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THE RELATIONSHIP BETWEEN LEADERSHIP STYLES AND ORGANIZATIONAL CHANGE READINESS IN SELECTED GOVERNMENT HOSPITALS OF ADDIS ABABA

BY

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March 2018

Declaration

I, Nitsuh Kassaye, hereby declare that the thesis entitled ***The Relationship Between Leadership Styles and Organizational Change Readiness In Selected Government Hospitals Of Addis Ababa*** is my own original work and has not been submitted for any degree in any other University. It is offered for the award of the degree of Master of Science in Management Specialization in Total Quality Management and Organizational Excellence from Addis Ababa University.

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Statement of Certificate

This is to certify that the thesis prepared by Nitsuh Kassaye Woldetsadique, titled: **The Relationship Between Leadership Styles and Organizational Change Readiness In Selected Government Hospitals Of Addis Ababa**. A Study on Government hospitals in Addis Ababa and submitted in Partial Fulfillment of the Requirements for the Degree of Master of Management Science complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

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ACRONYMS

BPR	Business Process Reengineering
BSC	Business Score Card
CA-OCMQ	California Organizational Change Management Questionnaire
CM	Change Management
COA	Coaching
COM	Communication
EMI	Ethiopian Management Institute
FMoH	Federal Ministry of Health
FRLT	Full Range of Leadership Theory
HIS	health information system
HRM	Human Resource Management
HSTP	Health Sector Transformation Plan
IC	Individualized consideration
II	Idealized Influence
IM	Inspirational motivation
IS	Intellectual stimulation
LFL	Laissez-faire Leadership
MBB	Marginal Budgeting for Bottleneck
MLQ	Multi-factor Leadership Questionnaire
MOH	Ministry of Health
REA	Readiness
ROPA	Result Oriented Program Appraisal
SPO	Sponsorship
STA	Stakeholders

TFL	Transformational Leadership
TRL	Transactional Leadership
TRA	Training
USAID	United States Agency for International Development
WHO	World Health Organization

ABSTRACT

The purpose of this study was to examine the relationship between leadership styles and organizational change readiness in three government hospitals of Addis Ababa. To this end, transformational and transactional leadership styles were independent variables and change readiness the dependent variable. Two research questions and ten hypotheses were developed to address the research objectives. The study used a quantitative and explanatory approach to examine the relationship among the variables. The data collection instruments were Multi-factor Leadership Questionnaire (has two forms the Leader form and rater form) and California Organizational Change Management Questionnaire. 71 administrative bodies and 341 non administrative employees were taken to take part in the study. Out of distributed questionnaires, 71(100%) valid responses were obtained from administrative bodies and 297 (87.1%) valid responses were obtained from employees. Both Descriptive and Inferential statistics were applied and the major statistical tools used were frequency, percentage, mean, standard deviation, an independent samples t-test, Pearson correlation and multiple regression analysis. It revealed transformational leadership style could be related to higher organizational change readiness implementation than transactional leadership style. The findings also showed that both transformational and transactional leadership styles explained a significant amount of variance infor organizational change. To this end, they jointly explained 42% of variance of organizational change readiness. Finally, it was recommended that tailor-made Leadership Development Strategies are needed to equip the entire staff. Besides, designing workable training and follow-up strategy by cooperating with the stakeholders is needed. The strategy need to show the direction towards criteria to compete for the service and change opportunity, array of health service, Further, it is recommended that frequent interaction is needed among Board of Directors of the hospitals, the hospitals administrative staff, Addis Ababa City Administration health bureau and the Federal Ministry of health. They need to work on linking leadership and change readiness with rewards, transparent and timely feedback process. Lastly the study identified area for future research.

Key words: *Transformational leadership style, transactional leadership style and change readiness*

CHAPTER ONE

INTRODUCTION

1.1. Background of the Study

A major enthusiasm of this research drawn first from the researcher personal observation of the problem. The researcher observed how the healthsectors leaders and employees deals with change tools implementations and the existing resistance. On the other hand the current challenge of achieving change practice in government institutions. Why hospitals? Because of its sensitivity and requirement of adaptation of change. In order to survive and develop effectively in this dynamic and uncertain environment, an organization should have the capacity for continuous and adaptive changes (Essawi & Tilchin, 2012).

Not only change but also leadership styles are also the major focus of authorities to provide dynamic and satisfactory service. A need therefore exists for greater understanding of the relationship between the leadership style and work-related attitudes in order to develop a leadership style that will encourage organisational commitment (Garg and Ramjee, 2013). The leadership styles and effectiveness in health sector is highly associated with individual readiness for change. The initiatives include leadership and employee focused change in health sectors. Change management experts have emphasized the importance of establishing organizational readiness for change and recommended various strategies for creating it (Weiner,2009).

Leaders and their leadership styles is one of the mostly studied topics of recent history (Arfeen and Mothi and Aslam, 2015). In different organizational structure and sectors having good leaders and suitable leadership style is mandatory. From this health sectors are the center of this study. Health is considered as the principal contributor to the wellbeing and all sided development of nations. Based on this belief many countries have been concerned in the access and quality of their health systems. A key challenge for both policymakers and healthcare professionals in this area is to create a professional culture in which health professionals seek to provide patients with the highest quality of care (Antwi& Kale, 2014).

To this end, health professionals are expected to be responsible, accountable and role models for their discipline and motivated for new practices like change. It is only motivated and accounttable health professionals who can impact the change tools implementation and healthcare process positively. Understanding the conditions conducive to individual readiness for organizational change, instead of the more traditional focus on resistance to change, can be useful for designing and implementing effective human resource and organization development interventions (Choi and Ruona, 2011).

Leaders' behaviour is significantly related with several facets of change readiness. This stance has been supported in a number of empirical studies undertaken in different countries and in a variety of organizational contexts, both non-educational and educational organizations (Khan and others, 2011). There is no single formula, recipe or agenda for national health sector reform. However, it is clear that economic and political circumstances as well as good leadership are most important for a reform movement and the implementation of change (WHO, 2004).

Though the contribution of effective leadership and change tools implementaton for health sector quality service is well understood, problems are encountered by health institutions in this regard. This has been mirrored by skill-gap of leaders in helath institutions and less job satisfaction of employees (Kumar, 2005). These problems are extended to ineffective leadership, delay in decision making, poor communication among leaders and inefficient products (Ahmed, 2010). The idea of organizational change became more popular because of the fact that more organizational change initiatives and or practices turn out to be unsuccessful (Glensor, 2010).

It is quite clear that one of the organizational leaders' emphasis is to realize suitable change for the organization which can consider proper utilization of resources and effectiveness. In health sectors, the consideration should be more vigilant and participatory. When we talk about change it mainly refers to individuals. The qualities of a change participant involve knowledge, skills, and competencies (Mohammed & Oleg, 2012). According to Khachian et al. (2013) management means keeping the staff and the organization prepared for continuous learning and development. Leaders should be organized and go hand in hand harmoniously in all aspects to play their major role. (Romana Martincic, 2010) pointed out the role of leadership in bringing changes is crucial. Leading an institution is one thing and looking at opportunities and threats

and organizing accordingly is the skill required from all business leaders/administrators. For this research the word Administrators, management and leaders used interchangeably and employees, followers and subordinates used interchangeably.

Due to different reasons taking all the possible opportunities might be impossible. Leaders face challenges at the time of implementing change to direct the organization to modest outcomes. The planned change implementation involves different activities in which leadership competencies might play different roles has thus largely been ignored by the leadership literature (Higgs & Rowland, 2005). The contribution of effective implementation of organizational change for successful service delivery is certain. Against a background of rapid technological development, a growing knowledge workforce and the shifting of accepted work practices, change is becoming an ever-present feature of organizational life (Burnes, 2004).

Generally, change readiness at individual level is significantly related with human effort and affect the entire role of an organization. According to Asrar-ul-Haq& Peter (2016) "In this ever-changing and competitive global market, human resource can become the competitive advantage of the organization, if managed effectively. This stance has been supported in a number of empirical studies undertaken in different countries and different organizational contexts. According to Robert Jaffe (2012) Effective nurse managers understand the physiological and psychological needs of their staff nurses. The change readiness model explores and elaborates upon the gap between preparation and action by asserting first that effective organizational change begins at the individual level of analysis.

Ethiopian government also understood the requirement of change in the sector. One of the major focus of government is to realize quality health service that match with the growing demand of the society. According to FMoH (2010) there have been a great effort to fulfill the ever growing demand of community and need to address the quality and equity of health services. Undoubtedly, realization of anticipated quality service all stake-holders motivation and clear understanding about the required changes and their respective role is so crucial. Various initiatives have been introduced for improving health of the community (HSTP, 2017).

As the country is in transition, the health sector intends to continue to serve the priority health needs of the majority of its people (FMoH, 2010). According to the case study taken by WHO (2013) despite progress, Ethiopia's population still faced a high rate of morbidity and mortality, and the overall health status remained relatively poor. In 2005, the Ministry of Health began looking for a method to strategically align all of its various tools (such as ROPA, BPR, and MBB), programs, processes, and personnel into a comprehensive system that would measurably improve the overall health of the citizens of Ethiopia. The Balance Scorecard (BSC) Institution training is given for higher officials of FMoH including the former Minister of FMoH. The objective was to bring strategic change at all levels of the health sector.

Studies have been carried out on leadership and individual readiness on change concepts separately and with the objective of addressing the problems encountered by healthcare institutions of different cultures. Studies are also conducted in the world on the relationship between leadership styles and organizational change readiness. As far as the researcher knowledge in this regard, no study conducted in Ethiopian health sector context. Since most of the studies in the area are focused on other countries' context this research is interested to carry out the study on public hospitals of Addis Ababa, Ethiopia. It was to examine the relationship between leadership styles and organizational change readiness in public hospitals.

1.2 Statement of the Problem

The concept of leadership and change are higly interrelated. Caldwell and et.al. (2008) reported on their assessment of implementing strategic change in a health care system that shifts in the environment can compel health care organizations to change their strategies. However strategic change frequently fails because individuals do not adopt the behaviors necessary to successfully implement the new strategy. Scholars argued that this is highly affecting leaders, also can enhance the results of the change to develop general norms such as teamwork and tolerance for mistakes that increase general readiness for change with the group.

WHO on its home page of African health observatory (2017) reported "The leadership and governance of health systems, is arguably the most complex but critical building block of any health system". It is about the role of authorities working for organizational success. As pointed

out by Arfeen, Mothi & Aslam (2015) leadership revolves around vision, ideas, direction, and has more to do with inspiring people.

The problems on leadership and organizational change readiness in hosptials are also apparent and widespread in other countries. Choi and Ruona (2011) in their study to investigate organizational change and its implication on Athens health performance point out organizational leaders are thus continually charged with introducing and implementing various initiatives to change their organizations. However, in reality, many change efforts do not result in their intended aims and do not foster sustained change.

Hallgrimission(2008) in his study of Organizational change and change readiness mentioned that the ability of organization to adapt change has become a central research issue focusing on the complexities of regulatory, political technological and social. It is true each organizational footstep is related with change and change readiness.

On the other hand, Mangunjaya (2013) from South Africa in his study on 'The role of leadership and readiness for change to commitment of change', found that little effort is made in providing employees with adequate support for change. He also adds the organization has to change and it needs commitment of the employees. Moreover, leaders gap should be seen as a change agent, sicne it is also important to lead, direct and managing the change process.

The above research findings show the presence of lack of leadership skills and lack of commitment of organizational change readiness. It also imply how critical the issues of leadership and organizational change readiness are in an organization. The relationship between leadership styles and organizational change readiness was also apparent and tested significant at different levels. The concept of leadership implies an interactive process between a leader and her followers. (Hirvank,2014).

The development and security of organization depends on leaders and subordinates. Ethiopian government launched Health Sector Transforming Program (HSTP) to improve health quality and access (FMoH, 2016). Government also give emphasis to upgrading health sector employee's skills at all levels including management to achieve its objective. Hotchkiss et al. (2015) reported that, there is concern that low health worker motivation may be undermining

the success of health sector reforms that the government has introduced over the past decade health programs.

The researcher referred other countries study in relation with leadership styles and organizational change readiness in health and other sectors but not in Ethiopia. The global climate of economic pressure and evolving political priorities, organizational change within public bodies is becoming an increasing priority (Barnard & Stoll, 2010). However, change is a complex process that can have positive as well as negative impact.

According to WHO (2014), the health status of Ethiopia is poor, even when comparted with other low-income countries including those in sub-Saharan Africa. This WHO idea shows the need of change to accelerate the facility of health. Besides, according to the profile in Ethiopian general hospitals (174) health centers which are located in Addis Ababa provide service to the population in the city and also roughly to an equal number of people from the surrounding areas and all regional states. With all this, public hospitals are trying to implement change in the sector at large for change. Although the growing need for change in organizations it is widely acknowledged that up to 70% of change initiatives fail (Higgs & Rowland, 2005). So, it needs researchers and other stakeholders focus.

Now a days, Ethiopia is witnessing and implementing change tools in different sectors including health. In order to sustain the positive change practice across all sectors, health sectors are in verge of reorienting their operations. The change requires general effort of implementers. It is believed that organizational success is a result of effective leadership and better coordination between leaders and workers (Arfeen, Mothi & Asiam, 2015). To this end, this study will focus on leadership styles and organizational change readiness in public health sectors.

The issues of access and health service quality improvement have been the focus of Ethiopian government since 1994. To this end, the government launched Health Sector Transformational Development Program (HSTDP) to improve healt quality, relevance, efficiency, equity and expand access to health (FMoH, 2015). The government also gives special emphasis to change tools implementation to provide quality and standardized service which contribute to the economic and social development of the country.

Ethiopian government acknowledged the significance of change tools implementation programs for health sector employees and leaders to enhance employees' scholastic achievement and health service quality. Though the role of equipping health sector with efficient leaders and employees is due recognized; yet, employees are not sufficiently aware and motivated, the leadership is criticized for skill-gap.

On the FMoH report in Ethiopia (2015/16) mentioned that country leadership development and management training as well as the actual establishment of management systems are needed. For doing this individual effort and role is undeniable. George & Jones, Porras & Robertson (cited in Choi, 2011), organizations only change and act through their members, and successful change will persist over the long term only when employees alter their on-the-job behaviors in appropriate ways. Researchers explained organizational level change as considered at micro system. Others like George & Jones (2001) argue micro level or individual level change should be emphasized. The above discussions show the requirement of leadership skills and individual readiness harmony. Also implies how critical the issue of leadership and readiness of employee is in bringing desirable change.

Though there are different leadership and individual change readiness theories to address the issues related to the most encompassing approaches is the study taken FRLT and cognitive behavior of individuals "beliefs, attitudes and intention. Armenakis et al. (1999) mentioned that the cognitive state comprising beliefs, attitudes, and intentions toward a change effort.

On the other hand ADKAR model.discusses the change readiness part. Though n Ethiopian context to the best knowledge of the researcher no study has been conducted to investigate the relationship between leadership styles and organizational change readiness in public hospitals of Addis Ababa. Using the two theories jointly; hence there was a gap in the literature.

The current situation calls for a much more attempt and a well-developed leadership and organizational change readiness in public health sectors of Addis Ababa. Government hospitals are highly expected to persuade and update their approach.

This study is, therefore different as it examines the relationship between leadership style and organizational change readiness at public hospitals of Addis Ababa with in framework of FRLT

and ADKAR theory. It is also believed that this study would bridge the gap in lack of studies on leadership and organizational change readiness in pyblic hospitals. In light of research questions developed.

1.3 Research Questions and Hypothesis

Attempts were made to answer the following research questions:

1. What is the relationship between transactional leadership styles and organizational change readiness in public hospitals?
2. What is the relationship between transformational leadership styles and organizational change readiness in public hospitals?

Hypothesis

In accordance with the research questions and the stated objectives, the study formulated the following hypothesis (**Ha**: Alternative hypothesis).

Hypothesis 1

H_{a11}: There is positive and significant relationship between transformational leadership style and effective communication for organizational change readiness.

H_{a12}: There is positive and significant relationship between transformational leadership style and sponsorship management for organizational change readiness.

H_{a13}: There is positive and significant relationship between transformational leadership style and stakeholders management for organizational change readiness.

H_{a14}: There is positive and significant relationship between transformational leadership style and coaching for organizational change readiness.

H_{a15}: There is positive and significant relationship between transformational leadership style and provided training for organizational change readiness

Hypothesis 2

H_{a21}: There is positive and significant relationship between transactional leadership style and effective communication for organizational change readiness.

H_{a22}: There is positive and significant relationship between transactional leadership style and sponsorship management for organizational change readiness.

H_{a23}: There is positive and significant relationship between transactional leadership style and stakeholders management for organizational change readiness.

H_{a34}: There is positive and significant relationship between transactional leadership style and coaching for organizational change readiness.

H_{a25}: There is positive and significant relationship between transactional leadership style and provided training for organizational change readiness.

1.4 Objectives of the Study

There is also a gap in literatures regarding these topics of interest due to absence of researches. Compared to other countries. The attention given to research and development in the areas of leadership and organizational change readiness is not satisfactory. To this end this research aimed to contribute its share to bridge the gap.

Generally, this study examines the relationship between leadership styles of the administrative bodies and organizational change readinessn in health sectors.

Specifically this study aimed at:

- Unveiling the leadership style most exercised in government hospitals.
- Investigating the relationship between transformational leadership style and organizational change readiness in public hospitals in Addis Ababa.
- Investigating the relationship between transactional leadership style and organizational change readiness in public hospitals in Addis Ababa.

1.5 Significance of the Study

The result of any investigation may serve to different stakeholders who may be directly or in-directly benefited. The findings of this study attempt to:

Enhance the awareness level of government hospitals leaders to give special emphasis to the link between leadership styles and organizational change readiness implementation.

Show ways to interested policy formulators in enhancing leadership capacities of administrative bodies and organizational change ireadiness n public hospitals. It may also help to show areas of future research from the health sector perspective.

1.6 Scope of the Study

The scope of this study merely focus on the government hospitals, which are under Addis Ababa Health Office Bureau. Namely: Menelik II Referral Hospital, Yekatit 12 Hospital and Zewditu Memorial Hospital. This is because such hospitals address majority of the low and average income level dwellers. In the context of hospitals service the research should have addressed private and NGO based health centers. Thus the generalizations are limited only on the above mentioned hospitals, under the specific conditions (leadership styles and organizational change readiness).

As known there are different leadership theories in leading and also change theories this study however focused on the Full Range of Leadership Theory (FRLT) and ADKAR model of change. To this end the study is only limited to examine the link between the leadership styles (transformational and transactional) and elements of ADKAR.

1.7 Limitation of the Study

The study had its own limitation. The FRLT is a leadership theory that has been designed and digested in different sectors in the context of other countries. In addition, its history showed as tested mostly in education and health sectors. Though it has been applied in hospital system of other countries, it was not extensively researched. Also, this theory has never been tested in hospitals of Addis Ababa as far as the knowledge of the researcher. What is more, there is

absence of researches in the relationship between leadership styles and elements of organizational change in Addis Ababa hospitals. Therefore, these could limit the generalizability of the findings of this study to the whole health system.

Researchers and scholars strongly agreed that inclusion of a large population size in the study could have a great value so as to get more credible information about any raised problem. However, conducting the research in more sites is impossible due to different constraints. In addition to this, participants of the study were those who serve in the hospitals for a period of at least a year. This is because the researcher believed that those who stayed for a relatively long period of time can have adequate knowledge to judge what is going around and therefore their response may help to reflect the image of the hospitals leadership style and elements of organizational change. Though, this will limit the generalizability of the research findings of this study to the whole population.

1.8 Operational Definition of Key Terms

Change Management: The process of change: the planning, coordinating, organizing and directing of the processes through which change is implemented (Spicker, 2012).

Healthcare Sectors: A category of stocks relating to medical and healthcare goods or services. The healthcare sector includes hospital management firms, health maintenance organizations.

Individual Change: Transformative change of a critical mass of individuals. (Rojer,2014)

Leaders: individuals who establish direction for a working group of individuals who gain commitment from this group of members to this direction and who then motivate these members to achieve the direction's outcomes (Conger, 1992)

Leadership: involves an influence process concerned with facilitating the performance of a collective task. (Yukl)

Leadership Style: The behavior and techniques used by the leaders to give vision and roadmap to reach the vision, formulations and executions of strategies and plan. (Arfeen et.al. 2015)

Readiness: prepared mentally and physically for an experience or action" and at the same time as "preparation of a gun for immediate aim and firing" (Merriam-Webster, 2005).

Readiness for change: refers to organizational members' shared resolve to implement a change (change commitment) and shared belief in their collective capability to do so (change efficacy).

Organizational readiness for change: the extent to which organizational members are psychologically and behaviorally prepared to implement organizational change (Bryan J & et.al.2008).

Transactional leadership style: leader-follower relationship that is based on a series of exchanges or bargains between leaders and followers (Howell &Avolio, 1993).

Transformational leadership style: idealized influence attributed to charisma, idealized influence behavior attributed to beliefs and values, inspirational motivation, intellectual stimulation, individualized consideration (Avolio,2010).

1.9 Organization of the Study

This thesis consists of five chapters: The first chapter covers the introductory part, which including the background of the study, statement of the problem, research questions, hypotheses, objectives, significance, scope, and limitation of the study, as well as operational definition of key terms.

The second chapter reviews literatures related to leadership styles and change readiness in general and health context. Studies were reviewed in relation to the objective of the study.

The third chapter presents research design and methodology. It discusses data sources, the study setting, sampling techniques, data collection instruments, procedures for data collection and the data analysis techniques.

The fourth chapter portrays data presentation, analysis and interpretation on the data obtained while addressing the research questions and hypotheses.

The final chapter provides the summary of major findings, conclusions and recommendations. Finally, references and appendices are attached.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

This chapter reviews literature that are relevant to the study. These include theory and concepts on leadership styles, concepts of organizational change, the relationship between leadership styles and organizational change and the conceptual framework of the study.

2.1 Concepts of Leadership

Leadership is conceptualized differently by different scholars. McCleskey (2014), argues that the search for a single definition of leadership may be in vain since the correct definition of leadership depends on the interest of the researcher and the type of problem or situation being studied. Leadership is a key organizational issue both in times of stable organizational operations and in times of organizational change (Aarons and Sommerfeld 2011). Leadership comes from leaders, also the success of organizations is heavily depend on its leader's leadership skill. (Jago, 1982) defined leaders as a results of never ending process besides, they are who can pass through training, education, and experience. Leadership is important and implemented in all formal and non-formal organizations, and all scales, and types of ownership. The concept defined by different scholars from different aspects since it exists in all social, economic and political phenomenon. As cited by Barr and Dowding (2012), Daft (2012) stated that 'scholars and other writers have offered more than 350 definitions of the term leadership' and concludes that leadership 'is one of the most observed and least understood phenomena on earth'. Due to this fact finding a unified definition in relation with leadership is impossible.

For instance Zeitchik (2012) defined leadership as it is inspiring others to pursue our vision within the parameters we set, to the extent that it becomes a shared effort, a shared vision, and shared success. Kotter (1996) showed that leadership is a set of processes that wishes the effectiveness of organization and modifies them according to changing process to make their performance effective.

According to Vijayarafavan (2014) leadership is required to: Direct group activities, Ensure effective utilization of manpower, Motivate all concerned, Develop good human relations

across the board, Promote spirit of coordination, Fulfill social responsibilities, Influence the behavior of the members, Create confidence among the members and Facilitate use of formal authority effectively.

Different scholars and authorities defined leadership in different ways "...leadership is like the Abominable Snowman, whose footprints are everywhere but who is nowhere to be seen" Bennis & Nanus: 'Leaders: Strategies for Taking Charge' (1997) "A leader is a dealer in hope."Napoleon Bonaparte. As cited by Keyredin (2016), Jones and George (2006) defined leadership as a process by which an individual influences other people, and inspires, motivates and directs their activities so that to achieve group or organizational goals.

Followers' perception is also one of the core value in leadership definitions. To achieve the goal of an organization follower's motivation, commitment and awareness level is a key factor. Brenner (2015) claim leaders' engagement was associated with followers' appraisal of change. Hoy & Miskel, (cited in Arfeen and others, 2015) Employees centered leaders have some kind of democratic leadership style, they involve their follower in decision making, they also like to delegate power to their followers, they help their follower in fulfilling their needs. They argued that leadership is significantly affected by the way followers construct their understanding of the leader's personality, behaviors, and effectiveness. This reveals that leaders need to consider their followers in each of their foot step.

According to Dumdum, Lowe & Avolio (cited in Garg &Ramjee, 2013) accumulating evidence suggests that leadership style is positively associated with work attitudes and behaviors at both an individual and organizational level. By selecting good leadership style, the managers can transfer their commitment to service quality to the employees by some measurements (Clark et al., 2009). The above idea supported by Hussain et.al (2017) on their study finding, that leadership style and employee involvement in the change is encouraging step for change process of organization. It is usually a group phenomenon. Two specific aspects of being a leader are: a) the individual attributes or styles needed to be an effective leader, b) the organizational skills required to manage the process of change (Shahzad & Zareen, 2012).

2.2 Emergence of Leadership Theories

Earlier leadership styles identified by Kurt and his colleagues in 1939. At that time they defined three major styles namely: authoritarian, democratic (participative) and laissez-fair (delegate). Accumulating evidence suggests that leadership style is positively associated with work attitudes and behaviors at both an individual and organizational level (Dumdum, Lowe & Avolio, 2002).

Most leadership theories focus on leaders and followers interactions. Muhammad, Wahbeeah & Usman (2015), each theory illustrates the distinct dimensions of leadership and each theory explains the leader and follower relation in different ways. The theory approach describes different dimensions of leadership and their effects on the relationship between leaders and their followers (Ajay & Ramjee, 2013). From the major leadership theories that have been developed over time Full Range Leadership Theory (FRLT) is the one and still implemented.

2.3 Full Range Leadership Theory

In attempting to understand the nature of leadership and its different aspects, it is necessary to understand the necessity of theories of leadership that have developed over time. These theories tried to identify various leadership styles. Of the many leadership theories, the Full Range of Leadership Theory (FRLT) is the focus of this study. It was proposed by Burns (1978) and developed by Bass (1985). The reason that the FRLT holds promise as an integrative theory of leaderships because it is built on, or can be explained by, theories, which, in their time, took a bold approach and questioned traditional notions of leadership. (House, 2015).

The Full Range Leadership Development Theory is a suitable theoretical construct of leadership (Sosik & Jung, 2012). Bass and Avolio (cited in Hariri, 2011); view transformational, transactional and laissez-faire leadership styles as a single continuum. This means, leadership ranges from one end of the continuum that is highly active and effective (transformational leadership style) to the other extreme which is highly inactive and ineffective (laissez-faire leadership style). The middle of the continuum (transactional leadership style) represents middle effectiveness. Each leadership style is explained briefly hereunder.

2.3.1 Transactional Leadership

Transactional leadership is focused on staff's basic and external demand, the relationship between leaders and subordinates is based on the contract (Wamy& Swamy,2014) They continued their discussion that transactional leaders tend to attain organizational goal by pacific job roles and mission design, their basic purpose is to maintain a stable organization. According to Bass (1985) and Bass and Avoid (1997) described transactional leadership in terms of two characteristics: the use of contingent rewards and management by exception. Principally, transactional leadership (TRL) consists of the stipulation of rewards and punishments contingent upon employee's performance. Which means the transactional leaders thought about exchange or concept of giving and taking in terms of reward which could be in cash or in kind. This form of leadership normally exists where there are various cultures in the society (2016)

According to Holton (2015) transactional leadership, being a more instrumental leadership style, represents a concrete platform from which managers can actively engage with followers in implementing the change. Bass and Avolio (cited in Garg & Ramjee, 2013) described transactional leadership in terms of two characteristics: the use of contingent rewards and management by exception. The two components are explained hereunder:

Contingent reward: as the reward that the leader will bestow on the subordinate once the latter has achieved goals that were agreed to. Contingent reward is, therefore, the exchange of rewards for meeting agreed-on objectives. By making and fulfilling promises of recognition, pay increases and advancement for employees who perform well, the transactional leader is able to get things done.

The second concept management by exception seen in two scenarios, under the umbrella of management by exception as active and passive.

Management by exception-Active which occurs when the leader monitors followers to ensure mistakes are not made, but otherwise, allows the status quo to exist without being addressed.

Management-by-exception-passive in passive in passive management by exception, the leader intervenes only when things go wrong (Nyengane, 2007). In general, one can conclude that

transactional leadership is an exchange relationship that involves the reward of effort, productivity and loyalty.

2.3.2 Transformational Leadership

Transformational leadership is one of the emerging pillar in the field of leadership. Many scholars agreed that the term transformational leadership devised by James Downtown in 1973, after that mostly in recent year's number of studies are taken and it seems the emerging pillar in the field of leadership.

Transformational leadership moderated the relationship between emotional exhaustion and turnover intention, indicating that having a transformational leader may suffer the effects of providers' emotional exhaustion on turnover intention. (Green & et.al. 2013).

Generally, literatures explain four components of transformational leadership. As defined by different literatures transformational leadership by the five key dimensions presented here under.

- ***Idealized influence (II):*** has two aspects they are attributes and behavior.

- **II Attribute-** refers to the socialized charisma of the leader, whereby the followers feel trust, admiration, loyalty and respect for the leader. Cited by Garg & Ramjee (2013) Avolio (2000), Hemsworth and others (2013), while idealized influence refers to employee's perceptions of the characteristics attributed to a leader.

- **II behavior**-which refers to the charismatic actions of the leader, whereby individuals transcend their self-interest for the sake of the organization and develop a collective sense of mission and purpose. Cited by Garg & Ramjee (2013) Avolio (2000),

- ***Inspirational motivation (IM)***: refers to the way in which transformational leaders energize their followers by articulating a compelling vision of the future – thus creating enthusiastic excitement, raising followers' expectations, and communicating confidence that followers can achieve ambitious goals. Cited by Garg & Ramjee (2013) Avolio (2000), (Hemsworth and others, 2013).IM in leaders who clearly communicate expectations, elaborate tasks, promote optimism, and demonstrate commitment to the shared vision of the team.

- ***Intellectual stimulation (IS)****:* refers to the way in which transformational leaders question the status quo, appeal to followers' intellect, stimulate them to question their assumptions, and invite innovative and creative solutions to problems. Cited by Garg & Ramjee (2013) Avolio (2000) IS demonstrated by leaders when they support followers to be creative and innovative, try new approaches, and challenge their own beliefs and values (Khan and others, 2011).

- ***Individualized consideration (IC) n***: refers to leadership behavior that contributes to follower satisfaction by paying close attention to the individual needs of followers, acting as a mentor or coach, and enabling them to develop and self-actualize. Cited by Garg & Ramjee (2013) Avolio (2000), IC is shown by leaders who create a supportive climate, listen to followers, and act as a coach and mentor (Bodla and Nawaz, 2010).

The above definitions also explained originally by Bass in 1985 and at different times also elaborated by other researchers. Transformational leaders want to give more attention to their followers. According to Avolo & Bass (Cited by Garg & Ramjee, 2013) in recent years, there has been considerable interest in the model of transformational leadership, because it has been shown that transformational leaders generate greater commitment in their followers than do those who use other leadership styles (Avolio, 1999; Bass, 1998).

2.4 Leadership in Health Sectors

Leadership in health sectors has more sensitive implication than leadership in other sectors because of the increasing range of complexity of leadership responsibilities in relation with someone's life. In healthcare centers, good leadership is more than just important- it is absolutely critical to the organization's success**.** (Schyve,2008). Healthcare organizations are complex, in part because of a confluence of professions, including physicians, nurses, pharmacists, and administrators, each with seemingly competing interests, perspectives, and time horizons. (Antwi &Kake ,2014).

According to Lonescu et.al. (2014) Managers and supervisors play a key role because of the relationship they have with employees within the organization. They also mentioned that the

Metran/Medical directors, vice medical director/Vice Metran and case team leaders are also important for effective leadership in hospitals. As a result, those people in the management layers hold the burden of transforming the health sector service culture and move forward to meet the needs of service providers and end users (patients).

2.5 Nature of Organizational Change

In organization change human beings or individuals are pillars of all actions and transactions. Adoption of change management practices undoubtedly increases the odds of success because focus is placed on the people in the organization who make things happen and the resultant effects (Varkey & Antonio, 2010). Change in any context the result matter on people engagement. According to Boikhutso (2013) for the change process to be effective, it requires the presence of change agents in the organization.

Health systems in Africa are undergoing considerable change, often in a context of ongoing health sector reforms (WHO, 2014). The key question for change agents appears to be how people get ready for changes in their environment in such a way that they are then ready to implement effective changes within their organization (Walinga, 2008). Change agents are individuals or groups of individuals, who act as catalysts in the organization. The same researcher explained that change is often resisted if leadership or management have distanced themselves, or are not part of the process. Different countries are working on the concept change by focusing on their health sector. The general service readiness index is increasingly being used in subnational or national assessments and has also been adapted for disease-specific studies (Leshe etal. 2017).

In Kenya technical assistance in the management of quality assurance and workforce development in health care, helping develop feasible, affordable approaches to comprehensive change in health service delivery (USAID, 2008).

The Ghana Health Service (GHS) is in liaison with the Ministry of Health (MOH) is dedicated to bringing quality healthcare and services to every door step and household with the commitment of change readiness (GHS,2010).

The influence of leadership style on employee commitment for the organisation has not been adequately addressed in the Parastatal companies in South Africa Garg and Ramjee,2013). In South Africa health sector change is planned and also understood the requirement of leader's motive. According to Doherty & Gilson (2011) they are supported passionately by the Minister of Health. However, bringing the vision alive will require leaders and managers who have the drive, commitment and entrepreneurial spirit to translate it into real changes on the ground.

Even outside Africa for example In Lebanon a study revealed that net worth readiness among healthcare professionals is enabling to encourage policy makers, especially the Ministry of Health to enhance and scale up the healthcare delivery (Saleh etal. 2016).

Organizational success start from individual readiness as a result change resistant behavior can be minimized. According to Rebecca and Marren (2017) Readiness for change is well known as a tool for decreasing resistance to change, but exactly what factors will create this condition and in what order the steps must occur has been studied less extensively. If there is readiness for change achieving an objective will be easy for all. Organizations change and act through their members and even the most collective activities that take place in organizations are the result of some amalgamation of the activities of individual organizational members (Sowm yaja, 2015)

Whoever the force, change is necessary for hospitals. Burritt (cited by Mitchell, 2013) various forces drive change in health care, without change readiness, there was no relationship between change management strategies with the outcomes of the strategy. Saragih, (2014), Probst & Raisch (2005) complained about organizational change efforts which are often managed poorly and precipitate organizational crises. According to Mitchell (2013) implementing change is more challenging than it is sometimes perceived.

It is believed that individual play an important role for organizational change. Smith (2005) suggested that the existing human resources within the organization, both as leader (management) as well as followers (employees) is critical factor that determine the success and failure of a strategic change initiative. In managing the change, it is critical to involve stakeholders if

success is to be achieved or else resistance or failure will occur when implementing change as suggested by the stakeholders' theory (Ng'ong'a & Alang'o, 2015).

Some frameworks examine the impact of a single type of factor, positing that constructs related to the individual provider. (Chaudoir, Dugan and Barr (2013). Armenakis et.al., & Cummings and Worley (As cited by Shah 2009) having different cognition levels, experiences, culture, habits, skills and mental processes, an employee reaction might be different to even the same change message. Besides, people rarely welcome change. As human beings we tend to be adverse to change and, in a world which is increasingly changing at an alarming rate, (Kirke, 2013). This adverse behavior is considered as an internal factor and un avoidable.

The antecedents for change readiness classified into three. They are: external, internal and personal (Rafferty, Jimmieson and Armenakis, 2013). This study will take as a variable the last two internal and personal. The same authors mentioned that no studies examined external factor as antecedent for individual readiness.

2.6 Role of Organizational Change

It is necessary to document and understand the organizational processes impacted by change (IT Leadership acadamy, 2014). When an organization run under the same vision, mission and objective individuals effort is basic. Cohen, (cited in Gillery ,2009) Organizations remain competitive when they support and implement continuous and transformational change. Employees are agents of this change to address the demand of customers and organization itself with their readiness. Change readiness is commonly defined in the literature as "the extent to which an individual or individuals are cognitively and emotionally inclined to accept, embrace, and adopt a particular plan to purposefully alter the status quo. (Lines, 2015). According to Shephered et.al. (2014) A number of factors influence the readiness for example, knowledge of shared governance concepts, the managers' understanding and acceptance of the change and their participative management style, and willingness of both the managers and the staff to maintain an open relationship in which controversial issues that emerge are addressed. But sometimes individuals may not have the same knowledge and awareness about the change. For organizations like Ethiopian public hospitals that are implementing change individual role and motive is unquestionable. As an organization-level construct, readiness for change refers to organizational

members' shared resolve to implement a change (change commitment) and shared belief in their collective capability to do so (change efficacy) (Weiner, 2009).

The issue of access, knowledge and individual readiness and other additional components are the elements used to implement change. According to Schein & Bennis (cited in Walinga, 2008), readiness takes its roots in early research on organizational change. When they continue their explanation they tried to relate sport team with organizational change with its elements like; challenge, leadership, teamwork, communication, strategy, policy, creative problem solving and decision making. For example Vogel (2013) mentioned components of change process as 'Assumptions' range from ideas about the context, ideas about the drivers of change, ideas about the cause-effect relationships between interventions, outcomes and context, as well as individual and organizational values.

Researches revealed that for successful change awareness of individual motive and attitude level is necessary. Changing individuals involves strategies that shift attitudes and perceptions, feelings, behaviors and motivations of participants in an intervention (Stein & Valters, 212). An immediate outcome of readiness is organizational members' change-related effort. For example, when readiness is high, organizational members are more likely to initiate the change (Shea and et.al, 2014).

2.7 Change Models and Change Implementers Consideration

Different change models presented and implemented by organizations starting from some years back. For change model as many authors agreed the pioneer is Kurt Lewin three stages model which is developed around 1951. Models are necessary as one aspect of change. Also identifying the right model is also the pillar of change according to the organizational and implementers context. Pearson and others (cited in Mitchell, 2013) put the importance of change model, therefore, that managers, or change agents, identify an appropriate change theory or model to provide a framework for implementing, managing and evaluating change. Scholars also argue the necessity of individual change implementers or employees in any organizational change plan. They tried to relate the change and individuals understanding for organizational change. Cameron & Green (2014) explained about different approaches to change that individuals do not always experience these changes in a consistent or uniform way.

Ethiopian health institution change system is at the beginning stage and this study prefer to consider ADKAR as a relative better model. Cadler (2013) study suggests that beginners want to use the ADKAR model because each change step is clearly defined. The founder of this model is Jeff Hiatt. The Prosci Acronym. ADKAR, or Prosci's model of individual change stands for Awareness, Desire, Knowledge, Ability, and Reinforcement. Prosci believes that for change to work in an organization, individuals must change and understand why and how to change.

The ADKAR model was developed by Prosci in 2001 after the research was made with more than 700 companies undergoing major change projects (Prosci, 2002). The ADKAR model can be employed in a variety of situations. It is used for planning new or to see the ongoing performance. According to Haitt (2013) it can be used to assess change efforts currently underway, as well as to plan for new change initiatives. According to Miscel and Bangun (2013) ADKAR is a model for change management. It has the ability to identify why changes are not working and help to take the necessary steps to make the change successful. Another researcher Calder (2013) explained the model as it focuses on principles of change that are effective on an individual level. These same principles are designed to be applied to a large group of people or even an entire organization.

In Ethiopian health management also there is a formal change and communicating plan of adopting ADKAR. According to BSC Institute (2013) Communication and Change Management Teams were created in 2012 after the Ministry adopted a hybrid of the Kaizen principle and ADKAR as its tool for change. Further the institute explained that "The ministry is now placing emphasis on stepping up strategy communication and change as well as building leadership and line management skills to harness the benefits of the Balanced Scorecard across the health sector". The model helps to measure effectiveness of the change management process through each of its parts. It is common in change readiness studies to look behavioral situation depending on the elements. In ADKAR model there is an expectation of each element achievement in an organization.

According to Cadler (2013) all change models have similarities

Table 1: Similarity between ADKAR, Lewin three steps and Kotter 8 step change model elements.

Lewin	**ADKAR**	**Kotter**
Unfreezing	Desire and knowledge	1-4 th steps
Changing	Ability	5-7^{t}h steps
Refreezing	Reinforcement	8th step

The five components of ADKAR model summarized by Cadler (2013) as follows:

Awareness- To initiate a change, an individual must know what needs to change and why. What are the risks of not changing? How will the change benefit the individual? What will she or he gain by making the change? Without knowing that there is a need for change, an individual will not likely have a desire to change. One interviewee, whose profession is based around organizational change, stated that making changes is all about relationships and trust (C. Ganiere, personal communication, August 22, 2012).

Desire- Once an individual knows what needs to be changed, it is imperative to help him or her find the desire to support the change. Without this support, a lot of resistance may be given to those who are implementing the change. "A common mistake made by many business leaders is to assume that by building *awareness* of the need for change they have also created *desire"* (Hiatt, 2006, p. 18, italics in original). Someone may know that smoking can lead to cancer, heart disease, and other undesirable health conditions but still continue to smoke because of a lack of desire to change. This individual is aware of the need to change and the risks involved for continuing to smoke, but the desire isn't there. The same can be true of organizational change.

What must be done to create desire? Several tactics may be used, which include utilizing past organizational habits and successes, showing how the change will benefit those affected by the change, drawing on past individual successes with similar changes, intrinsic motivation and extrinsic motivation. Intrinsic motivators are specific to an individual, not a group.

Knowledge- The information necessary to make a change is given to the individual. This includes information about the new programs, systems or behaviors that will be implemented. Providing the information is important because individuals don't always seek to do things they don't know how to do. For example, someone who doesn't know how to change the oil in a car will probably be less prone to do so until she or he receives instructions on how to do so.

Ability- This is the step where knowledge turns to action, or as one interviewee explained, this is where concepts turn into reality (D. lee, personal communication, August 20 and 24, 2013). Knowing how to change the oil and actually changing it are two different things, just like knowing how to swim and actually swimming are two different things. Thus, an individual will need support and help when utilizing the knowledge needed to make a change. Having someone to turn to for questions when you don't know what to do next, as may be the case with changing oil, is a welcomed support when learning something new.

Reinforcement- The individual needs to know when she or he is achieving the desired outcome. Using an accountability system is recommended. One interviewee, who works with PM, encouraged celebrating the small victories won toward the ultimate goal (D. lee, personal communication, August 20 and 24, 2012). Celebrating the small successes can be the key to continued implementation of a change. Recognizing the progress of an individual who has faced great difficulty in making a change is especially important, because this recognition encourages this individual to keep going.

2.8 The Prosci's Methodology of Leverage Change Management

The Prosci methodology helps to integrate individual and organizational change management. Based on Prosci's research, there are set of tools called the five key organizational change levers or change management approach. They are mentioned as follows:

- Communication plan
- Sponsorship roadmap
- Stakeholders
- Coaching plan
- Training plan

- **Communication:** is a tool used to build awareness of the need for change and desire to participate in and support the change. When ADKAR is used as this foundation, communication is more effective and provides information in the correct sequence to help employees understand and internalize the change.

- **Sponsorship**: when senior leaders demonstrate their and the organization's commitment to a change, employees take notice. Benchmarking research indicates that the sponsor is the preferred sender of messages related to the business reasons and organizational implications for a particular initiative; therefore, effective sponsorship is crucial in building an awareness of the need for change. Sponsorship is also critical in building the desire to participate and support the change with each employee and in reinforcing the change.

- **Stakeholders/ Resistance management:** is the effort success of change to engage key players of change effort early and consistently during the cycle. Identifying and managing change correspond to success of change effort.

- **Coaching:** This pillar puts it all together, it is about getting an entire group to accept and move forward with change.

- **Training**: is focused on building knowledge. The four remaining followed by.

The image below shows how the change management plans developed in the organizational change management process contribute to the progression of individual change described by the ADKAR model.

Table 2: Prosci methodology: leverage change management activities

	Awareness	Desire	Knowledge	Ability	Reinforcement
Communication	X				X
Sponsorship Roadmap	X	X			X
Stakeholders/Resistance		X			
Coaching	X	X	X	X	X
Training			X	X	

Source: Prosci Change Management Methodology Overview

Why Prosci's ADKAR model employed in this study. First, it describes successful change at the individual level and outlines the goals or outcomes of successful change (Abdallah and Mohammed, 2016). Second, ADKAR model is widely used goal oriented approach that would facilitate individual change by allowing change management teams to focus their activities on specific results (Adhikari, 2007). Third, the model link between individual performance, organizational change management and business result (Hiatt, 2006)

2.9 Healthcare Service

Healthcare facility is expanding from time to time. Though its development changes have occurred in the roles and responsibilities of leaders and subordinates. In other hand Falk and Smith (2003) argue these changes are caused by increased responsiveness to policy and strategies, increased accountability for outcomes, increased client-focus attitude to include business enterprises and communities.

If organizational leaders believe they can merely dictate organizational change and then expect their employees to follow suit, they jeopardize the credibility of the entire effort due to a lack of demonstrated "principal support" (Armankis ET al.1993). The change message should be delivered to organizational members before those members are asked to partake in change implementation actions (Lines. et.al. 2015).

Healthcare centers provide their service for people who have problem in different reasons. These service providers are expected to have good leaders and personal readiness to assess and implement change. As with any change or refinement in operations, there will be a need to assess and realign as new approaches are tried and current approaches are refined (USAID Ghana, 2013).

2.10 Public Hospitals and Their Service Providing System in Ethiopia

The introduction of modern health care services in Ethiopia can be traced back to the reign of Emperor Libne Dingel (1508-1540), when the Portuguese mission to his court brought in a physician named Bermudes. (FMoH, 2015). The same document mentioned the country's promising policy, strategy, coordination mechanism and the capacity improvement in health science and technology area. Since the government has given especial emphasis to this sector,

a number of health sector at different ownership and standard level opened besides, different changes are introduced in the system. On the other hand, according to FMoH (2010) despite major strides to improve the health of the population in the last one and half decades, Ethiopia's population still face a high rate of morbidity and mortality and the health status remains relatively poor.

Currently Ethiopian health sectors are getting good attention from government for their quality and customer satisfaction. According to Schyve (2009) for a healthcare organization, the primary goal is to provide high-quality, safe care to those who seek its help, whether they are patients, residents, clients, or recipients of care. According to FMoH (2010) ….the attributes that define services that the health sector should provide, the principles underpinning its relationship with the community and how the health sector wishes to be perceived. To this end, the nature of programme (implemented in IV phases), training and employees motivation system has become based on the demand level of the community. Such change with sophisticated technologies are continued to introduce and implementation in the sector.

On the other hand, the nature of changes implemented in Business Process Reengineering (BPR) of the health sector has introduced a three-tier health care delivery system. There is also initiation in developing the knowledge and skills of the staff and working conditions of public hospitals. To this end hospital service (174-General hospital profile) stated that it will employ medical, nursing and support staff to provide in-patient care to people who require close medical monitoring and out-patient care to people who need treatment but not constant medical attention. In this regard, efforts are made in enhancing the skill and knowledge of subordinates and the management and equipping the hospitals with necessary facilities. According to BSC institute case study (2005) quoted the former FMoH minister mentioned as the minister was confident if "connect the dots" in the Ethiopian health sector to manage the organizational, political, and infrastructure complexities and to decisively move the needle on Ethiopia's health problems. At that time the minister himself attended BSc training program to learn strategic tools needed to Ethiopian health sector.

The healthcare system is the area which the government of Ethiopia has led to minimizing poverty and bringing economic advancement in Addis Ababa and the country at large. There have

been also significant increases in the availability of health workers of all professional categories, particularly among of Nurses and Health Officers (MoH, 2010). In Addis Ababa hospital service provided to the city, surrounding and regional dwellers. Therefore, it will be more realistic to evaluate the health service coverage and quality of services provided in Addis Ababa from this perspective (174-General hospital profile, 2014). To this end, the current service provided in Addis Ababa hospitals show progress but not still at satisfactory level. Actually there is also imbalance number of patient and professionals and facilities are observed and researches also revealed this.

Though the hospital system of Ethiopia is on the process of changing in many ways. At the same time there are still problems in leadership and organizational change readiness.

2.11 The Relationship between Leadership Styles and Organizational Change Readiness

The link between leadership styles and organizational change readiness in health sectors will be evaluated in Ethiopian health sectors. According to Vorkey and Antonio (2014). Indications that suggest a readiness for change include high participant interest, high perceived success rate, management support, correlation with the goals and values of the organization, and adequate financial resources for the change project. Leaders in healthcare centers greatly impact on the motive of health professional or other supportive staff. In supporting this Garg& Ramjee (2013) discussed that a need therefore exists for greater understanding of the relationship between the leadership style and work -related attitudes. Literatures indicate that organizational change readiness is linked to various demographic variables, leadership style and trust. Besides according to (Armenakis, et al., 1999) change initiatives may not produce the intended results because recipients are simply not ready. The link between leadership styles and organizational change work closely in health sector setting. Leaders in healthcare institution as of other institution leaders greatly impact organizational change in various ways. Burritt (cited in Mitchell, 2013) various forces drive change in health care. Individuals, teams and organizations all play a part in the process of change, and leaders have a particularly onerous responsibility: that is, making all this happen (Cameron & Green, 2012). In view of this, it is possible to say leaders have the tendency to influence situations and decisions in a hospital compound either positively or negatively.

The literature on change readiness showed a reoccurring theme supporting the idea that leadership styles heavily affect organizational change readiness. In this study, the two leadership styles: TFL and TRL are discussed in relation to facets of organizational change.

Since hospital system is concerned with entrepreneurialism, transformational leadership is crucial for the hospitals service objective achievement. Jaffe (2012) argue transformational leadership at the management level, research indicates better overall nurse performance, safer nursing, and increased nurse satisfaction and retention rates. Fiedler and House, cited by (Poddar, 2012) proposed that transformational theories seek to address the actions of leaders that cause followers to change their values, needs, goals, and aspirations. The above arguments and findings show, transformational leadership behaviors are related to both intrinsic and extrinsic facets of teachers and nurses readiness for change in healthcare sectors of other countries.

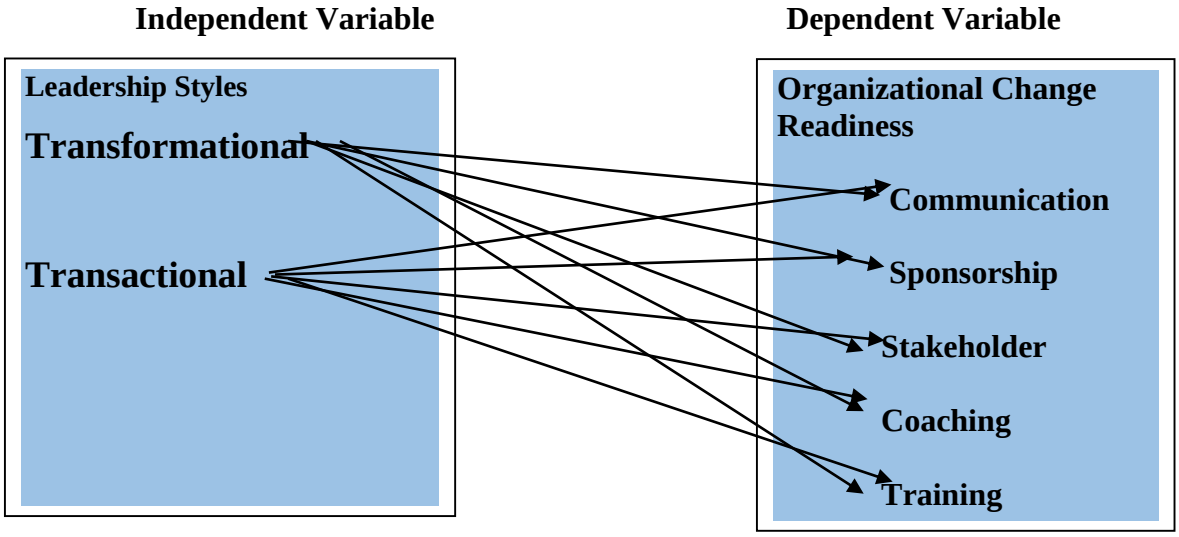
According to Basham (2010) transactional leadership is centered on exchanges and based on two factors: contingent rewards and management by exception. Research shows that reward and punishment serve as motivators in the lives of nurses and doctors. In this regard, Proddar (2012) argue transactional leaders involve structuring performance environment to assist subordinates in achieving organizational objectives and receiving rewards. To be effective, a transactional leader must be able to realize and respond to subordinates' changing needs and wants (Basham, 2010).

There are times and situations when leaders' exhibit laissez-faire leadership style despite researches has proven that such leadership are the least effective in healthcare setting. Bass (cited in Hariri, 2011) asserts there is a negative association between laissez-faire leadership and a variety of subordinate performance, effort and attitudinal indicators. Numerous researches in recent years also prove, LFL style has insignificant link with informed decision making, creativity, poor communication and lower job satisfaction in educational institutions (Khan and others, 2011).

2.12 Conceptual Framework of the Study

The conceptual framework of this study followed the objectives of the study and developed integrating variables from theories and empirical researches on leadership and change readiness. In this study, an administrative leadership style is assumed to be an independent variable. The administration is considered to be the agent of change, influencing directly or indirectly the change readiness of employees as the final outcome. Subsequently, the dependent variable is general change readiness. Based on the empirical studies and the literatures, a research model for this study is developed (see figure 1).

Figure 1: Research Model



Source: Developed for this Thesis

CHAPTER THREE

3 RESEARCH DESIGN AND METHODOLOGY

This chapter discusses the overall design of the study; method used; data sources; study setting; population of the study; sampling techniques; data collection instruments; validity and reliability, procedures and statistical treatments utilized in analyzing the data collected.

3.1 Research Design

The research was conducted from March 2017 to March 2018. In terms of research design explanatory and descriptive design is used.

This study bears the characteristics of descriptive correlation research. It was chosen: First, it helps to create snapshot of the current state of affairs and assess the relationship between and among two or more variables (Stangor, 2011), Second, it is desirable when the type of hypothesis used is non-directional (Anderson, 2005) and finally, it allows to make prediction about the dependent variable based on the independent variable using regression analysis (Anderson, 2005). Since the objective of this study was to examine relationship quantitative approach deemed appropriate to use.

3.2 Research Method

In a research one can select qualitative, quantitative or a mixed one. Due to this reason the study was aimed at using quantitative research approach. In this study, leadership styles are independent variables and organizational change readiness is the dependent variable. A survey design provides a quantitative or numeric of trends, attitudes or opinions of population by studying a sample of population (Creswell, 2009, p.146). Using descriptive correlation allow the researcher to apply both correlation and regression statistical tools that are used to predict the relationship between leadership style and organizational change readiness. In addition used to determine the impact of leadership styles organizational change.

3.3 Data Sources

Combinations of primary and secondary data sources were applied to get sufficient information in the area of the study.

3.3.1 Primary Sources

Primary data was collected to analyze the relationship between administrative styles and employs readiness for organizational change. This firsthand information, gathered form selected hospitals administrative bodies and subordinates.

3.3.2 Secondary Source

The Magazines on health activities and achievement, Addis Ababa City Administration health Plans, different electronics sources, Journals, Research papers from Ministry of Health (MOH) and Ethiopian Management Institute (EMI) different collections and from other secondary related data source literature was revised. Government and non-government organizations were also consulted to get clear idea and good background information pertinent to the research.

3.4 Study Setting

According to the latest report of Addis Ababa City Administration Health Bureau, six (6) public and nineteen (19) private hospitals are found under Addis Ababa administration health bureau.

In common, all hospitals have two main sub classifications. They are disease prevention and medical service team. This study focuses on medical service team which comprises three branches. Namely: inpatient, outpatient and emergency. This study was conducted in government hospitals found in the City Administration of Addis Ababa. This is because: first, taking the special interest and attention of the Ethiopian government to the health system, the researcher believed, the highest level of this sub-sector regional hospitals requires a great attention and follow-up in their activities to bring the desired result set by the government. Second, there is no intense research made in these hospitals on the relationship between leadership styles and organizational change readiness. Lastly, as a capital of the country, Addis Ababa is highly populated and from one of the main service sector, in hospitals there is an expectation from the dwellers to get better level of service in terms of time and quality in other word change.

Once hospitals were targeted, the researcher took only three hospitals from six. Which is half of them or 50% is taken by judgment sampling. (Namely: Menilik Referral Hospital Yekatit12 Medical college Hospital and Zewditu Memorial Hospital) with the intention of obtaining adequate information. That is representative of the population of interest. For simplicity purpose these hospitals Menilik II Hospital, Yekatit 12 Medical College Hospital and Zewditu Memorial Hospital are coded as hospital a, hospital B, and Hospital C respectively.

3.5 Population and Sampling Techniques

This section discusses the research population, consideration for the sample size and outlines the sampling techniques used.

3.5.1 Population

In this study, the source of population was all the six public hospitals in Addis Ababa Administration Bureau. They are administrative and subordinate staffs. The respondents are who had been working in the hospitals for a minimum period of one year.

3.5.2 Sampling Techniques

The sampling techniques employed in this study are different and are discussed separately for the study.

3.5.2.1 Sampling Technique of the Study

a) Hospitals

From the six hospitals three of them are taken by their establishment year. The three oldest are taken by judgment sampling.

b) Administrative bodies

There were 75 (53 male and 22 female) staffs within the administrative level: top, middle and lower (see Table 3). List of administrative bodies was obtained from the human Resource Management (HRM) office of the hospitals. To this end, a sample of 2 administrative bodies (2 male and 0 female), excluding the pilot study part takes, was solicit to participate in the quantitative

study. To get more reliable data and also because their number was less than 100 census sampling technique applied and all administrative bodies were included. Gay and others (2009) also suggest taking the whole target as a sample if the population is less than one hundred.

Table 3: Population List of Administrative Bodies

Administrative Staff	Sex	Government Hospitals			Total
		Hospital A	Hospital B	Hospital C	
Top	Male	5	5	5	15
	Female	-	-	-	0
Middle	Male	5	3	4	12
	Female	-	2	1	3
Lower	Male	10	9	7	26
	Female	5	6	8	19
Total		**25**	**25**	**25**	**75**

Source: HRM Offices of the hospitals

a) Case Teams and Subordinates

As for sampling procedure, at first, the government hospitals were selected by judgment. List of hospitals was available in Addis Ababa City Administration Health Bureau. After deciding to focus on Addis Ababa regional hospitals, from the six hospitals three are selected. Then, the case team selection was taken, from the major case teams of the hospitals: Health development, Medical service, Finance, purchase and treasure, Human Resource Management, Plan and Quality and Internal Audit. From the case teams one can understand the major task of the hospital is taken by medical service case team and it is taken by purposive sampling. Human resource was taken since all the employees have connection with this case team, it was taken again with purposive sampling. The other was plan and quality it was also taken by the same sampling method and included since the department evaluate and give feedback on implementation of change and the researcher believed that including this case team is necessary because it is directly related with the objective of the study.

Under the selected three case teams the number of employees in every Profession were taken from HR offices of the hospitals. There found 1,575 employees in total (see Table 4). From those who stayed for less than a year (316), department heads (71) and pilot-study participants (24) were excluded from the total study population. Case team heads were excluded for the reason that, they were considered as part of administrative body and pilot participants were targeted to merely respond to the pre-testing questionnaires and provide suggestions on the instruments. Consequently, the study population summed up to 1,162.

Table 4: Population List of Employees

S/N	Case Teams	Government Hospitals						
		Hospital A		Hospital B		Hospital C		Total
		M	F	M	F	M	F	
1	Specialist Doctors	21	8	19	6	13	6	73
2	General Doctors	25	15	16	5	19	24	104
3	Health Officers	11	10	11	9	5	9	55
4	Nurses	113	225	79	227	88	259	991
5	Anstesist	9	8	4	11	8	5	45
6	Imaging	4	4	9	3	15	4	19
7	Laboratory Technician	12	11	21	17	11	21	93
8	Pharmacistcian	14	3	18	15	11	16	77
9	Physiotherapy	1	0	3	3	3	1	11
10	Psychiatry	2	3	1	2	1	1	10
11	Quality and HR office	5	6	6	10	4	8	39
12	Radiologist	9	8	9	3	3	6	36
	TOTAL	226	301	196	311	181	360	1,575

Source: Offices of Human Resource of Government Hospitals

Proportion of allocated population

The sample size for employee's population determined by rule of thumb using Krejcie and Morgan table (1970). This table was used because it was widely applicable in service sector research. In determining the sample size, a 95% confidence level and a 5% margin of error were taken in consideration. Consequently, the sample size became 291 for employees/subordinates. In an attempt to maximize confidence on the representation of the sample, additional 50 employees were prepared and so a total of 341 respondents were chosen.

Table 5: Proportion Allocation of Employees Population

Stratum	Study population (a)	Pilot-study part takers (b)	Those who serve less than a year (c)	Department Heads Excluding those included in pilot (d)	Stratum population {a-(b+c+d)}	Stratum weight (in %) $\left(\frac{\text{Stratum population}}{\text{Total Stratum population}}\right)$	Proportional sample allocation {Stratum weight ×n} (Approximate value)
Hospital A	527	12	145	23	346	29.77	101
Hospital B	507	12	97	23	374	32.19	110
Hospital C	541	-	74	25	442	38.04	130
Total	**1575**	**24**	**316**	**73**	**1,162**	**100**	**341**

Key: n= Sample size (341)

Then after, proportional stratified sampling technique was employed to obtain respondents from each hospital. This sampling technique deemed appropriate because employees' population is dispersed in three hospitals and also because of the need to address the hospitals

case teams within the hospitals. Besides; proportional stratified sampling helps to make the strata sample size proportional to population sample size; it reduces sampling bias and also allow coming up with a better representative sample (Gay and others, 2009).

Through proportion allocation; 101 samples from Hospital A, 110 samples were from Hospital B, and 130 samples from hospital C were taken. (See Table 5).

Gender proportion

After the expected number of participants from each hospital was determined, the numbers are allocated in the ten case teams to each hospitals. In the process, efforts were made to make the sample proportional to gender wise (see Table 6).

Table 6: Gender Proportion

Government Hospitals					
Hospital A		Hospital B		Hospital C	
Total population		Total population		Total population	
M	F	M	F	M	F
195 (56%)	151 (44%)	159 (43%)	215 (57%)	156 (35%)	286 (65%)
Sample population		Sample population		Sample population	
M	F	M	F	M	F
5 (56%)	43 (44%)	48 (43%)	62 (57%)	46 (35%)	84 (65%)

Afterwards, non probability sampling was used to take the proposed number of participants from each case team. When one person was unavailable, the researcher chosen the next person based on convenient sampling.

3.6 Data Collection Instruments and Pilot-testing

This section discusses the data collection instruments, the pilot-testing, validity and reliability analysis of the instruments and the rate of return. For the data collection instruments both MLQ and CA-OCM) were standardized instrument. This was because standardized instruments usually have an already developed reliability and validity and are one of the frequently used data collection methods in correlation studies (Gray, 2004).

Demographic questionnaire

Demographic questions were designed by the researcher. They entail; gender, age, education level, years of experience and the hospital they are currently working. The demographic questionnaire is found under Section I of both modified MLQs and change readiness questions. There is a slight difference in the questionnaires for the administrative staffs and subordinates in MLQ. The one difference is on the alternatives given under highest level of education. For subordinates, the alternatives range from diploma to others; while, for the administrative bodies it ranges from First degree to others. The very reason is that there are nurses who are qualified in diploma level but, this qualification is not regarded by the Addis Ababa City Administration

health bureau to fill administrative positions. Originally, the demographic questions were designed in English.

3.7 Modified Multi-factor Leadership Questionnaire (MLQ)

The instrument selected to measure the independent variables in this study was Multi-factor Leadership Questionnaire (MLQ 5X-short) developed by Bass and Avolio (1995). It undergoes over several revisions and empirically tested by a number of researchers using a variety of samples drawn from non-educational and educational organizations (Hebert, 2011).

The MLQ (5X-short) is the new revised form. According to Bass and Riggio (2006), MLQ (5X-short) has two forms: Leader form and Rater form. A leader self-rating version is filled by leaders and tells how leaders perceive themselves. A rater form is the one completed by others (subordinates) to rate the leader.

The other most important points regarding MLQ (5X-short) are reliability and validity. This instrument has been checked for reliability and validity for each leadership factor ranges from .80 to .91. Also MLQ (5X-short) has a well-established validity.

There are four reasons as to why MLQ (5X-short) is employed in this study. First, it is the most extensively used tool for measuring transactional and transformational laissez faire leadership over the past twenty-five years in different institutional system (Hukpati, 2009; Hashim and others 2010; Hariri, 2011). Second, it has been used around the world in different research programs, doctoral dissertations and masters' theses (Marcus, 2002). Third, it has both a self-report version (filled by the administrative staffs) as well as a version for Raters (filled by employees). Fourth, according to the researcher knowledge it has never been treated in Ethiopian health sector context.

Though MLQ (5X-short) is composed of 45 items, the modified versions for the sake of this study entails only 32 items. The rest 13 items of LFL and that deal with outcomes of leadership are excluded because they are not related with the scope of this research. The 32 items are distributed among Section II (20-transformational leadership items) and Section III (12-transactional leadership items). The format of the instruments was also adjusted in a way that can be

easily understood by respondents. Responses were given by both groups using a 5 point Likert scale ranging from, 0= not at all, 1= once in a while, 2= sometimes, 3= fairly often to 4=frequently, if not always.

3.8 California Organizational Change Management Questionnaire (CA-OCMQ)

In terms of change readiness questionnaire there is a question designed by California State departments a practical overview of organizational change management questionnaire (CA-OCM). The document mentions that the approach is

There are three reasons as to why CA-OCM questionnaire employed in this study. First, it enable to assess the change itself. This assessment examines the scope, depth and overall size of the change (Creasey, 2011). Second, The CA-OCM is designed to assist organizations in managing the people-side of change in order to achieve business outcomes associated with that change (CA-PMO,2011) .Third, the questionnaire provides a practical overview of Organization Change Management (OCM) to help prepare organization for change during transition (ITLA,2014). Besides the ITLA explained the questionnaire focuses on key concepts that help individuals ready their department for organizational change.

The other most important points regarding are reliability and validity. This instrument has been checked for reliability and validity by different researchers. The internal consistency and inter-item reliability of CA-OCM, for each change factors range from .75 to .91. The questionnaire also checked for validity and has good validity.

CA-OCM has 25 questions in total and classified under five categories; communication, sponsorship, stakeholders, coaching and training. Each category contains 5 questions. The questions in this basic categories designed under six scale model 1= strongly agree, 2= Disagree 3= Neutral 4=somewhat agree 5=agree and 6=strongly agree.

Pilot-testing

Once content validity was checked, quantitative instruments were subject to pilot-testing to check the extent to which the patterns of interpretations are prevalent in health sector context,

to identify items or ideas that are ambiguous, and enable the researcher make necessary corrections.

Out of the three hospitals targeted, hospital A and hospital B were selected for pre-testing based on their accessibility to the researcher. In total, 20 employee staffs (10 from hospital A and 10 from hospital B) have formed part of the pilot-study. The sampling was allocated from nurses because of their large number. Also from administrative bodies 4 taken (2 from middle and 2 from lower level) the administrative bodies taken based on accessibility excluding top level. They are excluded because they were not available on the field days. Gender wise, 2 male and 22 female staffs have participated in the pre-testing.

There were two reasons as to why the number of administrative staffs' respondents kept to lower number. First, their number was below hundred and pooling large number of participants in the pilot-test might affect the number in the actual sample and the data generalizability. Second, since the aim of pilot-testing is to make necessary corrections, taking few numbers of participants was found enough. In relation to this, Gay and others (2009) stated having three or four individuals complete the questionnaire will help to identify problems in pilot-testing.

The data collection for the pre-testing was administered personally by the researcher. It helped to collect all the 24 questionnaires and suggestion was gathered from participants on the content of the questionnaires. The correction includes linguistic matters. Before making the adjustments, the researcher consulted the individuals who check the content validity on the suggestions made by participants and they agree with the adjustments. The final questionnaires were therefore typed to include the suggestions offered from pre-test.

Literatures suggest results of the pilot testing should not be incorporated in the actual analysis. The Gray (2004) also emphasizes pilot-testing is part of the process of question performance evaluation and is not a substitute for collecting data on a population. Thus, neither the pilot testing respondents were incorporated in the final study nor the researcher includes data from the pilot-test in the data analysis.

Reliability

Concerning reliability, the researcher checked internal consistency and inter-tem total reliability for each independent and dependent variables using the pilot-study results. The reliability analysis is reported using Cronbach's Alpha (α). Subsequently, internal consistency reliability for modified MLQ ranged from 0.80 to 0.91 and the item-total reliability account to 0.91 (see Appendix F: I and II). With regard to CA-OCM internal consistency ranged from 0.75 to 0.89 and the item-total reliability account to 0.95 (see Appendix F: III and IV).

After reliability analysis, the actual data collection took place. In total, 71 MLQs and CA-OCM questionnaires distributed for the administrative bodies. Similarly, 341 modified Rater MLQs and CA-OCM questionnaire were distributed for employees.

Content Validity

Before pilot-study, the first step was to modify the standardized questionnaires, and check the content validity. Prior to modification, discussed the objective of the questionnaires with the expert so as to help contextualize the linguistics in Ethiopian hospitals context. The MLQ and CA-OCM questions then modified.

After the modification of the questionnaires, the content validity of the modified MLQ was checked by two people who are believed to be knowledgeable in the area of leadership. They were graduates in the field of Transformational Leadership and Change from International Leadership Institute

Similarly, one HRM expert (who has worked as a teacher in one of the Private Colleges in Addis Ababa and is currently working her PhD in Addis Ababa University has reviewed the modified MLQ and change readiness questions. In both cases, these people judge how well the items fit to Ethiopian health care system context.

3.9 Procedures

This section discusses the steps followed while collecting the data from the research sites and data analysis. Each move is described in detail.

3.9.1 Data Collection Procedures

The data collection procedure followed eight-step process of (a) making personal contact with each hospital to get permission, (b) making personal contact with Addis Ababa Health Bureau Research and Development Office, which is located in Zewditu memorial hospital (c) collecting employee data, (d) design and modification of the questionnaires and validity check, (e) pilot-study and reliability test, (f) meeting with friends and family members who have practice in the area of research and assignment of facilitators and discussion, (g) making an on-site delivery of the questionnaires and follow-up, and (h) collecting the completed questionnaires.

First, the researcher went to public hospitals found in Addis Ababa administration they told to the researcher to conduct any research in the hospitals researchers should get permission from Addis Ababa Health Bureau Research and Development Department.

Second, contacted again Addis Ababa Health Bureau Research and Development team to get permission to conduct research in Addis Ababa Public Hospitals. Since their first response was to know the ethical consideration of the paper, advisor and department permission letter, the researcher went back to consult with the department and advisor. After getting the letters again went to get permission to start the research. After getting permission from research department directed to the hospitals.

Third, to confirm access to the hospital participating in the study, the researcher brought letters of cooperation from the university and Addis Ababa Health Bureau Research and Development Office letter to the Vices of each of the three hospitals to request their willingness in the study to assist the researcher. Before the approval, all the Vices of the hospitals asked for more information about the objective of the research as well as the role of the administration staff and employees on the study then gave their approval. The researcher also communicated with administrative bodies to assure the willingness of their respective staff to cooperate in any way.

Fourth, after receiving affirmative feedback, the HRM sub-process and the case team heads' offices were approached to get the number and other demographic data of the administrative bodies and employees' respectively. Consequently, the information was obtained in full.

Fifth, the two sets of questionnaires the content validity was checked by knowledgeable individuals in Leadership and Human Resource Management.

Sixth, pilot-study was undertaken personally by the researcher and internal consistency and item-total reliability were checked and the instruments were found reliable.

Seventh, the researcher has asked and get permission to put the questionnaire in one case team head to each hospital to facilitate the data collection process among case team selected respondents. Three days prior to the on-site delivery of the questionnaires, there was a kind of discussion with assignees on the nature of items and how to fill the questionnaires.

Eighth, on-site delivery was made. The researcher moved to each hospital and distributes few questionnaires personally and monitors the process on how to fill out the questionnaires. To ease information exchange and retrieval process, the researcher also put her contact address in case respondents came up with difficulties in filling the instruments. Besides, follow-up activities were made through frequent contact with the assignees by phone and in person. Three participants from nurse staff and two from administrative staffs have contacted the researcher through phone. These participants needed additional orientation on the questionnaires and brief explanation was given by the researcher.

Ninth was collecting the questionnaires from employees of different case teams and administrative staffs.

3.9.2 Data Analysis Procedures

Before the quantitative data analysis; data classification, coding, data entry and transformation were done respectively. Once the responses were collected, each item was coded on Microsoft Excel and each questionnaire was assigned with a three digit identification number. Then, the data were entered and transformed from a raw form to a more usable form for statistical analysis. To assist the transformation process, the scores were inspected visually for completeness on Ms Excel sheet. Then after, all the data were exported in to Statistical Package for the Social Science (SPSS) Version 20.

Having done that, the scores of the items corresponding to the different constructs were grouped together for each respondent and then averaged to form the scale scores for each respondent. Overall; TFL, TRL and Readiness elements were computed by calculating the means of the item scores for individual respondents.

3.10 Data Analysis Techniques

The statistical analysis for this thesis focused on relationships among variables and differences between groups. In this study descriptive statistics, independent-samples *t*-test, Pearson correlation and multiple regression were applied.

Descriptive Statistics

Frequency and percentage were used to describe demographic variables. Further, mean and standard deviations were used to describe the leadership variables TFL and TRL in an attempt to answer research question one.

Independent- samples *t*-test

Independent-samples *t*-test was used to compare the mean scores for perception of administrative bodies and subordinates on leadership styles as measured by Change Readiness Questions. This statistical tool was deemed appropriate for the reason that the samples were taken independently from the two groups. In this research, the assumptions to *t*-test: the needs of interval scale measurement and normality distribution have been met.

Pearson correlation

Pearson correlation was used to examine the relationship among leadership styles and change readiness. Plus, it is used to explore strength and direction of the relationship between the variables. A statistical expression for Pearson correlation results is correlation coefficient. According to Pallant (2001), the correlation coefficient (*r*) its range is between -1.00 to +1.00. To this end, the signs show the type of relationship and the numerical values show the strength of relationships. In this study, the assumptions regarding Pearson correlation: the needs of interval scale measurement, normality distribution and linearity have been met.

Multiple regression

Multiple regression was used to explore the predictive ability of a set of independent variables (TFL and TRL) on each element of Change Readiness. It revealed how well TFL and TRL able to predict a significant amount of variance in each elements of change readiness. The prominent statistical values to express multiple regression results in this study are r^2 and *β-coefficient.* To this end, these values are used in this study to explain the predictive ability of independent variables. The '$r^{2'}$ used to explain the variability caused by predictor variables on criterion variables; whereas, '*β-coefficient'* explained the degree of increment or decline on criterion variable due to predictive variable.

Of the regression models, step-wise regression was employed in this study. The very reason to use this model was, it allows the SPSS to choose which independent variable to enter and in what order they appear in to the model on the basis of statistical criteria (Pallant, 2001).

***P*-value**

P-value shows the significance of test results. This value is used in *t-test* and Pearson correlation. Significance of test results described in this study is, based on the suggestions of Alghabban (2004). Accordingly, when $p>0.05$ it symbolizes no significant relationship; when $p<0.05$ it symbolizes significant relationship (symbolized as *); when $p<0.01$ it symbolizes highly significant relationship (symbolized as **) and when $p<0.001$ it symbolizes very highly significant relationship (symbolized as ***). All probabilities reported in this study are based on two-tailed tests since the hypotheses are non-directional.

3.11 Ethical Consideration

Regarding ethical consideration confidentiality of the paper is informed to all respondents. Besides the purpose of the study also specified on the research question for each participant. According to Bryman and Bell (2007) adequate level of confidentiality of the research data should be ensured. In addition to this a letter was given to Addis Ababa Health Bureau research office from Addis Ababa University.

CHAPTER FOUR

4 PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

This chapter deals with the presentation, analysis and interpretation of the data. In doing so, the quantitative data are presented in table format and the results from addressing the research questions were analyzed using the associated descriptive and inferential statistical tools. Explanation of statistical results was made within the context of this study as well as prior studies reviewed in chapter two.

4.1 Characteristics of Respondents

As mentioned in chapter three, in order to collect primary data, two categories of sample population, administrative bodies (*n= 71)* and subordinates *(n= 297),* filled the questionnaires. This sub-section describes the demographic characteristics of the two sample groups. The five demographic questions focused on gender, age, education level, years of service and the hospital that the respondents work with. The basic characteristics of the sample population are described in Table 7.

4.1.1 Characteristics of Administrative Bodies

The descriptive statistics (frequency and percentage) of demographics of the 71 administrative bodies who responded in this study are shown in Table 7.

Gender

As Table demonstrates, 69% of the respondents were male and 31% were female. This may show that the leadership positions in the three public hospitals were dominated by male professionals. Literatures indicate lower rate of female participation in leadership positions in most institutions is a common phenomenon (Mahce, 2003). As a result, the lowest female ratio in administrative position is consistent with literatures.

Age

Approximately 18.3% of the respondents were between age of 29 and 39 years and 16.9% distributed for respondents of more than or equal to 51 years of age. Most of the respondents (64.8%) fall between ages of 40 and 50 years.

Samuel (2012) contends institutions could suffer from young and inexperienced leaders. He argues young leaders face difficulties in making decisions due to their short work experience. To this end, the fact that leadership positions in government hospitals are dominated by people of 40 years and above is a good indicator that public hospitals are administered by experienced leaders' age wise.

Educational Level

The administrative groups were also asked to report on their highest level of education and reported that most of them had possessed first degree (74.6%), followed by those who possessed second degree (25.4%). It is evident that, the provision of second degree education in Ethiopia is expanding from year to year. Apart from this fact, most of the people who assume the leadership positions within the selected hospitals have a highest educational level of 'first degree'. This shows less emphasis is given to the education level of the selected hospital leaders.

Years of service

The descriptive results captured data that identified the proportion of the respondents who fall in different years of service. Subsequently, 73.2 % of the respondents have 1-5 years of experience and 14.1% serve between 6-10 years. The rest, 7.1% have 11-15 years of experience and 5.6% served for more than 16 years.

According to the data, most of the administrative group serve between 1-5 years in the hospitals. This could be explained by different changes (like promotion, demotion, transfer) introduced in the selected three hospitals.

Hospitals

It is to be noted that most of the respondents were from hospital C (35.2%) followed by similar percentages of respondents (32.4%) were found in hospital A and B.

4.1.2 Characteristics of Subordinates

The descriptive statistics in terms of frequency and percentage of demographics of the 297 different profession staff members who have participated in this study highlights Table 7.

Gender

Statistical results indicated the female subordinate respondents constitute (54.9%) and 45.1% were male employees. This finding goes opposite to the sex-ratio findings of the administrative group. This is due to the fact that the subordinate group number dominated by nurse staffs and this group dominated by females.

Age

Most of the respondents were in the age bracket of 29-39 years (45.8%). The next large age group was 18-28 years (26.6%). The age group between 40-50 years accounts for 22.2% of the total respondents; while only 5.4% are more than or equal to 51 years of age. This shows the percentage of respondents above or equal to 51 years are very low.

Educational level

In examining the highest qualification of respondents in Table 7, large sum of the respondents (74.4%) possessed first degree; whereas, subordinates with Level IV certificate and second degree constituted 18.5% and 7.1% respectively. This result is similar to what is found from administrative bodies and it shows there is a gap in equipping different profession staff in higher level education.

Years of Service

With regard to years of service, 46.1% of the subordinate staffs served for 6-10 years in the hospitals, followed by 25.9% of respondents who served between 1-5 years and 16.2% who served between 11-15 years. Only 11.8% of the respondents worked for more than 16 years. This shows most of the employees in the selected hospitals stayed long enough in the hospitals and they could bring a reliable source of information for this research.

Hospital

As Table 7 illustrates, a little bit higher respondents were from Hospital C (35.2 %) followed by Hospital A and B (32.4%). It is possible to say the sample distribution is not highly variable and different from the population distribution.

Table 7: Demographics of Administrative Bodies and Subordinates

Demographics	Frequency	Percentage (%)	Frequency	Percentage (%)
	Administrative bodies		Subordinates	
Sex				
Male	49	69.0	134	45.1
Female	22	31.0	163	54.9
Age				
18-28 years	-	-	79	26.6
29-39 years	13	18.3	136	45.8
40-50 years	46	64.8	66	22.2
≥51 years	12	16.9	16	5.4
Education Level				
Level IV graduate	-	-	55	18.5
First Degree	53	74.6	221	74.4
Second Degree	18	25.4	21	7.1
Other	-	-	-	-
Years of service				
1-5 years	60	73.2	77	25.9
6-10 years	9	14.1	137	46.1
11-15 years	1	7.1	48	16.2
≥ 16 years	1	5.6	35	11.8
Hospitals				
Hospital A	23	32.4	87	29.3
Hospital B	23	32.4	97	32.7
Hospital C	25	35.2	113	38.0

4.2 FactorAnalysis

The factor analysis was used for all variables with multi-item scales. During all factor analysis procedures, principal axis factoring and orthogonal varimax rotation methods were employed. Correlation: items tested amd they are perfectly correlated and correlations between different items also stronger. The determinants value is above .00001 and items are related and correlation is high. Interms of item Multicollinearity the cutoff is .8 and none of the values exceed this figure. KMO according to Kaiser (1974) recommended results greater than 0.5 is acceptable and the result for this research is .866 which is under the category of great values which is between 0.8 and 0.9.and it indicates that the data were sufficient for explorartory factor analysis. On the other hand Bartlett's test of sphenicty the result of the null hypothesis having a significance value less than 0.05. is highly significant. The test x^2 (159)=10972.03.p <0.001showed that there were patterned relationship between the items.

Table 8. KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.866
Bartlett's Test of Sphericity	Approx. Chi-Square	10972.030
	df	159
	Sig.	.000

Using an eigenvalue cut-off of 1.0, there were 15 factor that explain a cumulative variance of 67.45% . The scree plot confirmed the findings of retaining of 1 factor. The factor loadings after rotation used a significant factor criterion of .4.

Communalities which indicates the variance of each items which is expected to explain by the extracted factor commonly for each item expected figure is above .5. To get the average result it is calculated below and get result of 0.6961 which is above .5.

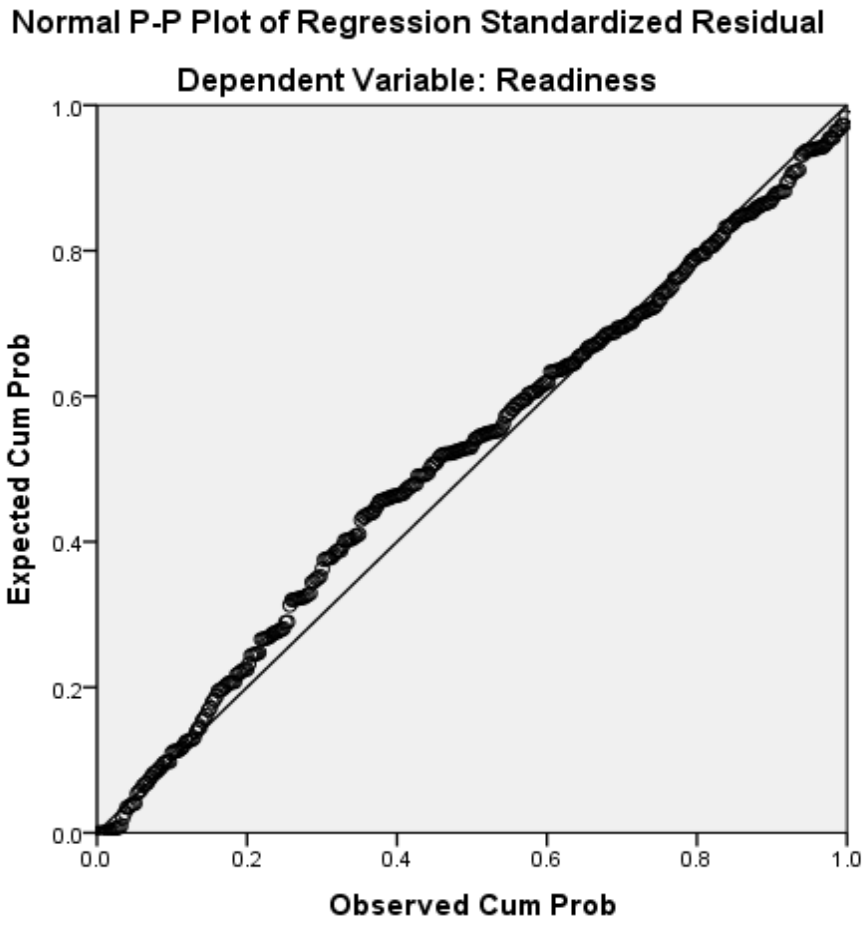
$$\text{Average of communalities} = \frac{\text{Total communalities}}{\text{Total items}} = \frac{38.168}{57} = 0.6961$$

4.3 Preliminary Data Analysis

4.3.1 Normality

This assumption used for determining whether the residuals are normally distributed. To say the normality assumption of this study is achieved, P-P Plot dots should be closer to the diagonal line; Normal P-P plot–points should lie in reasonably straight diagonal line from the bottom left to top right. Besides, the P-P plot the dots are almost drawn closer to the diagonal line, it indicates as the assumption of morality is achieved.

Figure 2. P-Plot Regression



4.3.2 Multicollinearity

In the case of correlation the highest degree of correlation between independent variables, there is an assumption for existence of similarity. It is considered as the problem of Multicollinearity

(Kothari, 2004). This is essentially the assumption that the predictors are not too highly correlated with one another.

Tolerance and Variance Inflation Factors (VIF); tolerance is the amount of variance in the individual variable not explained by the other predictor variables. The variation is expected between 0 and 1, a value close to 0 implies almost all the variance in the variable is explained by the other variables. On the other hand when the value is close to 1 it indicates that the other predictors do not explain the variance in that variable.

On VIF scores between 0.2 and 10.is the assumption of multiple regression.

Table 9: Test for Multicollinearity

Coefficients[a]

Model		Collinearity Statistics	
		Tolerance	VIF
	Communication	.196	5.106
	Sponsorship	.187	5.359
	Stakeholders	.287	3.485
	Coaching	.284	3.524
	Training	.735	1.360

4.3.3 Autocorrelation

The assumption is about the value of residuals should be uncorrelated. The assumption used model summary box. Durbin-Watson used to test the statistic assumption of residuals. The result vary from 0 to 4. In the case of autocorrelation assumption, static result of Durbin-Watson is expected to be near to 2.

In this research summary table 9, based on Durbin-Watson the study the result shown 1.838 which is closer to 2. To conclude that according to the statistical summary result when compared with Durbin-Watson there is no autocorrelation.

Table 10: Test for Autocorrelation

Model	R	R Square	Adjusted R Square	Durbin-Watson
1	.648[a]	.420	.417	1.838

a. Predictors: (Constant), Transactional Leadership, Transformational Leadership

b. Dependent Variable: Readiness

4.4 Reliability and Validity

There are different types of reliability measures. From all, this study focused on internal consistency. The internal consistency measure consistency within itself. Based on this the internal consistency is presented below on (Table 11 a and b)

11 a) Item-total Reliability for MLQ

Leadership Styles	Items	Cronbach's Alpha
Leadership Styles	1-32	0.91

11. b) Item-total Reliability for CA-OCMQ

Change readiness	Items	Cronbach's Alpha
General change readiness	1-25	0.86

Based on the test for reliability shown in Table 13 above, leadership was found to be highly reliable and which is (32 items; $\alpha = .91$) for Change readiness , (25 items; $\alpha = .81$). The reliability Cronbach's Alpha statistics of individual construct assumption above 0.773 have shown the highest reliability.

4.5 The Relationship between Leadership Styles and Organizational Change Readiness

Change initiatives are both time consuming and costly. It is therefore important to resolve how change is successfully adapted and sustained. (Ali, Sidow and Guleid, 2013). To examine the presence of any link between leadership styles and employ change readiness, MLQ (5X-Short) version and CA-OCM were used. To display the direction and significance of relationship between leadership styles and organizational change readiness, Pearson correlation was applied.

4.5.1 Transformational Leadership Style and Organizational Change Readiness

Literatures support the link between TFL style and change readiness. Transformational leadership had a positive direct effect on organizational change readiness and its dimension (Abasi, 2017). In this regard, this study tried to examine the link between the variables in government hospitals context in Addis Ababa using correlation statistics. The correlation results are illustrated in Table 12.

Table 12: A Statistical Summary TFL Style and Organizational Change Readiness

Correlations							
		Communication	Sponsorship	Stakeholders	Coaching	Training	Transformational Leadership
Communication	Pearson Correlation						.601**
Sponsorship	Pearson Correlation	.877**					.528**
Stakeholders	Pearson Correlation	.760**	.763**				.523**
Coaching	Pearson Correlation	.730**	.776**	.804**			.532**
Training	Pearson Correlation	.489**	.410**	.411**	.441**		.582**
Transformational Leadership	Pearson Correlation	.601**	.528**	.523**	.532**	.582**	

***p*< .05 (2-tailed)** ***r*= Pearson correlation coefficient** ***p*-value= significance level**

Research Question 1: Is there any relationship between transformational leadership style and organizational change readiness in public hospitals?

Under this basic question two, six hypotheses were developed. The data were analyzed to produce results for these hypotheses. *The first research hypothesis for research question two* states there is relationship between TFL style and COM. As Table 12 indicates, TFL style is significantly and positively related to COM (r= .60, p<.05). In this regard, the p-value (.000) is less than α value (.05); therefore the first alternative hypothesis for research question two is accepted. This result is consistent with literatures in a way TFL style is positively correlated with Communication.

As literatures suggest, transformational leadership style is related to communication. Further knowledge and opinion of health managers upon transformational leadership through their ideas

upon effective communication skills, collective mission, leader acting as a role model (Shahzad and Zareen, 2012).

Generally, the fact that there is a significant and positive relationship between TFL style and COM imply subordinates would be motivated if the administrative bodies in their respective hospital exhibits a TFL style. In addition; the issue of communication and common spirit on the job are strong contributors for TFL style and serve as motivators to subordinates change readiness.

The second research hypothesis for research question two states whether there is a relation between TFL style and SPO. As Table 12 indicates TFL is significantly and positively related to SPO (r=.53, p <.05). In this respect, quality sponsorship is determined by both action and position. Literature mentioned that individual is automatically a sponsor if they have people reporting to them who will be impacted by the change (Alsher, 2016). Other literatures mentioned that sponsors are expected to demonstrate their personal commitment to the change. The statistical data and the literatures shown that if there is commitment and initiative for TFL style and sponsorship followed by readiness for change.

Generally, the fact that there is a significant and positive relationship between TFL style and SPO imply employees would be motivated for change if the administration in their respective health institution exhibits a TFL style and spirit of SPO.

The third research hypothesis for research question two states whether there is a relationship between TFL style and STA. As Table 12 indicates, TFL style is significantly and positively related to STA (r= .52, p<.05). In this regard, the p-value (.000) is less than α value (.05); therefore the third alternative hypothesis for research question two is accepted. This result is consistent with literatures in a way TFL style is positively correlated with STA. Thus, forces for and against change are interpreted as being social in nature and the condition of a particular social 'reality', at any specific time, can be viewed as a consequence of the dominance of interests of particular stakeholder groups in an ongoing political contest Dovey,2008)

Transformational leadership is linked to work environment, technical and inter-personal skills of leaders, co-worker relationship and financial compensation which are considered as extrinsic facets of employees' satisfaction (Hashim and others, 2010).

Generally, the fact that there is a significant and positive relationship between TFL style and STA imply employees would be motivated for change readiness in their respective health institution if it exhibits a TFL style.

The fourth research hypothesis for research question two states whether there is a relationship between TFL style and COA. As Table 12 indicates, TFL style is significantly and positively related to COA (r= .53, p<.05). In this regard, the p-value (.000) is less than α value (.05); therefore the fourth alternative hypothesis for research question three is accepted.
Literature also support the interdependence nature of change and coaching. During the transition process the essence of coaching change by supervisors and managers are at the intermediate level (Ipnescu and et.al. 2014).

The fifth research hypothesis for research question two states whether there is a relationship between TFL style and TRA. As Table 12 indicates, TFL style is significantly and positively related to TRA (r= .58, p<.05). In this regard, the p-value (.000) is less than α value (.05); therefore the fifth alternative hypothesis for research question three is accepted. The idea is supported by literatures that the interdependence nature of change and training. Organizations should teach their leaders through the training program that they play the important roles in the organizational learning (Manshadi and et.al. 2014). Anoter iterature also support the interdependence nature of change and training. Pawar, cited by (Abasi, 2017) transformational leadership is the most basic element of successful or failed transformation program. Transformational strategies are those techniques and patterns, which practically cause changes in various fields.

Generally, change readiness motivators that are linked to the components of TFL style are communication, sponsorship, stakeholders, coaching and training. On the other hand, change readiness elements that are linked to the components of TFL style are idealized influence-awareness, desire, knowledge, ability and reinforcement consideration.

4.5.2 Transactional Leadership Style and Organizational Change Readiness

The success stories of TFL style with organziational change readiness has been emphasized by a number of scholars and researchers (Basham, 2010). Also a considerable number of researchers support the positive relationship between TRL style and organizational change readiness.

The link between these variables has never been tested in government hospitals of Addis Ababa according to the knowledge of the researcher. To examine the link between TRL style and organziational change readiness, Pearson correlation was used. The correlation results are presented in Table 13.

Table 13: A Statistical Summary of TRL Style and Organizational Change Readiness

Correlations[b]						
	Communication	Sponsorship	Stakeholders	Coaching	Training	Transactional Leadership
Communication						.514**
Sponsorship	.877**					.452**
Stakeholders	.760**	.763**				.413**
Coaching	.730**	.776**	.804**			.534**
Training	.489**	.410**	.411**	.441**		.654**
Transactional Leadership	.514**	.452**	.413**	.534**	.654**	

***p*< .05 (2-tailed)** **r= Pearson correlation coefficient** ***p*-value= probability level**

Research Question 2: Is there any relationship between transactional leadership style and organizational change readiness in government hospitals?

Under this basic question, six hypotheses were developed. The data were analyzed to produce results for these hypotheses. *The first research hypothesis for research question three* states whether there is a relationship between TRL style and COM. As Table 13 indicates, TRL style is significantly and positively related to COM (r= .51, $p<.05$). The *p*-value (.000) is less than α value (.05); therefore the first alternative hypothesis for research question three is accepted. This result is consistent with literatures in a way TRL style is positively correlated with change readiness. Relationships, communication, and personal reflection are the building blocks of effective change leadership. Indicator (Minnesota department of education, 2017).

The second research hypothesis for research question three states whether there is a relationship between TRL style and SPO. As Table13 indicates, TRL style is significantly and positively related to SPO (r= .45, $p<.05$). The *p*-value (.000) is less than α value (.05); therefore the second alternative hypothesis for research question three is accepted. This result is consistent with literatures in a way TRL style is positively correlated with SPO.

Transactional leader is reactive about the organizational goals, using a transaction approach to motivate followers. (Sayed, 2013). Sponsors must understand and embrace the agile mindset. Sponsor participation must become more precise and efficient (Prosci, 2002). Such documents help to clearly communicate what is expected of the organization and subordinates the approaches of TRL include rewards and motivation and the responsibility of leaders is to follow the execution of such motivational guidelines. To this end, administrative bodies in hospitals are expected to actively monitor the activities of employees and provide corrective criticism and/or punish wrong acts up on the policies and procedures.

The third research hypothesis for research question three states whether there is a relationship between TRL style and STA. As indicated in Table 13, TRL style is significantly and positively related to STA (r=0.41, p<.05). The p-value (.000) is less than α value (.05); therefore the third alternative hypothesis for research question three is accepted. This result is supported by prior studies. Change must also take into consideration values, fears, behaviors and the aspirations of all stakeholders involved in the change process. (D'Ortenizo,2012),

The fourth research hypothesis for research question three states whether there is a relationship between TRL style and COA. As indicated in Table 13 TRL style is significantly and positively related to COA (r=053, p<.05). The p-value (.000) is less than α value (.05); therefore the third alternative hypothesis for research question three is accepted. The Transformational Leaders clearly utilize more engaging interpersonal communication skills during their coaching discussion which we believe contributes to the positive organization and individual performance factors outlined (Starcevich, 2008).

The fifth research hypothesis for research question three states whether there is a relationship between TRL style and TRA. As indicated in Table 13 TRL style is significantly and positively related to TRA (r=0.65, p<.05). The p-value (.000) is less than α value (.05); therefore the third alternative hypothesis for research question three is accepted. This result is supported by prior studies; paying attention to the followers' needs and creating the opportunities for their development and promoting them to higher levels of individual development through determining their levels to participate in training courses (Manshadi, 2014).

The findings reflect subordinates would be motivated for change if the administration in government hospitals is transactional. The transactional component that is related to change readiness is contingent reward management-by exception-active. Since REA is the combination of change readiness elements and TRL style is significantly and positively related to the prior five elements of change readiness the significant and positive relationship between REA and TRL style is evident.

4.6 Multiple Regression Analysis

To explore the predictive ability of a set of independent variables (TFL and TRL) on change readiness, multiple regression was employed. To this end, r^2 and β- coefficient, are used to interpret the results. The multiple regression result is displayed in Table 14.

Table 14: A Statistical Summary of Regression Analysis Results

Model Summary				**Coefficients[a]**	**ANOVA[a]**				
Model	R	R Square	Adjusted R Square	Std. Coeff Std. Error	Sum of Squares	df	Mean Square	F	Sig.
1	.648[a]	.420	.417						
.496 (Constant)									.000
TFL				.496					.000
TRL				.219					.000
Regression					75.318	2	37.659	132.102	.000[b]
Residual					104.053	365	.285		
Total					179.371	367			
a. Dependent Variable: Readiness									
b. Predictors: (Constant), Transactional Leadership, Transformational Leadership									

The r^2 is the proportion of variation in the dependent variable (overall satisfaction) that is explained by the two independent variable. It is expressed as a percentage. So 42% of the variation in overall change readiness can be explained by two independent variables TFL and TRL, in the model. The figure indicate that 42% of the variance of change readiness was jointly explained by TFL and TRL styles. The rest 58% of variance of change readiness could be explained by other variables (personal life of subordinates, environmental factors, and others).

Table 14 shows whether the proportion of variance explained in the model summary table is significant. It also tells whether the overall effect of the two independent variables on over all change readiness is significant. Both the two independent variables have a significant combined effect on overall change readiness, p<.005.

In table 14 β-coefficient show the contribution of leadership styles in predicting REA Consequently, TFL style appear to make a significant contribution (β=*.496*) in predicting REA (p<.05). Whenever a higher level of TFL style is exhibited by the administrative bodies in government hospitals, the higher REA will be. Numerically explained; when TFL style increase by one standard deviation, REA increase by .496 standard deviations.

Regarding TRL style, it also makes a significant contribution (β=*.219*) in predicting REA (p<.05). Whenever a higher level of TRL style is exhibited by the administrative bodies in government hospitals, the higher REA will be exhibited. Numerically explained; when TRL style increase by one standard deviation, REA increase by .219 standard deviations.

The sig. or *p*-value is .000 which is below 0.05 level; hence, we conclude that the overall model is statistically significant, or that the variables have a significant combined effect on the dependent variable, explains a significant proportion of variance or overall model is statistically significant.

Generally, multiple regression examined whether leadership has impact on change readiness. The overall model explained 42% of variance in overall change readiness, which was revealed to be statistically significant, .p<.005. An inspection on individual predictor revealed that change readiness with Transformational leadership style (β=.496, p< .005) and change readiness with Transactional leadership style (β=.219, *p*< .005) are significant predictors of overall change readiness. Higher change readiness with transformational leadership and with transactional leadership were associated with higher levels of overall change readiness.

CHAPTER FIVE

5 SUMMARY, CONCLUSION AND RECOMMENDATION

This chapter illustrates summary, conclusion and recommendation of the study. These discussions are made based on the review of related literature, results of statistical analysis and discussions of findings from chapter four.

5.1 Summary of Major Findings

Comprehensive theories like FRLT and ADKAR were believed to provide answers to the competitive challenges faced by health sectors change practice. To this end, efforts were made to identify the relationship between leadership styles and organizational change readiness in government hospitals.

To achieve the objectives, two research questions were raised and ten hypotheses were developed. According to the finding all the alternative hypothesis are accepted.

Of the total administrative 71 sample population, 71 had returned the questionnaires and of the total 341 subordinates, 297 had returned the questionnaires. The major data collection instruments was questionnaire. Two standardized questionnaires were used: MLQ and CA-OCM. The Multi-factor Leadership Questionnaire (5X-Short) Leader form was distributed among hospitals administration, whereas; MLQ (5X-Short) Rater form was distributed among subordinates. The number of items in both MLQ forms were 32; whereas, the number of items CA-OCM form was 25. The questionnaires were modified to allow application in government hospitals. Demographic questions were also used as developed by the researcher

Demographic questions were analyzed using frequency and percentages. Research question wise, research question one analyzed using mean and an independent-samples *t*-test. While, research questions two and three were analyzed using Pearson correlation and variability in dependent variable due to independent variables are explained using multiple regression.

In chapter four, quantitative results were shown in tables associated with statistical tools employed and hypotheses were described in relation to statistical results and literatures.

5.1.1 Leadership Styles and Organizational Change Readiness

The findings from this study showed TFL style of administrative bodies in the three government hospitals would significantly and positively bring organizational change readiness, and boost general employee readiness (*r*=.60; *r*=.53; *r*=.52; *r*=.53; *r*=.58; *r*=.62).

Quantitative findings from this study showed TRL style of administrative bodies in the three government hospitals would significantly and positively bring change readiness and boost general organizational change readiness (*r*=.51; *r*=.45; *r*=.41; *r*=.53; *r*=.65; *r*=.51).

To summarize the effects of TFL and TRL styles on organizational change readiness; the result showed that; both leadership styles explain significant amount of variance for organizational change.

The administrative bodies and employees in government hospitals reflect on major problems they encounter in their day-to-day activities in their jobs. They contributed for the problems to be alleviated to bring organizational change and overall performance of public hospitals. The major problems and possible suggestions are pointed in the subsequent sections.

5.2 Conclusion

This study tried to examine the relationship between leadership styles and organizational change readiness in government hospitals of Addis Ababa. The results from the study findings showed that:

The administrative body in government hospitals mostly exhibit passive behavior. This behavior is unfavored behavior style. The passive behavior by scholars described (like absence when needed and avoid decision making) and account to lower or no motive to change readiness. The fact that the administrative bodies are identified as passive is an indicator of lower general readiness for change and blockage to success of government hospitals.

Apart from the desired leadership styles in government hospitals, the data identified problem areas which have negative impact on change readiness. These are related to: Communication between employees and other stakeholders including leaders. Also this leads to weak inter-

personal relation among administrative bodies and subordinates relationship. Training facilties or practice is also not at desited level and standard.

Another problem area identified by the research is in active sponsorship for change and less motivation of executives to manage resistance from all stakeholders.

Besides, the existence of less interest on getting people ready to adapt to the changes and in linking creativity to rewards and job promotion is additional problem for organizational change.

5.3 Recommendations

Based on the findings of the study, the following recommendations can be done:

- To alleviate problems regarding leadership the administrative bodies in government hospitals they need the support and guidance of authorities above the hospitals. There should be new strategy design, need to show the direction on identifying the skill gaps of administrators, nature of required support, criteria's to compete for health service opportunity, distinct approach for health service provided at different administrative levels, the time frame for trainings, follow-up activities and imply responsible person in charge to facilitate the follow-up activities.

- The leadership trainings need to focus on transformational and transactional leadership styles and be delivered by well experienced trainers in the country or abroad. Moreover, the strategy needs to have a room for possible amendment or adjustment. The government is also expected to raise fund annually for Leadership Development Programs in hospitals. To address problems on health service provision, the Addis Ababa City Administration Health Bureau and the Federal Ministry of Health are advised to design workable training and follow-up strategy in consultation with Board of Directors, the administrative bodies, and subordinates.

- Orgaqnizational change need employees and administrative bodies. To this end, Federal Ministry of health and the regional health bureau should incorporate important stakeholders (like subordinates, the administrative body of the hospitals, and the public) directly or indirectly in change and other policy and strategy design. This could be done by distributing comment forms to them to jot down on problems or difficulties they encounter and

the possible suggestions they have, in-depth interviewing, and creating opportunities for open discussions among the the above mentioned stakeholders and health planners to brainstorm inputs for change readiness. The change readiness regarding health sectors are expected to incorporate ideas and suggestions from the stakeholders.

- Considering compensation and reward package for employees, it was found that the motivating situation in government hospitals is not satisfactory. To this effect, The Federal Ministry of Health and the Regional Health Bureau should revise the scheme in government hospitals to realize organizatinal change. In time of revision, consultations need to be made with Economists and Financial Analysts to consider possible changes. In addition, the Federal Ministry of Health needs to assess the benefit package of other sectors and try to design a comprehensive and attractive compensation and benefit package for effective goal achievement.

- Finally, the health sector strategy need to be moving in the direction of development opportunity and organizational change. The sole part takers in identification of the health service needs time frame for creating awareness, trainings and transferring responsibilities. They need to undertake follow up linking success with rewards, transparent and timely execution of performance appraisal and promotion process. In addition, they also need to assign responsible body to monitor and follow-up organizational change.

5.4 Future Research

According to the multiple regression result leadership styles are not the only important factors for organizational change readiness. This implies the organizational change readiness could be impacted by other factors (personal life of employees, environmental factors, and others). To this effect, subsequent study need to be made to address the variables that account for organizational change readiness in government hospitals. On the same area, need to consider having additional healthsectors and study group to get better view of the relationship between leadership and organizational change readiness. This will help to get clear picture of the problem and area of solution.

Nevertheless, the validity and reliabllility of the questionnaire was tested, subjectivity could not be avoided all in all. It was concluded from this study that, data collection needed utmost care at the time of collection to control the quality of the data.

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APPENDIX A

Structure of Ethiopian Health Sector Organization



Source: Balanced Scorecard Institute Ethiopian Health Sector- Federal Ministry of Health Case Study.

APPENDIX B:

Modified Multi-factor Leadership Questionnaires

For Administrative Bodies

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF MANAGEMENT

Dear Respondents!

This questionnaire is aimed to examine the leadership styles of administrative bodies at government hospitals in Addis Ababa as perceived by the administrative bodies themselves. The questionnaire has four sections. Section I deals with demographic characteristics. Whereas section II, III and IV, deal with transformational, transactional and laissez-faire leadership behaviors respectively.

Please note that:

- No need of writing your name;
- Please read each statement carefully and answer all questions as much as you can;
- For descriptive statements, please respond in accordance with the five point Likert-scales provided under each section, put your answer circling in the corresponding boxes; and
- Multiple responses for a question are not possible.

The questionnaire is purely for academic purpose and you are assured that your response will be treated with utmost confidentiality.

Thank you in advance for your cooperation!

Nitsuh Kassaye

SECTION I. DEMOGRAPHIC DATA

1. Name of the hospital you are currently working _____
2. Gender : a. Male ☐ b. Female ☐
3. Age: a. 18-28 years ☐ b. 29-39 years ☐ c. 40-50 years ☐ d. ≥51 years ☐
4. Please indicate your highest level of education
   a. First degree ☐ b. Second degree ☐ c. Other_____
5. Years of service in this hospital
   a. 1-5 year ☐ b. 6-10 years ☐ c. 11-15 years ☐ d. ≥16 years ☐

SECTION II: TRANSFORMATIONAL LEADERSHIP BEHAVIOURS

This section includes 20 descriptive statements that will help you to rate how frequent you manifest transformational leadership behaviors. The behaviors are idealized influence-attributed, idealized influence-behavior, inspirational motivation, intellectual stimulation and individualized consideration. Please judge how frequent each statement fits you using the following 5 point Likert- scale. (Please circle your response)

0	1	2	3	4
Not at all	Once in a while	Sometimes	fairly often	Frequently if not

	Descriptive Statements on Idealized Influence-Attributed	**Rating Scales**				
1	I instil pride in employees for being associated with me	0	1	2	3	4
2	I go beyond self-interest for the good of employees'	0	1	2	3	4
3	I act in ways that build employees' respect for me	0	1	2	3	4
4	I display a sense of power and confidence	0	1	2	3	4
	Descriptive Statements on Idealized Influence-Behavior	**Rating Scales**				
5	I talk about my most important values and beliefs	0	1	2	3	4
6	I specify the importance of having a strong sense of purpose	0	1	2	3	4
7	I consider the moral and ethical consequences of my decisions	0	1	2	3	4
8	I emphasize the importance of having a collective sense of mission	0	1	2	3	4
	Descriptive Statements on Inspirational Motivation	**Rating Scales**				
9	I talk optimistically about the future	0	1	2	3	4
10	I talk enthusiastically about what needs to be accomplished	0	1	2	3	4
11	I articulate a compelling vision of the future	0	1	2	3	4
12	I express confidence that goals will be achieved	0	1	2	3	4
	Descriptive Statements on Intellectual Stimulation	**Rating Scales**				
13	I re-examine critical assumptions to question whether they are appropriate before making decisions	0	1	2	3	4
14	I seek differing perspectives from when solving problems	0	1	2	3	4
15	I get employees to look at problems from many different angles	0	1	2	3	4
16	I suggest new ways of looking how to complete assignments	0	1	2	3	4
	Descriptive Statements on Individualized Consideration	**Rating Scales**				
17	I spend time in administering and coaching employees	0	1	2	3	4
18	I treat subordinates as individuals rather than just as a member of a group	0	1	2	3	4
19	I consider each employee as having different needs, abilities, and aspirations from his/her colleagues	0	1	2	3	4
20	I help subordinates to develop their strengths	0	1	2	3	4

SECTION III: TRANSACTIONAL LEADERSHIP BEHAVIOURS

This section includes 12 descriptive statements that will help you to rate how frequent you manifest transactional leadership behaviors. The behaviors are contingent reward, management by exception-active and management by exception-passive. Please judge how frequent each statement fits you using the following 5 point Likert-scale. (Please circle on your response)

0	1	2	3	4
Not at all	**Once in a while**	**Sometimes**	**Fairly often**	**Frequently if not al-**

	Descriptive Statements on Contingent Rewards	**Rating Scales**				
21	I provide employees with assistance in exchange for their efforts	0	1	2	3	4
22	I discuss in specific terms who is responsible for achieving performance targets	0	1	2	3	4
23	I make clear what employees can expect to receive when performance goals are achieved	0	1	2	3	4
24	I express satisfaction when employees meet expectations	0	1	2	3	4
	Descriptive Statements on Management-by-Exception-Active	**Rating Scales**				
25	I focus attention on irregularities, mistakes, exceptions and deviations from standards	0	1	2	3	4
26	I concentrate my full attention on dealing with mistakes, complaints and failures	0	1	2	3	4
27	I keep track of all mistakes	0	1	2	3	4
28	I direct my attention toward failures to meet standards	0	1	2	3	4
	Descriptive Statements on Management-by-Exception-Passive	**Rating Scales**				
29	I fail to interfere until problems become serious	0	1	2	3	4
30	I wait for things to go wrong before taking action	0	1	2	3	4
31	I show that I am a firm believer in "If it isn't broke, don't fix it."	0	1	2	3	4
32	I demonstrate that problems must become chronic before I take action	0	1	2	3	4

APPENDIX C:

Multi-factor Leadership Questionnaires

For Subordinates

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF MANAGEMENT

Dear Respondents!

This questionnaire is aimed to examine the leadership styles of subordinates at government hospitals in Addis Ababa as perceived by Subordinates. The questionnaire has four sections. Section I deals with demographic characteristics. While section II, III and IV deal with transformational, transactional and laissez-faire leadership behaviors respectively.

Please note that:

- No need of writing your name;
- Please read each statement carefully and answer all questions as much as you can;
- For descriptive statements, please respond in accordance with the five point Liker-scales provided under each section, put your answer circling in the corresponding boxes; and
- Multiple responses for a question are not possible.

The questionnaire is purely for academic purposes and you are assured that your response will be treated with utmost confidentiality.

Thank you in advance for your cooperation!

Nish Kassie

SECTION I. DEMOGRAPHIC DATA

1. Name of the hospital you are currently working _____
2. Gender : a. Male ☐ b. Female ☐
3. Age: a. 18-28 years ☐ b. 29-39 years ☐ c. 40-50 years ☐ d. ≥ 51 years ☐
4. Please indicate your highest level of education
   a. Level IV graduate ☐ b. First degree ☐ c. Second degree ☐ c. Other _____
5. Years of service in this hospital.
   a. 1-5 years ☐ b. 6-10 years ☐ c. 11-15 years ☐ d. ≥16 years ☐

SECTION II: TRANSFORMATIONAL LEADERSHIP BEHAVIOURS

This section includes **20** descriptive statements that will help you to rate how frequent the admin manifest transformational leadership behaviors. The behaviors are idealized influence-attributed, idealized influence behavior, inspirational motivation, intellectual stimulation and individualized consideration. Please judge how frequent each statement fits you using the following 5 point Likert-scale. (Please circle your response)

0	1	2	3	4
Not at all	Once in a while	Sometimes	Fairly often	Frequently if not always

	Descriptive Statements on Idealized Influence-Attributed	**Rating Scales**				
1	Administrative staffs instil pride in employees for being associated with them	0	1	2	3	4
2	Administrative staffs go beyond self-interest for the good of employees	0	1	2	3	4
3	Administrative staffs act in ways that build employees respect for them	0	1	2	3	4
4	Administrative staffs display a sense of power and confidence	0	1	2	3	4
	Descriptive Statements on Idealized Influence-Behavior	**Rating Scales**				
5	Administrative staffs talk about their most important values and beliefs	0	1	2	3	4
6	Administrative staffs specify the importance of having a strong sense of purpose	0	1	2	3	4
7	Administrative staffs consider the moral and ethical consequences of their decisions	0	1	2	3	4
8	Administrative staffs emphasize the importance of having a collective sense of mission	0	1	2	3	4
	Descriptive Statements on Inspirational Motivation	**Rating Scales**				
9	Administrative staffs talk optimistically about the future	0	1	2	3	4
10	Administrative staffs talk enthusiastically about what needs to be accomplished	0	1	2	3	4
11	Administrative staffs articulate a compelling vision of the future	0	1	2	3	4
12	Administrative staffs express confidence that goals will be achieved	0	1	2	3	4
	Descriptive Statements on Intellectual Stimulation	**Rating Scales**				
13	Administrative staffs re-examine critical assumptions to question whether they are appropriate before making decisions	0	1	2	3	4
14	Administrative staffs seek differing perspectives from trainers when solving problems	0	1	2	3	4
15	Administrative staffs get employees to look at problems from many different angles	0	1	2	3	4
16	Administrative staffs suggest new ways of looking at how to complete assignments	0	1	2	3	4
	Descriptive Statements on Individualized Consideration	**Rating Scales**				
17	Administrative staffs spend time in administering and coaching employees	0	1	2	3	4
18	Administrative staffs treat employees as individuals rather than just as a member of a group	0	1	2	3	4
19	Administrative staffs consider each employee as having different needs, abilities and aspirations from other employees	0	1	2	3	4
20	Administrative staffs help employees to develop their strengths	0	1	2	3	4

SECTION III: TRANSACTIONAL LEADERSHIP BEHAVIOURS

This section includes **12** descriptive statements that will help you to rate how frequent the administrative bodies manifest **transactional leadership** behaviors. The behaviors are contingent reward, management by exception-active and management by exception-passive. Please judge how frequent each statement fits you using the following 5 point Likert-scale. (Please circle your response).

0	1	2	3	4
Not at all	**Once in a while**	**Sometimes**	**Fairly often**	**Frequently if not always**

	Descriptive Statements on Contingent Rewards	**Rating Scales**				
21	Administrative staffs provide employees with assistance in exchange for their efforts	0	1	2	3	4
22	Administrative staffs discuss in specific terms who is responsible for achieving performance targets	0	1	2	3	4
23	Administrative staffs make clear what employees can expect to receive when performance goals are achieved	0	1	2	3	4
24	Administrative staffs express satisfaction when employees meet expectations	0	1	2	3	4
	Descriptive Statements on Management-by-Exception-Active	**Rating Scales**				
25	Administrative bodies focus attention on irregularities, mistakes, exceptions and deviations from standards	0	1	2	3	4
26	Administrative staffs concentrate their full attention on dealing with mistakes, complaints, and failures	0	1	2	3	4
27	Administrative staffs keep track of all mistakes	0	1	2	3	4
28	Administrative staffs direct their attention toward failures to meet standards	0	1	2	3	4
	Descriptive Statements on Management-by-Exception-Passive	**Rating Scales**				
29	Administrative staffs fail to interfere until problems become serious	0	1	2	3	4
30	Administrative staffs wait for things to go wrong before taking action	0	1	2	3	4
31	Administrative staffs show that they are firm believers in "If it isn't broke, don't fix it."	0	1	2	3	4
32	Administrative staffs demonstrate that problems must become chronic before they take action	0	1	2	3	4

APPENDIX D

California Organizational Change Management Questionnaires

For Administrative Bodies

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF MANAGEMENT

Dear Respondents!

This questionnaire is useful in assessing where an organization is for the change. The questions below are for the administrative bodies to take assessment from an organization perspective, within the organization based on their relationship to change and their role in a change competent organization in government hospitals about the aspects of the change. The questionnaire has six sections. Section I deals with demographic characteristics. Whereas section II, III, IV, V and VI deals with Communication, Sponsorship roadmap, Resistance Management, Coaching and Training.

Please note that:

- No need of writing your name;
- Please read each statement carefully and answer all questions as much as you can;
- For descriptive statements, please respond in accordance with the rating-scales provided under each section, put your answer by circling in the corresponding boxes; and
- Multiple responses for a question are not possible.

The questionnaire is purely for academic purpose and you are assured that your response will be treated with utmost confidentiality.

Th**ank you in advance for your cooperation!**

Nitsuh Kassaye

SECTION I. DEMOGRAPHIC DATA

1. Name of the hospital you are currently working _____

2.Gender : a. Male ☐ b. Female ☐

3.Age: a. 18-28 years ☐ b. 29-39 years ☐ c. 40-50 years ☐ d. ≥51 years ☐

4.Please indicate your highest level of education

a. First degree ☐ b. Second degree ☐ c. Other_____

5.Years of service in this hospital

a. 1-5 year ☐ b. 6-10 years ☐ c. 11-15 years ☐ d. ≥16 years ☐

SECTION II. COMMUNICATION

1	2	3	4	5	6
Strongly disagree	Disagree	Neutral	Somewhat agree	Agree	Strongly Agree

S/N	**Communication- Informing who is affected and impacted regarding the change.**	**Rating scales**					
1	The health institution has a clearly defined vision and strategy and changes are continually communicated with all stakeholders.	**1**	**2**	**3**	**4**	5	6
2	Priorities are set and continually communicated regarding change projects and other competing initiatives.	**1**	**2**	**3**	**4**	5	6
3	The health institution uses multiple communication methods to keep stake-holders informed	**1**	**2**	**3**	**4**	5	6
4	The health institution's messaging about change projects is clear, concise and consistent	**1**	**2**	**3**	**4**	5	6
5	Mechanisms are in place to identify lapses in effective communication	**1**	**2**	**3**	**4**	5	6

SECTION III. SPONSORSHIP

1	2	3	4	5	6
Strongly disagree	Disagree	Neutral	Somewhat agree	Agree	Strongly Agree

S/N	**Sponsorship- Ensuring there is active sponsorship for the change at a senior executive level within the organization, and engaging this sponsorship to achieve the desired results,**	**Rating scales**					
6	Change initiatives in the organization have an executive sponsor identified	**1**	**2**	**3**	**4**	5	6
7	The executive sponsor has the necessary authority over the people, processes and systems to authorize and fund change initiatives	**1**	**2**	**3**	**4**	**5**	**6**
8	The executive sponsor can build awareness of the need for change(why the change is happening)	**1**	**2**	**3**	**4**	5	6
9	The executive sponsor will actively and visibly participate with the project team throughout the entire change process	**1**	**2**	**3**	**4**	5	6
10	The executive sponsor will resolve issues and make decisions relating to the change project schedule, scope and resources	**1**	**2**	**3**	**4**	5	6

SECTION IV. STAKEHOLDERS /RESISTANCE MANAGEMENT

1	2	3	4	5	6
Strongly disagree	**Disagree**	**Neutral**	**Somewhat agree**	**Agree**	**Strongly Agree**

S/N	**Stakeholders/ Resistance Management- gaining buy-in for the changes from those involved and affected, directly or indirectly. Involving the right people in the design and implementation of changes, to make sure the right change made.**	**Rating scales**					
11	The executive sponsor is willing and able to build a sponsorship coalition for change, and is able to manage resistance from all stakeholders.	**1**	**2**	**3**	**4**	**5**	**6**
12	Change is managed effectively and change success are celebrated, both in private and in public	**1**	**2**	**3**	**4**	5	6
13	Stakeholders hear a consistent and unified message from various levels of executives.	**1**	**2**	**3**	**4**	**5**	**6**
14	Change initiatives are accurately tailored to the particular needs and concerns of each stakeholders group.	**1**	**2**	**3**	**4**	5	6
15	Special tactics have been developed for handling resistance to change from various stakeholders	**1**	**2**	**3**	**4**	5	6

SECTION V. READINESS/ COACHING

1	2	3	4	5	6
Strongly disagree	**Disagree**	**Neutral**	**Somewhat agree**	**Agree**	**Strongly Agree**

S/N	**Readiness/ Coaching- getting people ready to adapt to the changes by ensuring they have the right information and toolsets.**	**Rating scales**					
16	A structured change management approach is being communicated and applied to change projects.	**1**	**2**	**3**	**4**	5	6
17	Change management team members have been identified. Managers and staff are trained on health institution change management	**1**	**2**	**3**	**4**	5	6
18	Project team and change management teams are tracking progress and able to resolve related issue through set project management process. A project plan has been integrated with a change management plan.	**1**	**2**	**3**	**4**	5	6
19	Resources for change projects are identified and acquired based on a project plan. Resources have the necessary time to complete work for the change.	**1**	**2**	**3**	**4**	5	6
20	Feedback processes are continually used to determine how effectively change is being adopted by stakeholders	**1**	**2**	**3**	**4**	5	6

SECTION VI. TRAINING

1	2	3	4	5	6
Strongly disagree	**Disagree**	**Neutral**	**Somewhat agree**	**Agree**	**Strongly Agree**

S/N	**Training- training the appropriate resources on the change.**	**Rating scales**					
21	Health institution recognizes and reinforces skills and behaviors required for the change effort	**1**	**2**	**3**	**4**	5	6
22	Skills and knowledge needed for transition have been identified	**1**	**2**	**3**	**4**	**5**	**6**
23	Skills assessments are continually conducted for change projects and gaps are identified for transition	**1**	**2**	**3**	**4**	5	6
24	Training is developed and scheduled proactively, based on gaps and need assessments	**1**	**2**	**3**	**4**	5	6
25	Flexible methods are employed for training i.e. web based, webcasts, guides, in class training etc	**1**	**2**	**3**	**4**	5	6

APPENDIX E:

Change Readiness Questionnaires

For: Subordinates Staffs

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF MANAGEMENT

Dear Respondents!

This questionnaire is useful in assessing where an organization is for the change. The questions below are for subordinate staffs take assessment from an organization perspective, within the organization based on their relationship to change and their role in a change competent organization in government hospitals about the aspects of the change. The questionnaire has six sections. Section I deals with demographic characteristics. Whereas section II, III, IV, V and VI deals with Communication, Sponsorship roadmap, Resistance Management, Coaching and Training.

Please note that:

- No need of writing your name;
- Please read each statement carefully and answer all questions as much as you can;
- For descriptive statements, please respond in accordance with the rating-scales provided under each section, put your answer by circling in the corresponding boxes; and
- Multiple responses for a question are not possible.

The questionnaire is purely for academic purpose and you are assured that your response will be treated with utmost confidentiality.

Th**ank you in advance for your cooperation!**

Nitsuh Kassaye

SECTION I. DEMOGRAPHIC DATA

5.5.2 Name of the hospital you are currently working _____

5.5.3 Gender : a. Male ☐ b. Female ☐

5.5.4 Age: a. 18-28 years ☐ b. 29-39 years ☐ c. 40-50 years ☐ d. ≥ 51 years ☐

6 Please indicate your highest level of education

a. Level IV graduate ☐ b. First degree ☐ c. Second degree ☐ d. Other _____

7 Years of service in this hospital.

a. 1-5 years ☐ b. 6-10 years ☐ c. 11-15 years ☐ d. ≥16 years ☐

SECTION II. COMMUNICATION

1	2	3	4	5	6
Strongly disagree	**Disagree**	**Neutral**	**Somewhat agree**	**Agree**	**Strongly Agree**

S/N	**Communication- Informing who is affected and impacted regarding the change.**	**Rating scales**					
1	The health institution has a clearly defined vision and strategy and changes are continually communicated with all stakeholders.	**1**	**2**	**3**	**4**	5	6
2	Priorities are set and continually communicated regarding change projects and other competing initiatives.	**1**	**2**	**3**	**4**	5	6
3	The health institution uses multiple communication methods to keep stakeholders informed	**1**	**2**	**3**	**4**	5	6
4	The health institution's messaging about change projects is clear, concise and consistent	**1**	**2**	**3**	**4**	5	6
5	Mechanisms are in place to identify lapses in effective communication	**1**	**2**	**3**	**4**	5	6

SECTION III. SPONSORSHIP

1	2	3	4	5	6
Strongly disagree	**Disagree**	**Neutral**	**Somewhat agree**	**Agree**	**Strongly Agree**

S/N	**Sponsorship- Ensuring there is active sponsorship for the change at a senior executive level within the organization, and engaging this sponsorship to achieve the desired results,**	**Rating scales**					
6	Change initiatives in the organization have an executive sponsor identified	**1**	**2**	**3**	**4**	5	6
7	The executive sponsor has the necessary authority over the people, processes and systems to authorize and fund change initiatives	**1**	**2**	**3**	**4**	**5**	**6**
8	The executive sponsor can build awareness of the need for change(why the change is happening)	**1**	**2**	**3**	**4**	5	6
9	The executive sponsor will actively and visibly participate with the project team throughout the entire change process	**1**	**2**	**3**	**4**	5	6
10	The executive sponsor will resolve issues and make decisions relating to the change project schedule, scope and resources	**1**	**2**	**3**	**4**	5	6

SECTION IV. STAKEHOLDERS/ RESISTANCE MANAGEMENT

1	2	3	4	5	6
Strongly disagree	Disagree	Neutral	Somewhat agree	Agree	Strongly Agree

S/N	**Stakeholder Management- gaining buy-in for the changes from those involved and affected, directly or indirectly. Involving the right people in the design and implementation of changes, to make sure the right change made.**	**Rating scales**					
11	The executive sponsor is willing and able to build a sponsorship coalition for change, and is able to manage resistance from all stakeholders.	**1**	**2**	**3**	**4**	**5**	**6**
12	Change is managed effectively and change success are celebrated, both in private and in public	**1**	**2**	**3**	**4**	5	6
13	Stakeholders hear a consistent and unified message from various levels of executives.	**1**	**2**	**3**	**4**	**5**	**6**
14	Change initiatives are accurately tailored to the particular needs and concerns of each stakeholders group.	**1**	**2**	**3**	**4**	5	6
15	Special tactics have been developed for handling resistance to change from various stakeholders	**1**	**2**	**3**	**4**	5	6

SECTION V. READINESS/ COACHING

1	2	3	4	5	6
Strongly disagree	Disagree	Neutral	Somewhat agree	Agree	Strongly Agree

S/N	**Readiness- getting people ready to adapt to the changes by ensuring they have the right information and toolsets.**	**Rating scales**					
16	A structured change management approach is being communicated and applied to change projects.	**1**	**2**	**3**	**4**	5	6
17	Change management team members have been identified. Managers and staff are trained on organizational change management	**1**	**2**	**3**	**4**	5	6
18	Project team and change management teams are tracking progress and able to resolve related issue through set project management process. A project plan has been integrated with a change management plan.	**1**	**2**	**3**	**4**	5	6
19	Resources for change projects are identified and acquired based on a project plan. Resources have the necessary time to complete work for the change.	**1**	**2**	**3**	**4**	5	6
20	Feedback processes are continually used to determine how effectively change is being adopted by stakeholders	**1**	**2**	**3**	**4**	5	6

SECTION VI. TRAINING

1	2	3	4	5	6
Strongly disagree	Disagree	Neutral	Somewhat agree	Agree	Strongly Agree

S/N	**Training- training the appropriate resources on the change.**	**Rating scales**					
21	Health institution recognizes and reinforces skills and behaviors required for the change effort	**1**	**2**	**3**	**4**	5	6
22	Skills and knowledge needed for transition have been identified	**1**	**2**	**3**	**4**	**5**	**6**
23	Skills assessments are continually conducted for change projects and gaps are identified for transition	**1**	**2**	**3**	**4**	5	6
24	Training is developed and scheduled proactively, based on gaps and need assessments	**1**	**2**	**3**	**4**	5	6
25	Flexible methods are employed for training i.e. web based, webcasts, guides, in class training etc	**1**	**2**	**3**	**4**	5	6

APPENDIX F:

Reliability Analysis

I. Internal Consistency for Modified MLQ

Leadership Styles	Items	Chronbach's Alpha
Transformational	1-20	0.91
Transactional	21-32	0.80

II. Item-total Reliability for Modified MLQ

Leadership Styles	Items	Chronbach's Alpha
Leadership Styles	1-32	0.91

III. Internal Consistency for Modified CA-OCMQ

Readiness elements	Items	Chronbach's Alpha
Communication	1-5	0.79
Sponsorship	6-10	0.75
Stakeholders	11-15	0.78
Coaching	16-20	0.88
Training	21-25	0.89

IV. Item-total Reliability for Modified CA-OCMQ

Change readiness	Items	Chronbach's Alpha
General change readi-ness	1-25	0.89

APPENDIX G:

Data Classification and Codebook

I. Respondents Profiles

Variable	SPSS Variable Name	Coding instruction
Identification number	**ID**	Number assigned to each questionnaire
Institution	**IN**	1= Hospital A, 2= Hospital B, 3= Hospital C
Gender	**Gender**	0= Male, 1= Female
Age	**Age**	1= 18-28 years, 2= 29-39 years, 3= 40=50 years, 4= ≥51 years
Highest Education level for Administrators	**EDU**	1= Level 4 graduate, 2= Diploma, 3= First degree, 4= Second degree, 5= Other
Highest Education level for subordinates	**EDU1**	1= First degree, 2= Second degree, 3= Other
Job position	**Position**	1= Subordinates, 2= Administrator
Years of Experience	**Exp**	1= 1-5 years, 2= 6-10 years, 3= 11-15 years, 4= ≥16 years

Leadership Styles

Variable	SPSS Variable Name	Coding instruction
Idealized Influence (Attributed)	IIA (items 1-4)	0= Not at all,1= Once in a while, 2=Sometimes 3= Fairly often, 4= Frequently, if not always
Idealized Influence (Behavior)	IIB (items 5-8)	>>
Inspirational Motivation	IM (items 9-12)	>>
Intellectual Stimulation	IS (items 13-16)	>>
Individualized Consideration	IC (items 17-20)	>>
Contingent Reward	CR (items 21-24)	>>
Management by exception (Active)	MEA (items 25-28)	>>
Management-by-exception (Passive)	MEP (items 29-32)	>>

III. Change Readiness

Variable	SPSS Variable Name	Coding Instruction
Activity	ACT 01	1= Strongly agree, 2= Disagree, 3= Neutral, 4= Somewhat agree, 5= Agree, 6=Strongly Agree
Communication	COMM (1-5)	>>
Sponsorship	SPO	>>
Stakeholders	STA	>>
Coaching	COA	>>
Training	TRA	>>

APPENDIX H:

Variable Symbols and Descriptors used for Analysis

Symbols (MLQ)	Descriptors
TFL	Mean score for modified MLQ transformational leadership subscale items (1-20)
TRL	Mean score for modified MLQ transactional leadership subscale items (21-32)
Symbols (CA-OCM)	**Descriptors**
COM	Mean score for CA-COM Communication on change readiness subscale items (1-5)
SPO	Mean score for CA-COM Sponsorship on change readiness subscale items (6-10)
STA	Mean score for CA-COM Stakeholder on change readiness subscale items 11-15)
COA	Mean score for CA-COM Coaching on change readiness subscale items (16-20)
TRA	Mean score for CA-COM Training on change readiness subscale items (21-25)
REA	Mean score for CA-COM on change readiness subscale items (1-25)