pretesting of the questionnaire. This gives an indication that the scales used had "adequate" internal consistency and therefore could be used to collect data for the study (see Appendix 5). These scales and approach have been used in US, UK, India, South Africa and Ghana to assess perception of fairness and organizational commitment (Moorman, 1991; Meyer & Allen, 1996; Tziner et al, 2001; Thurston, 2001; Dartey-Baah, 2014). The scales are quantitative in nature hence the adoption. The strength of the approach in this study is that the results could be generalised in a certain context that is relevant to the area of the study.

Sources of data

Data for the study was collected from two different sources. The first source was from human resource data from the regional offices of GHS and health facilities at Ho and Cape Coast. These are the nominal roll and the appraisal forms of the personnel working at the health facilities at Ho and

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Cape Coast. The nominal roll helped to determine the number of personnel working at the health facilities while appraisal forms enabled us to report on the ratings employees had as well as whether they had met their performance target in their last appraisal evaluation.

The second source of data was a primary data using questionnaire to assess perception of fairness and organizational commitment, evaluate perception of employees on the effectiveness of the current appraisal system as well as assess the level of awareness of employees on health related MDGs. Socio demographic data on age, education, gender, gross salary, staff category and region were also collected.

Study population

The target population for the study consisted of all employees of Ghana Health Service within the Cape Coast Metropolis and Ho Municipality who had been appraised on the current appraisal system. This was to ensure that only employees who had an exposure to the appraisal system were selected for the study. These staff members were expected to be appraised yearly as part of the requirement for their performance, promotion and for assessing their training needs and career progression in the service.

Sampling procedures

In all, 897 employees who were appraised at 6 health facilities at Ho and 8 at Cape Coast were selected for the study. The reason for the inclusion of all the members was to cover the 43 different health personnel in the service.

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Table 4: *Sample Size of GHS Staff at Cape Coast and Ho*

	Cape Coast			Ho		
Institution	Males	Females	N	Males	Females	N
Regional Health Directorates	39	17	56	35	15	50
Nursing Training Colleges	3	11	14	4	11	16
Regional Hospitals	111	161	272	79	118	197
Metropolitan/ Municipal Hospitals	30	90	120	26	76	102
Metropolitan/ Municipal Health Directorate	5	5	10	5	7	8
Polyclinics/ Health Centres	8	32	40	3	6	9
Total	196	316	512	152	233	385

Source: GHS (2012a; 2012b)

The lists of all personnel who were appraised were obtained from the two regional offices and were classified into the institutions where they worked. They were further stratified into four professional groups namely Medical, Paramedical, Nursing and Midwifery and Administrative and Support Services based on WHO's classification of health workers. This was to ensure that every group of health workers was selected since all health workers play either direct or indirect roles in meeting health targets such as the health related MDGs. Employees who were appraised from Cape Coast and Ho represented 58 per cent and 42 per cent respectively of the sample size of 897. Females formed 61.4 per cent compared to 38.6 per cent of males. At Cape Coast, females accounted for 61.7 per cent, while at Ho, they constituted 60.5 per cent.

Instruments of data collection

The questionnaire had six sections (see Appendix 4). The first section was on socio demographic characteristics of the respondents (i.e. gender, age, highest academic qualification attained, professional rank and monthly gross salary). The second section covered the effectiveness of the appraisal system.

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The third section measured the level of performance of staff in achieving the three health related MDGs. The fourth section was made up of items for measuring constructs of organizational justice (distributive, procedural, interpersonal and interpersonal). There were nine sub-factors (accuracy of rating, concern over rating, two way communication, trust in the supervisor, clarity of expectation, understanding the appraisal process, seeking appeals, treatment by supervisor, and explanation of rating decisions).

The study used two scales developed by Moorman (1991) and Tang and Sarsfiel-Baldwin (1996) to measure distributive justice. The scales were based on how rating decisions were made in terms of equity, accuracy and avoidance of bias (Tziner et al, 2001). For procedural justice, the study adopted items based on five issues developed by Tang and Sarsfield-Baldwin (1996). These are two way in communication, trust in the supervisor, clarity of expectation, understanding the appraisal process and seeking appeals. Items under interpersonal and informational justices were based on scales developed by Thurston (2001) to measure the treatment employees received from their supervisors and explanation of rating decisions.

The fifth section measured organizational commitment using three scales: affective commitment, continuance commitment and normative commitment. Affective commitment scale is made up of eight items which were used to evaluate various work experiences. The continuance scale had seven items that reflected perceived cost associated with leaving the organization. The normative scale had eight items that addressed issues about employees' obligation to the organization. The final section elicited suggestions for improvement of the appraisal

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Training of field assistants and pretesting of questionnaires

Ten field assistants were trained for the survey. This was done after the instrument was reviewed by the two supervisors and approval granted from both the University of Cape Coast and Ghana Health Service Ethical Review Boards on 4th June, 2013 and 29th May, 2013, respectively. The rationale for the training was to ensure that the items in the questionnaire were understood by both the respondents and the field assistants. This was necessary to deal with the likely problems to be encountered during the field work, and in addition, help to establish the average time required by the respondents to complete each questionnaire as a way of helping in planning for the field work.

Thirty questionnaires were pretested at the Winneba Municipal Hospital and Trauma and Specialist Hospital both at Winneba from 8th to 11th June, 2013. The two hospitals were chosen for the pretesting because they were outside the study area and were made up of the various complements of health workers required for the study.

The process first began with the submission of letters of permission to the heads of the two institutions to pre-test the instrument at their respective hospitals. Permission was granted and an officer was assigned from each of the institutions to assist in administering the questionnaires to the staff. The questionnaires were personally administered with the help of the trained field assistants after informed consent forms had been duly signed by the respondents. This approach was adopted to enable the researcher and the field assistants have first-hand information on the suitability of each item in the questionnaire and how easily it could be administered to the respondents.

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On the average, it took thirty minutes to complete a questionnaire. After the pretesting exercise, an item was added and four out of one hundred and four items in the questionnaire were reviewed to make their meanings clearer to the respondents. The item number four on the questionnaire dwells on the highest academic level attained but secondary and university diploma were left out. These were included and the "other' category for those who may not fall in any of the listed categories. Item 18 and 19 were reviewed to mean appraisal objective was set at the beginning or at the end of the year and who set appraisal objectives respectively. Item sixty five on the questionnaire contained a typographical error of "Employers" instead of "employees" and was corrected. The additional item which was included in the questionnaire was the region of the respondent.

Following the data collection in pre-testing, the study employed Cronbach Alpha reliability test to scientifically ascertain the reliability or otherwise of the instrument. Out of the 124 items on the questionnaire, 94 'qualified' to be used in computing the reliability coefficient and the results are summarized in Appendix 5. The items excluded were the socio-demographic variables and open ended questions. The reliability coefficient obtained for the instrument was .926 based on 94 items. This value far exceeded the acceptable cut-off point of .700, indicating that the questionnaire in general, had "adequate" internal consistency as postulated by Cohen (cited in Leech, Barrett & Morgan, 2005). Therefore, the instrument could be used for the main data collection without any modification.

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Ethical considerations

Clearance was sought and granted from both Ghana Health Service and University of Cape Coast (UCC) Ethical Review Boards (see Appendix 6 and 7). Letters of permission and informed consent for data collection were obtained from respondents and their institutions. In this regard, all the respondents participated out of their free will. Provision for counselling was made for possible psycho-social breakdown of the respondents in the course of the field work. However, no respondent suffered psycho-social breakdown during the field work. The procedures and the rationale for the research project were explained to each of the respondents after which they voluntarily consented to participate. Confidentiality and anonymity were also ensured by protecting the information provided by each respondent. Data obtained from the questionnaires and the appraisal forms were securely kept to avoid access to a third party. Names were not used so one cannot relate any data to an individual.

Field Work

Field work commenced on 17th June, 2013 and was completed on 15th October, 2013. It took four months instead of two months earmarked due to difficulty in meeting some respondents for the administration and retrieval of the questionnaire. A formal permission was always obtained from the institutions concerned by first submitting to the heads of the participating institutions the approval letters for data collection obtained from the Regional Directors of the Volta and Central Regions and the ethical clearance from both Ghana Health Service and UCC Ethical Review Boards. For each of these institutions, a human resource officer was assigned to assist in determining the

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shift on which each staff on the list belonged and also identify those who were on leave. Those on night and afternoon shifts in some cases were informed prior to meeting them to be sure they were at post. In some instances, respondents requested they were met on specific dates and times.

The questionnaires were hand-delivered to the respondents and items in the questionnaire were explained to them. The field assistants, together with the researcher, were available for further explanation during the completion of the questionnaire whenever the need arose. For individual respondents, their willingness to participate was obtained first, after which each respondent was taken through the questionnaire. All respondents could read and write so there was no need for an interpreter. The decision to complete the questionnaire immediately or later with the help of the researcher or the field assistants was made based on the respondents' time schedule. Only 30% of the questionnaires were filled immediately with the help of the researcher or research assistants. Due to the busy schedule of some respondents, 40% requested the questionnaire was left with them to be completed at their convenient times, while the other 30% scheduled specific dates and times to be met for the interview.

There was the need to do regular follow-ups and remind the 40% who self-administered the questionnaires through telephone conversation. They sought clarifications as and when the need arose. During retrieval, there were instances where certain portions of the questionnaires were left blank and sometimes not properly filled. Under such circumstances, the attention of the respondents was drawn and was assisted to complete them.

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Some of the respondents who requested to be interviewed at specific times had to be rescheduled. This often arose due to unforeseen circumstances on the part of the respondents. Nine of such interviews never happened. In one instance, the interview was rescheduled 11 times before it was finally conducted. There was also the need to cross-check the information on their last appraisal forms to be able to complete items 20 and 21 on the questionnaire. This was a major reason for the delay in completing the questionnaires on time. Some respondents asked for some time to enable them look for their copies that were later found while others could not trace their personal copies.

The questionnaires were retrieved as soon as the respondents had completed them. In all, a total of 700 questionnaires were administered out of which 519 were successfully completed and retrieved giving the rate of return to be 74.3%. One hundred and ninety seven (197) members of staff refused to participate in the study due to various reasons. The reasons given were that the questionnaire was too voluminous and several studies had been carried out without the findings implemented to improve the systems in the organization. One retorted "we have been filling these questionnaires every day and yet nothing improves." They were therefore not going to waste their time anymore on such a venture. Overall, all the heads of GHS institutions were helpful and the respondents were cooperative and ready to provide the needed responses.

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Table 5: *Number of Respondents at Cape Coast and Response Rates*

Health facilities at Cape Coast	Target Population	Questionnaire administered	Non Participants	Questionnaires completed and returned	%rate of return
Central Regional Hospital	200	155	45	109	68.1
Cape Coast Metro Hospital	110	85	25	69	81.2
Adisadel Health Centre	38	30	8	20	66.7
Ewim Polyclinic	55	45	10	35	77.8
Metro Health Directorate	30	25	5	19	76.8
Central Regional Health Directorate	50	40	11	32	80.0
Aged Clinic	18	15	3	10	66.7
Cape Coast Nursing Training College	11	5	6	3	60.0
Total for Cape Coast	512	400	113	297	74.3

Source: Field data (2013)

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Table 6: *Number of Respondents at Ho and Response Rate*

Health facilities at Ho	Target Population	Questionnaire administered	Non Participants	Questionnaires completed and returned	%rate of return
Ho Nursing Training College	20	15	5	5	33.3
Volta Regional Health Directorate	50	40	10	34	85.0
Ho Municipal Health Directorate	40	30	30	22	73.3
Ho Policlinic	50	40	10	31	77.5
Volta Regional Hospital	128	100	28	75	75.0
Ho Municipal Hospital	97	60	37	45	75.00
Total	385	300	85	222	74

Source: Field data (2013)

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Data processing and analysis

The study employed descriptive and inferential statistics in analysing the data gathered from the field, using the Statistical Product for Service Solutions (SPSS version 21.0), MINITAB (version 11.0) and Microsoft Excel, 2007. The questionnaires were edited to ensure they were fully completed. The research assistants engaged for the data collection were again trained on how to code and capture the data in SPSS template. The data were coded and entered into SPSS for descriptive and inferential analysis. Negative statements were coded in reverse direction to reflect the positive statement before they were used in the analysis.

Descriptively, the study used frequencies, percentages, means and standard deviations to address the objectives to assess the perception of fairness and organizational commitment, evaluate the perception of employees on processes of the current appraisal system and assess the levels of awareness of health workers of health related MDGs and their implications for the achievement of health related targets. Prior to the use of these statistics, three levels of indices (low, medium and high) were created from the four levels of likert scales used in the data collection. The creation was to take into consideration all the responses for each item on a factor. This took into account the minimum number of responses (x1) and the maximum (x4), where x is the number of items under a particular factor. The interval for each level was determined using the formula (x4-x1)/3.

Inferentially, multivariate and univariate inferential statistical tools such as bootstrap multiple regression approach, analysis of variance (ANOVA), Pearson's Product-Moment correlation, the Chi-square test and a

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data reduction technique known as factor analysis were employed. Multiple regression is a multivariate statistical tool for determining the influence of a number of independent variables simultaneously (e.g., socio-economic variables) on a given dependent variable, which is continuous in nature. The researcher considered organizational justice, organisational commitment, level of awareness of health workers and ratings employees received as continuous dependent variables. All inferential analyses were done at a 5% significance level. Specifically, ordinal logistic regression was used to develop three models to test the hypotheses that socio-economic variables were not related to perception of fairness and organizational commitment. The dependent variables for organizational commitment and perception of fairness had three ordered levels: low, medium and high. The same statistical tool was used to assess the variability in ratings employees received and their level of awareness by socioeconomic variables which had four ordered levels (marginal, good, very good and excellent). Binary logistic regression was used to develop three models to test the variability in the level of awareness of health related MDGs by age, gender, pay educational level, region and staff categorization because the dependent variable had two ordered categories (yes and no).

Pearson's Product-Moment correlation test was used to analyse the relationship between organizational justice and organisational commitment constructs at a 5% significance level since the variables (constructs) involved were numeric. According to Cherry (2012), correlation analysis looks for relationships between variables which requires three possible results, a positive correlation, a negative correlation, and no correlation.

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A confirmatory factor analysis was also performed to determine the appropriateness or otherwise of the classifications of the items in the various constructs. It was also meant to confirm the four factor organizational justice and three factor organizational commitment models used in the study. First, the KMO and Bartlett's tests were done to determine the suitability of the data set. According to Williams, Brown and Onsman (2012), the KMO index ranging from 0.5 to 1.0 and a Bartlett's Test of Sphericity which is significant ($p<.05$) is appropriate for factor analysis. With KMO value of 0.918 which is considered marvelous and acceptable, coupled with Bartlett's Chi-square value of 13710 ($p<.05$), factor analysis was considered appropriate for use on the four and three constructs for organizational justice and commitments (Table 24). Second, the correlation matrices for the factors were computed to determine the levels of correlation between the various constructs of organizational justice and commitment (see Appendix 1 and 2). The results revealed that the four organizational justice constructs correlated with each other but the correlations were not high to violate the multi-collinearity rule (see Appendix 2).

Summary

A total of 700 questionnaires were administered out of which 519 were filled and retrieved for further analysis. The challenge of non participation by employees during the field work was as a result of their past experiences in similar studies. This notwithstanding, the health institutions and the respondents were helpful and cooperative, resulting in 74.3 per cent return rate which is considered appropriate for the study.

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Preliminary analysis was done to assess the quality of the data set in doing further analysis. KMO and Bartlett's tests were first done to determine the suitability of the data set for confirmatory factor analysis. The results show that KMO value of 0.918 and Bartlett's Chi-square value of 13710 ($p<.05$) were appropriate for the confirmatory analysis. The correlation matrices for organizational justice and commitment constructs were also computed to determine the levels of correlation between the constructs (see Appendix 1 and 2). The results points out that though the factors correlated with each other, they did not violate the multi-collineariry rule. The data therefore met all the requirements for confirmatory analysis, multiple regression and correlation analysis to address the research objectives.

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CHAPTER FIVE

PERCEPTION OF HEALTH WORKERS ON PROCESSES OF PERFORMANCE APPRAISAL SYSTEM

Introduction

An appraisal system has the potential to provide benefits to the organization if both the supervisor and the employees are committed to playing their respective roles (Cropanzano, 2010). These roles are reflected in how targets for job performance are set, monitored and evaluated in accordance with the appraisal system (Armstrong & Baron, 2004; Kurgat, 2011). This chapter gives the distribution of socio demographic variables of health workers who were involved in the appraisal system and assesses the probable collinearity and multicollinerity problems of these variables in predicting the effect of the dependent variables. The socio demographic variables were age, gender, educational level, staff categorization, gross salary and region which were selected as independent variables due to their potential effect on performance (Palakurthi & Parks, 2000; Thoresen et al, 2001) as well as predict perception of fairness in performance appraisal and organizational commitment (Ishmael & Zakaria, 2009; Azeem, 2010; Ayub & Ratif, 2011; Mohammed & Elesweed, 2013; Dartey- Barh, 2014).

It discusses the role of supervision in an appraisal system. The rationale is to assess the expected roles of employees in the appraisal processes vis-à-vis what is perceived to be the processes involved in the appraisal system. The various processes in the appraisal system were the period appraisal objectives were set, joint involvement of employee and the supervisor in the process of setting performance standards, review of mid-year

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activities, monitoring and feedback. The ratings employees received during the appraisal evaluation and the factors which are likely to influence the ratings as well as the uses of appraisal evaluation outputs were assessed.

Socio demographic characteristics of the respondents

The likely collinearity or multicollinearity problem associated with the use of regression can be assessed using Variance Inflation Factor (VIF) and Tolerant Analysis (TI). The regression analysis in Appendix 1 seems to suggest significant relationships between salary level and all the socio demographic variables but the VIF and TI analysis in Appendix 2 revealed that the level of relationship did not violate the assumptions of collinearity. This is because the Tolerance for all the variables were more than 0.20 as well as the VIF was less than 5 as recommended by Leech et al. (2005) and O'Brien (2007). Hence, the socio-demographic variables could be used to predict the dependent variables.

Table 8 shows that 60 per cent of the respondents were from the Central Region. Fifty six per cent of males and 62 per cent of females were in Central Region. Fifty nine per cent of respondents were below 40 years with 57 per cent for males and 59 per cent for the females. The health care workers appear to be young in both sexes. Of the male respondents, 56 per cent had tertiary education compared to 53 per cent for the females. Medical staff constituted 7 per cent of the respondents while the nurses and midwives were 38 per cent.

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Table 7: *Background Characteristics of Respondents*

Variable	Gender		Total
	Male (n=222)	Female (n=297)	(N=519)
Gender			
Central	56.3	61.9	59.5
Volta	43.7	38.1	40.5
Age			
Less than 30	22.0	23.1	22.9
30 – 39	37.6	35.7	35.9
40 – 49	19.6	19.7	20.0
50 – 59	20.8	21.5	21.2
Educational level			
Middle School/JSS/JHS	9.0	9.2	9.1
SHS/SSS/Tech/Voc.	35.0	38.3	35.6
Diploma	22.1	25.2	22.2
1st Degree	21.7	18.9	20.8
Post-Graduate	12.2	8.4	12.3
Staff categorisation			
Nursing and Midwifery Staff	11.1	57.7	37.8
Medical Staff	12.9	4.7	7.3
Paramedical Staff	36.3	15.6	24.5
Administrative and Support Staff	39.7	22.0	30.4
Gross salary			
Less than 1,000	40.1	42.1	44.5
1000 – 1999	47.3	47.8	43.7
2,000 or more	12.6	10.1	11.8
Total	100.0	100.0	100.0

Source: Field data (2013)

Nurses and midwives were 58 per cent of female health workers and paramedical personnel were 40 per cent of the male health workers. Out of the 519 respondents, 88 per cent of them earned gross salaries below GH¢2,000.

Role of the supervision in the performance appraisal

Supervision makes the difference between effective and ineffective employees of health institutions (Marquez & Kean, 2002). To understand the role of supervision in performance appraisal, employees were asked if they

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had supervisory responsibility. This is because supervision and feedback have been found to enhance performance (Rowe et al, 2005; Egger et al, 2005). From Table 8, 52 per cent of males compared to 53 per cent of females indicated they had supervisory responsibilities

Table 8: *Respondents with supervisory responsibility*

Variables	(Males N=222)		(Females N=297)	
	Yes (%)	n (115)	Yes (%)	n (158)
Age (in year)				
Less than 30	2.7	2	7.9	5
30 – 39	49.4	41	75.7	81
40 – 49	68.8	30	63.3	37
50 – 59	88.5	42	55.0	35
Region				
Central	55.5	69	50.2	89
Volta	47.5	46	57.5	69
Educational level				
Middle/JHS	12.0	2	18.3	5
SHS/Tech/Voc	47.4	37	63.2	67
Diploma/HND	52.1	26	68.0	45
1st Degree	73.0	35	54.0	33
Postgraduate	54.0	15	23.0	8
Staff designation				
Nursing & Mid.	45.2	11	71.4	80
Medical	90.1	26	55.0	12
Paramedical	77.8	63	49.3	36
Administrative	17.2	15	33.1	30
Gross salary (GH¢)				
Less than 1,000	22.0	20	32.9	43
1,000-1,999	68.5	72	64.3	54
2,000 or more	82.4	23	89.5	32

Source: Field data (2013)

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Eighty nine per cent of males aged more than 49 years compared to 3 per cent aged less than 30 years had supervisory responsibilities. Fifty five per cent of females aged more than 49 years compared to 8 per cent aged less than 30 years had supervisory responsibilities. Sixty eight per cent of females with diploma and 23 per cent with postgraduate had supervisory responsibilities. Female respondents who earned gross salaries less than GH¢1,000 accounted for a third of those with supervisory responsibilities compared 90 per cent who earned GH¢2,000 or more.

Table 9: *Number of Employees Supervised by Respondents*

Number	Gender		Total (N=273)
	Males (n=115)	Females (n=158)	
1 – 5	53.5	52.5	53.0
6 – 10	28.0	29.9	28.4
11 and above	18.5	17.6	18.6
Total	100.0	100.0	100

Source: Field data (2013)

Respondents were asked to indicate their span of control. Span of control refers to the number of employees a supervisor directly supervises (Bohte & Meier, 2000). From Table 9, more than half of males (53.5%) and females (52.5%) supervised less than 6 employees. Twenty eight per cent of males compared to 30 per cent of females supervised between six and ten employees. Only 18.5 per cent of males and to 17.6 per cent of females supervised more than 10 employees.

The study investigated whether the respondents conducted appraisal for employees they supervised. Managers are in the best position to evaluate job performance of employees (Michelman, 2007). From Table 10, a third of males and a quarter of females had ever appraised employees they supervised.

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Table 10: *Respondents who Conducted Appraisal for Employees they Supervised*

Variables	(Males N=222)		(Females N=297)	
	Yes (%)	n (75)	Yes (%)	n (79)
Age (in year)				
Less than 30	5.0	2	11.9	8
30 – 39	49.4	41	14.0	18
40 – 49	37.7	16	27.6	16
50 – 59	34.3	16	63.9	40
Region				
Central	35.2	44	42.5	51
Volta	32.4	31	23.7	28
Educational level				
Middle/JHS	3.4	1	2.1	1
SHS/Tech/Voc	6.7	5	7.5	8
Diploma/HND	16.7	13	43.9	29
1st Degree	81.2	39	52.1	32
Postgraduate	64.1	17	23.9	9
Staff designation				
Nursing & Mid.	26.1	7	42.9	48
Medical	44.5	13	33.4	7
Paramedical	33.3	27	15.4	11
Administrative	32.1	28	14.2	13
Gross salary (GH¢)				
Less than 1,000	24.0	21	13.9	18
1,000-1,999	36.1	38	27.9	36
2,000 or more	55.6	16	70.0	25

Source: Field data (2013)

Sixty four per cent of females and 34 per cent of males aged 50-59 years said they had conducted appraisal for employees they supervised. Eighty one per cent of males and 52 per cent of females with 1st degree had conducted appraisal for employees they supervised. Seven percent of males and 19 percent of females with secondary education had appraised employees they supervised. Seventy per cent of females with gross salary more than GH¢1,999 and 14 per cent with less than GH¢1,000 had appraised the employees they supervised.

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To further clarify this issue, the respondents were asked to give reasons for not conducting an appraisal for the employees they supervised and the results are presented in Table 11. Of the numbers, two-thirds of males compared to 64 per cent of females reported that their heads of departments do the appraisal.

Table 11: *Reasons why some Respondents did not Appraise*

Reasons	Gender		Total (N=111)
	Males (n=44)	Females (n=67)	
My head of the unit/department does the appraisal	66.7	63.5	66.7
Staff I supervise are not due for appraisal	29.1	28.6	27.9
I have not been given the opportunity to appraise	2.1	3.2	2.7
Appraisal forms were not made available	2.1	4.7	2.7
Total	100.0	100.0	100

Source: Field data (2013)

Also, 29 per cent of males and 28 per cent of females said they did not conduct the appraisal because employees working under them were not due for promotion. This, they tied appraisal to promotion. Other reasons assigned for not conducting appraisal for employees they supervised were lack of appraisal forms and lack of opportunity to appraise employees.

Perception of the processes of the appraisal system

For any appraisal system, its effectiveness depends on the design and implementation. This involves outlining all the processes involved in the appraisal system against the appraisal practice in the organization. The

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existing appraisal system in GHS starts with a meeting of employees and their supervisors to set performance objectives at the beginning of the appraisal year. This is to ensure that there is an agreement on the target set by the employee. In view of this, respondents were asked whether their appraisal objectives were set at the beginning of the year and the results presented in Table 12.

Table 12: *Setting of Appraisal Objectives at the Beginning of the Year*

Variables	(Males N=222)		(Females N=297)	
	Yes (%)	n(94)	Yes (%)	n(122)
Age (in year)				
Less than 30	44.4	22	35.6	24
30 – 39	27.7	23	24.3	26
40 – 49	54.9	23	67.1	40
50 – 59	58.6	26	50.9	32
Region				
Central	40.0	50	44.9	79
Volta	45.6	44	35.8	43
Educational level				
Middle/JHS	13.4	3	51.9	14
SHS/Tech/Voc	35.9	28	33.3	35
Diploma/HND	50.4	25	42.2	28
1st Degree	49.8	24	69.5	43
Postgraduate	50.1	14	5.0	2
Staff designation				
Nursing & Mid.	25.6	6	45.5	51
Medical	33.6	10	32.9	7
Paramedical	42.0	34	44.5	32
Administrative	50.3	44	35.1	32
Gross salary (GH¢)				
Less than 1,000	38.8	35	49.6	65
1,000-1,999	44.6	50	30.2	39
2,000 or more	40.0	11	50.0	18

Source: Field data (2013)

Forty two per cent of males and 41 per cent of females set the appraisal objectives at the beginning of the appraisal year. Fifty five per cent of males and two thirds of females aged 40-49 years indicated they set appraisal

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objectives at the beginning of the year. A third of males with SHS compared to half with tertiary education set the appraisal objectives at the beginning of the year. Respondents who indicated they set appraisal objectives at the beginning of the year were a third of medical staff and a half of male administrative staff. Appraisal meeting is used as a medium to set standards and to give feedback on past performances. Respondents were asked to indicate whether their performance objectives were set together with their supervisors (Table 13). Fifty per cent of females compared to 46 per cent of males involved their supervisors in setting performance standards.

Table 13: *Respondents Setting Appraisal Objectives with their Supervisors*

Variables	(Males N=222)		(Females N=297)	
	Yes(%)	n(101)	Yes(%)	n(150)
Age (in year)				
Less than 30	29.4	14	55.1	38
30 – 39	47.0	39	50.5	54
40 – 49	56.8	24	37.2	22
50 – 59	51.7	24	57.1	36
Region				
Central	35.9	45	38.4	68
Volta	57.7	56	68.3	82
Educational level				
Middle/JHS	10.5	2	31.2	8
SHS/Tech/Voc	50.0	39	37.7	40
Diploma/HND	51.4	25	52.7	35
1st Degree	49.8	24	69.5	43
Postgraduate	40.1	11	65.3	24
Staff designation				
Nursing & Mid.	9.5	2	85.3	96
Medical	50.0	15	33.3	7
Paramedical	55.5	45	20.8	15
Administrative	44.8	39	35.6	32
Gross salary (GH¢)				
Less than 1,000	50.2	47	56.7	75
1,000-1,999	40.9	43	44.2	57
2,000 or more	36.4	11	50.0	18

Source: Field data (2013)

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Two thirds of females in the Volta Region and 38 per cent in the Central Region said they set performance objectives with their supervisors. Ten per cent of male nurses compared to half of male medical personnel jointly set performance objectives with their supervisors. Sixty five per cent of females with postgraduate education and 31 per cent with JHS qualifications had met their supervisors to set appraisal objectives. The results seem to suggest that not all employees involved their supervisors in setting appraisal objectives.

The second aspect of the appraisal system is the need for supervisors to monitor the performance of their subordinates as part of the appraisal process. The purpose is to provide enabling working environment for the supervisor and the employees to interact and provide feedback, direction and offer the assistance to ensure improved performance. In view of this, respondents were asked to indicate whether their appraisal objectives were reviewed at mid-year (Table 14).

Table 14: *Review of Activities at Mid-Year*

Variables	(Males N=222)		(Females N=297)	
	Agree (%)	n (89)	Agree (%)	n(122)
Age (in year)				
Less than 30	15.1	7	52.2	35
30 – 39	53.0	44	31.7	38
40 – 49	47.6	20	46.6	27
50 – 59	38.5	18	40.5	26
Region				
Central	20.6	26	39.1	69
Volta	64.9	37	44.1	53
Educational level				
Middle/JHS	25.0	5	57.3	15
SHS/Tech/Voc	17.9	14	49.1	52
Diploma/HND	52.5	26	36.4	24
1st Degree	55.5	27	41.4	26
Postgraduate	61.5	17	14.7	5

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Staff designation				
Nursing & Mid.	4.8	1	52.5	64
Medical	17.9	5	53.2	12
Paramedical	29.6	24	25.7	11
Administrative	67.7	59	34.4	31
Gross salary (GH¢)				
Less than 1,000	35.5	32	38.9	51
1,000-1,999	42.9	45	38.0	49
2,000 or more	50.0	14	60.0	22

Source: Field data (2013)

Mid-year review serves as a means of providing feedback to employees on their performance. Forty per cent of males and 43 per cent of females indicated that their activities were reviewed at mid-year. Fifty two per cent of females and 15 per cent of males aged less than 30 years had their activities reviewed in mid-year. Sixty two per cent of males with postgraduate education and a quarter with JHS qualification said their activities were reviewed at mid-year. Fifty three per cent each of female nurses and medical staff were involved in the mid-year review activity.

Table 15: *Daily Monitoring and Feedback on Performance*

Variables	(Males N=222)		(Females N=297)	
	Agree (%)	n(139)	Agree (%)	n (211)
Age (in year)				
Less than 30	37.3	18	87.1	59
30 – 39	91.3	76	70.1	75
40 – 49	48.8	21	59.3	35
50 – 59	51.1	24	66.7	42
Region				
Central	53.6	67	75.7	134
Volta	74.4	72	64.2	77
Educational level				
Middle/JHS	35.0	7	85.8	23
SHS/Tech/Voc	38.4	30	86.4	92
Diploma/HND	81.6	40	83.5	55
1st Degree	82.3	40	58.1	36
Postgraduate	82.4	22	13.9	5

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Staff designation				
Nursing & Mid.	40.0	10	77.2	86
Medical	33.8	10	63.6	14
Paramedical	77.0	62	47.2	34
Administrative	65.5	57	85.6	77
Gross salary (GH¢)				
Less than 1,000	61.6	55	75.7	100
1,000-1,999	70.4	74	68.2	93
2,000 or more	36.4	10	64.7	23

Source: Field data (2013)

Apart from the mid-year review, supervisors are expected to provide daily motoring and feedback to employees during the appraisal period. Table 15 reflects the views of respondents on whether they received daily feedback on their performance. Sixty three per cent of males compared to 71 per cent of females indicated that they had daily monitoring and feedback from their supervisors. Eighty six per cent of females and 38 per cent of males with secondary education said they received monitoring and feedback from their supervisors. Seventy seven per cent of female and 40 per cent of male nurses had received feedback. Eighty seven per cent of females and 37 per cent of males aged less than 30 years compared to 91 per cent of males and 56 per cent of females aged 30-39 years were provided with feedback. Male respondents who received monitoring and feedback were 74 per cent in the Volta Region and 54 per cent in the Central Region.

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Table 16: *Achievement of Objectives at the last Appraisal rating of the Respondents*

Status	Gender		Total (N=519)
	Males (n=222)	Females (n=297)	
Achieved	100.0	100.0	519
Exceeded	0.0	0.0	0
Not achieved	0.0	0.0	0
Total	100.0	100.0	519

Source: Field data (2013)

The final process in the appraisal system is to evaluate and rate employees on their performance. This is done on annual basis. The ratings employees obtained can serve as the basis for administrative decision, while the other appraisal outputs are used for training and other developmental purposes. The first part of the final process involves matching the actual performances with the objectives to determine whether the employees had achieved their set targets (Table 16). Of the figures, all the respondents reported that they had achieved their performance targets.

The second part of the final process is to assess the ratings employees received as was recorded on their appraisal forms. These were based on a scale spanning from unsatisfactory to excellent which was explained on the appraisal form as 1 to 1.5 as unsatisfactory, 1.6 to 2.5 as marginal, 2.6 to 3.5 as good, 3.6 to 4.5 as very good and 4.6 to 5 as excellent. Unsatisfactory rating disqualifies employees from promotion and salary increment.

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Table 17: *Ratings Respondents Received During their Last Appraisal Evaluation*

Demographics	Males (n=222)					Females (n=297)				
	Excellent	Very Good	Good	Marginal	Total	Excellent	Very Good	Good	Marginal	Total
	(n=15)	(n=121)	(n=63)	(n=23)	(222)	(n=14)	(n=148)	(n=114)	(n=21)	297
Age (in year)										
29 or less	1.1	45.6	45.9	7.4	100	4.3	31.9	52.2	11.6	100
30 – 39	5.0	56.7	28.3	10.0	100	5.2	48.1	39.0	7.8	100
40 – 49	8.6	51.4	44.0	17.1	100	6.9	48.3	41.4	3.4	100
50 – 59	3.6	60.2	34.6	1.6	100	3.8	76.9	17.3	1.9	100
Region										
Central	7.7	53.5	28.3	11.1	100	5.4	53.4	35.1	6.1	100
Volta	5.6	55.6	31.8	7.4	100	3.7	44.4	43.2	8.6	100
Educational level										
Middle/JHS	0.0	40	33.3	16.7	100	5.3	42.5	40.8	11.3	100
SHS/Tech/Voc	4.7	41.8	37.2	16.2	100	4.4	48.6	39.8	2.5	100
Diploma/HND	7.0	44.2	37.2	11.6	100	9.1	15.0	24.1	6.2	100
1st Degree	0.0	80.6	16.1	3.2	100	2.6	56.4	35.9	5.2	100
Postgraduate	14.3	66.7	16.1	0.0	100	25.0	50.0	25.0	0.0	100

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Staff designation										
Nursing & Midwifery	11.8	58.8	17.6	6.3	100	9.4	52.1	36.4	3.1	100
Medical	11.8	76.4	11.8	0.0	100	0.0	60.0	40.0	0.0	100
Paramedical	5.4	50.9	27.3	16.4	100	4.3	50.0	37.5	7.1	100
Administrative	4.7	39.6	39.7	11.8	100	2.3	40.9	45.5	11.4	100
Gross salary (GH¢)										
999 or less	7.3	56.1	19.5	17.1	100	6.9	28.7	53.8	10.9	100
1,000-1,999	5.6	51.9	27.8	14.8	100	3.1	61.2	30.6	5.1	100
2,000 or more	26.3	63.1	10.0	0.0	100	14.0	54.7	31.3	0.0	100

Source: Field data (2013)

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In view of this, respondents were made to state the average ratings they had received on their last appraisal form and the results are summarised in Table 17. The results show that no respondent had been rated "unsatisfactory". This seems to suggest that all the respondents in their last appraisal ratings had met the requirement for promotion and salary increment. Twelve per cent of females and 7 per cent of males aged less than 30 years compared to 2 per cent of those aged 50-59 years were rated "marginal". Seventy seven per cent of females and 60 per cent of males aged 50 to 59 were rated "very good". Eighty one per cent of males and 56 per cent of females with 1st degree were rated "very good". Half of females and two-thirds of males with post graduate education were rated "very good". No respondent with postgraduate education had received a "marginal" rating. Twelve per cent of male nurses and medical staff compared to 5 per cent of male paramedical and administrative staff were rated "excellent".

Following the descriptive results, further analyses were carried out on socio-economic factors which affect the ratings employees received. Using the ordinal logistic regression, three models were developed to test the hypothesis that socio-economic variables were not related to appraisal ratings employees received. Ordinal logistic regression was used because the dependent variable (the rating respondents received) had four levels (excellent =21, very good = 196, good = 132 and marginal = 31) with marginal as the reference. The references for the independent categories were: region (Volta) age (50-59 years), educational level (postgraduate), gender (females), staff categorisation (administrative staff) and gross salary (GH¢2,000 or more). The results of the

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models of the excellent appraisal ratings employees received with respect to marginal are presented in Table 18.

Table 18: *Predicting Appraisal Ratings of Respondents*

Demographic variables	Model I (OR)	Model II (OR)	Model III (OR)
Gender			
Males	1.13	1.13	1.13
Females (Ref.)	-	-	
Age (in year)			
Less than 30	2.70*	2.11*	2.13*
30 – 39	2.30*	2.14*	2.15*
40 – 49	2.25*	2.25*	2.25*
50 – 59 (Ref.)	-	-	-
Region			
Central	1.04	1.03	1.04
Volta (Ref.)	-	-	-
Educational level			
Middle/JHS		3.20*	1.79*
SHS/Tech/Voc		4.78*	1.12
Diploma/HND		3.62*	0.91
1st Degree		1.88	0.64
Postgraduate (Ref.)	-	-	-
Staff Categorisation			
Nursing & Mid.		1.30	1.29
Medical		1.54	1.54
Paramedical		1.28	1.29
Administrative (Ref.)	-	-	-
Gross salary (GH¢)			
Less than 1,000			1.32
1,000-1,999			1.39
2,000- or more (Ref.)	-	-	-
Pseudo R^2	0.089	0.400	0.403
p> χ^2	.000	.000	.000

**significant at α=.05*

In model I, when gender, age and region were used, the results show that respondents aged less than 30 years (OR=2.70; p<.05), 30-39 years (OR=3.0; p<.05) and 40-49 years (OR=3.62; p<.05) had different ratings compared to those aged more than 49 years. Employees less than 50 years

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appear more likely to be rated higher than the reference age group (50-59 years).

For Model 11, when education and gender were included with the other socioeconomic variables in Model 1, all the age groups less than 50 years appear more likely to be rated higher compared to the reference age group (50-59 years). Respondents with JHS qualifications (OR=3.20; $p<.05$), SHS (OR=4.78; $p<.05$) and diploma (OR=3.62; $p<.05$) had different ratings compared to those with post-graduate certificates. In the 3rd model with all the socio-economic variables, respondents with JHS qualifications (OR=1.79; $p<.05$) had different ratings compared to those with post-graduate certificates. Also, respondents aged less than 50 years appear more likely to be rated higher than the reference age group (50-59 years). Overall, age and education are likely to influence the ratings employees receive. This finding is consistent with Esfahani et al (2014) who found lower ratings among older employees. Also, in support of the finding, Fullford (2005) found a significant difference between the rating employees received and their level of education.

Respondents were asked to indicate the reasons for their appraisal in Table 19. Seventy five per cent of males and 76 per cent of females indicated promotion as the reason for their appraisal compared to 16 per cent of male and 15 per cent females who perceived improvement in performance as the reason for appraisal.

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Table 19: *Reasons for Staff Appraisal in Ghana Health Service*

Reasons	Gender		Total
	Male (267) %	Female (297) %	
Promotion	75.3	76.3	475
Improved performance	15.7	14.8	95
Training and Development	7.1	6.4	42
Salary increment	1.9	2.5	14
Total	100.0	100.0	626

Source: Field data, 2013

Two per cent of males and 3 per cent of females perceived salary increment while 7 per cent of males and 6 per cent of females indicated training and development as basis for their appraisal.

Perception of performance appraisal on staff behaviour and performance

The purpose of performance appraisal is to improve job performance of employees (Walsh & Fisher, 2005). This can be achieved by creating an enabling working environment for the employees to perform their jobs while the supervisors provide the needed guidance and direction to improve the job performance. This can be achieved if organizations adopt approaches in performance appraisal that promote behaviours and attitudes that are related to job (Holloway, 2009). The results in Table 20 revealed that 64 per cent of respondents indicated their appraisal could have positive effect on their morale to work harder. About half of the respondents reported their appraisal could have a positive effect on satisfaction with the appraisal system (53.3 per cent) and motivation to improve performance (53.3 per cent). The implication is that employees believe their appraisal could generally have positive effect on their behaviours.

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Table 20: *Appraisal and Performance*

Reasons	Effect			%	N
	Positive (%)	No (%)	Negative (%)		
Morale to work harder	64.4	30.3	5.3	100	544
Satisfaction with the appraisal system	55.3	37.2	7.5	100	521
Motivation to improve performance	53.3	37.2	10.4	100	519
Reduction in child mortality	57.2	36.0	2.1	100	519
Improvement in maternal health	59.9	37.8	2.3	100	519
Combating HIV/ TB/ Malaria	53.2	43.5	3.3	100	519

Source: Field data (2013)

For the health outcomes, 57.2 per cent, 59.9 per cent and 53.2 per cent reported that their appraisal could have positive effect on reduction of child mortality, improvement of maternal health and eradication of malaria and other diseases respectively. This may indicate that performance appraisal in GHS could have positive effect on employees to achieve their health related targets. This positive perception may have been influenced by the motivation to work harder to improve performance as well as their satisfaction with the appraisal system. These are job related attitudes and behaviours that have the potential to improve job performance at individual and organizational levels.

Discussions

Results indicated that 71 per cent of the respondents were not appraised by their supervisors. Employees who appraise people they do not supervise have the tendency to introduce subjectivity into the evaluation since they may lack the needed information on what goes into the job performance (Michelman, 2007).

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Respondents assigned reasons for not appraising their subordinates as: "my head of department does the appraisal, and my subordinates were not due for promotion". For the latter reason, they tied appraisal to promotion even though the employees are not promoted yearly. This may be due to inability of the employees to follow the appraisal process as prescribed by the policy as well as possible pay raise associated with promoting employees. According to Quality Health Partners (2005), in 2004, employees of GHS in the Central Region were appraised because they were due for promotion. The later reason also suggests that some managers delegate their supervisory roles to their subordinates and yet fail to mandate them to appraise the employees working under them. The implication is that the effective role of monitoring and feedback in appraisal would be lost since the appraiser is not the direct supervisor.

The results show that more than 80 per cent of the employees supervised less than 11 employees in support of the range of span of control proposed by Gittell (2001) for an effective supervision leading to high performance. This is because supervisors are able monitor and provide the needed feedback to employees when the job is being done.

Employees were assessed on extent to which they implemented and followed up with the processes involved in the appraisal policy. The processes involved were joint setting of objective at the beginning of the year, daily monitoring and providing mid-year feedback on the activities, and the evaluation of the appraisal system. The results revealed that a number of employees failed to set objective at the beginning of the year which could undermine the appraisal process. Thus, employees are more likely to accept

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performance outcome if the appraisal processes are followed (Michelman, 2007).

The results on the assessment of the daily monitoring and mid-year review of the appraisal process shows that two-thirds of employees were engaged in providing daily monitoring and feedback and 41 per cent were involved in reviewing their mid-year activities. Employees may have considered feedback as part of their supervisory responsibility hence their daily involvement in monitoring of performance but not necessarily that they had conformed to the appraisal policy. This is in support of the view that supervisors provide monitoring and feedback as part of supervisory role and not necessarily due to their role in the appraisal system (Egger et al, 2005).

The final level of the appraisal process is the evaluation stage. Here, the respondents were made to indicate whether they had achieved the targets set and the ratings they received in their last appraisal evaluation as captured on their appraisal form. All the respondents reported that they had achieved the target set and had not been rated "unsatisfactory" in their last appraisal evaluation. As provided by the appraisal policy, employees with "unsatisfactory ratings" do not qualify for promotion and salary increments. It therefore implies that all the employees, in their last appraisal ratings, had met the requirement for promotion and were likely to receive salary increments. This level of performance could arise because raters may want to give favourable ratings to avoid having confrontation with their subordinates (Michelman, 2007).

In the light of the favourable ratings employees received, the hypotheses of no relationship between the socio-economic variables and the

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ratings employees received were tested as predictors of rating bias. The results were mixed. While gender, region, staff categorization and gross salary were not likely to predict ratings employees received, educational level and age were found to predict their ratings. This is not surprising as the model on bias proposes that individual differences in gender, age, race, level of education etc. can influence the extent to which bias can occur (Bellemare & Shearer, 2009). Specifically, significant differences were found between respondents aged less than 30 years and 50 or more years. This finding is consistent with Esfahani et al (2014) who found lower ratings among older employees. Also, significant differences were found between respondents with basic level of education and those with post graduate qualification. This is also in agreement with Fullford (2005) who found a significant difference between the rating employees received and their level of education.

The result suggests that there was high perception among employees to use appraisal mainly for promotion. This may be due to possible pay raise associated with promoting employees as well as their inability to follow the processes in accordance with the appraisal policy. This is in support of the finding by Quality Health Partners (2005) that indicated that employees in GHS were not appraised annually as expected unless they were called to attend promotion interviews. The results also revealed that only 9 per cent of the respondents indicated they were trained based on their needs through the appraisal system. Failure to use the appraisal output for training may indicate specific performance needs of employees in the appraisal system are not being addressed. This has the potential of affecting employees to meet their personal goals of self-development and to acquire new competences to perform on the

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job (Odhiambo, 2005; Kuvaas, 2006).

On the perception of the appraisal on behaviour of employees, the results revealed that the appraisal system could a positive effect on their morale to work harder and satisfaction with the appraisal system. Similarly, the appraisal could have positive effect on reduction in infant mortality (57.2%), maternal mortality (59.9%) and combating malaria and other diseases (53.2%). The findings mean that the employees believed the appraisal system generally could have positive effect on their behaviour and performance. The positive behaviours have the potential to promote effectiveness in their job performance, which is necessary to improve the individual and organizational performances.

Span of control of less than 11 employees may enhance effective supervision because supervisors could monitor and provide feedback while the job is being done. Predictors of performance ratings reflect the potential biases in appraisal evaluation. Thus in GHS, educational level and age could serve as potential sources of bias in the appraisal ratings. Appraisal system in GHS is mainly used when people are due for promotion because of the expected pay raise associated with it, while ignoring the other important uses of the appraisal system, which are to identify training and developmental needs. Moreover, various processes of the appraisal system intended to make it effective such as appraisal meeting, mid-year review of activities, daily monitoring and feedback were being ignored by some of the employees.

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CHAPTER SIX

ORGANISATIONAL JUSTICE AND COMMITMENT

Introduction

Organizational justice in performance appraisal has been identified as an important factor in assessing the effectiveness of an employee and organizational performance (Erdogan, 2002; Greenberg, 2006). Its dimensions of distributive, procedural, informational and interpersonal justices are related to aspects of organizational attitudes which are commitment and trust in the organization (Rammmoorthy & Flood, 2004; Robbins et al, 2005; Lambert et al, 2007; Ponu & Chuah, 2010; Okanbi et al, 2013).

Changes in socio-demography have been found to influence organizational performance (Palakurthi & Parks, 2000) and organizational justice (Coetzee, 2005; Esterhuizen, 2008; Owolabi, 2012; Khalili & Asmani, 2012). In the organizational context, the theory suggests that employees who have similar characteristics such as age, sex, race, tenure and profession are likely to have similar perceptions and attitudes that can impact on performance (Thoresen et al, 2001).

This chapter discusses results on four organizational justice constructs (distributive, procedural, informational and interpersonal) and three organizational commitment constructs (affective, continuance and normative) to predict perception of fairness of performance appraisal and levels of commitment among employees in GHS. It discusses the determinants of organizational justice and commitment. It also attempts to establish a relationship between organizational justice and commitment. Issues that may influence perception of fairness are accuracy of rating, concern over rating,

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two way communication, trust in the appraisal rating, clarity of the appraisal rating, understanding of the appraisal rating, seeking appeal, explanation of rating decisions and interpersonal justice. Confirmatory factor analyses (CFAs) were performed to determine the appropriateness of the classifications of the four and three constructs of organizational justice (Colquitt, 2001) and organizational commitment (Meyer et al, 2002).

Confirmatory factor analysis for organizational justice and commitment constructs

To assess the suitability of the data on the four organizational justice constructs (distributive, procedural, informational and interpersonal) as proposed by Colquitt (2001) and organizational commitment constructs (affective, normative and continuance) as proposed by Meyer et al (2002), the Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy and Bartlett's Test of Sphericity were used. According to Williams, Brown and Onsman (2012), the KMO index ranging from 0.5 to 1 is considered acceptable. The acceptable ranges are 0.5 to 0.59 as miserable, 0.6 to 0.69 as mediocre, 0.7 to 0.79 as middling, 0.8 to 0.89 as meritorious and 0.9 to 1 as marvelous. Similarly, the Bartlett's Test of Sphericity should be significant (p<.05). The results of the tests are summarised in Table 21.

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Table 21: *Kaiser-Meyer-Olkin and Bartlett's Tests*

Kaiser-Meyer-Olkin Measure of Sampling Adequacy		0.918
Bartlett's Test of Sphericity	Approx. Chi-Square	1.371E4
	Df	1128
	p-value	.000

With KMO value of 0.918, which is considered marvelous and acceptable, coupled with Bartlett's Chi-square value of 13710 which is significant ($p<.05$), factor analysis can be used on the four and three constructs of organizational justice and commitments. The results from correlation matrix in Appendix 3 also revealed that the four organizational justice constructs correlated with each other but the correlations were not high to violate the multi-collinearity rule (see Appendix 2).

Table 22: *Four Constructs of Organizational Justice*

	Initial Eigenvalues		
Component	Total	% of Variance	Cumulative %
Procedural Justice	15.450	41.333	41.333
Interpersonal Justice	8.835	28.523	69.856
Distributive Justice	4.598	11.772	81.628
Informational Justice	1.821	6.047	87.675

The results from the confirmatory factor analysis as shown in Table 22 indicate that procedural justice, interpersonal justice, distributive justice and informational justice accounted for 88 per cent of variance in the organizational justice, with each having eigenvalue greater than 1.

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The first factor, procedural justice, accounted for 41.3 per cent variation, implying the most important factor. This is followed by interpersonal justice with 29 per cent variability and informational justice with 11.8 per cent as the third factor. The result of the confirmatory factor analysis was consistent with the four-factor organizational justice construct model (Colquitt, 2001).

Table 23: *Three Constructs of Organizational Commitment*

	Initial Eigen values		
Component	Total	% of Variance	Cumulative %
Affective commitment	6.263	33.923	33.923
Normative commitment	3.512	28.419	62.342
Continuance commitment	2.600	16.271	78.613

Affective, normative and continuance commitment cumulatively explained 78.6 per cent of variation on organizational commitment with each of them having an eigenvalue greater than 1. Affective commitment explained 33.9 per cent and continuance commitment was 28.4 per cent of the variations. These results also show consistency with the three-factor organizational commitment proposed by Allen and Meyer (1996).

The next section assesses the perception of fairness based on four-factor organizational justice and commitment, using the three-factor organizational commitment models.

Perception of fairness of performance appraisal

The study assessed perception of fairness of performance appraisal based on four organizational justice constructs (distributive, procedural, informational and interpersonal justice). Three levels of index low, medium

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and high were created from the four (4) levels of likert scale to measure the perception of the various factors. The minimum number of responses (x1) and the maximum (x4) were used, where x is the number of items under a particular factor. The intervals for the indices, low (11-22), medium (23-33) and high (34-44) were determined by (x4-x1)/3 and the results presented in Tables 24 to 31. Fairness of the performance appraisal was assessed to be high, medium or low if the various organizational justice constructs were rated high, moderate or low respectively.

Distributive justice

Distributive justice is used in predicting perception of fairness of the ratings employees receive. This was assessed based on two issues, the accuracy of rating and the concern over rating (Cropanzano et al, 2007). Supervisors who display personal goals besides those perceived to support equity and accuracy may be seen as unfair and the ratings employees received from them may also be seen as unfair (Tziner, et al, 2001).

On accuracy of rating, 317 respondents perceived it to be high compared to 190 and 16 who perceived it to be medium and low respectively. Thus to make meaning out of the figures, the number of respondents who perceived low responses (16 respondents) was combined with those with medium and the results presented in Table 24.

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Table 24: *Perception of accuracy of Staff Appraisal Rating*

Demographics	Males (n=222)				Females (n=297)			
	Low /Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	50.0	50.0	100.0	49	44.8	55.2	100.0	68
30 – 39	33.8	62.2	100.0	83	38.6	61.5	100.0	107
40 – 49	44.4	55.6	100.0	43	25.6	74.4	100.0	59
50 – 59	28.2	71.8	100.0	47	40.8	59.2	100.0	53
Region								
Central	40.0	60.0	100.0	125	34.2	65.8	100.0	177
Volta	37.0	63.0	100.0	97	46.9	53.1	100.0	120
Educational level								
Middle/JHS	33.3	66.7	100.0	20	43.6	56.4	100.0	27
SHS/Tech/Voc	48.9	51.1	100.0	78	47.0	53.0	100.0	106
Diploma/HND	37.5	62.5	100.0	49	42.0	58.0	100.0	66
1st Degree	25.5	74.5	100.0	48	21.1	78.9	100.0	62
Postgraduate	32.4	67.6	100.0	27	30.0	70.0	100.0	36
Staff designation								
Nursing & Mid.	50.0	50.0	100.0	25	32.0	68.0	100.0	112
Medical	50.0	50.0	100.0	29	27.7	72.3	100.0	22
Paramedical	42.0	58.0	100.0	81	49.0	61	100.0	73
Administrative	33.0	67.0	100.0	87	5.9	94.1	100.0	90
Gross salary (GH¢)								
Less than 1,000	43.3	56.7	100.0	89	43.0	57.0	100.0	132
1,000-1,999	35.1	64.9	100.0	105	35.7	64.3	100.0	129
2,000 or more	35.5	64.5	100	28	26.3	73.7	100.0	36

Source: Field data (2013)

Sixty one per cent of males and females perceived accuracy of rating to be high. Seventy two per cent of males aged 50-59 years and 34 per cent aged 30-39 years perceived accuracy of ratings to be high. Seventy five per cent of males with first degree and two thirds with postgraduate qualifications perceived accuracy of rating to be high. Seventy per cent of females with first degree compared to 53 per cent with SHS certificate holders perceived accuracy of rating to be high. Ninety four per cent of female administrative staff and two thirds of female nurses perceived accuracy of rating to be high. Fifty seven per cent of males and females with gross salaries less than

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GH¢1,000 compared to 74 per cent of females and 65 per cent of males with gross salaries more than GH¢1,999 or more perceived high accuracy of rating. From the results, high perception of accuracy of rating seems to increase with increase in education and gross salary in females.

For concern over rating, 13 respondents perceived it to be low compared to 454 and 49 who perceived it to be medium and high respectively. This indicates that 88 per cent of males and 87 per cent of females perceived concern over rating to be moderate.

Distributive justice measures the overall effect of accuracy of rating and concern over rating. Six and 251 respondents perceived distributive justice to be low and medium respectively were combined and the results compared to results with 182 respondents who perceived it to be high (Table 25).

Table 25: *Distributive Justice in Performance Appraisal*

Demographics	Males (n=222)				Females (n=297)			
	Low/Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	69.6	30.4	100.0	49	71.1	28.9	100.0	68
30 – 39	68.9	31.1	100.0	83	66.7	33.3	100.0	107
40 – 49	62.3	37.7	100.0	43	60.5	39.5	100.0	59
50 – 59	53.1	46.1	100.0	47	54.9	45.1	100.0	63
Region								
Central	66.4	33.6	100.0	125	60.3	39.7	100.0	177
Volta	66.0	34.0	100.0	97	70.0	30.0	100.0	120
Educational level								
Middle/JHS	100.0	0.0	100.0	20	53.9	46.1	100.0	27
SHS/Tech/Voc	77.8	22.2	100.0	78	67.9	32.1	100.0	106
Diploma/HND	61.0	39.0	100.0	49	66.7	33.3	100.0	66
1st Degree	58.8	41.2	100.0	48	56.1	43.9	100.0	62
Postgraduate	64.8	35.2	100.0	27	80.0	20.0	100.0	36

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Staff designation								
Nursing & Mid.	73.9	26.1	100.0	25	64.7	35.3	100.0	112
Medical	81.0	19.0	100.0	29	84.6	15.4	100.0	22
Paramedical	63.0	37.0	100.0	81	57.4	42.3	100.0	73
Administrative	63.2	36.8	100.0	87	62.5	37.5	100.0	90
Gross salary (GH¢)								
Less than 1,000	71.1	28.9	100.0	89	67.4	32.6	100.0	132
1,000-1,999	65.0	35.0	100.0	105	61.9	38.1	100.0	129
2,000 or more	58.1	41.9	100.0	28	55.2	44.8	100.0	36

Source: Field data (2013)

The results show 65 per cent of males and 63 per cent of females moderately perceived distributive justice. Thirty per cent of males aged less than 30 years and 46 per cent aged above 49 years perceived distributive justice to be high. All the males with JHS compared to 65 per cent with postgraduate moderately perceived distributive justice. Distributive justice appears to increase with increase in age.

Procedural justice

Procedural justice is used in predicting fairness in the procedure used in determining the outcome of performance of an employee in the appraisal system (Tyler, 2006). This is assessed on five factors: two-way communication, trust in the supervisor, clarity of expectation, understanding the appraisal process and seeking appeals (Tang and Sarsfield-Baldwin, 1996; Thurston, 2001; Walsh, 2003). In two-way communication, supervisors engage subordinates to discuss performance objectives and clarify performance duties that form goal setting and planning phase of the appraisal (Findley et al, 2000).

Similar to the results presented under distributive justice, 17 and 231 respondents who perceived two-way communication to be low and medium respectively were combined and the results compared to 271 respondents who

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perceived it to be high (Table 26). Fifty six per cent of females compared to 47 per cent of males perceived two-way communications to be high.

Table 26:*Two-Way Communication in Staff Performance Appraisal*

Demographics	Males (n=222)				Females (n=297)			
	Low/ Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	50.0	50.0	100.0	49	46.0	54.0	100.0	68
30 – 39	51.1	48.9	100.0	83	47.9	52.1	100.0	107
40 – 49	60.6	39.4	100.0	43	46.0	54.0	100.0	59
50 – 59	46.2	53.8	100.0	47	26.4	73.6	100.0	63
Region								
Central	49.6	50.4	100.0	125	40.8	59.2	100.0	177
Volta	56.7	43.3	100.0	97	50.4	49.4	100.0	120
Educational level								
Middle/JHS	75.0	25.0	100.0	20	35.9	62.1	100.0	27
SHS/Tech/Voc	68.9	31.1	100.0	78	49.3	50.7	100.0	106
Diploma/HND	46.9	53.1	100.0	49	27.0	73.0	100.0	66
1st Degree	39.3	60.7	100.0	48	42.1	57.9	100.0	62
Postgraduate	50.0	50.0	100.0	27	70.0	30.0	100.0	36
Staff designation								
Nursing & Mid.	87.0	13.0	100.0	25	43.9	56.0	100.0	112
Medical	69.0	41.0	100.0	29	23.1	76.9	100.0	22
Paramedical	51.8	48.2	100.0	81	46.2	57.4	100.0	73
Administrative	43.8	56.2	100.0	87	50.0	50.0	100.0	90
Gross salary (GH¢)								
Less than 1,000	55.5	44.5	100.0	89	52.4	47.6	100.0	132
1,000-1,999	49.5	50.5	100.0	105	35.7	64.3	100.0	129
2,000 or more	61.3	38.7	100.0	28	38.1	61.9	100.0	36

Source: Field data (2013)

Half of males aged less than 30 years and 54 per cent more than 49 years perceived two-way communication to be high. Twenty five per cent of males and 62 per cent of females with JHS education compared to 61 per cent of males and 58 per cent of females with first degree perceived two-way communication to be high. Sixty nine per cent of male medical staff perceived two-way communication to be moderate while 77 per cent of the females

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perceived it to be high. For nurses, while 87 per cent of the males perceived two-way communication to be moderate, 56 per cent of the males perceived it to be high.

Trust in the supervisor is the second factor that was considered in procedural justice. It involves work ethics that encourages trustworthy relationships through improved communication mechanisms between supervisors and their subordinates (Ellikson and Loksdon, 2002). The result indicate that 6 and 84 respondents perceived trust in the supervisor to be low and medium respectively, while 429 perceived it to be high. Ninety per cent of males and 77 per cent of females perceived trust in their supervisors to be high.

The third issue under procedural justice was how expectations of the employees on the appraisal system were clarified. This depends on how the appraisal system is considered simple, easy to understand and comprehended by the various operators in the system (Findley et al, 2001). Uncertainty, regarding how appraisal system works is not likely to provide positive perceptions among ratees over the appraisal system. Holbrook (2002) predicted that clarity in the performance standards and the expectation of outcomes may positively influence the procedural justice.

Of the figures, 243 respondents perceived clarity of expectation to be high compared to 237 and 39 who perceived it to be medium and low respectively (Table 27). Forty five per cent of males and 48 per cent of females perceived clarity of expectation of the appraisal system to be high.

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Table 27: *Clarity of Expectation in the Appraisal System*

Demographics	Males (n=222)				Females (n=297)			
	Low/ Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	64.6	35.4	100.0	49	50.5	49.5	100.0	68
30 – 39	52.2	47.8	100.0	83	59.4	40.6	100.0	107
40 – 49	53.6	44.4	100.0	43	53.5	46.5	100.0	59
50 – 59	51.6	48.4	100.0	47	42.2	57.8	100.0	63
Region								
Central	50.5	49.5	100.0	125	48.9	51.1	100.0	177
Volta	57.7	42.3	100.0	97	56.7	43.3	100.0	120
Educational level								
Middle/JHS	50.0	50.0	100.0	20	41.0	59.0	100.0	27
SHS/Tech/Voc	71.2	28.8	100.0	78	55.7	44.3	100.0	106
Diploma/HND	50.0	50.0	100.0	49	51.8	39.2	100.0	66
1st Degree	49.0	51.0	100.0	48	45.6	54.4	100.0	62
Postgraduate	48.4	51.6	100.0	27	30.0	70.0	100.0	36
Staff designation								
Nursing & Mid.	78.3	21.7	100.0	25	49.2	50.8	100.0	112
Medical	63.6	36.4	100.0	29	53.9	46.1	100.0	22
Paramedical	59.2	40.8	100.0	81	40.4	59.6	100.0	73
Administrative	40.7	59.3	100.0	87	78.2	21.8	100.0	90
Gross salary (GH¢)								
Less than1, 000	60.0	40.0	100.0	89	51.3	39.7	100.0	132
1,000-1,999	48.5	51.5	100.0	105	42.9	57.1	57.1	129
2,000 or more	61.3	38.7	100.0	28	50.0	50.0	100.0	36

Source: Field data (2013)

Thirty five per cent of males and half of females aged less than 30 years perceived clarity of expectation to be high. Half of males and 51 per cent of females in the Central Region constituted respondents with high perception of clarity of expectation in appraisal. Twenty nine per cent of males and 44 per cent of females with SHS perceived clarity of expectation to be high. For respondents with postgraduate education, 52 per cent of males and 70 per cent of females perceived clarity of expectation to be high. Among males, 78 per cent of nurses and 64 per cent of medical staff perceived clarity of expectation

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to be moderate, while 59 per cent of administrative staff perceived it to be high. Fifty one per cent of female nurses and 60 per cent of female paramedical staff perceived it to be high.

The fourth factor that may affect the procedural justice is the understanding of the appraisal system. This is about how supervisors explain the rules of the appraisal system to the understanding of the employees ((Tang and Sarsfield-Baldwin, 1996). Positive perception is predicted if employees are able to participate and understand the appraisal process and make their voices heard (Dorfman et al, 1986; Walsh, 2003).

Twelve and 241 respondents who perceived the understanding of the appraisal system to be low and medium respectively were combined and the results compared to 266 respondents who perceived it to be high (see Table 28). The results indicate that 55 per cent of males compared to 48 per cent of females perceived understanding of the appraisal process to be high.

Table 28: *Understanding the Appraisal Process by the Respondents*

Demographics	Males (n=222)				Females (n=297)			
	Low/ Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	50.0	50.0	100.0	49	64.3	35.7	100.0	68
30 – 39	46.0	54.0	100.0	83	52.1	47.9	100.0	107
40 – 49	45.9	54.1	100.0	43	44.2	55.8	100.0	59
50 – 59	33.3	66.7	100.0	47	38.0	62.1	100.0	63
Region								
Central	44.0	56.0	100.0	125	50.0	50.0	100.0	177
Volta	47.4	52.6	100.0	97	51.8	48.2	100.0	120
Educational level								
Middle/JHS	50.0	50.0	100.0	20	51.3	48.7	100.0	27
SHS/Tech/Voc	62.3	37.7	100.0	78	58.6	41.4	100.0	106
Diploma/HND	43.8	56.2	100.0	49	47.9	52.1	100.0	66
1st Degree	32.3	61.7	100.0	48	45.0	55.0	100.0	62
Postgraduate	36.6	63.4	100.0	27	30.0	70.0	100.0	36

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Staff designation								
Nursing & Mid.	52.2	47.8	100.0	25	53.8	46.2	100.0	112
Medical	68.1	45.5	100.0	29	52.2	47.8	100.0	22
Paramedical	49.3	50.7	100.0	81	44.7	55.3	100.0	73
Administrative	40.7	59.3	100.0	87	50.0	50.0	100.0	90
Gross salary (GH¢)								
Less than 1,000	53.3	46.7	100.0	89	61.7	38.3	100.0	132
1,000-1,999	42.1	57.9	100.0	105	39.7	60.3	100.0	129
2,000 or more	64.5	35.6	100.0	28	53.3	46.7	100.0	36

Source: Field data (2013)

Thirty six per cent of females aged less than 30 years compared 62 per cent aged more than 49 years perceived understanding of the appraisal system to be high. Thirty eight per cent of males and 41 per cent of females with SHS education compared to 63 per cent of males and 70 per cent of females with postgraduate education perceived high understanding of appraisal system. Fifty four per cent of female nurses and 55 per cent of female paramedical staff perceived it to be high. Perception of high understanding of the appraisal system appears to increase with the level of education and age in females.

The fifth factor is how to seek appeal. In this case, provision is made to correct biases or errors in appraisal if it occurs (Murphy and Clevaland, 1991; Thurston, 2001). Table 29 shows that 45 per cent of males and 57 per cent of females had high perception of seeking appeal.

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Table 29: *Views of Respondents on how they Seek Appeal in Appraisal*

Demographics	Males (n=222)				Females (n=297)			
	Low/ Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	59.4	40.6	100.0	49	51.3	48.7	100.0	68
30 – 39	57.7	42.3	100.0	83	38.6	61.4	100.0	107
40 – 49	54.7	45.3	100.0	43	36.4	63.6	100.0	59
50 – 59	43.5	56.5	100.0	47	34.9	65.1	100.0	63
Region								
Central	51.2	48.8	100.0	125	42.3	57.7	100.0	177
Volta	60.8	39.2	100.0	97	43.6	56.4	100.0	120
Educational level								
Middle/JHS	75.0	25 0	100.0	20	55.8	44.2	100.0	27
SHS/Tech/Voc	71.1	28.9	100.0	78	51.5	48.5	100.0	106
Diploma/HND	57.9	42.1	100.0	49	38.2	61.8	100.0	66
1st Degree	47.1	52.9	100.0	48	25.7	74.3	100.0	62
Postgraduate	44.5	55.5	100.0	27	23.1	76.9	100.0	36
Staff designation								
Nursing & Mid.	60.9	39.1	100.0	25	53.5	46.5	100.0	112
Medical	71.4	28.6	100.0	29	26.7	73.3	100.0	22
Paramedical	64.2	35.8	100.0	81	27.8	72.2	100.0	32
Administrative	49.0	51.0	100.0	87	33.8	66.2	100.0	90
Gross salary (GH¢)								
Less than 1,000	68.9	31.1	100.0	89	48.5	51.5	100.0	132
1,000-1,999	51.5	48.5	100.0	105	60.2	39.8	100.0	129
2,000 or more	58.1	41.9	100.0	38	35.0	65.0	100.0	36

Source: Field data (2013)

Forty one per cent of males and 49 per cent of females aged less than 30 years had high perception of seeking appeal. A quarter of males and 44 per cent of females with JHS education compared to 56 per cent of males and 77 per cent of females with postgraduate education had high perception of seeking appeal. High perception of seeking appeal in appraisal appears to increase with increase in age and education. Seventy per cent per of male medical staff compared to 63 cent of their females had moderate perception of seeking appeals

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Procedural justice measures the overall effect of the five factors two-way communication, trust in the supervisor, clarity of expectation, understanding the appraisal process and seeking appeals. Of the figures, 8 and 154 respondents who perceived procedural justice to be low and high respectively were compared to 357 those who perceived it to be high (Table 30). The results show that two-third of males compared to 70 per cent of females perceived high procedural justice.

Table 30: *Procedural Justice in Performance Appraisal*

Demographics	Males (n=222)				Females (n=297)			
	Low/ Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	37.5	62.5	100.0	49	39.8	60.2	100.0	68
30 – 39	34.8	65.2	100.0	83	30.2	69.8	100.0	107
40 – 49	31.2	69.0	100.0	43	25.0	75.0	100.0	59
50 – 59	28.8	71.2	100.0	47	24.8	75.3	100.0	63
Region								
Central	32.6	67.4	100.0	125	27.4	72.6	100.0	177
Volta	32.3	67.7	100.0	97	35.1	64.9	100.0	120
Educational level								
Middle/JHS	57.1	42.9	100.0	20	40.8	59.2	100.0	27
SHS/Tech/Voc	52.4	47.6	100.0	78	39.0	61.0	100.0	106
Diploma/HND	27.7	72.3	100.0	49	25.1	74.9	100.0	66
1st Degree	22.3	77.7	100.0	48	23.3	76.9	100.0	62
Postgraduate	31.0	69.0	100.0	27	30.0	70.0	100.0	36
Staff designation								
Nursing & Mid.	60.0	40.0	100.0	25	33.0	67.0	100.0	112
Medical	31.8	68.2	100.0	29	15.4	84.6	100.0	22
Paramedical	36.3	63.7	100.0	81	22.0	78.0	100.0	73
Administrative	23.0	77.0	100.0	87	33.4	66.6	100.0	90
Gross salary (GH¢)								
Less than 1,000	38.6	61.5	100.0	89	38.0	62.0	100.0	132
1,000-1,999	78.4	21.6	100.0	105	33.1	66.9	100.0	129
2000 or more	21.9	78.1	100.0	28	26.3	73.7	100.0	36

Source: Field data (2013)

Three quarters and 71 per cent of females aged more than 49 years perceived high procedural justice. Forty three per cent of males and 59 per

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cent of females with JHS education compared to 78 per cent of males and 77 per cent of females with 1st degree perceived procedural justice to be high. The results seem to suggest that high procedural justice increases with increase in age and education. Two thirds of female nurses and 85 per cent of female medical staff perceived procedural justice to be high.

Interpersonal justice

The interpersonal justice construct reflects the interactional dimensions of appraisal practice. This involves how employees are treated by their supervisors in terms of respect and sensitivity (Greenberg, 1993; Thurston, 2001; Greenberg, 2006). Therefore, interpersonal justice assesses the perception of treatment employees receive from their supervisors.

The figures revealed that, 6 and 170 respondents perceived interpersonal justice of the appraisal system to be low and medium respectively while 266 respondents perceived it to be high (Table 31). Sixty five per cent of males and two thirds of females perceived interpersonal justice to be high.

Table 31: *Perceived Treatment Respondents Received from their Supervisors in the Appraisal System*

Demographics	Males (n=222)				Females (n=297)			
	Low/Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	34.6	65.4	100.0	49	44.0	56.0	100.0	68
30 – 39	43.9	56.1	100.0	83	30.5	69.5	100.0	107
40 – 49	27.6	72.6	100.0	43	40.6	59.4	100.0	59
50 – 59	40.0	60.0	100.0	47	23.6	76.4	100.0	63
Region								
Central	39.3	60.3	100.0	125	27.8	72.3	100.0	177
Volta	30.2	69.8	100.0	97	41.1	58.9	100.0	120

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Educational level								
Middle/JHS	44.5	55.5	100.0	20	28.2	71.8	100.0	27
SHS/Tech/Voc	42.5	57.5	100.0	78	35.9	64.1	100.0	106
Diploma/HND	39.4	60.6	100.0	49	33.4	66.6	100.0	66
1st Degree	26.5	73.5	100.0	48	30.1	69.9	100.0	62
Postgraduate	33.0	67.0	100.0	27	36.9	63.1	100.0	36
Staff designation								
Nursing & Mid.	22.6	77.4	100.0	25	32.6	67.4	100.0	112
Medical	50.0	50.0	50.0	29	30.8	69.2	100.0	22
Paramedical	36.5	63.5	100.0	81	28.3	71.7	100.0	73
Administrative	33.0	67.0	100.0	87	36.9	63.1	100.0	90
Gross salary (GH¢)								
Less than 1,000	35.9	64.1	100.0	89	41.7	58.2	100.0	132
1,000-1,999	35.0	65.0	100.0	105	26.8	73.2	100.0	129
2,000 or more	27.6	72.4	100.0	28	15.5	84.5	100.0	36

Source: Field data (2013)

Seventy two per cent of males and 59 per cent of females aged 40-49 years perceived interpersonal justice to be high. Sixty one per cent of males and 72 per cent of females in the Central Region perceived interpersonal justice to be high. Fifty six per cent of males and 72 per cent of females with JHS qualification compared to 74 per cent of males and 70 per cent of females with first degree perceived high interpersonal justice. Seventy seven per cent of male nurses and half of male medical staff perceived interpersonal justice to be high.

Informational justice

Informational justice factor places emphasis on the social dimensions of events and the quality of these events which precede the determination of the outcome. It reflects the explanation offered to employees during appraisal process and decision making (Lind and Tiler, 1998; Greenberg, 1990; Blader and Tyler, 2000). Inferring from the data, 12 and 223 respondents who perceived interpersonal justice of the appraisal system to be low and medium respectively were compared to 266 of those who perceived it to be high in

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Table 32. The results revealed that 65 per cent of males and two thirds of females perceived interpersonal justice to be high.

Table 32: *Views of Respondents on Explanations Supervisors Offer in Appraisal Decisions*

Demographics	Males (n=222)				Females (n=297)			
	Low/Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	56.3	43.7	100.0	49	50.7	49.3	100.0	68
30 – 39	47.7	52.3	100.0	85	45.8	54.2	100.0	107
40 – 49	50.8	49.2	100.0	43	53.5	46.5	100.0	59
50 – 59	41.0	59.0	100.0	47	32.4	67.6	100.0	63
Region								
Central	47.2	52.8	100.0	125	35.5	64.5	100.0	177
Volta	51.0	49.0	100.0	97	51.3	48.7	100.0	120
Educational level								
Middle/JHS	62.5	37.5	100.0	20	43.6	57.4	100.0	27
SHS/Tech/Voc	63.6	36.4	100.0	78	49.3	50.7	100.0	106
Diploma/HND	43.8	56.2	100.0	49	35.3	64.7	100.0	66
1st Degree	37.3	62.7	100.0	48	35.1	64.9	100.0	62
Postgraduate	50.0	50.0	100.0	27	30.0	70.0	100.0	36
Staff designation								
Nursing & Mid.	69.5	30.5	100.0	25	42.7	57.3	100.0	112
Medical	54.5	45.5	100.0	29	38.5	61.5	100.0	22
Paramedical	51.8	48.2	100.0	81	37.8	62.8	100.0	73
Administrative	39.6	60.4	100.0	87	47.0	53.0	100.0	90
Gross salary (GH¢)								
Less than 1,000	50.0	50.0	100.0	89	46.1	53.9	100.0	132
1,000-1,999	49.6	50.4	100.0	105	62.5	37.5	100.0	129
2,000 or more	16.7	83.3	100.0	28	36.7	63.3	100.0	36

Source: Field data (2013)

Half of males and females aged 40-49 years perceived informational justice to be moderate, while 59 per cent of males and two third of females aged more than 49 years perceived it to be high. Fifty three per cent of males and 65 per cent of females in the Central Region perceived informational justice to be high. Sixty three per cent of males with JHS certificates and 64 per cent with SHS certificates perceived informational justice to be moderate.

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Fifty five per cent of female nurses and 63 per cent of female medical staff perceived it to be high. Also, half of males with gross salary less than GH¢1,000 and 83 per cent with gross salary more than GH¢1,999 perceived procedural justice to be high.

Overall Organisational Justice

The overall organizational justice measures the perception of fairness in the performance appraisal. This'2 is the combination of the effects of the four organizational justice constructs: distributive, procedural, informational and interpersonal to predict the overall perception of fairness of the performance appraisal (Fullford, 2005; Greenberg, 2006; Cropanzano et al, 2007). Of the figures, 3 and 204 respondents who perceived perception of fairness to be low and medium respectively were compared to 309 who perceived it to be high in Table 33.

Table 33: *Organisational Justice in Performance Appraisal*

Demographics	Males (n=222)				Females (n=297)			
	Low/ Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	53.1	46.9	100.0	49	47.1	52.9	100.0	68
30 – 39	44.4	55.6	100.0	83	40.4	59.6	100.0	107
40 – 49	36.1	63.9	100.0	43	39.5	60.5	100.0	59
50 – 59	35.9	64.1	100.0	47	37.6	62.4	100.0	63
Region								
Central	44.8	55.2	100.0	125	34.4	65.6	100.0	177
Volta	43.4	56.6	100.0	97	47.4	52.6	100.0	120
Educational level								
Middle/JHS	50.0	50.0	100.0	20	44.0	56.0	100.0	27
SHS/Tech/Voc	49.6	50.4	100.0	78	46.0	54.0	100.0	106
Diploma/HND	43.8	56.2	100.0	49	30.4	69.6	100.0	66
1st Degree	29.4	70.6	100.0	48	29.1	70.1	100.0	62
Postgraduate	48.9	51.1	100.0	27	30.0	70.0	100.0	36

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Staff designation								
Nursing & Mid.	60.9	39.1	100.0	25	43.4	56.6	100.0	112
Medical	45.6	54.4	100.0	29	30.8	69.2	100.0	22
Paramedical	47.7	52.3	100.0	81	26.1	73.9	100.0	73
Administrative	40.9	59.1	100.0	87	39.1	60.9	100.0	90
Gross salary (GH¢)								
Less than 1,000	47.8	52.2	100.0	89	44.0	56.0	100.0	132
1,000-1,999	39.6	58.4	100.0	105	34.9	65.1	100.0	129
2,000 or more	0.0	100.0	100.0	28	36.7	63.3	100.0	36

Source: Field data (2013)

Two thirds of females and 65 per cent of males perceived fairness in the performance appraisal to be high. Forty seven per cent of males and 53 per cent of females aged less than 30 years perceived fairness in the appraisal system to be high. Half of males and 56 per cent of females with SHS qualifications compared to 71 per cent of males and 70 per cent of females with first degree perceived fairness of the appraisal system to be high. "High" perception of fairness in the appraisal system appears to increase with increase in age and education. Sixty one per cent of male nurses moderately perceived fairness of the appraisal system, while 57 per cent of female nurses perceived it to be high.

Variability in perception of fairness

The study also attempted to test the hypotheses of no relationship between socioeconomic factors and perception of fairness of performance in the Ghana Health Service. The study employed the ordinal logistic regression because the dependent variable (organisational justice) had three ordered categories (low= 3, high= 207, high= 309) with low as the reference. Table 34 presents the results from the three separate models.

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Table 34: *Predicting Respondents' Perception of Organisational Justice*

Demographic variables	Model I (OR)	Model II (OR)	Model III (OR)
Gender			
Males	1.64		1.59
Females (Ref.)	-		
Age (in year)			
Less than 30	1.81*	1.85*	1.84
30 – 39	1.39	1.43	1.36
40 – 49	1.30	1.40	1.30
50 – 59 (Ref.)	-	-	-
Region			
Central	0.77	0.77	0.75
Volta (Ref.)	-	-	-
Educational level			
Middle/JHS	-	1.11	1.35
SHS/Tech/Voc	-	1.11	1.24
Diploma/HND	-	0.73	0.79
1st Degree		0.51*	0.60
Postgraduate (Ref.)	-	-	-
Staff Categorisation			
Nursing & Mid.		1.09	1.36
Medical		1.03	0.98
Paramedical		1.85	0.77
Administrative (Ref.)	-	-	-
Gross salary (GH¢)			
Less than 1,000			0.80
1,000-1,999			0.66
2,000 or more (Ref.)	-	-	-
Pseudo R^2	0.033	0.043	0.052
$p > \chi^2$	.000	.000	.000

**significant at α=.05*

When gender, age and region were simultaneously included in Model 1, employees aged 29 years or less perceived the system to be fair compared to those aged 50-59 years (OR=1.81, p<.05). In Model 11, education and staff categorisation were added to other socioeconomic variables in Model 1. The results revealed that employees aged 29 years or less perceived the system to be fair compared to those aged 50-59 years (OR=1.85, p<.05). Respondents with first degree also perceived the existing organisational justice differently

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vis-à-vis their counterparts with post-graduate qualifications (OR=0.51, $p<.05$). But when all the six socioeconomic variables (age, gender, staff categorization, gross salary and region) were simultaneously included in the model I11, none of them was found to be significant. From the results age and education were significant predictors of perception of fairness of appraisal in GHS. Age as a predictor of perception of fairness is in support of various studies that found significant age differences in perception of fairness (Van Zyl & Roodt, 2003; Duweke, 2004; Ozyer et al, 2014). Colquitt (2001) proposes that when employees feel that they are being treated fairly, they reciprocate through commitment and satisfaction. It is therefore necessary to establish the level of commitment among the employees of GHS in the two regional capitals.

Organizational commitment

The study assessed organizational commitment based on three constructs: affective, continuance and normative commitment and reflect emotional ties, perceived obligation and perceived cost invested in the organization (Allen & Meyer, 2000). Three levels of index low, medium and high were created from the four (4) levels of likert scale to measure the perception of the various factors. The minimum number of responses (x1) and the maximum (x4) were used, where x is the number of items under a particular factor. The intervals for the indices for affective; low (6-12), medium (13-18) and high (19-24); normative; low (10-20), medium (21-30) and high (31-40) and continuance; low (7-14), medium (15-21) and high (22-27) were determined by (x4-x1)/3 and the results are presented in table 36 to 39.

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Affective commitment

Affective commitment dimension evaluates various work experiences and reveals positive feelings such as a sense of belonging, emotional attachment and accepting the organizational challenges about the organization (Meyer et al, 2002). Inferring from results in Table 35, 215 respondents perceived affective commitment to be high compared to 298 and 2 respondents who perceived it to be medium and low respectively.

Table 35: *Affective Commitment of Respondents in GHS*

Demographics	Males (n=222)				Females (n=297)			
	Low/ Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	70.9	29.1	100.0	49	54.0	46.0	100.0	68
30 – 39	70.5	29.5	100.0	83	63.7	36.3	100.0	107
40 – 49	61.6	38.4	100.0	43	57.2	42 8	100.0	59
50 – 59	51.3	48.7	100.0	47	42.7	57.3	100.0	63
Region								
Central	64.8	35.2	100.0	125	57.7	46.8	100.0	177
Volta	63.9	36.1	100.0	97	55.9	44.1	44.1	120
Educational level								
Middle/JHS	100.0	0.0	100.0	20	53.8	46.2	100.0	27
SHS/Tech/Voc	68.9	31.1	100.0	78	48.3	51.7	100.0	106
Diploma/HND	66.7	33.3	100.0	49	51.9	48.1	100.0	66
1st Degree	58.8	41.2	100.0	48	66.1	33.9	100.0	62
Postgraduate	58.1	41.9	100.0	27	100.0	0.0	100.0	36
Staff designation								
Nursing & Mid.	73.9	26.1	100.0	25	48.6	51.4	100.0	112
Medical	65.2	34.8	100.0	29	53.8	46.2	100.0	22
Paramedical	56.8	43.2	100.0	81	63.6	36.4	100.0	73
Administrative	70.2	29.8	100.0	87	65.0	35.0	100.0	90
Gross salary (GH¢)								
Less than 1,000	77.0	23.0	100.0	89	58.4	41.6	100.0	132
1,000-1,999	57,2	42.8	100.0	105	56.5	43.5	100.0	129
2,000 or more	60.0	40.0	100.0	28	27.0	73.0	100.0	36

Source: Field data (2013)

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The results revealed that 36 per cent of males and 46 per cent of females perceived affective commitment to be high. Seventy one per cent of males and 54 per cent of females aged less than 30 years perceived affective commitment to be moderate. All the males with JHS qualification and females with postgraduate education perceived affective commitment to be moderate. Seventy per cent of male nurses perceived affective commitment to be moderate, while 51 per cent of the females perceived it to be high. For the medical staff, 65 per cent of the males and 54 per cent of the females perceived affective commitment to be moderate. Sixty per cent of males and 73 per cent of females with gross salary more than GH¢1,999 perceived affective commitment to be moderate and high respectively.

Continuance commitment

Continuance factor relates to perceived cost associated with employees leaving the organization. It also reflects availability of employment opportunities (Meyer et al, 2002). Continuance commitment therefore assesses perception of willingness of employees to leave the organization based on the associated investment made in the organization and availability of employment opportunities.

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Table 36: *Continuance Commitment of Respondents in GHS*

Demographics	Males (n=222)				Females (n=297)			
	Low/ Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	60.0	40.0	100.0	49	52.6	47.4	100.0	68
30 – 39	63.2	36.8	100.0	83	70.9	29.1	100.0	107
40 – 49	69.6	30.4	100.0	43	77.5	22.5	100.0	59
50 – 59	74.3	25.7	100.0	47	79.1	20.9	100.0	63
Region								
Central	69.3	30.7	100.0	125	67.2	32.8	100.0	177
Volta	64.2	35.8	100.0	97	64.3	35.7	100.0	120
Educational level								
Middle/JHS	62.5	37.5	100.0	20	61.5	38.5	100.0	27
SHS/Tech/Voc	44.4	55.6	100.0	78	66.7	33.3	100.0	106
Diploma/HND	66.1	33.9	100.0	49	68.0	32.0	100.0	66
1st Degree	7.5	69.8	22.7	48	78.6	21.4	100.0	62
Postgraduate	9.1	65.5	25.5	27	85.9	14.1	100.0	36
Staff designation								
Nursing & Mid.	65.2	34.8	100.0	25	70.5	29.5	100.0	112
Medical	77.8	22.2	100.0	29	74.6	13.4	100.0	22
Paramedical	62.8	37.2	100.0	81	60.9	39.1	100.0	73
Administrative	50.5	49.5	100.0	87	49.7	50.3	100.0	90
Gross salary (GH¢)								
Less than 1,000	52.2	47.8	100.0	89	53.9	46.1	100.0	132
1,000-1,999	72.3	27.7	100.0	105	74.8	24.2	100.0	129
2,000 or more	78.9	21.1	100.0	28	87.1	12.9	100.0	36

Source: Field data (2013)

Sixteen and 335 respondents perceived continuance commitment to be low and medium respectively compared to 168 respondents who perceived it to be high (Table 36). A third of males and 32 per cent of females perceived continuance commitment to be high. Sixty per cent of males aged less than 30 years and 74 of males aged more than 49 years perceived continuance commitment to be moderate. Seventy eight per cent of male medical staff and 71 per cent of female nurses perceived continuance commitment to be moderate, while 50 per cent each of male and female administrative staff perceived it to be high. Seventy nine per cent of males and 87 per cent of females with gross salary more than GH¢1,999 perceived continuance

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commitment to be moderate. Perception of continuance commitment appears to be higher in administrative staff compared to other categories of staff.

Normative commitment

Normative dimension addresses the issues on social factors that compel the employee to remain in the organization (Meyer et al, 2002). It relates to an obligation to remain in the organization. Of the results, 204 respondents who perceived affective commitment to be high were compared to 310 respondents who perceived it to be medium and low in Table 37.

Table 37: *Normative Commitment of Respondents in GHS*

Demographics	Males (n=222)				Females (n=297)			
	Low/ Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	71.0	29.0	100.0	49	56.3	43.7	100.0	68
30 – 39	69.2	30.8	100.0	83	63.5	36.5	100.0	107
40 – 49	73.0	27.0	100.0	43	51.2	48.8	100.0	59
50 – 59	46.2	58.8	100.0	47	50.4	49.6	100.0	63
Region								
Central	67.2	32.8	100.0	125	57.9	42.1	100.0	177
Volta	64.9	35.1	100.0	97	54.9	45.1	100.0	120
Educational level								
Middle/JHS	87.5	12.5	100.0	20	48.7	51.3	100.0	27
SHS/Tech/Voc	58.1	41.9	100.0	78	59.2	40.8	100.0	106
Diploma/HND	74.6	25.4	100.0	49	45.1	54.9	100.0	66
1st Degree	66.1	33.9	100.0	48	62.5	37.5	100.0	62
Postgraduate	61.1	38.9	100.0	27	70.0	30.0	100.0	36
Staff designation								
Nursing & Mid.	54.4	45.6	100.0	25	55.2	44.8	100.0	112
Medical	70.9	29.1	100.0	29	53.8	46.2	100.0	22
Paramedical	70.5	29.5	100.0	81	66.0	34.0	100.0	73
Administrative	61.5	38.5	100.0	87	54.7	45.3	100.0	90
Gross salary (GH¢)								
Less than 1,000	69.7	30.3	100.0	89	54.6	45.4	100.0	132
1,000-1,999	67.3	32.7	100.0	105	62.7	37.5	100.0	129
2,000 or more	65.9	34.1	100.0	28	63.3	36.7	100.0	36

Source: Field data (2013)

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Thirty four per cent of males and 43 per cent of females perceived normative justice to be high. Fifty nine per cent of males and half of the females aged more than 49 years perceived it to be high, while 71 per cent of males aged less than 30 years perceived it to be moderate

Overall organizational commitment

The overall organizational commitment measures the perception of commitment in the organization. This is the combination of the effects of the three organizational constructs affective, normative and continuance commitment to predict the commitment levels of employees in the organization.

Three and 326 respondents who perceived overall commitment to be low medium respectively were compared to 189 who perceived it to be high in Table 38.

Table 38: *Overall Organisational Commitment of Respondents*

Demographics	Males (n=222)				Females (n=297)			
	Low/ Medium	High	%	N	Low/ Medium	High	%	N
Age (in year)								
Less than 30	67.7	33.3	100.0	49	57.5	42.5	100.0	68
30 – 39	73.0	27.0	100.0	83	65.6	34.5	100.0	107
40 – 49	68.8	31.2	100.0	43	60.5	39.5	100.0	59
50 – 59	45.0	55.0	100.0	47	62.8	37.2	100.0	63
Region								
Central	67.0	33.0	100.0	125	58.9	41.1	100.0	177
Volta	66.3	33.7	100.0	97	65.2	34.8	100.0	120
Educational level								
Middle/JHS	70.0	30.0	100.0	20	64.9	35.1	100.0	27
SHS/Tech/Voc	66.7	33.3	100.0	78	58.5	41.5	100.0	106
Diploma/HND	73.0	27.0	100.0	49	45.3	54.7	100.0	66
1st Degree	64.2	35.8	100.0	48	73.2	26.8	100.0	62
Postgraduate	58.1	41.9	100.0	27	80.0	20.0	100.0	36

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Staff designation								
Nursing & Mid.	77.4	22.6	100.0	25	59.6	40.4	100.0	112
Medical	60.0	40.0	100.0	29	71.7	21.3	100.0	22
Paramedical	62.1	37.9	100.0	81	61.5	38.5	100.0	73
Administrative	50.1	49.9	100.0	87	46.2	53.8	100.0	90
Gross salary (GH¢)								
Less than 1,000	71.6	28.4	100.0	89	56.3	43.7	100.0	132
1,000-1,999	65.7	34.3	100.0	105	68.5	31.5	100.0	129
2,000 or more	54.3	45.7	100.0	28	48.4	51.6	100.0	36

Source: Field data (2013)

The results revealed that 65 per cent of males and 61 per cent of females perceived organizational commitment to be moderate. Two-third of males aged less than 30 years perceived organizational commitment to be moderate, while 55 per cent of males aged more than 49 years perceived it to be high. Two-thirds and 70 per cent of males with SHS and JHS qualifications respectively perceived organizational commitment to be moderate. Seventy seven per cent of male nurses as well as half of male administrative staff perceived it to be high. Seventy two per cent of males and 57 per cent of females with gross salary less than GH¢1,000 perceived organizational commitment to be moderate.

Variability in organizational commitment

The study attempted to test the hypotheses of no relationship between socioeconomic factors and commitment in the Ghana Health Service. The study employed the ordinal logistic regression to model the socioeconomic factors on the perception of respondents to organisational commitment because the dependent variable (organisational commitment) had three ordered categories (low= 16, high= 335, high= 168) with low being the reference and the results are presented in Table 39.

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Table 39: *Predicting Respondents' Organisational Commitment in GHS*

Demographic variables	Model I (OR)	Model II (OR)	Model III (OR)
Gender			
Males	1.26	1.40	1.36
Females (Ref.)	-	-	-
Age (in year)			
Less than 30	1.51	1.79*	1.83*
30 – 39	1.46	1.32	1.41
40 – 49	1.36	1.48	1.53
50 – 59 (Ref.)	-	-	
Region			
Central	.094	0.96	0.92
Volta (Ref.)	-	-	-
Educational level			
Middle/JHS	-	1.67	2.17
SHS/Tech/Voc	-	1.29	1.72
Diploma/HND	-	0.89	1.07
1st Degree	-	1.33	1.62
Postgraduate (Ref.)	-	-	-
Staff Categorisation			
Nursing & Mid.	-	0.90	0.99
Medical	-	0.85	0.65
Paramedical	-	0.95	1.13
Administrative (Ref.)	-	-	-
Gross salary (GH¢)			
Less than 1,000	-		0.20
1,000-1,999	-		0.49*
2,000 or more (Ref.)	-		-
Pseudo R^2	0.029	0.017	0.042
p> χ^2	.000	.000	.000

**significant at α=.05*

The analysis revealed that employees aged less than 30 years (OR=1.83, p<.05) were more likely to commit themselves to GHS compared to the reference age group (50-59 years) in model I. Respondents aged less than 30 years (OR=1.79, p<.05) again emerged the predictor of commitment levels in GHS compared to the reference age group (50-59 years) in model II. Dartey-Baah (2014), in a similar study in a banking sector of Ghana, found significant

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age differences in organizational commitment. In model III, those who earned between GH¢1,000-1,999 (OR=0.49, $p<.05$) had different commitment level in GHS compared to those with gross salary above GH¢1,999. This implies that employees who earned less than GH¢1,999 had lower propensity to be committed to GHS compared to those who earned more than GH¢1,999. This finding lends credence to the argument that financial benefits are necessary to promote hard work and retain employees in the organization. This is in support of Suma and Lesha (2013) who also found a significant relationship between pay levels and organizational commitment in public institutions in Albania. Also, Gandhi and Hyde (2013), in a study in the public banks in India, found significant differences between pay and commitment levels among managerial and non-managerial levels and suggest that people who have high salaries may be unwilling to change their jobs.

Organizational justice and commitment in performance appraisal

An objective of the study was to determine the nature of relationship between the constructs of organizational justice and commitment. Therefore, Pearson's Product-Moment correlation test was conducted since the variables (constructs) involved are numeric. According to Cherry (2012), correlation analysis looks for relationships between variables. There are three possible results of a correlation, namely, a positive correlation, a negative correlation, and no correlation.

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Table 40: *Perception of Fairness and Organisational Commitment*

		Organizational justice constructs					Organizational commitment constructs		
		Distributive	Procedural	Interpersonal	Information	Org'nal justice	Affective	Continuance	Normative
Procedural	*r*	0.588*							
justice	*p*	.000							
Interpersonal	*r*	0.420*	0.585*						
justice	*p*	.000	.000						
Information	*r*	0.474*	0.772*	0.558*					
justice	*p*	.000	.000	.000					
Organisational	*r*	0.750*	0.945*	0.825*	0.734*				
justice	*p*	.000	.000	.000	.000				
Affective	*r*	0.367*	0.338*	0.330*	0.338*	0.404*			
commitment	*p*	.000	.000	.000	.000	.000			
Continuance	*r*	0.068	0.066	0.187*	0.161*	0.123*	0.158*		
commitment	*p*	.124	.136	.000	.000	.005	.000		
Normative	*r*	0.327*	0.398*	0.329*	0.403*	0.437*	0.577*	0.229*	
commitment	*p*	.000	.000	.000	.000	.000	.000	.000	
Organisational	*r*	0.341*	0.358*	0.381*	0.405*	0.532*	0.808 *	0.633*	0. 778*
commitment	*p*	.000	.000	.000	.000	.000	.000	.000	.000

**Correlation is significant at the 0.05 level (2-tailed).*

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The correlation matrix in Table 40 shows a correlation coefficient of 0.532 between organizational justice and commitment. This implies that workers of Ghana Health Service who are committed will perceive that there is fairness. Furthermore, it could also be seen that the distributive justice (r= 0.341), procedural justice (r= 0.358), interpersonal justice (r= 3.81) and informational justice (r= 0.405) were significantly related to organizational commitment, albeit moderate. This means that the employees are likely to be committed to GHS if any of the organizational justice constructs are perceived to be high. In support of this, procedural and distributive are found to be associated with higher levels of organizational commitment (Okanbi & Ofoegbu, 2013; Ponu & Chuah, 2010; Robbins et al, 2005; Lambert et al, 2007; Rammmoorthy & Food, 2004).

The correlation matrix in table 40 also shows that organizational justice is positively correlated with affective (r= 0.404), normative (r= 0.437) and continuance commitment (r= 0.123). This is in support of Cohen-Chasash and Spector's (2001) work that indicated that findings in respect to how perceived fairness is measured may vary, but the relationship between perceived fairness and affective commitment should fall within a range between 0.37 and 0.43. With respect to the relationship between organizational justice and its three constructs, the results show that 'procedural justice' had the strongest relationship (r=0.945; p=.000) with organizational justice. This means that the respondents perceived this construct as the main determinant of fairness (justice) in the Ghana Health Service, followed by interpersonal justice' with r=0.825 and p=.000, distributive justice' with r=0.750 and p=.000 and lastly 'information justice' with r=0.734 and p=.000.

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Discussions

Descriptive statistical results of the various constructs of organizational justice revealed that procedural and interpersonal justices produced the two highest effect of perception of fairness for both male (67%; 65%) and female (71%; 67%) respondents. This implies that if the two factors are high employees are likely to perceive their appraisal to be fair. This finding also confirms the CFA value which shows that procedural justice and interpersonal justice constructs accounted for the main variations in the organizational justice. This is considered good for the effective management of the appraisal system because high interpersonal and procedural justice have the potential to counteract any negative effect of the appraisal system (Starlicki & Folger, 1997; Goldman, 2003). Informational justice produced the least effect on perception of fairness. Fifty one per cent of males compare to 57 per cent of females perceived it to be high.

The use of organizational justice to assess perception of fairness has attracted attention of researchers based on the suggestion made by Greenberg (2001) that when individuals form an impression about justice, they are making a holistic judgment (Lind, 2001; Shapiro, 2001; Greenberg, 2001; Cropanzano & Ambrose, 2001; Greenberg, 2006). Based on this suggestion, the overall perception of fairness was assessed using the combined effects of the procedural, informational, distributive and interpersonal justice. The results show that respondents had high perception of fairness. From the results, one is inclined to believe that the high overall perception of fairness may be influenced by the high procedural and interpersonal justices. Thus, lending credence to the view that, if at least one of the components of the

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organizational justice is high, the overall justice is likely to be high (Goldman, 2003).

The study further assessed the socioeconomic factors that are likely to influence perception of fairness of performance appraisal in GHS. In this regard, the null hypothesis of no significant relationship between socioeconomic variables and perception of fairness was tested. The expectation is to reject the null hypotheses based on rational demography theory (Riordan, 2000). Consistent with this expectation, there was significant relationship between perception of fairness on one hand age and educational level on the other. For instance, employees younger than 30 years compared to those older than 49 years were more likely to perceive fairness of the appraisal in GHS because they may have been focused on the understanding the appraisal processes at the early stages of their career and may have had cordial relationship with their supervisors. This finding is in support of various studies that found significant age differences in perception of fairness fairness (Van Zyl & Roodt, 2003; Duweke, 2004; Ozyer et al, 2014). Similarly, employees with first degree were more likely to perceive the appraisal to be fair compared to those with postgraduate qualification. These differences may have been occasioned by different levels of understanding in the appraisal process due to age and educational qualifications. Dabbagh, et al. (2012) found positive but negative relationship between perception of fairness and educational levels similar to the earlier finding by Yaghoubi, et al (2010). However, contrary to this finding, Bahrami et al. (2013), in a study of determinants of organizational justice among hospital employees, found no significant differences in perception of fairness by levels of education in Iran.

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The descriptive evidence suggests that affective commitment in comparison to other constructs measured the highest level of commitment. This implies that the employees are attached to the organization and may potentially remain in the organization to enjoy their membership with the service (Lee et al, 2007). The second moderately perceived level of commitment which measures the social factors that compel the employee to remain in GHS is normative. These findings confirm the CFA value which shows that affective and normative constructs accounted for the main variations in the organizational commitment data sets. Less than half of the respondents perceived the three constructs of organizational commitment to be high. This is an indication that all the three constructs of commitment were moderately perceived. Continuance commitment measures perceived cost associated with employees leaving an organization. It appears that high level of continuance commitment was found in administrative staff compared to medical staff and nurses, which may support the view of Shores and Martins (1989) that professionals are more committed to their profession than the organization due to other employment opportunities.

The expectation in the organizational context as suggested by Thoresen, et al. (2001) based on rational demography theory (Riordan, 2000) is that employees who have similar characteristics such as age, sex, race, tenure, educational level and profession are likely to have similar perceptions and attitudes that can impact on performance. The results show that gender, region, staff categorization and educational level had no significant relationship with commitment in GHS. These may be explained by other factors which could influence socioeconomic factors in determining

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commitment levels of employees in GHS. This may be because the initial differences in demography may be counteracted by time as people learn about their similarities in value (Chatman & Flynn, 2001; Polzer, Milto & Swan, 2002). For instance, Polzer et al. (2002) found no effect of demography on the individual employees, suggesting that similarity in personality and values can moderate the effects of demographic differences. Indeed, several studies in recent times found no significant gender difference in organizational commitment (Thorsteinson, 2003; Riketta, 2005; Steward et al, 2007; Suki & Suki, 2011; Khalili & Asmawi, 2012).

Consistent with rational demography theory, employees aged less than 30 years were more likely to be committed to GHS compared to those older than 49 years in GHS. This may be due to possible lack of experience to seek for other job opportunities. Dartey-Baah (2014), in a similar study in a banking sector of Ghana, found significant age differences in organizational commitment. The results also found that gross salary could influence commitment levels in GHS. For instance, employees with gross salaries GH¢1,000-GH¢1,999 were less likely to be committed compared to those who earned more than GH¢1,999. This finding lends credence to the argument that financial benefits are necessary to promote hard work and retain employees in the organization. This is in support of Suma and Lesha (2013) who also found a significant relationship between pay levels and organizational commitment in public institutions in Albania. Also, Gandhi and Hyde (2013), in a study in the public banks in India, found significant differences between pay and commitment levels among managerial and non-managerial levels and suggest that people who have high salaries may be unwilling to change their jobs.

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The relationship between organizational justice and commitment constructs was assessed by testing for the null hypotheses. This is because perceived fairness in appraisal has implications for organizational behaviour such as organizational commitment and citizenship behaviour (Greenberg, 2009). The results generally point to the rejection of the null hypotheses indicating that there was positive relationship between organizational justice and organizational commitment constructs. Specifically, overall perception of fairness was positively correlated with overall organizational commitment. This is an indication that, when employees perceive the performance appraisal to be fair, they will reciprocate by showing commitment to the organization (Ambrose & Schminke, 2007; Cropanzano et al, 2011). Similarly, procedural, interpersonal, informational and interactional justice constructs correlated with organizational commitment. That is, when employees perceive the ratings they received through the appraisal system to be fair or the procedure through which the ratings are given or whether their supervisor's treats them with respect and dignity or whether they are given information on why certain decisions are taken or why certain procedures are used they will intend compensate by showing commitment to the organization. Studies in the literature in support of this finding are mixed. For instance, while procedural and distributive justice are found to be significant predictors of organizational commitment (Colquit et al, 2013) and are also associated with higher level of organizational commitment (Okanbi & Ofoegbu, 2013; Ponu & Chuah, 2010; Robbins et al, 2005; Lambert et al, 2007; Rammmoorthy & Food, 2004), a similar study in Arizona found no significant association between organizational justice and organizational commitment.

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On the other hand, organizational justice constructs correlated with all the three organizational commitment constructs with affective commitment and normative commitment having somewhat stronger positive correlates (0.404 and 0.437 respectively) than that of continuance commitment. This is in support of Cohen-Chasash and Spector's (2001) work that indicated that findings in respect to how perceived fairness is measured may vary, but the relationship between perceived fairness and affective commitment should fall within a range between 0.37 and 0.43. This implies that when employees perceive their appraisal system to be fair, they will positively respond by getting involved and be more loyal to the organization, invest in the organization through their experience and create social networks that would keep them in the organization for a long time.

On the part of organizational justice and how it relates with its three constructs, the results show that 'procedural justice' had the strongest positive relationship with organizational justice. This means that procedural justice is the main determinant of fairness (justice) in the Ghana Health Service. Similarly, if the procedural justice is fair, the outcome may also be perceived as favourable, likewise support for decisions since the relationship between the procedural justice and distributive justice is positively significant. This is in support of the view that when procedural justice is perceived to be fair, the outcome may also be considered to be favourable and fair (Brockner, 2002). It is also in support of the assertion by Goldman (2003) that when procedural justice is high, it counteracts the negative effects of other injustices in the organization.

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The results indicated that affective commitment highly correlated with organizational commitment as compared to the other two constructs. This further confirms the results obtained through the use of the confirmatory factor analysis on organizational commitment that affective commitment is the main determinant of organizational commitment. However, across the constructs of organizational justice and commitment, the result shows that there was no significant relationship between distributive and procedural justice, on one hand and continuance commitment on the other hand. This means that distributive and procedural justices may not guarantee employees of the Ghana Health Service to make side bets and remain in the organization.

Perceived fairness in appraisal seems to have positive consequence on the level of commitment of employees to achieve the organizational goals. The enhancement of salaries of employees therefore has the propensity to promote hard work and retain employees in GHS. These are necessary for managers to appreciate the importance of treating every employee fairly to promote organizational commitment. The next chapter discusses perception of performance and the health related MDGs.

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CHAPTER SEVEN

PERCEPTION OF PERFORMANCE AND THE HEALTH RELATED MDGS

Introduction

Health workers provide the link to every health system (WHO, 2006b). A functional health system ensures that health workers are sufficient in their numbers, competent, motivated and responsive to achieving certain health outcomes based on the needs of the population and the resources available (WHO, 2006b). Performance of health workers are said to be influenced by the orientation, level of awareness and knowledge acquired, expectations in the healthcare delivery system and performance (Khiavi, 2015).

This chapter presents results on the awareness of health workers of the three health related MGDs. It assesses the implications of their perception of the appraisal system in the achievement of the MDGs. The rationale is that their understanding and perception of appraisal system could contribute to the achievement of individual goals which would invariably feed into the achievement of the institutional goals.

Level of awareness of health workers on Millennium Development Goals

Health workers are seen as a component of the health system that can operate to achieve the MDGs (WHO, 2006b). Knowledge and level of awareness of health workers have been found to be associated with their performance (Khiavi, 2015). In this regard, employees were asked whether they were aware of the MDGs (Table 41)

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Table 41: *Awareness of MDGs among Employees of GHS at Ho and Cape Coast*

Variables	(Males N=222)		(Females N=297)	
	Yes (%)	n(180)	Yes (%)	n (230)
Age (in year)				
Less than 30	71.3	41	54.0	53
30 – 39	83.1	69	77.1	82
40 – 49	77.0	34	69.8	40
50 – 59	76.9	36	71.4	55
Region				
Central	86.4	108	76.1	134
Volta	74.2	72	80.2	96
Educational level				
Middle/JHS	44.2	9	62.3	16
SHS/Tech/Voc	75.0	58	49.1	52
Diploma/HND	78.1	38	66.1	44
1st Degree	100.0	48	100.0	62
Postgraduate	100.0	27	100.0	36
Staff designation				
Nursing & Mid.	91.3	23	46.6	105
Medical	100.0	29	100.0	22
Paramedical	81.2	65	70.2	51
Administrative	72.4	63	57.8	52
Gross salary (GH¢)				
Less than 1,000	69.2	62	61.7	81
1,000-1,999	85.7	90	87.5	113
2,000 or more	100.0	28	100.0	36

Source: Field data (2013)

Eighty one per cent of males and 77 per cent of females were aware of health related MDGs. All the males and females with first degree and postgraduate degrees were aware of the MDGs. All the medical staff compared to 58 per cent of female administrative staff were aware of the MDGs. Sixty nine per cent of males and 62 per cent of females with gross salary less than GH¢1,000 compared to all the respondents who earned more than GH¢1,999 were aware of the MDGs. The level of awareness seems to be higher in the medical personnel, paramedical staff and nurses than in

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administrative staff. It also appears to be higher in respondents with higher education and earnings than those with lower education and earnings.

The second level was to assess their level of awareness on the health related MDGs in Table 42. Three out of eight millennium goals are health related. This was necessary since the various roles the respondents play in the health system can be linked to the health related MDGs.

Table 42: *Awareness of the Health-Related MDGs among Respondents in Ho and Cape Coast*

Variables	Males(N=222)		Females(N=297)	
	Yes (%)	n(150)	Yes (%)	n (198)
Age (in year)				
Less than 30	55.6	27	54.0	37
30 – 39	66.2	55	74.7	80
40 – 49	70.9	30	65.3	39
50 – 59	79.9	38	67.0	42
Region				
Central	70.4	88	67.3	119
Volta	63.9	62	65.8	79
Educational level				
Middle/JHS	35.0	7	62.3	16
SHS/Tech/Voc	55.1	43	41.5	44
Diploma/HND	57.8	28	66.1	44
1st Degree	100.0	48	94.1	58
Postgraduate	92.3	24	100.0	36
Staff designation				
Nursing & Mid.	64.0	16	70.5	79
Medical	100.0	29	100.0	22
Paramedical	69.1	56	75.3	53
Administrative	56.3	49	46.9	42
Gross salary (GH¢)				
Less than 1,000	41.1	37	46.8	62
1,000-1,999	81.0	85	82.2	106
2,000 or more	100.0	28	83.3	30

Source: Field data (2013)

Two thirds of males and females were aware of health related MDGs. This also means that there is an awareness gap between the respondents who

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perceived the general MDGs compared to those who proved to be aware of health related MDGs. Two thirds of females and 80 per cent of males aged more than 49 years were aware of health related MDGs. All the males and 94 per cent of females with first degree were aware of health related MDGs. All the medical personnel compared to 47 per cent of female and 56 per cent of male administrative staff were aware of the health related MDGs. All the male respondents and 83 per cent of females with gross salary more than GH¢1,999 were aware of the MDGs. Level of awareness appears to be higher in the medical personnel, paramedical staff and nurses than in administrative staff. It also appears to be higher in respondents with higher education and earnings than those with lower education and earnings.

The study went further to assess the extent to which the respondents were aware of the specific MDGs. Goal four is to reduce infant mortality, goal five is to improve maternal mortality, and goal six is to combat HIV/AIDS, malaria, tuberculosis and other diseases.

Table 43: *Health-related MDGs Known (n=348)*

Health-related MDGs	Male (150)	Female (198)
Goal 4 only	13.3	15.1
Goal 5 only	13.3	2.0
Goal 6 only	10.1	7.6
Goals 4 and 5	13.3	15.0
Goals 4 and 6	9.3	7.6
Goals 5 and 6	10.0	10.3
Goals 4, 5 and 6	30.7	23.7
Total	100.0	100.0

Source: Field data (2013)

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The results in Table 43 indicate that 31 per cent of males compared to 24 per cent of females were aware of all the three goals. A third of the females compared to 27 per cent of males were aware of two goals.

Factors influencing the level of awareness of health related MDGs

To assess the factors that influence the level of awareness of respondents on health-related MDGs, three sequential binary logistic models with odds ratios (OR) were developed. The binary logistic regression was used because the dependent variable (Are you aware of the health related MDGs?) had two levels, namely "Yes" or "No" (348 responses) with "No" (171) being the reference. Based on these responses, the models were built and the results were presented in Table 44.

Table 44: *Predicting Respondents' Awareness of Health-Related MDGs*

Demographic variables	Model I (OR)	Model II (OR)	Model III (OR)
Constant	0.11	0.67	0.61
Gender			
Males	1.71	1.66	1.14
Females (Ref.)	-	-	-
Age (in year)			
Less than 30	3.05*	4.74*	2.97*
30 – 39	2.48*	4.21*	2.94*
40 – 49	2.26*	4.16*	2.38*
50 – 59 (Ref.)	-	-	-
Region			
Central	1.00	1.00	0.99
Volta (Ref.)	-	-	-
Educational level			
Middle/JHS		0.26*	0.18
SHS/Tech/Voc		0.47*	0.44
Diploma/HND		0.68*	0.62
1st Degree		0.78	0.93
Postgraduate (Ref.)	-	-	-

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Staff Categorisation			
Nursing & Mid.		1.65	0.88
Medical		4.01*	2.01
Paramedical		2.58*	2.45
Administrative (Ref.)	-	-	-
Gross salary (GH¢)			
Less than 1,000			1.02
1,000-1,999			0.31
2,000 or more (Ref.)	-	-	-
-2log Likelihood	393.31	580.46	524.30

*significant at α=.05

The results show that gender was statistically insignificant in the three models and so are region and gross salary. However, age was found to be consistently significant in all the models. For instance, in the first model with gender, age and region, respondents aged 29 years or less were found to be aware of the health-related MDGs as compared to respondents aged 50 or more years (OR=3.05, p<.05). The likelihood of being aware of the health-related MDGs due to age factor appears higher among employees aged less than 29 years (range 2.94, p<.05 in model I to 4.16, p<.05 in model 111) as compared to the reference age group of 50-59 years.

With educational level and staff categorisation included in Model II, respondents with JHS qualification appear less likely to be aware of the health-related MDGs compared to those with post-graduate degrees (OR= 0.26, p<.05). A similar result was obtained for those with secondary school qualifications. This is similar to the finding that observes differences in the level of knowledge and awareness by academic qualifications (WHO, 2006b; Khiavi, 2015). However, there was no significant difference between the awareness levels of respondents with bachelor degrees compared to those with post-graduate certificates. Medical staff appears to be a stronger predictor of awareness of health related MDGs compared to administrative staff (OR=4.01,

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p<.05). A similar finding was arrived at with regard to paramedical staff (OR=2.58, p<.05). However, the difference in the awareness levels of nursing and midwives was not statistically significant compared to their administrative counterparts (OR=4.01, p>.05). This is in support of the finding that indicated that level of awareness of employees could be influenced by their age, educational level and the type of employee (Charkraborty et al, 2015). This is also in consonance with the findings that show differences in awareness among different health workers (Setia et al, 2013; Khiavi, 2015). This further reflects the direct roles medical and paramedical staff play in the health delivery system (WHO, 2006b).Thus, the significant determinants of awareness level of respondents of health-related MDGs are age, educational level, and staff categorisation.

Performance appraisal and achievement of health related MDGs

Performance appraisal is basically meant to monitor and measure performance of employees, and the information obtained can be used to plan and correct future job performance related challenges to achieve key organizational goals. The collective efforts and performance of individual employees is an aggregate of the overall organizational performance (Duraisingam & Skinner, 2005). It is on this basis that organizations would focus on dealing with individual performance in the organization. Health related MGDs are health targets that can be achieved through the efforts and performance of health workers. Every health worker has a role to play to ensure the health system functions well (WHO, 2006b). Performance appraisal can help supervisors assist employees set targets at the national and organizational levels and monitor them to ensure that targets are achieved. The

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achievement of these individual targets could feed into the achievement of the three health related MDGs.

In this regard, the views of employees were sought on the various processes in the appraisal system that could impact on the achievement of the health goals. First, the respondents were asked whether the MDGs were incorporated into their appraisal objectives in Table 45. This was necessary because the appraisal objectives are the standards for which employees' performances are measured. Incorporating health related MDGs into appraisal objectives could link performances of employees to their organizational goals.

Table 45: *Incorporating Health-Related MDGs into Staff Appraisal Objectives*

Variables	Males(N=222)		Females(N=297)	
	Yes (%)	n(52)	Yes (%)	n (84)
Age (in year)				
Less than 30	5.2	3	3.4	2
30 – 39	19.2	16	21.5	23
40 – 49	40.2	17	65.1	38
50 – 59	33.7	16	34.1	21
Region				
Central	20.8	26	37.0	65
Volta	26.8	26	15.8	34
Educational level				
Middle/JHS	5.0	1	9.9	3
SHS/Tech/Voc	2.2	2	16.5	18
Diploma/HND	16.6	13	28.6	19
1st Degree	50.9	24	47.3	29
Postgraduate	45.8	12	42.3	15
Staff designation				
Nursing & Mid.	39.3	10	37.6	42
Medical	100.0	29	66.7	15
Paramedical	11.1	9	26.0	19
Administrative	4.2	4	10.9	8
Gross salary (GH¢)				
Less than 1,000	14.4	13	18.4	24
1,000-1,999	21.9	23	34.1	44
2,000 or more	58.3	16	45.5	16

Source: Field data (2013)

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The results indicate that 23 per cent of males and 28 per cent of females said they had incorporated the health related MDGs into their appraisal objectives. Sixty per cent of females and 40 per cent of males had incorporated health related MDGs into their appraisal objectives. Five per cent of males and 10 per cent of females with JHS certificates compared to 51 per cent of males and 47 per cent of females with first degree had incorporated health related MDGs into their appraisal objectives. All the male and two thirds of female medical personnel said they had incorporated the health related MDGs. Thirty nine per cent of male and 38 per cent of female nurses compared to 4 per cent of male and 11 per cent of female administrative staff said they had incorporated health related MDGs into their appraisal objectives.

Second, the study assessed the extent to which individual performance objectives are obtained from the institutional goals that focus on health related MDGs in Table 46. The rationale was to assess the top-down goal setting approach that ensures that the performances of employees are linked to the organizational goals and targets. In view of this, the respondents were asked to indicate whether their appraisal objectives were related to institutional goals that focused on MDGs.

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Table 46: *Performance Objectives and Institutional Goals on Health-Related MDGs*

Demographics	Males (n=222)				Females (n=297)			
	Low	High	%	N	Low	High	%	N
Age (in year)								
Less than 30	78.2	21.8	100.0	49	81.8	18.2	100.0	68
30 – 39	64.7	35.3	100.0	83	67.2	32.8	100.0	107
40 – 49	53.8	46.2	100.0	43	42.3	57.7	100.0	59
50 – 59	56.5	43.5	100.0	47	39.7	60.3	100.0	63
Region								
Central	62.1	37.9	100.0	125	62.2	37.8	100.0	177
Volta	56.1	43.9	100.0	97	48.6	51.4	100.0	120
Educational level								
Middle/JHS	100.0	0.0	100.0	20	100.0	0.0	100.0	27
SHS/Tech/Voc	78.0	22.0	100.0	78	54.5	45.5	100.0	106
Diploma/HND	36.7	63.3	100.0	49	58.8	41.2	100.0	66
1st Degree	42.0	58.0	100.0	48	42.9	57.1	100.0	62
Postgraduate	30.8	69.2	100.0	27	0.0	100.0	100.0	36
Staff designation								
Nursing & Mid.	57.5	42.5	100.0	25	54.2	45.8	100.0	112
Medical	0.0	100.0	100.0	29	0.0	100.0	100.0	22
Paramedical	60.2	39.8	100.0	81	86.1	39.1	100.0	73
Administrative	61.2	38.8	100.0	87	77.8	22.2	100.0	90
Gross salary (GH¢)								
Less than 1,000	78.8	12.2	100.0	89	72.4	27.6	100.0	132
1,000-1,999	51.2	48.8	100.0	105	48.3	51.7	100.0	129
2,000 or more	100.0	0.0	100.0	28	0.0	100.0	100.0	36

Source: Field data (2013)

Forty per cent of males and 42 per cent of females indicated that their appraisal objectives were linked to institutional goals that relate to the MDGs. Eighty one per cent of females and 78 per cent of males aged less than 30 years perceived a link between their objectives and the institutional goals on MDGs to be low, while 44 per cent of males and 60 per cent of females aged more than 50 years perceived it to be high. All the respondents with JHS qualification perceived the link to be low, while all the females with

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postgraduate degree perceived it to be high. All the medical personnel and respondents with gross salary more than GH¢1,999 perceived it to be high.

Third, the study assessed the extent to which the duties employees performed were linked to institutional goals that focus on the health related MDGs (Table 47).

Table 47: *Duties Employees Perform and Achievement of Institutional Goals on MDGs*

	Males (n=222)				Females (n=297)			
Demographics	Low	High	%	N	Low	High	%	N
Age (in year)								
Less than 30	72.5	27.5	100.0	49	56.0	44.0	100.0	68
30 – 39	75.0	25.0	100.0	83	50.0	50.0	100.0	107
40 – 49	71.1	28.9	100.0	43	67.9	32.1	100.0	59
50 – 59	18.6	81.4	100.0	47	66.7	33.3	100.0	63
Region								
Central	61.4	38.6	100.0	125	65.4	34.6	100.0	177
Volta	47.4	52.6	100.0	97	49.0	51.0	100.0	120
Educational level								
Middle/JHS	66.7	33.3	100.0	20	70.6	29.4	100.0	27
SHS/Tech/Voc	78.3	21.7	100.0	78	52.0	48.0	100.0	106
Diploma/HND	56.9	43.1	100.0	49	63.2	36.8	100.0	66
1st Degree	35.3	64.7	100.0	48	66.6	36.4	100.0	62
Postgraduate	51.2	43.8	100.0	27	0.0	100.0	100.0	36
Staff designation								
Nursing & Mid.	57.1	48.9	100.0	25	46.7	53.3	100.0	112
Medical	0.0	100.0	100.0	29	0.0	100.0	100.0	22
Paramedical	62.5	37.5	100.0	81	40.0	60.0	100.0	73
Administrative	75.4	24.6	100.0	87	83.0	17.0	100.0	90
Gross salary (GH¢)								
Less than 1,000	69.5	30.5	100.0	89	65.7	34.3	100.0	132
1,000-1,999	48.5	51.5	100.0	105	53.4	46.9	100.0	129
2,000 or more	16.7	83.3	100.0	28	0.0	100.0	100.0	36

Source: Field data (2013)

The duties and the activities employees perform are the means through which individual performance targets can be achieved. This can feed into the achievement of the institutional goals if the individual performance is related

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to the institutional goals. In this regard, respondents were asked to indicate whether the duties they performed were linked to the achievement of the institutional goals on MDGs. The figures revealed that 42 per cent of males and 42 per cent of females perceived that their duties had positively related to the achievement of institutional goals on MDGs. Two-thirds of females and 81 per cent of males aged more than 49 years had high perception of their duties on the achievement of institutional goals on MDGs. All the medical personnel had high effect of their duties on achievement of MDGs. For other professions, 49 per cent of male and 53 per cent female nurses compared to a quarter of male and 17 per cent of female administrative staff had high perception of their duties on the achievement of goals on MDGs. The effect of duties on the achievement of goals on MDGs seems to be in favour of respondents with postgraduate education, medical staff and nurses.

Fourth, the study assessed in Table 48 whether the ratings employees received had any link with the health related MDGs. This is necessary to ascertain whether the appraisal output can be related to organizational goals. Appraisal rating is the outcome of the individual job performance. It therefore stands to reason that, if individual performance is related to the institutional performance, the outcome of the individual performance will lead to the outcome of institutional performance.

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Table 48: *Linking Appraisal Ratings to Institutional Goals on MDGs*

Variables	Males(N=222)		Females(N=297)	
	Yes (%)	n(88)	Yes (%)	n (99)
Age (in year)				
Less than 30	6.3	3	6.9	5
30 – 39	45.7	38	14.0	15
40 – 49	52.5	23	86.0	51
50 – 59	50.0	24	45.1	28
Region				
Central	33.3	42	35.9	63
Volta	47.4	46	30.0	36
Educational level				
Middle/JHS	12.5	3	30.7	8
SHS/Tech/Voc	4.4	3	31.1	33
Diploma/HND	63.2	12	27.5	18
1st Degree	66.7	32	43.3	29
Postgraduate	70.4	19	29.7	11
Staff designation				
Nursing & Mid.	45.6	11	39.7	44
Medical	86.4	25	76.9	17
Paramedical	45.7	37	32.8	24
Administrative	17.8	15	15.6	14
Gross salary (GH¢)				
Less than 1,000	25.6	23	10.6	14
1,000-1,999	41.9	44	41.1	53
2,000 or more	73.7	21	88.5	32

Source: Field data (2013)

Forty per cent of males compared to a third of females indicated that their appraisal evaluations were related to institutional goals on MDGs. Fifty three per cent of males and 86 per cent of females aged 40-49 years compared to 6 per cent of males and 5 per cent of females aged less than 30 years indicated the ratings they received were linked to institutional goals on MDGs. Two thirds of males with first degree and 70 per cent with postgraduate certificates said their appraisal ratings were linked to institutional goals on health related MDGs. Eighty six per cent of male and 77 per cent of female medical personnel had their appraisal ratings linked to institutional goals on

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MDGs. For other professionals, 46 per cent of male and 40 per cent of female nurses compared to 18 per cent of male and 16 per cent of female administrative staff said their appraisal evaluations were related to institutional goals on MDGs. Twenty six per cent of males and 11 per cent of females with gross salary less than GH¢1,000 compared to 74 per cent of males and 89 per cent of females with gross salary more than GH¢1,999 had their ratings related to institutional goals on MDGs. Linking appraisal ratings to institutional goals on MDGs appears to increase among nurses, medical personnel and respondents with higher education and gross salary.

Discussions

The main objective of this chapter was to assess the perception of the level of awareness of health related MDGs and their implications on the achievement of health related MDGs. The assessment of perception of awareness of health related MDGs among health workers was done at two levels (i.e. the descriptive and inferential). The descriptive analysis assessed the level of awareness among the health workers and the inferential analysis was done to assess socio-economic factors influencing their level of awareness. The expectation is that health workers who are aware of the MDGs in general are likely to be aware of the health related MDGs. The results nonetheless point to the contrary. There was an awareness gap between the respondents who perceived the general MDGs compared to those who proved to be aware of health related MDGs. Employees were less aware of the health related MDGs compared to the general MDGs. Personal awareness and knowledge were found to influence performance (Khiavi, 2015). The awareness gap has the tendency to impact negatively on the performance of

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the health targets since more than a third of the respondents were not aware of the health related MDGs. However, the awareness level appears to be higher in respondents with higher education and earnings than those with lower education and earnings. Level of awareness also seems to be higher in the medical staff, paramedical staff and nurses than in administrative staff. This may be attributed to the direct roles of the medical staff, paramedicals and nurses in the health service provision (WHO, 2006b) for which the health related MDGs are focused.

The results on the inferential analysis partly points to the rejection of the null hypotheses. Thus, factors such as age, educational level and staff categorization significantly influenced awareness of health related MDGs. This is in support of the finding that level of awareness could be influenced by age, educational level and the type of employee (Charkraborty et al, 2015). For instance, there was a significant difference in awareness level of employees aged less than 29 years compared to those with 50 or more years. Also, significant difference in the level of awareness was found between employees with JHS and SHS qualifications on the one hand and postgraduate qualifications on the other. This is similar to the finding that observes differences in the level of knowledge and awareness by academic qualifications (WHO, 2006b; Khiavi, 2015). Also, significant differences in awareness existed between medical and paramedical staff compared to administrative staff. This is also in consonance with the findings that show differences in awareness among different health workers (Setia et al, 2013; Khiavi, 2015). This finding again confirms the finding in the descriptive analyses that found high level of awareness among medical and paramedical

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staff compared to the administrative staff. This further reflects the direct roles medical and paramedical staff play in the health delivery system (WHO, 2006b). There was an expectation that gender, salary and region would also influence the awareness level (Charkraborty et al, 2015) of the health workers. Contrary to this expectation, the results show no significant relationship between the awareness level and gender as well as region and salary level.

The chapter also assessed the individual performance and how it relates to MDGs and the achievement of institutional goals. The expectation was that the performance of employees could relate positively with the institutional goals on MDGs. Contrary to this expectation, the results generally showed lack of link between performance of employees and achievement of institutional goals that focus on health related MDGs. In fact, less than a third of the respondents had their appraisal objectives and ratings based on health related MDGs. Also, less than half of the respondents indicated that their appraisal objectives were related to institutional goals. Similarly, less than half of male and female respondents had positive perception on the effect of their duties on the achievement of institutional goals.This means that more than half of the employees did not relate their goals to the MDGs. The implication is that individual performances are not based on the institutional goals on MDGs. As such, institutional goals are not likely to be achieved since individual performance feeds into organizational performance. This is consistent with the assertion that poor organizational performance is the product of workers not providing care according to standards and organizational goals (Hughes et al, 2002). Nonetheless, the effect of the duties performed on the institutional goals was higher among male medical and

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paramedical staff as well as nurses compared to administrative staff. This may be because the three health related MDGs were directly related to the duties of nurses, medical and paramedical staff. This is, however, contrary to growing evidence that supports a shift to establishing targets for all health workers based on overall vision of the institution. This will help them attain the expected level of service coverage for other categories of service providers such as mid-level health providers, community health workers, and management and support staff (Mullan & Frehywot, 2007; Lewin, 2010; Bangdiwala et al, 2010). This is because the impact of the frontline employees alone may not be enough to achieve the institutional goals since the inputs of the other workers are equally important.

In conclusion, the findings of this chapter show that awareness levels of employees of GHS on institutional goals are necessary to ensure achievement of the individual targets leading to the institutional goals. The study underscores the importance of age, educational level and staff categorization in predicting the awareness level of employees of health related MDGs. This further reflects the emphasis on the roles medical, paramedical staff and nurses play compared to the role of administrative staff that are necessary for the proper function of the health system. Moreover, the evidence also shows a weak link between performance of some health workers in GHS and the achievement of the institutional goals that focus on health related MDGs even though the link was relatively higher among medical staff, paramedical personnel and nurses as compared to administrative staff. It is now necessary to discuss the key findings, draw conclusions, and make recommendations in the final chapter.

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CHAPTER EIGHT

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

Introduction

Ghana lags behind in achieving its health related MDGs. Performance appraisal is one way through which health workers can be motivated to perform optimally on their jobs to meet the three health related MDGs. An appraisal system helps to identify skills and resources needed to improve performance. It is perceived to be fair if it has the potential to increase morale, leading to improved performance, high commitment and productivity to achieve organizational goals. This study sought to assess perception of fairness of performance appraisal and organizational commitment in GHS. It further assessed the relationship between organizational justice and commitment, evaluated perception of employees on processes of the current appraisal and assessed the level of awareness of employees on health related MDGs and their performance and achievement of health related MDGs.

The study used post-positive approach due to theoretical views on the use of already developed and validated scales that can measure perception of fairness and organizational commitment to achieve the desired output. Scales developed by Moorman (1991) and validated by Tang and Sarsfield-Baldwin (1996) and another developed by Thurston (2001) and Meyer and Allen (1996) were adopted to measure the various constructs of organizational justice and commitment respectively. Both descriptive and inferential statistics were used to analyze the data to address the objectives and test for the

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hypotheses. The highlights of the key findings, conclusions and recommendations are presented in this chapter.

Findings on perceptions of fairness and organizational commitment

The results of confirmatory factor analysis support the four and three constructs of organizational justice and commitments in the literature which form the basis for this study. The results from the study show that employees of GHS perceived fairness of performance appraisal in GHS to be high. All the organizational justice constructs (procedural, distributive, informational and interpersonal justices) were perceived to be high but procedural and interpersonal justices were found to be the main determinants of fairness in GHS. This is important because fairness of procedure has the potential to improve the outcome of the appraisal system. It is particularly good for the management of the appraisal system because any negative perceptions could be counteracted by the high procedural and interpersonal justices.

The results on inferential analysis also revealed that age and educational qualification could predict perception of fairness in GHS. For instance, employees younger than 30 years compared to those older than 49 years were more likely to perceive fairness of the appraisal in GHS because they may have been focused on understanding the appraisal process at the early stages of their career. Similarly, there was a significant difference in perception of fairness between employees with first degree and those with postgraduate qualification.

On the other hand, findings on the organizational commitment show that employees in the two regional capitals moderately perceived affective, normative and continuance commitment. Nevertheless, affective and

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normative commitments were found to be the main determinants of organizational commitment. Perception of continuance commitment appears to be higher among administrative staff compared to medical staff and nurses. Continuance commitment measures perceived cost associated with leaving the organization, which is an indication of lack of employment opportunities. Therefore, low continuance commitment may reflect availability of employment opportunities among nurses and doctors.

The evidence from the study indicated that there was no significant relationship in perception of organizational commitment by gender and staff categorization, region and educational level. However, a significant relationship was found between organizational commitment and educational level and gross salary. For instance, those earning gross salaries GH¢1,000-GH¢1,999 were less likely to be committed to GHS compared to employees who earned more than GH¢1,999. This finding lends credence to the argument that financial benefits are necessary to promote hard work and retain employees in the organization. Also, significant differences in commitment levels were found between employees aged less than 29 years and those older than 49 years.

The result also shows a significant positive relationship between organizational justice and commitment. This means that when the health workers perceive the appraisal to be fair, they will reciprocate by showing commitment to their work. The constructs of organizational justice (distributive, procedural, informative and interpersonal) correlated positively with organizational commitment, implying that if employees perceive the ratings they receive through the appraisal system to be fair or the procedures

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through which the ratings are given to be fair or that their supervisors are treating them with respect or dignity or they are given reasons why certain decisions are taken or why certain procedures are used, they will show commitment. Also, there was moderate significant positive relationship between all the organizational justice constructs and that of the organizational commitment constructs though the relationship was weak for the continuance commitment.

Findings on the processes of the current appraisal system

The results show that not all the employees who had supervisory responsibility were made to conduct appraisal for their subordinate. Employees who appraised people they do not supervise have the tendency to introduce subjectivity into the evaluation since they may lack the needed information on what went into the task performed. The reasons assigned to failing to appraise their subordinates were "my supervisor does the appraisal and my subordinates were not due for promotion". This is an indication that employees tied appraisal to promotion, while managers delegated their supervisory roles to their subordinates and yet they failed to mandate them to appraise the employees working under them. This is likely to affect effective monitoring and feedback in the appraisal system since the appraiser is not responsible for supervision. Nonetheless, among those who supervised employees they appraised, over 80 per cent of them supervised less than 11 employees, which is likely to enhance supervision leading to high performance. This is good for the appraisal system because the supervisor could monitor and provide feedback to employees while the job is being done.

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The available evidence shows that less than half of the employees set appraisal objectives at the beginning of the year. That is, more than half of the respondents had no expectations on which their performances could be measured as required by the appraisal system. Failure to set objectives at the beginning of the year and jointly agree on appraisal objectives could undermine the appraisal process. This may affect the extent to which employees receive feedback from their supervisors.

The results also show two-third of employees were engaged in daily monitoring and feedback compared to 41 per cent involved in the mid-year review. This may reflect the role monitoring and feedback play in supervision but not necessarily that employees had conformed to the appraisal policy. This is in support of the view that supervisors provide monitoring and feedback as part of supervisory role and not necessarily due to their role in the appraisal system.

The results on the evaluation of the performance of employees revealed that all respondents had achieved their appraisal targets though more than half of them did not set any targets at the beginning of the appraisal year. Similarly, all the respondents were rated in the range considered to be acceptable. It therefore appears that all the employees, in their last appraisal ratings, had met the requirement for promotion and were likely to receive salary increments. This level of performance provides support to the earlier suggestion that raters are likely to give favourable ratings if the appraisal is to be used for administrative decisions such as pay raise and promotion This reflects the disadvantage of the use of a single-rater over the multi-rater. This

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is because raters may want to avoid confrontations with their employees in order to maintain cordial relationship with them.

Age and educational level were also found to be associated with the ratings employees received. For instance, significant differences in performance ratings were found between employees younger than 30 years and those older than 40 years. Similarly, significant differences in performance ratings were found between employees with basic education and those with post graduate education. This underscores the potential sources of biases in appraisal ratings based on educational level and age. That is, supervisor as a rater may have introduced rating errors by being lenient towards younger employees and those with higher education.

Moreover, the appraisal system in GHS is to address both administrative and developmental needs of the employees, but over 90 per cent of the employees in GHS attributed the reason for their appraisal to promotion compared to 8.1 per cent and 18.3 per cent of the employees who perceived training and development and improvement in performance respectively as the reason for their appraisal. Failure to use the appraisal output for training shows that employees are not being trained according to the needs identified through the appraisal system. This has the potential of affecting employees to meet their personal goals of self-development and to acquire new competences to perform on the job.

Nonetheless, the employees perceived that the appraisal system could have positive effect on their morale to work harder. They also perceived satisfaction with the appraisal system and believe it could motivate them to work harder. They believe the appraisal system has the potential to positively

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influence the reduction of infant mortality, improvement in maternal health and combating diseases such as malaria, TB and HIV/ AIDS.

Findings on awareness level of employees and achievement of health related MDGS

The study also revealed that there was an awareness gap between the respondents who perceived the general MDGs compared to those who proved to be aware of health related MDGs. More than a third of both male and female respondents were not aware of the health related MDGs. Employees were thus less aware of the health related MDGs compared to the general MDGs. Personal awareness and knowledge could influence performance. Therefore, the awareness gap has the tendency to negatively impact on the performance of the health related MDGs. However, there was higher level of awareness among males who were medical and paramedical staff and female nurses compared to administrative staff. This may be attributed to the direct roles played by medical, nursing and paramedical staff in the health system for which the health related MDGs are focused.

The results also revealed that factors such as age, educational level and staff categorization significantly influenced the awareness level of employees of health related MDGs. Specifically, there was a significant difference in awareness level of employees aged less than 40 years compared to those more than 49 years. Also, significant difference in the level of awareness was found between employees with JHS and SHS qualifications on the one hand and postgraduate qualifications on the other. Higher awareness was also found among the medical and paramedical staff compared to administrative staff. This finding confirms the view in the descriptive analyses that indicated high

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level of awareness among medical and paramedical staff compared to the administrative staff. This further reflects the direct roles medical and paramedical staff play in the health delivery system.

The results generally showed lack of link between performance of employees and achievement of institutional goals. In fact, less than a third of male and female respondents had their appraisal objectives and ratings based on the health related MDGs. Also, less than half of the respondents indicated that their appraisal objectives were related to institutional goals. Similarly less than half of male and female respondents had positive perception of the effect of their duties on the achievement of institutional goals. The implication is that individual performances are not based on the institutional goals on MDGs. As such, institutional goals are not likely to be achieved since individual performance feeds into institutional performance. This reflects the view that poor organizational performance is the product of workers not providing care according to standards and organizational goals. However, the effect of duties performed on the institutional goals was higher among male medical and paramedical staff as well as nurses compared to the administrative staff. This may be because the three health related MDGs were directly related to the duties of nurses, medical and paramedical staff.

Conclusion

Performance appraisal continues to serve as the means through which organizations measure and improve performance of their employees to achieve organizational goals. The findings of this study revealed that when employees perceive their appraisal to be fair, it has a positive consequence to increase the level of commitment of employees to achieve the organizational goals. The

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study also underscores the importance of age and educational level in driving perception of fairness of performance appraisal. Similarly, educational level and gross salary were found as determinants of organizational commitment. The enhancement of salaries of employees therefore has the propensity to promote hard work and retain employees in GHS. These are necessary for managers to appreciate the importance of treating every employee fairly to promote organizational commitment.

This notwithstanding, perception of fairness of the appraisal system alone cannot drive the achievement of health targets if the individual targets are not set, monitored and evaluated based on the organizational targets in accordance with the appraisal policy. Also, the knowledge and awareness of the targets are necessary to ensure achievement of the individual targets leading to the institutional goals. The study underscores the importance of age, educational level and staff categorization in predicting the awareness level of employees of health related MDGs. The level of awareness was higher among medical, paramedical and nurses compared to the administrative staff. This further reflects the emphasis on the roles medical, paramedical staff and nurses play compared to the role of administrative staff that are necessary for the proper function of the health system. Moreover, the evidence also shows lack of link between performance of some health workers in GHS and the achievement of the institutional goals that focus on health related MDGs even though the link was relatively higher among medical staff, paramedical personnel and nurses as compared to administrative staff. This could be the reason why employees of GHS in the two regions had high perception of fairness of appraisal and moderate level of commitment. They had also

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achieved their individual targets and all had received favourable ratings in their last appraisal evaluation for promotion and possible salary raise and yet the institution still lags behind in achieving its targets. This brings to the fore the need to see the appraisal system as a holistic approach in solving organizational problems where both managers and employees have a shared responsibility to ensure the organization succeeds.

Span of control of less than 11 employees may enhance effective supervision because supervisors could easily monitor the job performance of all their subordinates. The study revealed age and educational level as predictors of performance ratings among employees of GHS. Predictors of performance ratings reflect the potential biases in appraisal evaluation. Thus, educational level and age could serve as potential sources of bias in the appraisal ratings. This is because supervisor as a rater may have introduced rating errors by being lenient towards younger employees and those with higher education.

The appraisal system in GHS also provides the means for developmental needs of the organization to be achieved, while the outputs from the appraisal system are used to take administrative decisions such as promotion and salary raise. However, evidence from the study shows that the appraisal system in GHS is mainly used when people are due for promotion, thus ignoring the other important uses of the appraisal system, which are to identify training and developmental needs. Moreover, various processes of the appraisal system intended to make it effective such as appraisal meeting, mid-year review of activities, daily monitoring and feedback were being ignored by some of the employees.

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Policy implications and recommendations

The study has a number of key findings that have implications for policy. The findings of the study show high perception (60%) of fairness of performance appraisal among employees of GHS, with procedural and interpersonal justices as the main determinants of perception of fairness. This means that GHS could devote attention and effort on issues that promote procedural and interpersonal justice in order to ensure and sustain fairness of the appraisal system to derive the benefits that are associated with it. In this regard, GHS may ensure that a two-way communication practice between the employees and the supervisors is kept. The appraisal system could be made simple and the processes made clear to understand and well explained to the employees. The employees may develop trust for their supervisors, and provision may be made for appeal during the process when the need arises. In addition, the supervisors may treat their subordinates with respect and dignity.

The study also found significant age and educational level as predictors of perception of fairness. In this regard, GHS can consider educational opportunities for their employees as a way of ensuring fairness in the appraisal system. Similarly, age and gross salary were found to be associated with commitment level of employees in GHS. This may require management of GHS to consider enhancement of salaries as a means of improving commitment level of employees.

The study also found a weak link between individual performance and performance of GHS on health related MDGs. In view of this, Managers of GHS may consider a system where the appraisal goals are set with the view of linking appraisal objectives of individual employees to that of the

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organization. This could be based on top-down goal setting approach by linking individual performance to the organizational goals and performance.

The study revealed that all the employees in the two regional capitals reported that they had achieved their appraisal targets and were also rated favourably and yet the organizational targets were hardly met. This could be attributed to the leniency bias that supervisors may have introduced into the evaluation process in order to avoid confrontation with their employees. These can be eliminated if peers, subordinates and supervisor are involved in the appraisal process instead of only the supervisor.

There was also lack of link between performance of health workers in GHS and the achievement of the institutional goals that focus on health related MDGs. Nonetheless, the link was relatively higher among medical staff, paramedical personnel and nurses as compared to administrative staff. This may indicate the direct roles medical personnel, paramedical staff and nurses play in the health delivery system. Managers of GHS may ensure that the performance of all health workers is linked to the organizational goals. They may also design programmes that will enhance the knowledge of staff on key health targets, taking into consideration their age and educational levels. There is also the need to create awareness of health targets among all employees.

The appraisal system in GHS is used mainly for promotional purposes to the neglect of developmental and other purposes for which reason the appraisal system was set up. This may call for a renewed effort at the top management level to reassess the appraisal system. This can help in designing a new approach for implementation coupled with training to achieve the purpose.

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Building on existing knowledge

The study revealed that employees younger than 30 years consistently predicted perception of fairness of performance appraisal, organizational commitment, the ratings employees received as well as awareness levels of health related MDGs. The implication is employees younger than 30 years are more likely to influence different aspects of GHS. These employees may be enthusiastic about their organization at the early stage because they may be adapting to the new systems, processes, procedures and policies but as they stay longer, they get used to the system and the enthusiasm goes down.

Reflecting on the study model on perception of fairness, the CFA results confirmed organizational justice as a four-factor model namely distributive, procedural, informative and interpersonal justice. It also revealed interpersonal and distributive justices as the main determinants of organizational justice which reflects the social and structural components of the model (Colquitt, 2001). This means that structurally, employees could perceive fairness if the appraisal process is clarified and employees have trust in their supervisors as well as there is communication between the two while provision is also made for appeal. On the social aspect, employees could perceive fairness if they are treated with respect and dignity. This appears to address the issues relating to the approaches used in measuring perception of fairness as separate justices or as an overall justice. The study adopted the two approaches in order to understand the dichotomy between the two. The findings revealed that perception of fairness was high in all the separate constructs as well as in the overall organizational justice. It therefore stands to reason that irrespective of the approach used the outcome is likely to be the

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same. This could be explained by the determinant effect of the procedural and interpersonal justices among the employees of GHS which means that if the two are favourably perceived by the employees, all the other constructs of organizational justice would be favourable likewise the overall fairness.

Limitations of the study

This study is limited in some ways, but the limitations outlined in this section should provide an opportunity for further research in advancing knowledge in the area of perception of fairness and its influence on organizational outcomes.

First, the study is cross-sectional in nature, which means that the data was collected at a single point in time. It may happen that the relationship between the constructs of organizational justice and commitment and other variables may change at specific points over a period of time; therefore the current findings may not be conclusive. Second, the study adopted a quantitative approach which was based on theoretical justification for its use for the study. Nonetheless, qualitative approach could support in providing deeper understanding of the phenomenon. Another limitation is that the data was collected from only two regional capitals of Ghana making a small percentage of the total employees of GHS. Thus, many health care providers in GHS in other districts, municipalities and metropolis in Ghana were not represented.

Despite the limitations, the quantitative approach adopted in the data collection and analysis allowed for the testing of deductive models in organizational justice and commitment to confirm or otherwise the hypothesised relationships between the two. The approach also helped to

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make inferences from the findings which could be generalised in a context similar to the one from which data was drawn. The approach helped in comparing various socio-demographic variables and how they influence perception of fairness, organizational commitment, and awareness levels among health personnel and possible sources of errors in appraisal ratings.

Suggestions for further research

The study revealed that employees younger than 30 years was predicted perception of fairness of performance appraisal, organizational commitment, the ratings employees received and awareness levels of health related MDGs in GHS. However, this study was only conducted in the regional capitals of Central and Volta Regions which form a small percentage of the total employees in GHS. It could happen that the age factor may vary across the entire GHS employees. Therefore a study of age effect on the dependent variables covering all the staff of GHS in the ten regions would be more conclusive.

The study used theoretical justification for the use of quantitative approach in assessing perception of fairness and organizational commitment but further research using the qualitative approach would provide deeper understanding of the phenomenon in GHS. Also, a longitudinal research is recommended for the future to assess the point of time changes in the relationship of the dependent and independent variables. It is documented that perception of fairness could influence behaviours (organizational commitment and citizenship behaviour) and attitudes (job satistaction) of employees in an organization. This study focused on the behavioural (commitment) aspects of employees in GHS. A study on attitudinal aspect will provide another

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dimensions on how behaviours and attitudes of employees are influenced by their perception of fairness in GHS.

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APPENDICES

Appendix 1: Test of Multicollinearity among Socio-Economic Variables of Respondents

		Gender	Age	Region	Educational Level	Gross salary
Age	Pearson Correlation	-0.071				
	Sig. (2-tailed)	.106				
	N	*519*				
Region	Pearson Correlation	-0.057	0.011			
	Sig. (2-tailed)	.195	.797			
	N	*519*	*519*			
Educational Level	Pearson Correlation	-0.381*	-0.098*	-0.009		
	Sig. (2-tailed)	.012	.026	.845		
	N	*519*	*519*	*519*		
Gross salary	Pearson Correlation	-0.140**	0.395**	-0.083	0.386**	
	Sig. (2-tailed)	.001	.000	.060	.000	
	N	*519*	*519*	*519*	*519*	
Staff categorisation in GHS	Pearson Correlation	-0.407**	0.090*	0.141**	0.363*	0.135
	Sig. (2-tailed)	.009	.042	.001	.021	.072
	N	*519*	*519*	*519*	*519*	*519*

***. Correlation is significant at the 0.01 level (2-tailed).*
**. Correlation is significant at the 0.05 level (2-tailed).*

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Appendix 2: Variance Inflation Factor Analysis

Model	Unstandardised Coefficients		T	Sig.	Collinearity Statistics	
	B	Std. Error			Tolerance	VIF
(Constant)	2.178	0.157	13.891	.000		
Gender	0.112	0.051	2.205	.028	0.767	1.303
Age	0.039	0.024	1.616	.107	0.742	1.347
Region	-0.043	0.046	-0.951	.342	0.968	1.033
Educational Level	0.044	0.024	1.857	.064	0.619	1.616
Gross salary	-0.013	0.032	-0.409	.683	0.653	1.532
Staff categorisation in GHS	0.046	0.026	1.759	.079	0.757	1.322

Dependent variable: Justice

Appendix 3: Correlation Matrix of Organisational Justice Constructs

	Statistic	**Distributive**	**Procedural**	**Interpersonal**
Procedural	Pearson Correlation	.387**		
	Sig. (2-tailed)	.000		
	N	*519*		
Interpersonal	Pearson Correlation	.159**	.343**	
	Sig. (2-tailed)	.000	.000	
	N	*519*	*519*	
Informational	Pearson Correlation	.319**	.685**	.291**
	Sig. (2-tailed)	.000	.000	.000
	N	*519*	*519*	*519*

***. Correlation is significant at the 0.01 level (2-tailed).*

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Appendix 4: Correlation Matrix of Organisational Commitment Constructs

	Statistic	Affective	Normative
Normative	Pearson Correlation	.315**	
	Sig. (2-tailed)	.000	
	N	519	
Continuance	Pearson Correlation	.082	-.006
	Sig. (2-tailed)	.061	.887
	N	519	519

**. *Correlation is significant at the 0.01 level (2-tailed).*

Appendix 5: Cronbach's Alpha Reliability Test

Cases	N	%	Cronbach's Alpha	N of Items
Valid	26	86.7	.926	94
Excluded[a]	4	13.3		
Total	**30**	**100.0**		

[a]*Listwise deletion based on all variables in the procedure*

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Appendix 6:

QUESTIONNAIRE

This questionnaire is designed to fulfill an academic requirement for an award of a degree in Population and Health. Its aim is to solicit your responses in gathering relevant information on the topic: *Perception of fairness of performance appraisal and organisational commitment among employees of Ghana Health Service in two regional capitals of Ghana.*

Your participation in this study is completely voluntary and will be treated confidentially and anonymously.

SECTION A
SOCIO ECONOMIC FACTORS

1. Gender Male [ ] Female [ ]

2. Age (in complete years) [ ] [ ]

3. Name of Department where you work…………………………………………………

4. Region……………………………..

5a. Highest academic level attained

MSLC/ JSS [ ] Secondary/ SHS/ SSS/ Technical/ Vocational [ ]
Polytechnic [ ] University Diploma [ ] University first degree [ ]
University Post Graduate degree [ ]
Other (specify)……………………………………………………………………………

5b. Highest professional certificate attained……………………………………………………….

5c. Last training programme received (in month and year) [ ] [ ] [ ][ ][ ][ ]

6. Gross salary (in Ghana Cedis)

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Less than 1000 ☐

1000 - 1999 ☐

2000 - 2999 ☐

3000 - 3999 ☐

4000 - 4999 ☐

5000 and above ☐

7. Official rank in the service……………………………………………………………….

SECTION B
EFFECTIVENESS OF CURRENT APPRAISAL SYSTEM

8. If a supervisor, the number of staff directly supervised? ....

9. Do you conduct performance appraisal for employees you supervise?
   Yes ☐ No ☐

10. If No, why not…………………………………………………………………

If yes, please answer question 11 to 13:

	Month	Year
11. Indicate the last time you appraised a staff?	[ ] [ ]	[ ] [ ] [ ] [ ]

11a. Did you discuss any issue with the appraisee during the appraisal?
Yes ☐ No ☐

11c. If yes, what was discussed?………………………………………………..
………………………………………………………………………………………

11c. What was the outcome of the discussion?...
………………………………………………………………………………………

12. How many people did you last appraise? [ ] [ ]

13. What was/ were the reason(s) for the appraisal?

Promotion ☐
Salary increments ☐

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Training and development ☐
Improve performance ☐
Other(s) (specify)
……………………………………………………………………………

14. Are you supervised by a superior? Yes ☐ No ☐

15. If No, why not…………………………………………….

If yes, please answer question 16 to 21:

Month Year

16. Indicate the last time you were appraised by your supervisor? [ ] [ ] [ ] [ ] [ ] [ ]

17. What was/ were the reason(s) for your appraisal

Promotion ☐

Salary increments ☐

Training and development ☐

Improve performance ☐

Other(s) (specify)
……………………………………………………………………………

18. For your last appraisal, which period of the appraisal year were your objectives set?
Beginning ☐ End ☐

19a. Did you meet your supervisor to set the objectives together?
Yes ☐ No ☐

19b. If no, who set your objectives? My supervisor ☐ myself ☐

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20. Please complete the table below?

No	Objectives	Expectation	Remarks [Achieved/ not Achieved and the reason(s)]

21. Indicate average score for your last appraisal rating? [ ] [ ]

Carefully consider each statement in questions 22 to 31 and mark the answer that represents the extent to which you agree with the statement:
1= strongly disagree, 2= disagree, 3=agree and 4=strongly agree.

22. I meet my supervisor at the beginning of every year on my appraisal
1 ☐ 2 ☐ ☐ 4 ☐

23. My performance objectives are set with measurable targets at the beginning of every year.
1 ☐ 2 ☐ ☐ 4 ☐

24. My supervisor provides guidance and feedback regularly on my performance.
1 ☐ 2 ☐ ☐ 4 ☐

25. My activities are reviewed at the end of every half year.

1 ☐ 2 ☐ ☐ 4 ☐

26. My performance is reviewed regularly to ensure I am on course to achieve my objectives.
1 ☐ 2 ☐ ☐ 4 ☐

27. My supervisor rates my performance at the end of every year.
1 ☐ 2 ☐ 3 ☐ 4 ☐

28. My ratings reflect my performance.
1 ☐ 2 ☐ ☐ 4 ☐

29. My training needs are determined from my performance assessment
1 ☐ 2 ☐ ☐ 4 ☐

30. My promotion is based on my performance appraisal output
1 ☐ 2 ☐ ☐ 4 ☐

31. My career development is based on the assessment of my appraisal
1 ☐ 2 ☐ ☐ 4 ☐

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SECTION C

EMPLOYEES PERFORMANCE AND ITS IMPLICATIONS FOR HEALTH RELATED MDGS

32. Do you know what the MDGs stand for? Yes ☐ ☐

33. If yes, what is it? ....

34. Are you aware of the health related MDGs Yes No ☐

35. If Yes, please list them…………………………………………………
36. Which of the stated MDGs are related to your work? ....

37. Has your supervisor incorporated any of the health related MDGs into your appraisal?
    Yes ☐ No ☐

38. If yes, state them…………………………………………………………
39. Did your last appraisal rating have any links to your duties which relate to the MDGs
    Yes ☐o ☐

40. If No, why not…………………………………………………………

41. If yes, please complete the table below

NO	MDG	Nature of Linkage

42. How does your last performance appraisal rating affect the following?

Effect	Positive	Negative	No
Morale to work harder	☐	☐	☐
Satisfaction with the appraisal system	☐	☐	☐
Motivation to improve performance	☐	☐	☐

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Reduction in child mortality ☐ ☐ ☐

Improvement in maternal health ☐ ☐ ☐

Eradication of HIV/TB/Malaria ☐ ☐ ☐

Consider each statement in 43 to 44 and mark (√) the answer that represents your knowledge on the following.

1. Not Aware 2. Aware

43. I am aware of institutional goals that focus on achieving health related MDGs

1. ☐ 2. ☐

44. I am aware of departmental goals that focus on health related MDGs

1. ☐ 2. ☐

Consider each statement in 45 to 54 and mark (√) the answer that represent the extent to which agree with the statement:

1=strongly disagree, 2=disagree, 3= agree 4=strongly agree

45. My performance objectives are related to the institutional goals which focus on health related MDGs

1 ☐ 2 ☐ 3 ☐ 4 ☐

46. My performance objectives are related to the departmental goals that focus on health related MDGs

1 ☐ 2 ☐ 3 ☐ 4 ☐

47. The duties I perform impacts on achieving institutional goals that are related to MDGs

1 ☐ 2 ☐ 3 ☐ 4 ☐

48. The duties I perform impacts on achieving departmental goals that are related to MDGs

1 ☐ 2 ☐ 3 ☐ 4 ☐

50. Failure to achieve my performance targets will affect any of the institutional goals that are health related MDGs

1 ☐ 2 ☐ 3☐ 4☐

51. Failure to achieve my performance targets will affect the departmental goals that are related to the MDGs

1 ☐ ☐ 2 ☐3 ☐ 4

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52. My supervisor explains to me how my performance can impact on achieving departmental goals that focus on the health related MDG.

1 ☐ 2 ☐ 3 ☐ 4☐

53. My supervisor is particularly concerned about my objectives that focus on achieving the health- elated MDGs

1 ☐ 2 ☐ 3☐ 4 ☐

54. My supervisor identifies my weaknesses that bother on achieving health related MDGS.

1 ☐ 2 ☐ 3 ☐ 4 ☐

55. The in-service training I received helped to improve my skills to achieve my performance objectives in the health related MDGs

1 ☐ 2 ☐3 ☐ 4 ☐

SECTION D:
ORGANIZATIONAL JUSTICE

DISTRIBUTIVE JUSTICE

Think about Performance Appraisal Process in the Ghana Health Service (GHS) as it is conducted in your institution, carefully consider each statement and mark the answer that represents the extent to which you agree with the statement:
1= strongly disagree, 2= disagree, 3=agree and 4=strongly agree.

a. Accuracy of rating

56. My performance rating is based on how well I do my work

1 ☐ 2 ☐ 3 ☐ 4 ☐

57. My performance rating reflects how much work I do.

1 ☐ 2 ☐ 3 ☐ 4 ☐

58. My performance rating is based on the many things that help at work.

1 ☐ 2 ☐ 3 ☐ 4 ☐

59. My recent performance rating is based on the effort I put into the job.

1 ☐ 2 ☐ 3 ☐ 4 ☐

60. The most recent performance rating I received is based on the many things I am responsible for at work.

1 ☐ 2 ☐ 3 ☐ 4 ☐

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b. Concern over rating

61. My superior gives me the rating I earn even if it might upset me.

1 ☐ 2 ☐ 3 ☐ 4 ☐

62. My rating is based on my superior trying to avoid bad feelings among his or her subordinate.

1 ☐ 2 ☐ 3 ☐ 4 ☐

63. The rating I got is not higher than one I should earn based on my effort and contribution.

1 ☐ 2 ☐ 3 ☐ 4 ☐

64. The performance rating is based on the quantity and quality of work and not my personality or position.

1 ☐ 2 ☐ 3 ☐ 4 ☐

65. Supervisors rate employees based in part on their personal likeness or dis-likeness of employees.

1 ☐ 2 ☐ 3 ☐ 4 ☐

66. Supervisors give the same performance rating to all subordinates in order to avoid resentment.

1 ☐ 2 ☐ 3 ☐ 4 ☐

PROCEDURAL JUSTICE

1. Two way communication

67. The goals set in the previous appraisal meeting were reviewed with me by my supervisor.

1 ☐ 2 ☐ 3 ☐ 4 ☐

68. My supervisor provided guidance during the appraisal cycle.

1 ☐ 2 ☐ 3 ☐ 4 ☐

69. My supervisor sat down with me and discussed the results of my performance evaluation.

1 ☐ 2 ☐ 3 ☐ 4 ☐

70. I freely express my feelings whenever my performance is evaluated.

1 ☐ 2 ☐ 3 ☐ 4 ☐

Trust

71. My supervisor is competent enough to evaluate my work.

1 ☐ 2 ☐ 3 ☐ 4 ☐

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72. My supervisor is familiar with the details and responsibilities that my job entails

1 ☐ 2 ☐ 3 ☐ 4 ☐

73. My supervisor can be trusted to be fair to everybody.

1 ☐ 2 ☐ 3 ☐ 4 ☐

74. My supervisor accurately reports on my performance to his/her superior

1 ☐ 2 ☐ 3 ☐ 4 ☐

Clarity

75. I have been told clearly at the beginning of the appraisal cycle that my appraisal ratings will be linked to my promotion.

1 ☐ 2 ☐ 3 ☐ 4 ☐

76. I have been giving enough information about the appraisal cycle

1 ☐ 2 ☐ 3 ☐ 4 ☐

77. I have been told clearly that my performance appraisal will be evaluated yearly.

d. Understanding

78. I fully understand the performance appraisal process in Ghana Health Service (GHS)

1 ☐ 2 ☐ 3 ☐ 4 ☐

79. I fully discussed my job related problems with my supervisor

1 ☐ 2 ☐ 3 ☐ 4 ☐

80. I feel comfortable to express my feelings to my superior during the appraisal process

1 ☐ 2 ☐ 3 ☐ 4 ☐

e. Seeking appeals

81. I am free to appeal to a performance rating that I think is based on inaccuracy.

1 ☐ 2 ☐ 3 ☐ 4 ☐

82. I know I can get a fair review of my performance rating if I request one.

1 ☐ 2 ☐ 3 ☐ 4 ☐

83. I can challenge a performance rating if I think it is unfair.

1 ☐ 2 ☐ 3 ☐ 4 ☐

84. My performance rating can change if I can show that it is incorrect or unfair.

1 ☐ 2 ☐ 3 ☐ 4 ☐

85. A process to appeal a rating is available to me anytime I may need it.

1 ☐ 2 ☐ 3 ☐ 4 ☐

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86. I am comfortable in communicating my feelings of disagreement about my rating to
my superior

1 ☐ 2 ☐ 3 ☐ 4 ☐

INTERPERSONAL JUSTICE

Treatment by superior

87. My supervisor is rarely rude to me

1 ☐ 2 ☐ 3 ☐ 4 ☐

88. My supervisor is almost always polite

1 ☐ 2 ☐ 3 ☐ 4 ☐

89. My supervisor treats me with dignity

1 ☐ 2 ☐ 3 ☐ 4 ☐

90. My supervisor treats me with respect

1 ☐ 2 ☐ 3 ☐ 4 ☐

91. My supervisor does not invade my privacy

1 ☐ 2 ☐ 3 ☐ 4 ☐

92. My supervisor is courteous to me

1 ☐ 2 ☐ 3 ☐ 4 ☐

93. My supervisor does not make hurtful statements to me.

1 ☐ 2 ☐ 3 ☐ 4 ☐

94. My superior shows concern for my right as an employee.

1 ☐ 2 ☐ 3 ☐ 4 ☐

95. My supervisors treats me with kindness

1 ☐ 2 ☐ 3 ☐ 4 ☐

INFORMATION JUSTICE

Explanation of rating decision

96. My rater gives me clear and real example to justify his/her rating of my work.

1 ☐ 2 ☐ 3 ☐ 4 ☐

97. My rater helps me to understand the process used to evaluate and rate my performance

1 ☐ 2 ☐ 3 ☐ 4 ☐

98. My supervisor takes the time to explain decisions that concern me.

1 ☐ 2 ☐ 3 ☐ 4 ☐

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99. My supervisor allows me to ask him/her questions about my performance rating.
1 ☐ 2 ☐ 3 ☐ 4 ☐
100. My rater helps me understand what I need to do to improve performance.
1 ☐ 2 ☐ 3 ☐ 4 ☐

SECTION E
ORGANISATIONAL COMMITMENT
a. Affective commitment

Consider each statement and mark the answer that represents the extent to which you agree with the statement:
1= strongly disagree, 2= disagree, 3=agree and 4=strongly agree.

101. I would be very happy to spend the rest of my career with Ghana Health Service (GHS)
1 ☐ 2 ☐ 3 ☐ 4 ☐
102. I enjoy discussing Ghana Health Service (GHS) with people outside it.
1 ☐ 2 ☐ 3 ☐ 4 ☐
103. I really feel as if Ghana Health Service (GHS) is my own
1 ☐ 2 ☐ 3 ☐ 4 ☐
104. I think that I could easily become attached to another organization as I am in Ghana
Health Service (GHS)
1 ☐ 2 ☐ 3 ☐ 4 ☐

105. I don't feel like part of family in Ghana Health Service (GHS)
1 ☐ 2 ☐ 3 ☐ 4 ☐

106. This organization has a great deal of personal meaning to me.
1 ☐ 2 ☐ 3 ☐ 4 ☐
107. I do not feel a strong sense of belonging to Ghana Health Service (GHS)

1 ☐ 2 ☐ 3 ☐ 4 ☐
b. Continuance commitment
108. I am not afraid of what might happen when I quit my job without having another lined up.
1 ☐ 2 ☐ 3 ☐ 4 ☐

109. It would be very hard for me to leave Ghana Health Service (GHS) right now, even
if I wanted to.
1 ☐ 2 ☐ 3 ☐ 4 ☐
110. Too much in my life will be disrupted if I decide I want to leave Ghana Health Service (GHS) now
1 ☐ 2 ☐ 3 ☐ 4 ☐

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111. It wouldn’t be too costly for me to leave Ghana Health Service (GHS) now.

1 ☐ 2 ☐ 3 ☐ 4 ☐

112. Right now staying with Ghana Health (GHS) is a matter of necessity as much as I desire.

1 ☐ 2 ☐ 3 ☐ 4 ☐

113. I feel that I have too few moments to consider leaving Ghana Health Service (GHS).

1 ☐ 2 ☐ 3 ☐ 4 ☐

114. One of the few consequences of leaving this organization would be scarcity of available alternative.

1 ☐ 2 ☐ 3 ☐ 4 ☐

c. Normative commitment

115. I think that people these days move from company to company too often.

1 ☐ 2 ☐ 3 ☐ 4 ☐

116. I do not believe that a person must always be loyal to his/her organization.

1 ☐ 2 ☐ 3 ☐ 4 ☐

117. Jumping from organization to organization does not seem at all unethical to me.

1 ☐ 2 ☐ 3 ☐ 4 ☐

118. One of the major reasons I continue to work for Ghana Health Service (GHS) is that I believe loyalty is important.

1 ☐ 2 ☐ 3 ☐ 4 ☐

119. If I get an offer for a better job elsewhere I would not feel obliged to be with GHS

1 ☐ 2 ☐ 3 ☐ 4 ☐

120. I was taught to believe in the value of remaining loyal to one’s organization.

1 ☐ 2 ☐ 3 ☐ 4 ☐

121. Things were better in the days when people stayed with one organization for most of their careers.

1 ☐ 2 ☐ 3 ☐ 4 ☐

122. I do not think that wanting to be a company man or woman is sensible anymore.

1 ☐ 2 ☐ 3 ☐ 4 ☐

123. Please provide additional comments and suggestions about the performance appraisal system in the Ghana Health Service?.............................

124. Indicate how performance appraisal system in GHS can be improved? (Give two suggestions)...

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UNIVERSITY OF CAPE COAST
Institutional Review Board
School of Graduate Studies and Research

TELEPHONE: +233 42 32440-9 & 32480-9 Ext. 237
DIRECT: +233 42 35351 & 028 9670793(4)
TELEGRAM: UNIVERSITY, CAPE COAST

C/O UNIVERSITY POST OFFICE
CAPE COAST GHANA

Our Ref: UCC/IRB/2A
Your Ref:

4th June, 2013

David Korku Kwamifoli – Principal Investigator
Department of Population and Health
University of Cape Coast

ETHICAL CLEARANCE –ID NO: UCCIRB:4/06/13

The University of Cape Coast Institutional Review Board (UCCIRB) has granted Provisional Approval for implementation of your research protocol titled:

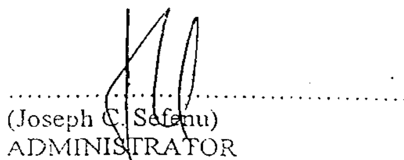
"Perception of fairness of performance appraisal and organizational commitment among employees of Ghana Health Service in two regional capitals"

This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol



(Joseph C. Sefenu)
ADMINISTRATOR

cc: The Chairman, UCCIRB

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GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

My Ref. :GHS-ERC: 3
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: nanatuesdaykad@yahoo.com

29th May, 2013

David Korku Kwamifoli
University of Cape Coast
Faculty of Health Sciences
Cape Coast

ETHICAL APPROVAL - ID NO: GHS-ERC: 12/05/13

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

"Perception of fairness of performance appraisal and organization commitment among employees of Ghana Health Service in two Regional Capitals"

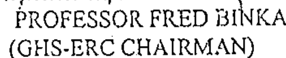
This approval requires that you inform the Ethical Review Committee (ERC) when the study begins and provide Mid-term reports of the study to the Ethical Review Committee (ERC) for continuous review. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification without ERC approval is rendered invalid.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your sponsor before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED..........................
PROFESSOR FRED BINKA
(GHS-ERC CHAIRMAN)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

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