

Relationship Between Administrative, Strategic, and Training Dimensions of Total Quality Management and Performance Evaluation in Public Healthcare Facilities in the Gaza Strip

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Abstract

This study examined the relationship between the administrative, strategic, and training dimensions of Total Quality Management (TQM) and human resource performance evaluation in public healthcare facilities affiliated with the Ministry of Health in the Gaza Strip. A descriptive-analytical cross-sectional design was used. The study population comprised approximately 9,270 employees, from whom a simple random sample of 369 participants was selected. Data were collected through a structured questionnaire measuring administrative leadership, strategic planning, training, and performance evaluation and were analyzed using the Statistical Package for the Social Sciences (SPSS). The findings indicated statistically significant relationships between the examined TQM dimensions and performance evaluation. Administrative leadership showed the strongest relationship, followed by strategic planning and training, while differences were also observed across job categories in perceptions of selected TQM dimensions and appraisal practices. The study concludes that strengthening administrative leadership, aligning strategic planning with performance indicators, and expanding continuous training can improve the fairness, transparency, and effectiveness of performance evaluation systems in public healthcare institutions. Practical interventions should particularly address the needs of technical and support staff, who reported lower levels of satisfaction.

Keywords: Total Quality Management; Administrative Leadership; Strategic Planning; Training; Human Resource Performance Evaluation; Public Healthcare.

المخلص

هدفت هذه الدراسة إلى فحص العلاقة بين الأبعاد الإدارية والاستراتيجية والتدريبية لإدارة الجودة الشاملة وتقييم أداء الموارد البشرية في مرافق الرعاية الصحية العامة التابعة لوزارة الصحة في قطاع غزة. استخدمت الدراسة المنهج الوصفي التحليلي بتصميم مقطعي، وتكون مجتمعها من نحو (9,270) موظفًا، اختيرت منهم عينة عشوائية بسيطة بلغت (369) موظفًا. جمعت البيانات بواسطة استبانة منظمة تقيس القيادة الإدارية والتخطيط الاستراتيجي والتدريب وتقييم الأداء، وحُللت باستخدام برنامج الحزمة الإحصائية للعلوم الاجتماعية (SPSS). أظهرت النتائج وجود علاقات ذات دلالة إحصائية بين أبعاد إدارة الجودة الشاملة وتقييم الأداء، كما سجلت القيادة الإدارية أقوى علاقة بتقييم الأداء، تلاها التخطيط الاستراتيجي ثم التدريب، وظهرت فروق بين الفئات الوظيفية في تصورات بعض الأبعاد وممارسات تقييم الأداء. وخلصت الدراسة إلى أن تعزيز القيادة الإدارية، وربط التخطيط الاستراتيجي بمؤشرات الأداء، وتطوير التدريب المستمر يمكن أن يدعم عدالة وشفافية وفاعلية أنظمة تقييم الأداء في المؤسسات الصحية العامة، مع ضرورة توجيه تدخلات عملية للطواقم الفنية والمساندة التي أظهرت مستويات رضا أقل.

الكلمات المفتاحية: إدارة الجودة الشاملة؛ القيادة الإدارية؛ التخطيط الاستراتيجي؛ التدريب؛ تقييم أداء الموارد البشرية؛ الرعاية الصحية العامة.

Introduction

Total Quality Management (TQM) has become one of the most influential managerial approaches adopted by healthcare organizations to improve service quality, organizational efficiency, and workforce performance. The concept of TQM emphasizes continuous improvement, customer satisfaction, evidence-based decision-making, employee involvement, and leadership commitment as essential components for achieving sustainable organizational excellence. Within healthcare systems, the implementation of TQM principles has been associated with improved patient safety, higher service quality, enhanced employee performance, and increased institutional effectiveness (Mosadeghrad, 2014; World Health Organization et al., 2018).

Healthcare organizations operate in highly complex and resource-constrained environments that require effective managerial and strategic practices to maintain service quality and operational sustainability. In this context, administrative leadership plays a critical role in promoting quality culture, facilitating communication, supporting employee engagement, and guiding organizational change. Previous studies have demonstrated that leadership commitment is a fundamental determinant of successful TQM implementation and improved organizational outcomes in healthcare institutions (Talib et al., 2011; Zhao et al., 2024).

Strategic planning is another central dimension of TQM, as it enables healthcare organizations to align institutional goals with available resources and emerging healthcare challenges. Effective strategic planning contributes to organizational adaptability, performance improvement, and long-term sustainability by ensuring clear objectives and systematic evaluation processes. Empirical evidence indicates that healthcare institutions with effective strategic planning mechanisms tend to achieve better organizational performance and service quality outcomes (Wongsin et al., 2025).

Training and continuous professional development are also considered essential elements of quality management systems. Healthcare employees require ongoing training to enhance their technical, managerial, and communication competencies in rapidly evolving healthcare environments. Continuous training programs have been linked to improved employee productivity, greater adherence to quality standards, and enhanced organizational performance (World Health Organization, 2022; Giovanelli et al., 2019).

Performance evaluation systems represent a critical managerial tool for assessing employee effectiveness, identifying professional development needs, and aligning workforce performance with organizational objectives. Effective performance appraisal systems contribute to accountability, motivation, transparency, and continuous quality improvement within healthcare organizations. Previous literature suggests that integrating TQM principles into performance evaluation systems can significantly strengthen institutional effectiveness and employee engagement (van Elten & van der Kolk, 2020).

Despite the growing interest in TQM implementation in healthcare settings, limited studies have explored the relationship between administrative leadership, strategic planning, training, and performance evaluation within public healthcare institutions operating under fragile and resource-limited conditions such as the Gaza Strip. Understanding these relationships is essential for strengthening healthcare workforce management and improving institutional performance. Therefore, this study aims to examine the relationship between the administrative, strategic, and training dimensions of Total Quality Management and performance evaluation in public healthcare facilities affiliated with the Ministry of Health in the Gaza Strip.

Conceptual Framework

Total Quality Management (TQM) provides the theoretical foundation for the conceptual framework of this study. It views quality as a shared organizational responsibility that requires the integration of leadership, strategic planning, training, performance measurement, and continuous improvement. de Kok et al. (2023) explained that the learning and improvement capacity of healthcare organizations is associated with supportive leadership, an open organizational culture, and clear mechanisms for performance monitoring. Endalamaw et al. (2024) further indicated that the success of continuous quality improvement initiatives depends on clear objectives, employee participation, and effective monitoring and evaluation systems. Recent evidence also suggests that the systematic application of TQM can improve employee efficiency and enhance indicators of healthcare quality and safety (Shi, 2025).

The proposed framework is also informed by structural empowerment theory and self-determination theory. Structural empowerment theory assumes that employees perform more effectively when they have access to information, resources, professional development opportunities, and managerial support. Lundin et al. (2024) found that access to organizational information, support, and resources was associated with improved staff well-being and quality of care in hospital settings. Self-determination theory, meanwhile, suggests that performance evaluation systems are more likely to be accepted when they support employees' sense of competence and professional autonomy rather than functioning solely as control mechanisms. The use of accurate, relevant, and verifiable performance indicators can therefore strengthen trust in performance management systems and reduce perceptions of unfairness (van Elten & van der Kolk, 2025).

Administrative leadership represents the first independent variable in the proposed model because it shapes the way organizational policies are communicated, resources are allocated, employees are involved in decision-making, and performance standards are implemented. Effective leadership extends beyond issuing instructions; it includes clarifying expectations, listening to employees, supporting innovation, and creating an environment that encourages learning and improvement. Zhao et al. (2024) discovered that support for resources and a supportive environment was associated with increased satisfaction for health care providers. In this regard, the present study hypothesizes that good administrative leadership will lead to better evaluation criterion clarity, enhanced procedural fairness, higher employee participation, and increased confidence in performance appraisal processes.

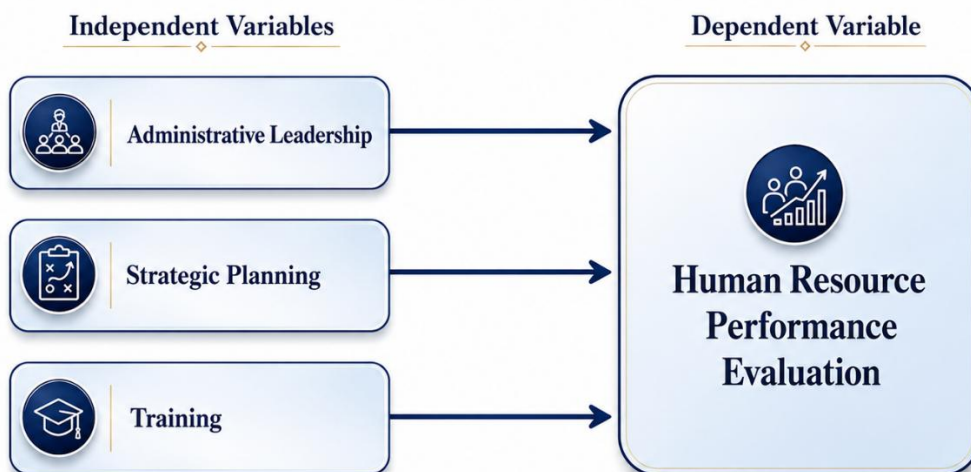
Strategic planning constitutes the second independent variable. It enables healthcare organizations to translate their missions and long-term priorities into operational objectives, measurable indicators, clearly assigned responsibilities, and appropriate resource allocations. Wongsin et al. (2025) concluded that strategic planning facilitates the success of organizations in the field of public health only if it is done in conjunction with human resource development, allocation of resources, performance indicators, and evaluation systems. With well-formulated strategic objectives, there are specific criteria that enable the organization to define what the staff is supposed to accomplish and evaluate their performance. Strategic planning will thus help avoid the subjectivity of evaluation of staff members.

Training represents the third independent variable in the conceptual framework because it develops the technical, interpersonal, and managerial competencies required for effective healthcare

performance. Ravaghi et al. (2021) reported that training programs designed for hospital managers improved competencies in leadership, planning, communication, supervision, teamwork, monitoring, evaluation, and quality improvement. Giovanelli et al. (2024) Additionally, they have shown that the success of health care training is dependent on how relevant it is in terms of professional development needs, prior experience, management duties, and application of the gained knowledge in the workplace. It follows that continual training will allow the staff members to learn about performance requirements and help their supervisors detect any performance gaps.

Human resource performance evaluation will be considered as the dependent variable in the current study. Human resource performance evaluation may be defined as the process that organizations follow to measure and evaluate the performance of employees, their strong and weak points, training needs, and promotions. Pomaranik and Kludacz-Alessandri (2024) found that formal practices related to employee development, talent management, and performance evaluation were positively associated with employee performance in the public healthcare sector. However, the effectiveness of appraisal systems depends not only on the use of forms or numerical scores but also on the presence of clear standards, reliable measures, employee participation, and practical feedback. The quality and credibility of performance indicators are particularly important for strengthening employee trust in evaluation outcomes (van Elten & van der Kolk, 2025).

Figure 1. Conceptual Framework of the Study



Based on the proposed conceptual framework and previous empirical evidence, the following hypotheses were formulated.

Study Hypotheses

H1: Administrative leadership has a statistically significant positive relationship with human resource performance evaluation in public healthcare facilities in the Gaza Strip at $\alpha \leq 0.05$

H2: Strategic planning has a statistically significant positive relationship with human resource performance evaluation in public healthcare facilities in the Gaza Strip at $\alpha \leq 0.05$

H3: Training has a statistically significant positive relationship with human resource performance evaluation in public healthcare facilities in the Gaza Strip at $\alpha \leq 0.05$.

H4: Administrative leadership, strategic planning, and training jointly make a statistically significant contribution to predicting human resource performance evaluation in public healthcare facilities in the Gaza Strip at $\alpha \leq 0.05$.

Methodology

Study design:

This study used a descriptive–analytical cross-sectional design to investigate the association between the administrative, strategic, and training components of total quality management and performance evaluation within public healthcare facilities in the Gaza Strip.

Study setting and period:

The present study was conducted between December 14, 2024 and February 20, 2025 in public healthcare institutions under the Ministry of Health in the Gaza Strip.

Study Population

The study population consisted of all healthcare providers included in the investigation. The target population comprised all employees working at the Ministry of Health in the Gaza Strip, with an estimated total of approximately 9,270 staff members (MOH, 2024).

Eligible participants included all Ministry of Health employees involved in administrative, clinical, or support roles who had at least six months of experience in their current positions. Employees who were on long-term leave during the data collection period, as well as interns, trainees, and volunteers not formally employed by the Ministry, were excluded. In addition, staff members who refused to participate or failed to complete the questionnaire were not included in the study.

Data collection

Data were collected using a structured, interview-based questionnaire developed by the researcher following an extensive review of relevant literature and previous studies on TQM and human resource performance evaluation in healthcare settings. The questionnaire was administered electronically through Google Forms. The instrument was designed in line with the objectives of the current study. Its construction was guided by established research addressing core TQM dimensions such as administrative leadership, strategic planning, training, and performance evaluation within healthcare and organizational contexts.

The questionnaire included two sections. The first gathered participants' sociodemographic and occupational characteristics, including gender, age, educational level, years of experience, supervisory role, and job category. The second section assessed the main study variables through four domains: administrative leadership, strategic planning, training, and human resource performance evaluation. All items in this section were rated on a five-point Likert scale (1–5), where 1 indicated "strongly disagree" and 5 indicated "strongly agree." Domain scores were calculated by summing or averaging the item responses, with higher scores reflecting greater perceived implementation or effectiveness of the corresponding TQM dimensions and performance evaluation practices.

Validity and reliability

Content validity was established by submitting the questionnaire to a panel of experts in healthcare management, business administration, and research methodology. The experts reviewed the relevance, clarity, and appropriateness of the items in relation to the study objectives and variables.

Their comments were used to revise the wording of several items and improve the overall structure of the instrument.

Construct validity was examined using corrected item–total correlations. Each item was correlated with the total score of its corresponding domain after excluding that item from the domain score. All correlations were positive and statistically significant at $p < 0.001$. The corrected item–total correlations ranged from 0.485 to 0.814 for training, from 0.464 to 0.726 for administrative leadership, from 0.589 to 0.743 for strategic planning, and from 0.410 to 0.829 for human resource performance evaluation. These results indicate that the items were adequately related to their intended constructs.

Further evidence of construct validity was obtained by correlating each domain score with the overall questionnaire score. The correlations were statistically significant and reached 0.899 for training, 0.917 for administrative leadership, 0.877 for strategic planning, and 0.890 for human resource performance evaluation. These findings support the internal construct validity of the questionnaire.

The internal consistency reliability of the instrument was assessed using Cronbach's alpha. The coefficients were 0.896 for training, 0.867 for administrative leadership, 0.881 for strategic planning, and 0.900 for human resource performance evaluation. Cronbach's alpha for the overall instrument was 0.960. All coefficients exceeded the recommended threshold of 0.70, indicating a high level of internal consistency.

Table1: Construct Validity and Reliability of the Study Instrument

Domain	Number of items	Corrected item–total correlation range	Cronbach's alpha
Training	7	0.485–0.814	0.896
Administrative leadership	7	0.464–0.726	0.867
Strategic planning	7	0.589–0.743	0.881
Human resource performance evaluation	10	0.410–0.829	0.900
Overall instrument	31	—	0.960

Pilot study

A pilot study was carried out on 20 employees before the commencement of the main data collection to evaluate the clarity, comprehensibility, and practicality of the questionnaire items. Participants were selected from the target population and represented various professional categories within the healthcare sector. Based on the feedback obtained, minor revisions were made to the wording and structure of several items to enhance clarity and coherence. Individuals who participated in the pilot study were not included in the final analysis.

Statistical analysis

Data were coded and analyzed using the Statistical Package for the Social Sciences (SPSS), version 25. Frequencies and percentages were used to describe participants' sociodemographic and occupational characteristics, while means and standard deviations were calculated for the study

domains. The internal consistency of the questionnaire was assessed using Cronbach's alpha, and construct validity was examined through corrected item-total correlations.

Chi-square tests were used only to examine differences in response distributions across job categories. The relationships between administrative leadership, strategic planning, training, and human resource performance evaluation were examined using Pearson's correlation coefficients after calculating the mean score of each domain from the original five-point Likert-scale responses. Multiple linear regression analysis was conducted with human resource performance evaluation as the dependent variable and administrative leadership, strategic planning, and training as the independent variables. The analysis assessed the combined explanatory power of the model and the relative contribution of each independent variable. Regression assumptions, including linearity, normality of residuals, homoscedasticity, independence of errors, and absence of multicollinearity, were examined before interpreting the model. Statistical significance was determined at $p < 0.05$, and all tests were two-tailed.

Ethical considerations

Ethical approval for the study was obtained from the Ministry of Health in the Gaza Strip (Approval No. 24665442, dated 26/11/2024). Prior to participation, informed consent was obtained from all respondents through a consent form included at the beginning of the electronic questionnaire. Participants were provided with clear information regarding the purpose of the study, voluntary nature of participation, and their right to withdraw at any time without any consequences. Confidentiality and anonymity were strictly maintained throughout the study. No identifying personal information was collected, and all responses were used solely for research purposes. Data were securely stored and accessed only by the researcher to ensure privacy and protection of participants' information.

Results

Table 1 presents the main sociodemographic characteristics of the participants (N = 369). The sample was predominantly male (65.9%) and mainly aged 30–45 years (55.6%). Most participants were married (88.1%) and held a bachelor's degree (59.3%). Nearly half of the respondents had 11–20 years of work experience (44.7%), and more than half reported having no supervisory position (53.9%). In terms of job distribution, the largest group was nursing and allied health staff (41.4%), followed by administrative staff (34.7%), medical staff (15.2%), and technical and support staff (8.7%).

Table2: Distribution of sociodemographic characteristics

Variables	Frequency (N =369)	Percent (100%)
Gender		
Males	243	65.9
Females	126	34.1
Age		
Less than 30 years	58	15.7

30-45 years	205	55.6
More than 45 years	106	28.7
Marital status		
Single	44	11.9
Marred	325	88.1
qualification		
Diploma or lower	47	12.7
Bachelor's	219	59.3
Master's	77	20.9
PhD	26	7.1
Years of service		
1-10 Years	131	35.5
11-20 Years	165	44.7
21 and more	73	19.8
Supervisory title		
None	199	53.9
Section head	38	10.3
Department head	82	22.2
Director	39	10.6
General director	11	3.1
Job title		
Administrative	128	34.7
Medical (physicians & dentists)	56	15.2
Nursing & allied health	153	41.4
Technical & support	32	8.7

Table 2 presents participants' responses regarding the training dimension across different job categories. About, 53.9% of respondents reported positive perceptions of training, while 46.1% reported neutral or negative responses, with a statistically significant difference across job

categories ($p = 0.001$). Significant differences were observed across all training-related dimensions. These included the alignment of training with job performance ($p = 0.046$), management support for training programs ($p = 0.001$), availability of opportunities for workshops and advanced courses ($p = 0.001$), and provision of learning resources for professional development ($p = 0.001$). Additional significant variations were found in the contribution of training to performance improvement ($p = 0.022$), employee involvement in selecting training programs ($p = 0.001$), and monitoring and evaluation of training effectiveness ($p = 0.041$). Nursing and allied health staff generally reported more favorable perceptions of training practices compared with other job categories, whereas technical and support staff showed comparatively lower positive responses in several dimensions.

Table3: Distribution of participants' responses to training domain across job categories

Variables	Total N=369	Administrat ive n=128 (34.7%)	Medical (physicians & dentists) n=56 (15.2%)	Nursing & allied health n=153 (41.4%)	Technical & support n= 32 (8.7%)	P Values
1. The training you receive is tailored to your job performance						
Strongly agree	30 (8.1)	8.0 (26.7)	6.0 (20.0)	16 (53.3)	0.0 (0.0)	0.046
Agree	183 (49.6)	64 (35.0)	22 (12.0)	84 (45.9)	13 (7.1)	
Neutral	109 (29.5)	43 (39.4)	14 (12.8)	39 (35.8)	13 (11.9)	
Disagree	37 (10.0)	10 (27.0)	11 (29.7)	12 (32.4)	4.0 (10.8)	
Strongly disagree	10 (2.7)	3.0 (30.0)	3.0 (30.0)	2.0 (20.0)	2.0 (20.0)	
2. Your management strongly supports employee training programs						
Strongly agree	39 (10.6)	16 (41.0)	1.0 (2.6)	22 (56.4)	0.0 (0.0)	0.001
Agree	203 (55.0)	60 (29.6)	42 (20.7)	92 (45.3)	9.0 (4.4)	
Neutral	67 (18.2)	35 (52.2)	6.0 (9.0)	15 (22.4)	11 (16.4)	
Disagree	44 (11.9)	8.0 (18.2)	5.0 (11.4)	22 (50.0)	9.0 (20.5)	
Strongly disagree	16 (4.3)	9.0 (56.2)	2.0 (12.5)	2.0 (12.5)	3.0 (18.8)	
3. Management provides opportunities to attend workshops or advanced training courses						
Strongly agree	38 (10.3)	13 (34.2)	3.0 (7.9)	22 (57.9)	0.0 (0.0)	0.001
Agree	182 (49.3)	56 (30.8)	32 (17.6)	82 (45.1)	12 (6.6)	
Neutral	87 (23.6)	38 (43.7)	12 (13.8)	29 (33.3)	8.0 (9.2)	
Disagree	38 (10.3)	9.0 (23.7)	5.0 (13.2)	18 (47.4)	6.0 (15.8)	
Strongly disagree	24 (6.5)	12 (50.0)	4.0 (16.7)	2.0 (8.3)	6.0 (25.0)	
4. Management provides you with learning resources to help you develop professionally						

Strongly agree	38 (10.3)	18 (47.4)	4.0 (10.5)	16 (42.1)	0.0 (0.0)	0.001
Agree	129 (35.0)	28 (21.7)	18 (14.0)	73 (56.6)	10 (7.8)	
Neutral	114 (30.7)	54 (47.4)	25 (21.9)	28 (24.6)	7.0 (6.1)	
Disagree	62 (16.8)	16 (25.8)	5.0 (8.1)	29 (46.8)	12 (19.4)	
Strongly disagree	26 (7.0)	12 (46.2)	4.0 (15.4)	7.0 (26.9)	3.0 (11.5)	
5. Management-provided training contributes to improving your professional performance						
Strongly agree	28 (7.6)	13 (46.4)	1.0 (3.6)	14 (50.0)	0.0 (0.0)	0.022
Agree	174 (47.2)	59 (33.9)	29 (16.7)	71 (40.8)	15 (8.6)	
Neutral	89 (24.1)	34 (38.2)	13 (14.6)	40 (44.9)	2.0 (2.2)	
Disagree	53 (14.4)	15 (28.3)	8.0 (15.1)	20 (37.7)	10 (18.9)	
Strongly disagree	25 (6.8)	7.0 (28.0)	5.0 (20.0)	8.0 (32.0)	5.0 (20.0)	
6. Management involves employees in selecting appropriate training programs						
Strongly agree	25 (6.8)	10 (40.0)	3.0 (12.0)	12 (48.0)	0.0 (0.0)	0.001
Agree	155 (42.0)	57 (36.8)	12 (7.7)	74 (47.7)	12 (7.7)	
Neutral	109 (29.5)	48 (44.0)	31 (28.4)	27 (24.8)	3.0 (2.8)	
Disagree	56 (15.2)	6.0 (10.7)	8.0 (14.3)	30 (53.6)	12 (21.4)	
Strongly disagree	24 (6.5)	7.0 (29.2)	2.0 (8.3)	10 (41.7)	5.0 (20.8)	
7. Management monitors and evaluates the impact of training on employee performance after course completion						
Strongly agree	23 (6.2)	14 (60.9)	1.0 (4.3)	8.0 (34.8)	0.0 (0.0)	0.041
Agree	145 (39.3)	50 (34.5)	19 (13.1)	67 (46.2)	9.0 (6.2)	
Neutral	115 (31.2)	38 (33.0)	20 (17.4)	45 (39.1)	12 (10.4)	
Disagree	68 (18.4)	20 (29.4)	14 (20.6)	23 (33.8)	11 (16.2)	
Strongly disagree	18 (4.9)	6.0 (33.3)	2.0 (11.1)	10 (55.6)	0.0 (0.0)	
Total scores of training domain						
Strongly agree and agree	199 (53.87)	66.5 (51.9)	27.5 (49.1)	93.3 (61.0)	11.4 (35.6)	0.001
Other responses	170 (46.12)	61.5 (48.1)	28.5 (50.9)	59.7 (39.0)	20.6 (62.5)	

Table 3 presents participants' responses regarding administrative leadership dimensions across job categories. About, 58.9% of respondents reported positive perceptions, while 41.0% reported neutral or negative responses, with a statistically significant difference across job categories ($p = 0.003$). Significant variations were observed across all administrative leadership dimensions. These included employee empowerment in resource use ($p = 0.020$), management as a model of excellence ($p = 0.004$), and consideration of staff morale in decision-making ($p = 0.001$). Additional significant differences were found in providing clear guidance for achieving work objectives ($p = 0.004$), valuing employee contributions ($p = 0.001$), encouraging idea sharing for quality improvement ($p = 0.003$), and addressing unintentional errors ($p = 0.022$). Nursing and allied health staff generally reported more positive perceptions of administrative leadership compared with other job categories, while medical and technical/support staff showed comparatively lower positive responses in several dimensions.

Table 4: Distribution of participants' responses to administrative leadership dimensions across job categories

Variables	Total 369	Administrative n=128 (34.7%)	Medical (physicians & dentists) n=56 (15.2%)	Nursing & allied health n=153 (41.4%)	Technical & support n= 32 (8.7%)	P Values
1. Management empowers employees to control the resources necessary to accomplish their tasks						
Strongly agree	22 (6.0)	15 (68.2)	1.0 (4.5)	6.0 (27.3)	0.0 (0.0)	0.020
Agree	145 (39.3)	50 (34.5)	19 (13.1)	67 (46.2)	9.0 (6.2)	
Neutral	114 (30.9)	37 (32.5)	20 (17.5)	45 (39.5)	12 (10.5)	
Disagree	70 (19.0)	20 (28.6)	14 (20.0)	25 (35.7)	11 (15.7)	
Strongly disagree	18 (4.9)	6.0 (33.3)	2.0 (11.1)	10 (55.6)	0.0 (0.0)	
2. The management of your workplace serves as a model of excellence						
Strongly agree	24 (6.5)	11 (45.8)	0.0 (0.0)	13 (54.2)	0.0 (0.0)	0.004
Agree	218 (59.1)	78 (35.8)	29 (13.3)	95 (43.6)	16 (7.3)	
Neutral	95 (25.7)	30 (31.6)	23 (24.2)	29 (30.5)	13 (13.7)	
Disagree	19 (5.1)	4.0 (21.1)	4.0 (21.1)	11 (57.9)	0.0 (0.0)	
Strongly disagree	13 (3.5)	5.0 (38.5)	0.0 (0.0)	5.0 (38.5)	3.0 (23.1)	
3. Management considers the impact of its decisions on your morale						
Strongly agree	12 (3.3)	10 (83.3)	0.0 (0.0)	2.0 (16.7)	0.0 (0.0)	0.001
Agree	139 (37.7)	43 (30.9)	11 (7.9)	75 (54.0)	10 (7.2)	
Neutral	136 (36.9)	46 (33.8)	31 (22.8)	52 (38.2)	7.0 (5.1)	
Disagree	60 (16.3)	21 (35.0)	8.0 (13.3)	20 (33.3)	11 (18.3)	

Strongly disagree	22 (6.0)	8.0(36.4)	6.0 (27.3)	4.0 (18.2)	4.0 (18.2)	
4. Management provides clear guidance to help you achieve work objectives						
Strongly agree	50 (13.6)	25 (50.0)	3.0 (6.0)	22 (44.0)	0.0 (0.0)	0.004
Agree	209 (56.6)	72 (34.4)	33 (15.8)	88 (42.1)	16 (7.7)	
Neutral	71 (19.2)	22 (31.0)	10 (14.1)	26 (36.6)	13 (18.3)	
Disagree	30 (8.1)	6.0 (20.0)	6.0 (20.0)	15 (50.0)	3.0 (10.0)	
Strongly disagree	9.0 (2.4)	3.0 (33.3)	4.0 (44.4)	2.0 (22.2)	0.0 (0.0)	
5. Management values your contributions and efforts						
Strongly agree	49 (13.3)	25 (51.0)	1.0 (2.0)	23 (46.9)	0.0 (0.0)	0.001
Agree	166 (45.0)	57 (34.3)	23 (13.9)	76 (45.8)	10 (6.0)	
Neutral	109 (29.5)	36 (33.0)	24 (22.0)	32 (29.4)	17 (15.6)	
Disagree	28 (7.6)	6.0 (21.4)	6.0 (21.4)	11 (39.3)	5.0 (17.9)	
Strongly disagree	17 (4.6)	4.0 (23.5)	2.0 (11.8)	11 (64.7)	0.0 (0.0)	
6. Management encourages you to submit ideas for improving work quality						
Strongly agree	33 (8.9)	19 (57.6)	1.0 (3.0)	13 (39.4)	0.0 (0.0)	0.003
Agree	194 (52.6)	71 (36.6)	24 (12.4)	86 (44.3)	13 (6.7)	
Neutral	104 (28.2)	29 (27.9)	23 (22.1)	38 (36.5)	14 (13.5)	
Disagree	26 (7.0)	6.0 (23.1)	4.0 (15.4)	11 (42.3)	5.0 (19.2)	
Strongly disagree	12 (3.3)	3.0 (25.0)	4.0 (33.3)	5.0 (41.7)	0.0 (0.0)	
7. Management addresses unintentional errors made by individuals						
Strongly agree	28 (7.6)	9.0 (32.1)	6.0 (21.4)	13 (46.4)	0.0 (0.0)	0.022
Agree	234 (63.4)	88 (37.6)	32 (13.7)	97 (41.5)	17 (7.3)	
Neutral	77 (20.9)	22 (28.6)	12 (15.6)	34 (44.2)	9.0 (11.7)	
Disagree	28 (7.6)	9.0 (32.1)	4.0 (14.3)	9.0 (32.1)	6.0 (21.4)	
Strongly disagree	2.0 (0.5)	0.0 (0.0)	2.0 (100.0)	0.0 (0.0)	0.0 (0.0)	
Total scores of administrative leadership domain						
Strongly agree and agree	218 (58.9)	81.8 (63.9)	26.3 (46.9)	95.6 (62.5)	13 (40.6)	0.003
Other responses	151 (41.0)	46.2 (36.0)	29.7 (53.1)	57.4 (37.5)	19 (59.4)	

Table 4 presents participants' responses regarding strategic planning dimensions across different job categories. Overall, 55.3% of respondents reported positive perceptions of strategic planning, while 44.7% reported neutral or negative responses, with a statistically significant difference across job categories ($p = 0.001$). Significant variations were observed across all strategic planning dimensions. These included understanding of the Ministry of Health's strategic objectives ($p = 0.007$), resource allocation for implementing strategic plans ($p = 0.001$), and the contribution of departmental strategic plans to improving work quality ($p = 0.002$). Additional significant differences were found in the inclusion of managerial skills development within strategic plans ($p = 0.001$), adaptability of the Ministry's plan to changing conditions in Gaza ($p = 0.001$), clarity of departmental strategic objectives ($p = 0.001$), and communication regarding progress toward strategic goals ($p = 0.001$). Nursing and allied health staff tended to report more favorable perceptions of strategic planning compared with other job categories, while technical and support staff showed relatively lower positive responses in several dimensions.

Table 5: Distribution of participants' responses to strategic planning dimensions across job categories

Variables	Total 369	Administrative n=128 (34.7%)	Medical (physicians & dentists) n=56 (15.2%)	Nursing & allied health n=153 (41.4%)	Technical & support n= 32 (8.7%)	P Values
1. I have a clear understanding of the Ministry of Health's strategic objectives						
Strongly agree	63 (17.1)	28 (44.4)	8.0 (12.7)	27 (42.9)	0.0 (0.0)	0.007
Agree	201 (54.5)	59 (29.4)	27 (13.4)	88 (43.8)	27 (13.4)	
Neutral	70 (19.0)	31 (44.3)	11 (15.7)	25 (35.7)	3.0 (4.3)	
Disagree	31 (8.4)	8.0 (25.8)	10 (32.3)	11 (35.5)	2.0 (6.5)	
Strongly disagree	4.0 (1.1)	2.0 (50.0)	0.0 (0.0)	2.0 (50.0)	0.0 (0.0)	
2. Your department allocates the necessary resources to implement the strategic plans						
Strongly agree	31 (8.4)	18 (58.1)	7.0 (22.6)	6.0 (19.4)	0.0 (0.0)	0.001
Agree	199 (53.9)	67 (33.7)	20 (10.1)	95 (47.7)	17 (8.5)	
Neutral	94 (25.5)	27 (28.7)	17 (18.1)	38 (40.4)	12 (12.8)	
Disagree	32 (8.7)	8.0 (25.0)	12 (37.5)	9.0 (28.1)	3.0 (9.4)	
Strongly disagree	13 (3.5)	8.0(61.5)	0.0 (0.0)	5.0 (38.5)	0.0 (0.0)	
3. The strategic plans developed by your department contribute to improving the quality of work						
Strongly agree	58 (15.7)	28 (48.3)	10 (17.2)	20 (34.5)	0.0 (0.0)	0.002
Agree	210 (56.9)	74 (35.2)	26 (12.4)	90 (42.9)	20 (9.5)	
Neutral	79 (21.4)	21 (26.6)	12 (15.2)	34 (43.0)	12 (15.2)	

Disagree	18 (4.9)	3.0 (16.7)	8.0 (44.4)	7.0 (38.9)	0.0 (0.0)	
Strongly disagree	4.0 (1.1)	2.0 (50.0)	0.0 (0.0)	2.0 (50.0)	0.0 (0.0)	
4. Your department's strategic plan includes provisions for developing your managerial skills						
Strongly agree	42 (11.4)	21 (50.0)	6.0 (14.3)	15 (35.7)	0.0 (0.0)	
Agree	204 (55.3)	69 (33.8)	29 (14.2)	92 (45.1)	14 (6.9)	
Neutral	82 (22.2)	28 (34.1)	11 (13.4)	35 (42.7)	8.0 (9.8)	0.001
Disagree	37 (10.0)	8.0 (21.6)	10 (27.0)	9.0 (24.3)	10 (27.0)	
Strongly disagree	4.0 (1.1)	2.0 (50.0)	0.0 (0.0)	2.0 (50.0)	0.0 (0.0)	
5. The Ministry's plan is appropriate for the changing circumstances we are experiencing in the Gaza Strip						
Strongly agree	25 (6.8)	13 (52.0)	0.0 (0.0)	12 (48.0)	0.0 (0.0)	
Agree	167 (45.3)	54 (32.3)	33 (19.8)	68 (40.7)	12 (7.2)	
Neutral	94 (25.5)	39 (41.5)	6.0 (6.4)	41 (43.6)	8.0 (8.5)	0.001
Disagree	60 (16.3)	17 (28.3)	11 (18.3)	29 (48.3)	3.0 (5.0)	
Strongly disagree	23 (6.1)	5.0 (21.7)	6.0 (26.1)	3.0 (13.0)	9.0 (39.1)	
6. The strategic objectives of your department's plan are clear						
Strongly agree	33 (8.9)	19 (57.6)	2.0 (6.1)	12 (36.4)	0.0 (0.0)	
Agree	201 (54.5)	65 (32.3)	21 (10.4)	98 (48.8)	17 (8.5)	
Neutral	100 (27.1)	34 (34.0)	24 (24.0)	35 (35.0)	7.0 (7.0)	0.001
Disagree	20 (5.4)	4.0 (20.0)	5.0 (25.0)	6.0 (30.0)	5.0 (25.0)	
Strongly disagree	15 (4.1)	6.0 (40.0)	4.0 (26.7)	2.0 (13.3)	3.0 (20.0)	
7. The department keeps you informed of the progress made in achieving the strategic plan's objectives						
Strongly agree	33 (8.9)	19 (57.6)	4.0 (12.1)	10 (30.3)	0.0 (0.0)	
Agree	212 (57.5)	63 (29.7)	31 (14.6)	104 (49.1)	14 (6.6)	
Neutral	81 (22.0)	40 (49.4)	9.0 (11.1)	29 (35.8)	3.0 (3.7)	0.001
Disagree	26 (7.0)	3.0 (11.5)	7.0 (26.9)	7.0 (26.9)	9.0 (34.6)	
Strongly disagree	17 (4.6)	3.0 (17.6)	5.0 (29.4)	3.0 (17.6)	6.0 (35.3)	
Total scores of strategic planning domain						
Strongly agree and agree	205 (55.3)	85.3 (66.6)	32 (57.1)	105.3 (68.8)	17.3 (54.0)	0.001

Other responses	164 (44.7)	42.7 (33.4)	24 (42.9)	47.7 (31.2)	14.7 (46.0)	
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Figure 1 shows that administrative leadership received the highest overall agreement (59%), followed by strategic planning (55%) and training (54%). Nursing and allied health staff reported the highest agreement across all domains, particularly for strategic planning (68%). Administrative staff also demonstrated high agreement levels, while technical and support staff showed the lowest agreement, especially for training (34%). Medical staff reported moderate agreement, with strategic planning rated higher than the other domains. These findings suggest that perceptions of organizational performance differ by staff category, with stronger positive responses observed among nursing and administrative personnel, while technical and support staff may require additional engagement and support, particularly in training-related areas.

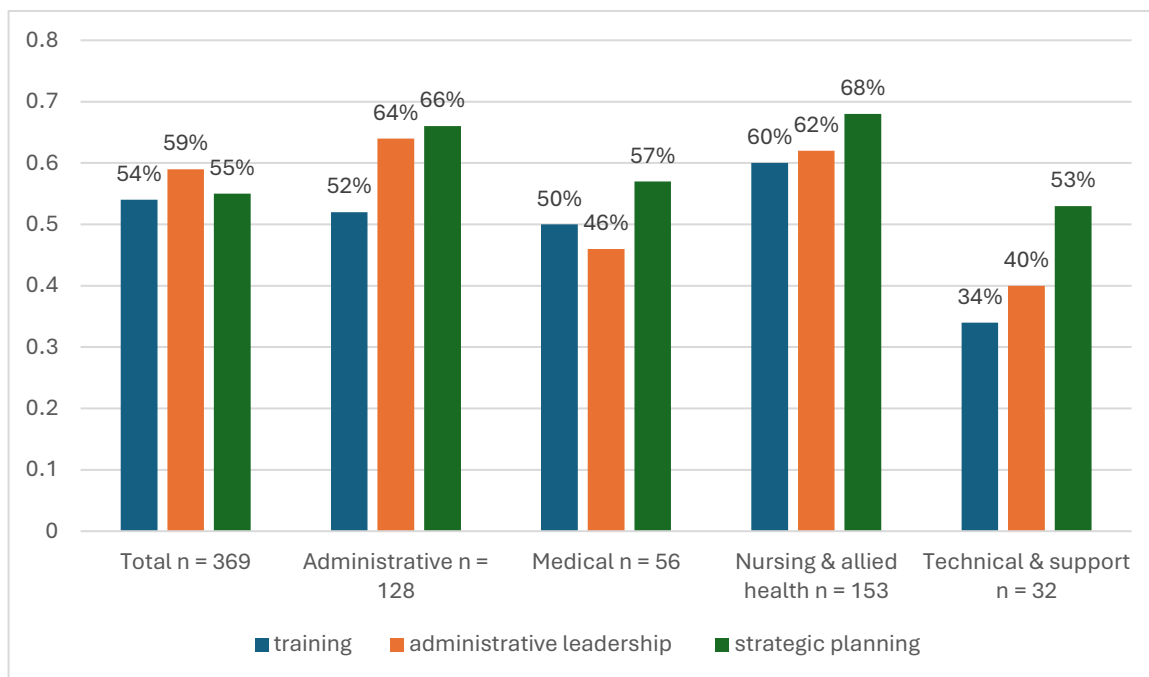


Figure 2. Distribution of percentage of agreement responses by staff category

Table 5 presents participants' perceptions of performance evaluation dimensions across different job categories. Overall, 57.3% of respondents reported positive perceptions, while 42.7% reported neutral or negative views, with a statistically significant difference across job categories ($p = 0.004$). Significant variations were found in several dimensions. These included clarity of appraisal criteria ($p = 0.040$), the contribution of the work environment to achieving service objectives ($p = 0.001$), feedback after performance appraisal ($p = 0.001$), and managerial discussion of appraisal results ($p = 0.023$). Differences were also significant for inclusion of technical performance criteria ($p = 0.001$), fairness of promotion and reward decisions based on appraisal results ($p = 0.001$), responsiveness to complaints about the appraisal process ($p = 0.001$), and follow-up on appraisal outcomes ($p = 0.010$). In contrast, no statistically significant differences were observed for measurability and achievability of performance objectives ($p = 0.072$) and inclusion of managerial performance criteria

($p = 0.138$). Nursing and allied health staff generally reported more favorable perceptions across most performance evaluation dimensions, while technical and support staff showed relatively less positive perceptions in several areas.

Table 6: Distribution of participants' responses to performance evaluation dimensions across job categories

Variables	Total 369	Administrative n=128 (34.7%)	Medical (physicians & dentists) n=56 (15.2%)	Nursing & allied health n=153 (41.4%)	Technical & support n= 32 (8.7%)	P Values
1. The performance appraisal criteria are clear						
Strongly agree	22 (6.0)	10 (45.5)	2.0 (9.1)	10 (45.5)	0.0 (0.0)	0.040
Agree	221 (59.9)	82 (37.1)	32 (14.5)	92 (41.6)	15 (6.8)	
Neutral	90 (24.4)	21 (23.3)	20 (22.2)	37 (41.1)	12 (13.3)	
Disagree	29 (7.9)	13 (44.8)	2.0 (6.9)	9.0 (31.0)	5.0 (17.2)	
Strongly disagree	7.0 (1.9)	2.0 (28.6)	0.0 (0.0)	5.0 (71.4)	0.0 (0.0)	
2. Performance objectives are measurable and achievable						
Strongly agree	32 (8.7)	18 (56.2)	1.0 (3.1)	13 (40.6)	0.0 (0.0)	0.072
Agree	220 (59.6)	72 (32.7)	34 (15.5)	96 (43.6)	18 (8.2)	
Neutral	87 (23.6)	30 (34.5)	18 (20.7)	30 (34.5)	9.0 (10.3)	
Disagree	26 (7.0)	6.0 (23.1)	3.0 (11.5)	12 (46.2)	5.0 (19.2)	
Strongly disagree	4.0 (1.1)	2.0 (50.0)	0.0 (0.0)	2.0 (50.0)	0.0 (0.0)	
3. The work environment helps achieve service objectives effectively						
Strongly agree	38 (10.3)	20 (52.6)	1.0 (2.6)	17 (44.7)	0.0 (0.0)	0.001
Agree	167 (45.3)	52 (31.1)	30 (18.0)	68 (40.7)	17 (10.2)	
Neutral	126 (34.1)	39 (31.0)	23 (18.3)	56 (44.4)	8.0 (6.3)	
Disagree	28 (7.6)	15 (53.6)	2.0 (7.1)	9.0 (32.1)	2.0 (7.1)	
Strongly disagree	10 (2.7)	2.0 (20.0)	0.0 (0.0)	3.0 (30.0)	5.0 (50.0)	
4. I receive clear feedback on my performance after each appraisal						
Strongly agree	25 (6.8)	6.0 (24.0)	10 (40.0)	9.0 (36.0)	0.0 (0.0)	0.001
Agree	155 (42.0)	54 (34.8)	12 (7.7)	77 (49.7)	12 (7.7)	

Neutral	95 (25.7)	35 (36.8)	18 (18.9)	37 (38.9)	5.0 (5.3)	
Disagree	75 (20.3)	28 (37.3)	11 (14.7)	27 (36.0)	9.0 (12.0)	
Strongly disagree	19 (5.1)	5.0 (26.3)	5.0 (26.3)	3.0 (15.8)	6.0 (31.6)	
5. My manager discusses the results of my performance appraisal with me						
Strongly agree	34 (9.2)	12 (35.3)	7.0 (20.6)	15 (44.1)	0.0 (0.0)	0.023
Agree	145 (39.3)	48 (33.1)	19 (13.1)	68 (46.9)	10 (6.9)	
Neutral	75 (20.3)	34 (45.3)	8.0 (10.7)	28 (37.3)	5.0 (6.7)	
Disagree	84 (22.8)	23 (27.4)	19 (22.6)	32 (38.1)	10 (11.9)	
Strongly disagree	31 (8.4)	11 (35.5)	3.0 (9.7)	10 (32.3)	7.0 (22.6)	
6. The performance appraisal includes criteria related to managerial performance aspects of the job						
Strongly agree	28 (7.6)	9.0 (32.1)	4.0 (14.3)	15 (53.6)	0.0 (0.0)	0.138
Agree	227 (61.5)	86 (37.9)	25 (11.0)	94 (41.4)	22 (9.7)	
Neutral	68 (18.4)	22 (32.4)	16 (23.5)	25 (36.8)	5.0 (7.4)	
Disagree	39 (10.6)	8.0 (20.5)	9.0 (23.1)	17 (43.6)	5.0 (12.8)	
Strongly disagree	7.0 (1.9)	3.0 (42.9)	2.0 (28.6)	2.0 (28.6)	0.0 (0.0)	
7. The performance appraisal includes criteria related to technical performance aspects of the job						
Strongly agree	17 (4.6)	4.0 (23.5)	3.0 (17.6)	10 (58.8)	0.0 (0.0)	0.001
Agree	247 (66.9)	77 (31.2)	29 (11.7)	117 (47.4)	24 (9.7)	
Neutral	59 (16.0)	35 (59.3)	12 (20.3)	9.0 (15.3)	3.0 (5.1)	
Disagree	33 (8.9)	6.0 (18.2)	10 (30.3)	12 (36.4)	5.0 (15.2)	
Strongly disagree	13 (3.5)	6.0 (46.2)	2.0 (15.4)	5.0 (38.5)	0.0 (0.0)	
8. Promotion and reward decisions are based on the results of your performance appraisal						
Strongly agree	34 (9.2)	8.0 (23.5)	1.0 (2.9)	25 (73.5)	0.0 (0.0)	0.001
Agree	147 (39.8)	64 (43.5)	17 (11.6)	51 (34.7)	15 (10.2)	
Neutral	91 (24.7)	21 (23.1)	19 (20.9)	44 (48.4)	7.0 (7.7)	
Disagree	55 (14.9)	27 (49.1)	10 (18.2)	16 (29.1)	2.0 (3.6)	
Strongly disagree	42 (11.4)	8.0 (19.0)	9.0 (21.4)	17 (40.5)	8.0 (19.0)	
9. Management responds to your complaints about the appraisal process						
Strongly agree	19 (5.1)	1.0 (5.3)	7.0 (36.8)	11 (57.9)	0.0 (0.0)	0.001
Agree	152 (41.2)	54 (35.5)	11 (7.2)	73 (48.0)	14 (9.2)	

Neutral	118 (32.0)	45 (38.1)	19 (16.1)	45 (38.1)	9.0 (7.6)	
Disagree	56 (15.2)	20 (35.7)	16 (28.6)	14 (25.0)	6.0 (10.7)	
Strongly disagree	24 (6.5)	8.0 (33.3)	3.0 (12.5)	10 (41.7)	3.0 (12.5)	
10. Management follows up on your appraisal results and uses them to improve your performance						
Strongly agree	27 (7.3)	9.0 (33.3)	3.0 (11.1)	15 (55.6)	0.0 (0.0)	0.010
Agree	158 (42.8)	51 (32.3)	16 (10.1)	79 (50.0)	12 (7.6)	
Neutral	100 (27.1)	40 (40.0)	18 (18.0)	33 (33.0)	9.0 (9.0)	
Disagree	57 (15.4)	15 (26.3)	16 (28.1)	18 (31.6)	8.0 (14.0)	
Strongly disagree	27 (7.3)	13 (48.1)	3.0 (11.1)	8.0 (29.6)	3.0 (11.1)	
Total scores of performance evaluation domain						
Strongly agree and agree	212 (57.3)	73.7 (57.5)	26.4 (47.1)	87.1 (56.9)	15.9 (49.6)	0.004
Other responses	157 (42.7)	54.3 (42.5)	29.6 (52.9)	65.9 (43.1)	16.1 (50.4)	

Correlation Analysis

Pearson's correlation analysis was conducted using the mean scores calculated from the original five-point Likert-scale items. As shown in Table 6, administrative leadership, strategic planning, and training were positively and significantly correlated with human resource performance evaluation. Administrative leadership demonstrated the strongest correlation with performance evaluation ($r=0.772$, $p<0.001$), followed by strategic planning ($r=0.727$, $p<0.001$) and training ($r=0.698$, $p<0.001$). These findings support the first three study hypotheses and indicate that more favorable perceptions of the examined TQM dimensions were associated with more favorable perceptions of performance evaluation practices.

Table 7. Descriptive Statistics and Pearson Correlations among the Study Variables

Variable	Mean	SD	1	2	3	4
1. Administrative leadership	3.501	0.666	1			
2. Strategic planning	3.612	0.681	0.728***	1		
3. Training	3.375	0.785	0.795***	0.698***	1	
4. Human resource performance evaluation	3.418	0.695	0.772***	0.727***	0.698***	1

Note: $N=369$. Higher scores indicate more favorable perceptions.

* $p<0.001$, two-tailed.

Multiple Regression Analysis

A multiple linear regression analysis was conducted to determine the combined and relative contributions of administrative leadership, strategic planning, and training to human resource

performance evaluation. The overall regression model was statistically significant, $F(3,365)=235.704$, $p<0.001$, and explained approximately 66.0% of the variance in performance evaluation ($R^2=0.660$, adjusted $R^2=0.657$).

Administrative leadership made the strongest unique contribution to the model ($\beta=0.439$, $p<0.001$), followed by strategic planning ($\beta=0.319$, $p<0.001$). Training also made a smaller but statistically significant contribution ($\beta=0.126$, $p=0.017$). The variance inflation factor values ranged from 2.319 to 3.232, indicating that multicollinearity did not reach a problematic level. Therefore, the fourth hypothesis was supported.

Table 7. Multiple Regression Predicting Human Resource Performance Evaluation

Predictor	B	SE	Standardized β	t	p-value	95% CI for B	Tolerance	VIF
Constant	0.259	0.123	—	2.112	0.035	0.018–0.501	—	—
Administrative leadership	0.458	0.057	0.439	7.998	<0.001	0.345–0.571	0.309	3.232
Strategic planning	0.326	0.047	0.319	6.867	<0.001	0.233–0.419	0.431	2.319
Training	0.112	0.047	0.126	2.403	0.017	0.020–0.203	0.338	2.962

Model summary: $R=0.812$, $R^2=0.660$, adjusted $R^2=0.657$, standard error of the estimate =0.407, $F(3,365)=235.704$, $p<0.001$.

Hypothesis Testing Summary

Hypothesis	Statistical result	Decision
H1: Administrative leadership is positively related to performance evaluation.	$r=0.772$, $\beta=0.439$, $p<0.001$	Supported
H2: Strategic planning is positively related to performance evaluation.	$r=0.727$, $\beta=0.319$, $p<0.001$	Supported
H3: Training is positively related to performance evaluation.	$r=0.698$, $\beta=0.126$, $p=0.017$	Supported
H4: The three dimensions jointly predict performance evaluation.	$R^2=0.660$, $F=235.704$, $p<0.001$	Supported

Discussion

The present study found that administrative leadership, strategic planning, and training were positively and significantly associated with human resource performance evaluation in public healthcare facilities in the Gaza Strip. Together, the three dimensions explained 66.0% of the variance in performance evaluation, indicating that appraisal practices are closely connected with

the broader managerial environment of healthcare institutions. This finding supports the view that Total Quality Management should be implemented as an integrated system involving leadership, planning, staff development, performance monitoring, and continuous improvement. Shi (2025) similarly found that systematic TQM implementation improved staff efficiency and different indicators of healthcare quality. Endalamaw et al. (2024) also emphasized that continuous quality improvement depends on leadership support, workforce participation, clear objectives, and effective monitoring systems.

Administrative leadership was the strongest correlate and the most influential predictor of performance evaluation. This suggests that employees are more likely to perceive appraisal systems as fair and effective when managers clarify expectations, provide appropriate resources, involve staff in decisions, recognize employee contributions, and discuss evaluation results constructively. Zhao et al. (2024) found that leadership support, resource provision, and a supportive work environment were associated with greater satisfaction among healthcare professionals. Wu et al. (2024) further highlighted the importance of transformational, authentic, and ethical leadership for staff and organizational outcomes in healthcare. In addition, Andargie et al. (2024) reported that effective healthcare leadership was associated with managerial training, organizational communication, experience sharing, and managerial experience.

Strategic planning was the second strongest predictor of performance evaluation. Clear strategic priorities can provide an objective foundation for appraisal by translating institutional goals into measurable responsibilities and performance indicators. Employees who understand their department's objectives are more likely to recognize how their individual performance contributes to service quality and organizational outcomes. Wongsin et al. (2025) concluded that strategic planning is linked with organizational performance when it is integrated with resource allocation, human resource development, performance indicators, and evaluation mechanisms. Singh and Conley (2023) also showed that hospital strategic plans can formalize institutional priorities and identify the initiatives required to achieve them. These findings suggest that appraisal criteria should be derived from clearly communicated strategic and departmental objectives.

Training remained a statistically significant predictor of performance evaluation, although its unique contribution was smaller than those of leadership and strategic planning. This may be because training is often planned, supported, and evaluated through administrative and strategic processes. Ravaghi et al. (2021) found that educational programs improved hospital managers' knowledge and competencies in leadership, planning, communication, monitoring, evaluation, and quality improvement. Giovanelli et al. (2024) indicated that training effectiveness depends on participants' professional needs, previous competencies, managerial responsibilities, and opportunities to apply learning in practice. Park et al. (2023) further demonstrated that training outcomes depend on the successful transfer of acquired knowledge and skills to the workplace. Therefore, training should be linked directly to identified performance gaps, job requirements, post-training follow-up, and subsequent appraisal results.

The differences observed across job categories indicate that employees do not experience leadership, training, planning, and performance evaluation in the same way. Technical and support staff reported less favorable perceptions in several areas, suggesting possible differences in access to development opportunities, managerial communication, recognition, and involvement in appraisal discussions. Pomaranik and Kludacz-Alessandri (2024) found that employee development and talent-management practices were associated with performance in public healthcare institutions. Bilotta et al. (2022) also showed that fairness perceptions influence both employee and organizational outcomes, particularly when employees are able to express their views. Moreover,

van Elten and van der Kolk (2025) stressed that the quality of performance measurement tools in terms of accuracy and relevance increases confidence in health-care performance management system. Therefore, performance appraisal process must make use of job-related standards, offer feedback, involve discussion of results between employee and his/her supervisor, as well as pay more attention to technical and support staff. Being cross-sectional in nature, the findings show strong correlation and prediction, but no causality.

Practical Recommendations

Recommendations that can be made based on the results of the conducted research are as follows for those who make decisions at the Palestinian Ministry of Health:

1. Make leadership accountable by making managers hold appraisal discussion with their subordinates individually, issue them with written developmental feedback and record the actions they undertake as a result of each appraisal cycle.
2. Focus on technical and support staff members by conducting needs assessment, organizing job-related training programs and holding meetings aimed at finding out what makes technical and support staff rate leadership, training and performance appraisals differently from other professionals.
3. Align performance appraisal criteria with strategic goals by translating the strategy of the Ministry and its departments into performance indicators for each job position and professional category.
4. Create individual development plans according to the results of performance appraisals in which performance gaps will be linked to the training programs, mentoring and learning opportunities.
5. Bring standardization to the appraisal process through such tools as transparent criteria, planned discussion, well-organized complaints procedure and follow up.
6. Assess the results of training programs when they are finished in terms of application of the gained knowledge and skills and the impact on the performance appraisals. Create a periodic monitoring system to compare appraisal experiences across administrative, medical, nursing, allied health, technical, and support staff and implement corrective actions when significant disparities are identified.

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