



HEFP

HEALTH ECONOMICS &
FINANCING PROGRAMME

**Exploring the Influence of Workplace Trust
over Health Worker Performance**

Preliminary National Overview Report: Tanzania

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1. OVERVIEW OF STUDY

A study exploring the influence of workplace trust over health worker performance at primary care level was undertaken in Tanzania and South Africa in 2003¹. The study aimed to: -

- a) review the policy environment and contextual factors influencing primary care delivery and health worker motivation;
- b) explore the managerial and organizational influences over workplace trust at primary care level;
- c) consider the influence of workplace trust over health worker motivation and performance, with particular regard to attitudes and behaviours towards patients;
- d) draw preliminary recommendations for improving primary care management
- e) establish a foundation for future investigation of the workplace trust and health worker performance.

As summarised in Annex 1, the notion of workplace trust is comprised of three elements, trust in colleagues, trust in supervisor and trust in employing organisation; each of which is assumed to be made of specific behaviours and procedures. Although human resource management practices are central to this notion, it also goes beyond them to consider how such practices are implemented and how people in different positions within an organisation relate to each other. The nature of financial rewards is a specific element of trust in the employing organisation, but the level of such reward is not a central element of workplace trust. Nonetheless, the study did seek to explore the importance of salary relative to other factors as a driver of health worker motivation and performance.

Drawing on the conceptual framework presented in Annex 2, the key questions explored in the study were:

- How do health workers behave towards their patients and what underlies this behaviour?
- How important are financial incentives as a motivating factor in comparison with non-financial incentives?

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- Is workplace trust a relevant and useful concept for investigating motivation and behaviour towards patients? Which elements are more or less important as an influence over motivation and caring performance?
- What influence do interactions with the wider community have over health worker motivation and behaviour towards patients?
- What managerial action is relevant and necessary in order to strengthen motivation and performance?

A central aspect of this work was to look at the issues of health worker performance and motivation through the eyes of health workers and patients. The intention was to seek to understand their experiences through in-depth inquiry.

This national overview report

This overview report provides a description of the methods and key initial findings of the work conducted in Tanzania, drawn from an early stage of analysis. More detailed analyses will be published subsequently. It complements a similar report also prepared for South Africa, and available at www.lshtm.ac.uk/hpu/hefp and www.wits.ac.za/chp

2. STUDY DESIGN AND METHODS

The two Tanzanian lead researchers (Manzi and Kida) both participated in the study preparation workshop, held in May 2003 with South African and British colleagues. This workshop discussed the overall study design and, in particular, finalised site selection criteria, discussed initial drafts of data collection tools and planned the logistics of each country study. Data collection and initial data analysis was then undertaken during the latter half of 2003 and into early 2004, before the study analysis workshop of April 2004, which discussed initial analyses. The study's conceptual framework guided all data collection and analysis activities.

Before commencing work, approval to conduct the study was obtained from relevant government and church authorities. Ethics clearance was secured from the Ethical Review Board of the Ifakara Health Research and Development Centre, Tanzanian Medical Research Coordinating Committee under the National Institute for Medical Research and from the London School of Hygiene and Tropical Medicine (LSHTM), UK. Verbal informed consent was obtained for every interview conducted. In addition, in accordance with the stipulation of the LSHTM ethics clearance, every effort every effort has been made to protect the anonymity of respondents in data collection and analysis.

Site selection

A case study design was adopted within each country study, involving, in Tanzania, rapid ethnographic/ in-depth inquiry in and around four primary care facilities (*zahanati*, or dispensaries).

The four facilities were purposively selected, through discussions with relevant managers, to ensure inclusion of different managerial experiences (as a probable direct influence over

workplace trust). At the same time, however, site selection sought to limit the influence of other variables likely to influence health worker motivation. Finally, the four were intended to represent typical rural dispensaries, performing neither particularly well nor particularly badly.

The three main selection criteria were to:

1. include two government-owned facilities and two church-owned facilities, to allow exploration of the influence of ownership over health worker motivation and behaviours (given the common understanding that health workers in church owned facilities are better motivated than those in government facilities);
2. include one facility per ownership group from each of two government districts, to allow exploration of the influence of district-level management over health worker motivation and behaviours (given the role of district managers in managing government facilities, in particular, in Tanzania);
3. ensure that all four facilities were reasonably similar in terms of services provided; offering curative and reproductive and child health (RCH) care, (including deliveries, but without in-patient beds), staffing levels, and all were located in rural locations, (to try and limit the influence of resource levels, remoteness and influence of other health worker motivation and behaviours).

Table 1 summarises key details about each dispensary included in the study. As it indicates, despite intentions, there were some important differences between the facilities. As many church dispensaries offer some form of in-patient care, it was difficult to apply the third selection criterion to them. The two church-owned facilities eventually included in the study had lower staffing levels, and were located in more remote areas, than either government dispensary. In both cases, staffing level differences were a result of resignations among church-employed health workers. The two facilities were not only located in different districts, but also fell under different church management structures. Of all facilities, the government facility in district 1 benefited both from a better building and better water availability than the other three dispensaries, and from regular drug availability. The church facility in district 2 suffered particular problems of drug availability. Where the government facility in district 2 was the only facility not charging fees for services, the church facility in district 2 was the facility most reliant on fee income to cover operating costs (including salaries and drug supply). Rough utilisation data were only available for two facilities.

Table 1: Case study dispensaries		
	Government	Church
District 1	New building (3 years old), reasonable condition 4 health workers, & 2 other staff (guard, fee collector) 40km from referral hospital Cost sharing in place (with registration, lab & prescription fees) Drug supply regular, from district management Water available; communication equipment installed but not functioning Approx. 30 patients a day	Old building, poor condition 2 health workers, & 1 other staff Across a river from referral hospital Cost sharing in place (roughly same fee level as government) Drug supply from church management, with problems during rainy season No water, electricity or communication facilities
District 2	Old building, poor condition 5 health workers, & guard Approx. 35 km from referral hospital No cost sharing (small payment for soap & guard) Drug supply variable, from district management No water, electricity or communication facilities Fairly busy facility	Old building, in good condition 2 health workers, 1 volunteer Approx. 80km from referral facility (health centre) Cost sharing (roughly same fee level as government) No secure drug supply No water, electricity or communication facilities Approx. 10 patients a day

Data collection in case study sites

Two teams of two field workers were involved in data collection, visiting each facility for a period of three weeks each. They were initially trained together for a four day period and were then involved in translating the data collection tools, which had been developed for both country studies, from English to kiSwahili. Minor adaptations were made to the tools as a result of piloting.

The fieldworkers stayed with or close by the health workers during their stay at each facility. The first week of data collection involved observation in and around the dispensary, including informal discussions with staff and patients. During the second and third weeks individual in-depth interviews were then conducted with staff members and patients. The fieldworker taped the interviews, with consent, and also kept field notes of their observations and informal conversations. The field supervisor visited the teams once during their stay in each dispensary, to talk through findings and assist in identifying specific issues to follow up further. Following completion of each site visit, the supervisor again met with the research team for a final de-briefing session on the visit. The fieldworker teams then completed the transcriptions and finalised notes for that site, before visiting the next site.

Wherever possible two interviews were conducted in kiSwahili with every health worker. In church facilities, interviews were also conducted with staff members who had recently retired or resigned to capture their experiences and, in one instance, with the guard (see Table 2). The first interview, the

critical incident interview², was quite open and sought to elicit key events or issues of concern to the health worker, as well as build trust with the interviewer. The second, more detailed interview also adopted a fairly open approach, but sought specifically to inquire about the health worker's views about each element of workplace trust as an influence over motivation (Annex 3).

To support managerial analysis and action wider experience suggests that is acceptable to investigate the conditions leading to trust without specifying the precise dimensions of the construct of trust³. In the detailed interview, therefore, a series of exploratory questions were first asked about each element of workplace trust, to elicit the respondent's views about the nature of that particular relationship. Eventually, the respondent was specifically asked whether s/he trusted colleagues / supervisor / employing organisation, why and whether that trust mattered to her/him. In addition, questions were asked about the respondent's experience of key human resource management practices and of interaction with the wider community. All interviews were initially transcribed into kiSwahili from tapes by the fieldworkers, and then used in the preparation of site reports. English summary translations were also prepared to allow the full study team access to the data. Any direct discussion of trust was specifically translated into English to identify the kiSwahili words used and ensure common understanding.

In each site interviews were also conducted in kiSwahili with 12 patients and 5-6 community key informants. Given the possibility that patient experience and views differs by condition or service used⁴, the patients were selected to include 4 patients each from three groups: those attending for acute curative care, those attending for RCH care and those attending with chronic conditions. Patients with chronic illnesses were identified and selected by health workers, and other patients were selected through an initial screening interview, conducted as they left the facility. Key informants were selected from the leaders in each community, and included leaders of local committees, women's development groups and ward councillors.

The interview guidelines (Annex 4) allowed exploration of respondents' views about the services provided by the facility of focus, and in comparison with others. As with the staff interviews, only after an initial, open discussion about their views and experiences were respondents asked whether they trusted health workers, the facility and the owner organisation, and why. Again all interviews

² The critical incident approach has been used previously to study trust relations and is useful in the early stages of an investigation to access links between context and outcomes. It also avoids the early imposition of a set research agenda by allowing interviewees to identify things that they define as important to their work experiences. (Butler J. Towards understanding and measuring conditions of trust: Evolution of a conditions of trust inventory. *Journal of Management*; 1991; 17(3): 643-663.)

³ Butler, 1991 *op cit*.

⁴ Mechanic, D., & Meyer, S. (2000) Concepts of trust among patients with serious illness. *Social Science and Medicine* 51(5):657-668.

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In total, as summarised in Table 2, 104 interviews were conducted; 34 (2 per person) with 17 staff members (9 government employees and 8 current or past church employees), and 70 with patients and community key informants.

Table 2: Interviews conducted by site		
	Government	Church
District 1	<u>Total = 26</u> 4 health workers 12 patients 6 key informants	<u>Total = 25</u> 2 health workers, 1 guard, 1 recently resigned staff member 12 patients 5 key informants
District 2	<u>Total = 28</u> 5 health workers 12 patients 6 key informants	<u>Total = 25</u> 2 health workers, 1 recently retired staff member & 1 recently resigned staff member 12 patients 5 key informants

National and district data collection activities

In order to understand the context in which the four case study dispensaries operate data collection was also undertaken at national and district level.

National level data collection activities involved, first, a total of eight key informant interviews with national and regional officials from the Minister of Health and President's Office (Public Service Management and Office Regional Administration and Local Government), purposively selected because of their responsibility for human resource management issues. The interview (Annex 5) again explored respondents' views about primary level health worker performance and the key issues influencing it, as well as the human resource management practices of government, in particular. Interviews were conducted and transcribed in English. When respondents did not wish to be taped, notes were taken during the interview and subsequently transcribed. Second, a review of key policy and other documents around the issues of primary health worker motivation, human resource management practices and influencing factors was undertaken. Documents were identified through the key informant interviews and informal discussions with other knowledgeable people. In total 39 documents were reviewed, drawn from the period 1990 to 2003 (Annex 6).

A total of ten in-depth interviews were undertaken with purposively selected respondents at district level. Two government-employed district managers in each study district were interviewed, two

church-employed managers from each diocesan authority associated with the study and two other leaders from a different church organisation. These interviews (Annex 7) sought to elicit respondents' views on primary level health worker performance and the key issues influencing it, as well as on the human resource management practices of the different management authorities. Interviews were conducted in kiSwahili and taped, then were transcribed into kiSwahili before, finally, preparing English summary translations to allow the full study team access to the data.

Data analysis

The process of data analysis underlying this report involved three steps.

First, preliminary analysis was undertaken by the Tanzanian research team, with Manzi leading the case study and district level analysis, and Kida, the national level analysis.

For each case study site, an initial report was prepared summarising the key findings drawing on observation data, fieldnotes, staff and patient/community interviews. These reports were prepared in a common format for all sites in both countries, and considered all of the issues incorporated within the conceptual framework. They included discussion of each staff member interviewed, as well as the experience of the facility as a whole. They also included important commentary from field teams about key elements of health staff and community experiences, the discussion of trust and the main problems experienced in the field. National level data were also summarised against key themes in an overview report. The draft reports were initially reviewed by Gilson (overall study leader) for comprehension and comprehensiveness, and then finalised.

Second, the case study site and national reports were discussed with the entire study team at the study analysis workshop of April 2004. These discussions allowed an overall view of the emerging findings in each country and finalised common approaches to key elements of analysis for both country studies to be confirmed.

In particular, it was agreed that:

- ◆ the main performance variable of focus in the study would be health worker behaviour and attitudes towards patients, rather than the broader performance of the facility as a whole;
- ◆ following Franco et al., 2002⁵, motivation would be understood in this study as 'an individual's willingness to exert and maintain effort towards organizational goals', and the motivational outcomes of focus would include those associated with:

⁵ Franco L. M, Bennett S, Kanfer R. Health sector reform and public sector health worker motivation: a conceptual framework. *Social Science and Medicine* 2002;54:1255-1266.

- a) what workers feel: job satisfaction (with pay, co-workers, supervisors, management) and organisational commitment (shared values, pride in workplace);
 - b) what workers think: satisfaction with autonomy, progress towards professional goals, recognition as a professional by superiors; and
 - c) what workers do: such as conscientiousness, getting along with others, punctuality and absenteeism, focus on work;
- ◆ three questions drawn from the conceptual framework would be explicitly explored through qualitative judgements, focussing on:
 - ◆ H1: The importance of salary as a motivating factor at different levels of motivation, compared to other motivating factors
 - ◆ H2: The overall of workplace trust as a motivating factor at different levels of motivation
 - ◆ H3: The overall influence of community interaction as a motivating factor at different levels of motivation
 - ◆ analysis would be undertaken at both the individual and facility level.

Third, drawing on the data and initial judgements of the case study reports, additional analysis of case study site data was initially undertaken by Gilson, and then reviewed by Manzi and Mbuyita, to:

- ◆ determine the motivation level of each staff member interviewed;
- ◆ test, for each individual, each of the three hypotheses:
 - ◆ H1: at high/mixed motivation levels, salary is less important than other motivating factors; at a low motivation level, salary is more important than other motivating factors;
 - ◆ H2: at high/mixed motivation levels, relatively high levels of workplace trust are evident; at a low motivation level, a relatively low level of workplace trust is evident;
 - ◆ H3: at high/mixed motivation levels, community interaction has a positive or mixed influence over motivation; at a low motivation level, community interaction has a negative influence over motivation.

The assessment of health worker motivation levels involved careful review of all available interview and observation data for each person in four steps of judgement. First, Mbuyita and Manzi made independent overall assessments of motivation level by person; second, Gilson made an independent assessment of motivation levels using the available data to consider explicitly each of the three commonly accepted facets of motivation (think, feel and do); third, Mbuyita and Manzi reviewed their initial assessments against Gilson's judgements and identified any with which they disagreed; fourth, the three researchers discussed each difference of judgement until they reached agreement on a motivation level assessment for that person. A similar process was involved in considering influences over motivation and testing the related hypotheses.

Across all stages of analysis respondent anonymity has been protected, first, by assigning codes to each facility and respondent, and then only using these codes in subsequent analysis. Second, given the small sample sizes, even these codes have not been used in this report to reduce further the possibilities of identifying respondents.

Overall, this analytical process allowed the following steps of reflection and triangulation to be undertaken in relation to case study data:

reflection:

- ◆ by fieldworkers during data collection amongst themselves and with their supervisor in each case study visit and across visits;
- ◆ on case study facility reports by Tanzanian research team and wider study team during analysis workshop;

triangulation in analysis:

- ◆ across interviews for each staff member;
- ◆ across interviews for all health workers based in the same facility;
- ◆ across all patient and key informant interviews associated with the same facility;
- ◆ across observation, staff interview, patient and key informant interview data for each facility;
- ◆ across case study facility reports;

triangulation across analysts in relation to judgements about:

- ◆ the pattern of site experiences;
- ◆ motivation levels of staff members;
- ◆ staff experiences against hypotheses.

Data collection and analysis issues

The three main issues influencing data collection, and the ways in which they were addressed, were:

- ◆ the complexity of translating interview guides initially developed in English into kiSwahili and using these guides appropriately – addressed through careful fieldworker training and supervision;
- ◆ in some sites, health workers were initially reserved in the fieldworkers' presence, due to some mis-perceptions about their role, but this problem was largely overcome in each site due to the length of time fieldworkers spent with the health workers;

- ◆ some problems in how questions in the critical incident interviews were understood by health workers, with a primary focus on health not health management issues – addressed through the second interview.

In terms of data analysis, the key issues were:

- ◆ that qualitative judgements were made about the motivation level of each individual and in testing hypotheses – but these judgements were made through a process that involved: three researchers (Manzi, Mbuyita and Gilson) assessing each person independently, using a common framework; comparing the resulting assessments; and, where differences were identified, discussing the judgements among the researchers until a final, agreed judgement was made;
- ◆ as some health workers had problems in answering the question about trust in employer due to limited experience with the employer, judgements about whether or not trust existed were sometimes based on assessment of a range of questions around the employer;
- ◆ due to time limitations, not all patient and key informant interviews were fully transcribed into English and instead notes about the key issues were made and used by the research team members who did not speak kiSwahili.

3. FINDINGS

National and district context and perspectives

The health sector is identified as a leading sector in national development in Tanzania's Development Vision 2025, based on the important contribution of good health to life expectancy and well-being. As a priority sector within poverty reduction efforts, it is expected to benefit from an increased share of the government's budget as well as in absolute levels of funding. Health policy goals include the provision of equitable and good quality health care that is responsive to the needs of the population. A range of policy reforms has been initiated to promote the achievement of these health and development goals.

Health sector reforms implemented over the last 15 years include:

- ◆ the de-regulation of private health care;
- ◆ the initiation of a sector wide approach and health basket funding to allow better management of available financial resources through setting common priorities for the use of pooled government and donor funds;
- ◆ definition of an essential package of health services to guide priority-setting and service delivery;

- ◆ a series of health care financing reforms including: the implementation of user fees across health care levels, the introduction of a pre-payment scheme (the Community Health Fund) at primary care level in some areas, and a national health insurance fund for civil servants working in both local and central government;
- ◆ establishment of a drug revolving fund within hospitals and changes to the drug ordering and distribution system at primary care level;
- ◆ the performance improvement programme (first phase of the Public Service Reform Programme 2000-2011) that, aiming to improve accountability, transparency and resource management, has underlain the preparation of new planning activities within the health sector and the development of a Client Service Charter.

These have been complemented by a set of public service management reforms that include:

- ◆ decentralisation of decision-making concerning personnel, planning and financing of service delivery to district level local governments;
- ◆ the Public Service Management and Employment policy of 1999 which requires merit-based employment;
- ◆ then introduction of an open performance appraisal system (OPRAS) under which performance-related contracts are established, currently limited to central government officials in some ministries;
- ◆ the selective accredited salary enhancement scheme (SASE) under which officials filling what are identified as critical positions receive salary supplementation, largely limited to national and regional levels of administration;
- ◆ the performance improvement programme (first phase of the Public Service Reform Programme 2000-2011), already being implemented within the health sector.

These reforms seek to tackle the long-standing problems of the health system and the wider public sector. In particular, there is a lack of public confidence in public services due to their failure to deliver services efficiently and effectively and civil servants' lack of integrity and accountability for their actions (Public Service Reform Programme 2000-2001). Despite acknowledging that a key strength of the public health system is the wide availability of primary care facilities across the country, respondents identified a range of more specific problems with health care provision. These include poor management of financial resources, problems with equipment and drug availability, low salaries and limited skills' levels, staff shortages, and poor staff morale.

Although it is difficult to judge the success of the reforms that have been implemented, due to lack of data and the limited period of implementation in some cases, respondents identified both positive and

negative experiences. Overall funding levels for the health sector have increased significantly due particularly to additional donor funding (as indicated by the 2003 Public Expenditure Review) and interviewees also felt that drug availability has improved. Salaries have also been increased in line with the public service medium term pay agreement of 1998. However, weak management capacity at district level undermines efficient management of resources and central supervision capacity is too limited to enable effective support to be provided. Up-to-date expenditure reports are rarely available at district level. Nonetheless, interviewees at both national and district levels sense that community views of the public health system have improved due, in particular, to better drug availability, some improvements in health worker performance and a growing sense of accountability to the community.

Interviewees specifically acknowledged the importance of health worker attitudes and behaviours to patient experiences of health care. In the public sector, the continuing problems of abusive language, poor treatment, demanding unofficial payments and dual practice (working in private facilities on government time) were also recognised by some interviewees. Indeed, when asked, most national interviewees indicated that they perceived the motivation of public health workers to be quite low although some suggest it is improving. In contrast, government interviewees at district level felt that health worker motivation and performance is improving.

Some government interviewees suggested that public services are beginning to be better perceived than those provided by the private sector. There was also widespread recognition among district level interviewees, both from government and church organisations, that health workers employed by church organisations are increasingly resigning and looking for government posts. Government salaries are acknowledged to be both slightly higher and more secure. However, where government respondents felt that motivation amongst public sector workers was improving, respondents from church organisations generally suggested that the health workers they employed had a stronger inner spirit or ethic, leading them to care for patients. They suggested that whereas government employees were primarily driven by financial motives, or took their employment security as a reason for not working hard, church employees tended to be driven by more selfless motivations.

In general, the main factors identified by respondents as underlying poor health worker performance and motivation in the public sector were:

- ◆ staff shortages and low salaries;
- ◆ poor working conditions (equipment, housing);
- ◆ favouritism and lack of transparency in human resource management practices (e.g. transfers, selection for training and upgrading);
- ◆ limited supervision and monitoring;
- ◆ weak disciplinary procedures;

- ◆ limited and slow opportunities for promotion, which are anyway based more on seniority than merit;
- ◆ differential salary levels resulting from implementation of the SASE scheme (although this does not yet affect primary care workers);
- ◆ rigid employment management policies which discourage labour mobility
- ◆ slow decision-making across the public service;
- ◆ conflicting lines of accountability at district level, with some health activities (vertical programmes) managed from national level whilst human resource and financing decisions are managed locally.

Annex 8 also summarises national and district interviewees' perspectives on current practices, problems and reforms in relation to a range of human resource management functions within government.

Although salary levels were seen to be important they were not necessarily the most important issue: *'The issue of motivation and hence performance is not only explained by good pay, there are people who are highly paid and yet still not motivated, and others less paid but motivated to perform. Thus there is no logic to think that low pay impacts more on the performance of the health sector. For instance, there is great variation in performance between public health facilities in the same rank and same resource endowment'* (national level interviewee). Many interviewees noted the importance of human resource and general management practices. A national respondent suggested that an improved promotion and upgrading system would motivate staff. One government interviewee working at district level spontaneously commented that issues such as a perceived unfairness in training opportunities and weak facility leadership leads to a lack of trust among the staff team that undermines motivation and performance. Several church interviewees also agreed that employer practices directly influenced health worker motivation.

In addition, for church organisations, the key problems undermining motivation were identified as relatively low, and insecure, salaries and limited opportunities for training. The latter is particularly important as government intends to phase out the two traditional primary care cadres, the Rural Medical Aide (sometimes called Assistant Clinical Officer) and Auxiliary Nurses, across public and private sectors, and instead to train all staff to higher levels (that of at least Clinical Officer and Public Health Nurse).

A final observation of note focuses on the apparent differences between policy language about the range of reforms being introduced and interviewees' understandings of the main factors influencing health worker motivation and performance. In some instances reform goals acknowledge the

importance of values and processes (such as those around transparency and accountability), but more commonly the language around reform appears to focus on harder issues such as structures and restructuring, funding levels, new forms of financing and resource availability. Interviewees also suggest that some of the problems of motivation are linked to low salaries, lack of drugs and poor housing. But across interviewees there is also wide acknowledgement that the practices of human resource management and more general decision-making are critical to health worker motivation levels. Although the important influence of the way in which reforms, such as revised pay levels or new appraisal procedures, are introduced is little acknowledged in the policy documentation, it seems to be a clear issue within managers' perspectives.

Patient and community views of primary care facilities

General experiences of care

Two key factors commonly influencing patients' views of primary care facilities seemed to be:

- the conduct and empathy of the health workers, with positive attitudes towards patients being seen positively;
- the performance of clinical work according to patient expectations, for example, whether tools such as microscopes are available to make diagnoses, and whether drugs are available.

Although the views of a range of patients were sought at each facility, no significant differences in the patterns of their perspectives were identified. ANC attendees were clearly most likely to comment on RCH services, but all groups of patients commented on the curative services. Differences between patients in their views seemed most likely to reflect different personal experiences than other factors.

Patient/provider trust

Specific investigation of patient trust in health facilities and workers suggests that it is appropriate to speak about such trust in relation to patient views of health facilities.

The level of this trust seems, in turn, to be linked to the issues affecting the overall experience of care, that is:

- health workers' attitudes towards, and treatment, of patients;
- the availability and willingness of health workers during working hours and, particularly, after working hours;
- their perceived competence and the thoroughness of their practices;
- the availability of drugs within the facility;
- and, ultimately, whether or not patients judge that they recover after treatment

Patients using church facilities commonly, but not universally, comment that the health workers have caring attitudes, are open-hearted, feel the suffering of patients, have good habits, and are prompt. A few criticisms are directed at the absence of staff even during working hours. Patients using government facilities appear to be more critical and may, particularly given recent reforms giving them a greater role in facility management, have higher expectations of government staff. They commonly comment that health workers are uncaring, particularly in being unwilling to provide care after normal working hours; and are likely to perceive a lack of drugs as a sign of health worker corruption.

However, at the same time, patients' views about health workers are also clearly influenced by judgements of staff competence, whether there is adequate drug availability and by how firmly health workers enforce cost sharing payments on patients. The institutional environment of the health workers, thus, influences patient trust in them. Some patients say that they do not trust the health workers, or sometimes the facility itself, because of these sorts of problems.

Finally, trust in health workers or the facility may also be influenced by the lack of alternatives and by the history of the dispensary, perhaps particularly for church facilities. The mother church organisation is sometimes said to be trusted because by building the dispensary in a place with not other health facilities it met a felt community need – and this trust may then rub off onto the facility and its health workers.

Health worker motivation and performance

Motivation and performance

Out of the seventeen staff interviewed, 5 (29%) were judged to have low, 7 (41%) mixed and 5 (29%) high motivation levels. There were no clear motivation differences between more and less highly trained staff.

Health workers with low motivation levels generally stated that they liked their jobs and gained some satisfaction from helping people. However, all were identified (from observation and community interviews) as either behaving rudely towards patients, being unwilling to work out of hours (perhaps even demanding informal charges for such services) or refusing to be co-operative in the workplace. In contrast, those with high motivation levels clearly demonstrated not only positive feelings about their work and workplace, but also positive behaviours towards patients and colleagues. These include

routinely arriving early for work, being willing and available to provide care after hours, regularly providing support to colleagues and actively seeking to strengthen facility performance. The underlying commitment seemed, however, to be to the nature of the work involved in their jobs rather than (as inherent in Franco et al's definition of motivation⁶) to their organisation's goals, as very few health workers were familiar with those goals (Annex 9).

Finally, five of the seven assessed as having mixed motivation levels worked in church facilities. This group clearly demonstrated positive attitudes and behaviours towards patients and each other. However, at the same time, they were either often not available in their dispensary or were thinking of, or had, resigned from their employer. The other two, government employed, health workers of mixed motivation spoke positively about their jobs but also expressed important reservations about aspects of their work or workplace, or were identified as behaving relatively poorly towards patients or colleagues.

Given the variation in individual experiences it is perhaps not surprising that there are no clear patterns linking performance and motivation levels at facility level. There were indications of both positive and negative performance across all facilities and in all facilities there were staff working at a range of motivation levels.

⁶ Franco L. M, Bennett S, Kanfer R. Health sector reform and public sector health worker motivation: a conceptual framework. *Social Science and Medicine* 2002;54:1255-1266.

Financial and non-financial motivating factors

How important is salary as an influence over motivation?

Motivation level	Against data, hypothesis was:		
	proven	not entirely proven	unproven
high	3	2	0
mixed	3	4	0
low	0	3	2

Note:

1. H1 = at high/mixed motivation levels, salary is less important than other motivating factors; at a low motivation level, salary is more important than other motivating factors;
2. This assessment was made using all available interview data for each respondent and represents an overall assessment of their position based on what individuals spontaneously discussed as personal motivating factors and how they spoke about financial and non-financial factors.

Table 3 summarises the test of hypothesis 1 against the available individual-level data. It indicates that, as expected, salary is not the most important motivating influence at higher motivation levels; but also, and more surprisingly, that salary is also not the dominant influence at the low motivation level.

Across respondents, the more important motivational influences include the clearly intrinsic motivation that comes from being able to help people and see them recover: *‘the big incentive to me is the spirit I feel inside me that I should help people’* (government health worker). As a result, higher motivation appears to be associated with the development of competence and confidence in one’s own skills, generated through training and support from colleagues and supervisor. Also important are good relations (and trust) amongst colleagues within the facility, and often stressed, with the surrounding community.

Working conditions (see Table 1) were another factor commonly identified as an influence over motivation – affecting either health workers’ ability to do their jobs, and so feelings of competence and, ultimately, reward from helping others, or their sense of personal frustration with their workplace. Problems with staff housing were particularly important to the latter sense. In some instances obtaining new equipment had clearly made a difference to feelings of competence and the provision of care. For example, the acquisition of a microscope and fridge in one church facility were identified by the in-charge as strengthening the community’s trust in the facility and so, as making him feel good. However, working conditions were not the most important motivational issue raised in interviews with health workers, and were often identified in response to specific questions and prompting. In many cases problems with working conditions seemed to be more a known frustration, commonly understood as inevitable when working in rural areas, rather than an experience likely to tip the balance between being highly motivated or highly frustrated.

The combined influence of financial and non-financial motivating factors is also clear. Training, for example, is sometimes seen as not only being important in developing the skills necessary to provide good care, but also as a means of accessing additional financial rewards (workshop allowances) or as the basis for promotion to higher status/higher salary positions. The importance of financial incentives is summarised by one health worker: *‘Aaa! Everyone likes to live nicely. I need to manage my living needs without difficulty, and that will not come from anywhere else but from my work. I need to eat good food, to dress nicely etc. Such things create a feeling of utility and satisfaction! We have started changes in that direction and we hope they will continue’* (government health worker).

In addition, being intrinsically rewarded is not enough to compensate for failing to receive a salary. The four respondents of mixed motivation level for whom the hypothesis was not entirely proven all complained that as they were not certain from month to month whether they would receive a salary, they were forced to search for other jobs and to resign when they found them. These complaints were also strongly linked to a lack of trust in the (church) employer.

Does workplace trust influence motivation?

Table 4: Testing hypothesis 2, influence of workplace trust over motivation			
Motivation level	Against data, hypothesis was:		
	proven	not entirely proven	unproven
high	4	1	0
mixed	6	0	1
low	2	1	2

Notes:
 1. H2 = at high/mixed motivation levels, relatively high levels of workplace trust are evident; at a low motivation level, a relatively low level of workplace trust is evident

Table 4 summarises the test of hypothesis 2 against the available data. It suggests that high levels of workplace trust may be a positive influence over motivation and low levels, a negative influence. This is also supportive of the general conclusion that non-financial incentives are important motivating factors.

For the two ‘not entirely proven’ cases, although workplace trust was evident other factors (specifically intrinsic motivation and negative community interactions) seemed to be more important influences over motivation levels. Similarly, for the three unproven cases the dominant influence over health workers’ motivation seemed to be frustrations with their current posting. One, whilst used to living in rural areas, was living away from his family and both frequently away out of hours and unwilling to support colleagues. The other two, in their first appointments, clearly found living and working in rural areas difficult – expressed as an unwillingness to work after hours and feelings of frustration with the community.

How does workplace trust influence motivation?

Table 5 summarises the individual-level data in relation to the elements of workplace trust that may vary between facilities associated with the same employer. These elements include trust in colleagues, trust in the in charge and trust in the external supervisor. Although the conceptual framework only identified one ‘trust in supervisor’ variable, the findings indicate that some health workers see their primary supervisor as the in-charge rather than a supervisor external to the facility.

Colleagues and in-charge

Clearly the small numbers make it difficult to judge patterns across motivation levels, but, overall, the data do suggest that health workers trust each other and those in-charge of the facilities to a fair degree. For some, trust in colleagues and the in-charge is primarily on work issues, but for others it also extends to personal matters. The role of this trust in relation to motivation is commonly explained in interviews as allowing the co-operation necessary to establishing a positive and enjoyable working atmosphere and so, to performance – including good attitudes towards patients. This is fully understandable given that these small groups of health workers work on their own, at a distance from their external supervisors and so essentially have only themselves to rely on as they face their work and personal challenges.

Table 5: Elements of workplace trust, analysed by motivation level across individual-level data				
	Motivation level			<i>total</i>
	low	mixed	high	
1. Trust in colleagues				
none/little	0	0	0	0
trust only some	2	2	0	4
trust for work only	2	2	2	6
trust entirely	1	2	3	6
<i>total</i>	5	6	5	16 ¹
2. Trust in in-charge				
no	0	0	0	0
yes & no	1	3	1	5
yes	3	2	3	8
<i>total</i>	4	5	5	13 ²
3. Trust in external supervisor				
no	1	1	0	2
yes & no	0	0	0	0
yes	3	3	2	8
<i>total</i>	4	4	1	10 ³
Note:				
1. One non-response from two-person facility.				
2. Responses from four in-charges not relevant.				
3. Seven respondents do not identify external supervisor as having relevance to their work.				

The positive motivating influence of trust in colleagues is clearly demonstrated by two examples. In one church facility, a staff member who had subsequently found work elsewhere commented that her

trust in her colleagues, and their continued willingness to work there, was the reason why she remained working so long (2 years) in this facility, given its remoteness and other problems (church health worker). Elsewhere comments on the value of trusting colleagues included that the resulting co-operation '*can help to fill knowledge gaps*', gives the peace of mind that allows you to enjoy your work (government health worker) and '*is a pre-requisite towards any kind of success*' (government health worker).

In addition, the concerns generated when health workers express doubts about colleagues only affirms the importance of this trust. In one church site the clinician's lack of trust in a colleague's skills offsets his broader trust in her resulting from their good working relations. His lack of trust in her skills frustrates him as he feels he must shoulder much of her workload burden by himself. In another (government) facility, the community accused the health workers of stealing equipment from the dispensary. Although the matter was eventually settled without legal action, through intervention by the Council Health Management Team (CHMT), the consequences appeared to include an increased fragility in relations among the staff. One staff member complained that she had been embarrassed and humiliated by being questioned by the police over the matter, particularly as she had been away from the village at the time. She felt let down by her colleagues, blaming them both for the theft and for her experiences; and complaining that the experience had undermined her trust in them.

Across health workers, the foundations of trust in colleagues are identified as positive experiences of teamwork and of working in harmony (without conflict). These allow health workers to tackle work problems together and effectively, and allow peace of mind when at work. Where identified, the personal behaviours underlying these experiences are seen as kindness, good manners and respect for each other.

Table 6: The foundations of trust in the health worker in-charge	
Positive experiences	Negative experiences (only few complaints)
<p><u>Work behaviours:</u></p> <ul style="list-style-type: none"> ◆ supportiveness: gives good advice, encouraging, work in harmony, offers personal support to others by solving work & personal problems ◆ decision-making: delegates roles, asks for opinions, right and fair decisions <p><u>Personal behaviours:</u> polite, not rebuke or offend others, listens, respectful, fair</p> <p><u>Personal characteristics:</u> respects self good skills, competent, hard worker</p>	<p><u>Work behaviours:</u></p> <ul style="list-style-type: none"> ◆ supportiveness: does not respond quickly to issues, not follow-up on problems ◆ decision-making: slow in making decisions, unpredictable, few meetings among staff <p><u>Personal behaviours:</u> quiet, doesn't share with others, not good communicator, sometimes in bad mood and won't help, harsh, impolite</p>

In addition, judgements about trust in the in-charge are rooted in three sets of factors, as reflected in both positive and negative experiences: work behaviours, personal behaviours and personal characteristics (Table 6). Positive experiences of the work and personal behaviours of in-charges are associated with practices such as developing work rosters, especially for after-hours care, and sharing that workload equally among all staff, providing support to colleagues in their daily duties and helping out with their work, listening to and addressing colleagues' complaints, being courteous and respectful in personal interactions, and interceding for colleagues with the external supervisor, community or employer. Although the technical skills and competence of the health workers in-charge are important to others' trust in them; more important is the way in which they treat their colleagues. Such practices help create an open and supportive environment in which health workers feel comfortable and work well: *'I think trust in colleagues is very important and we need it at any working place, as I said earlier that it helps in creating peace of mind. It is only when there is trust that we can enjoy our jobs... As I told you earlier that if we get any problem of a challenging situation we consult him [the health worker in-charge] and he shows us the way. That kind of cooperation is very useful'* (government health worker).

External supervisors

The external supervisors include, for government facilities, district officials and, sometimes, health workers from the nearest health centre and for, church dispensaries, officials from the dispensary's mother hospital/employing authority. The influence of external supervisors is clearly linked both to the frequency of visits and the activities they undertake, including facilitating communication between the facility staff and the district managers, as well as to the way in which they undertake them.

Where possible to determine, views on external supervisors seem broadly positive, but with hints of problems (Table5). However, the nature of external supervision clearly varies between facilities in reflection of different employer practices.

In only one, government, facility did most health workers identify an external supervisor as having any influence over them. This facility received visits not only from members of the council health management team, based at some distance from them, but also frequent visits from the manager of the nearest health centre. The visits both provided work guidance for the small health team and allowed regular communication with district managers – even through the health centre manager, who could use the radio telephone in her facility to receive message from, and pass messages to, district officials. Interestingly, the church dispensary located in the same district also received visits from its local health centre manager. Such visits were seen as valuable because these health workers received absolutely no supervision from their own employer and because the external supervisors helped to resolve operational problems. In yet another facility, supervision focussed much more closely on patient treatment, and offering direct professional support, rather than addressing broader managerial issues.

Table 7: The foundations of trust in the external supervisor	
Positive experiences	Negative experiences
<p><u>Work behaviours:</u></p> <ul style="list-style-type: none"> ◆ supportiveness: co-operative, helpful, learn from them, solves problems, acts as communicator up and down, guides us, advises on personal and work issues, regular visits <p><u>Personal behaviours:</u> respectful, listener, smiling, polite, seem to value us, confident, fair</p> <p><u>Personal characteristics:</u> respect selves and of others,</p>	<p><u>Work behaviours:</u></p> <ul style="list-style-type: none"> ◆ supportiveness: not spend time together, never visits, not supportive, ◆ decision-making: don't ask staff to participate in decisions, not fulfil promises <p><u>Personal behaviours:</u> speak sharply, not listen, not fair</p>

The foundations of trust in the supervisor (Table 7) clearly point to the importance of how activities are undertaken, and reflect the issues raised in relation to trust in the in-charge. Where criticised, external supervisors were seen as performing a policing rather than a supportive function. Even within a facility, perceptions of the supervisor can vary between health workers as a result of differences in how the same supervisor is experienced. In one church site, the clinician experienced the supervisor as both professionally and personally supportive. During visits the supervisor stayed with the clinician and routinely offered personal and professional advice, sustaining the clinician’s motivation despite a broader lack of trust in his employer. However, the same supervisor was experienced negatively by another health worker in the facility because he never spent time with her, nor tried to teach her or

offer her advice. For this worker the supervisor’s lack of personal support was, therefore, only evidence of her employer’s lack of caring.

The employer

Table 8 indicates that, across health workers, there were more mixed views about the employer than any other element of workplace trust. Eight expressed clear or some lack of trust, three expressed weak trust and only five clearly stated that they trusted their employer.

Table 8: Trust in the employer, analysed by motivation level				
	Motivation level			
	low	mixed	high	<i>total</i>
no	1	3	0	4
yes & no	1	2	1	4
yes, but weak	0	0	3	3
yes	3	1	1	5
<i>total</i>	5	6	5	16

However, many respondents found it a little difficult to answer the direct question about trust in their employer. Some appeared to have had little direct interaction with their employer on which to base a judgement of trust. Other implied that they trusted simply because they were employed, even whilst also complaining about aspects of their experience with the employer that could, in principle, affect trust. The respondents who did indicate that employer trust influenced their motivation level seemed to see the employer as a sort of safety net for their lives – possibly providing leadership for their work but more, a general sense of support (or lack of it).

For some government staff, therefore, employer trust appeared to be rooted either in their experience of not being in trouble with the employer or of being confident they would get their basic employment rights (a regular salary and retirement pension). In other instances, this extended to a feeling that the employer actively cared for them. Or, with negative experiences, of church employers specifically, to the feeling of being de-valued, treated unfairly, or denied employment rights. As Annex 9 indicates health workers in church facilities commonly felt their employer’s communication practices and decision-making procedures were poor, in contrast with more positive views in at least one government dispensary.

It is inevitably difficult to discern a pattern across motivation levels from Table 8. However, whereas seven out of eleven respondents with low or mixed motivation expressed little or no trust in their employer, four out of five highly motivated respondents expressed weak or full trust in their employer. This hint of the motivational influence of trust in the employer is supported by the clearly different experiences of church and government employees. Although seven out of eight health workers employed by churches expressed little or no trust in their employer, seven out of nine government health workers expressed weak or full trust in their employer. All but one of the church health

workers, moreover, had resigned or would have liked to resign from their current employer, in order to pursue training opportunities and secure salaries. Some specifically state that they would prefer to work for government. The other one, a guard, is satisfied with his job not least because there is little other employment for him in his village. In contrast, no government employee expressed a desire to resign and only a few (auxiliary staff) felt that they had little chance of getting further training.

Critical to the differences between employing organisations were different experiences around job security and training. Government health workers felt confident that they would get their salary every month, if sometimes a little late, and their pension on retirement, but church health workers commonly experienced problems in these matters and, in one facility, were simply not getting paid. At the same time, most government health workers were reasonably comfortable about the possibility of getting both in-service and promotion related training, but church health workers were unanimous in their complaints about training. Their only training opportunities came from invitations to attend government-organised workshops and their employer routinely told them that there was no money for training.

Experiences across the range of other human resource management functions are summarised in Annex 9. This again highlights the different experiences of staff in government versus church facilities, as well as the weakness of government appraisal and disciplinary procedures.

Health worker interactions with the community

Table 9: Testing hypothesis 3, influence of community interaction over motivation¹			
Motivation level	Against data, hypothesis was:		
	proven	not entirely proven	unproven
high	3	1	1
mixed	3	2	1
low	4	0	1

Notes:
 1. H3 =at high/mixed motivation levels, community interaction has a positive or mixed influence over motivation; at a low motivation level, community interaction has a negative influence over motivation.

Table 9 summarises the test of hypothesis 3 against the available data, broadly suggesting that while community interactions may support higher motivation levels they may also contribute to low motivation levels. Those with positive views see this interaction as a source of motivation because they feel respected and valued by the community. Such feelings can, for those with mixed motivation, sometimes offset other more negative experiences of the community. In contrast, those with negative views find the community demanding and dis-respectful, and routinely complain about health seeking behaviour.

The factors underlying this pattern appear to include specific experiences and personalities. For example, three of the contrary cases identified in Table 9 (those where the hypothesis was unproven) all provide interesting insights into how the influence of community interaction may be experienced. The highly motivated health worker for whom community interactions were largely negative, suffered the humiliating experience, despite years of faithful service, of being accused by the community of stealing equipment from the dispensary. Although still feeling positive about the community, and the respect he receives as a health worker, it is not surprising that this health worker also felt unappreciated. In contrast the health worker of mixed motivation who feels positive about the community has positive experiences of community interaction through the facility's health board. Although he has concerns about health seeking behaviour, and expects villagers to complain about him, he feels this structure allows relations between the facility staff and community members to be effectively mediated. Finally, for the health worker with a low motivation level factors other than community interactions undermine her low motivation.

This strong influence of the community over primary care workers is not surprising. In all four sites, due to the remote location of the facilities and the small size of staff teams, the health workers were very enmeshed in the local community and so were sensitive to community views of themselves and their facility. Patient and community appreciation of, and respect for, health workers was often identified as a source of motivation.

However, the nature and formality of interactions with the community varied quite considerably across sites.

At one level these interactions were simply around community use of the health facility, with health workers commonly making two, inter-linked, complaints. First, that patients put their own lives at risk and made the health workers' job more difficult by seeking care when the condition was already too serious to be treated locally. Sometimes, health workers had to go with patients being transferred to a referral facility, leading government health workers to complain that they were left to cover their costs themselves. The second common complaint was about feeling forced to provide services after hours, even though there is, again, no allowance for this activity.

As one government health worker said forcefully, *'You know, to be employed does not mean that you have sold your freedom. It is a job with limits in terms of time and other aspects. As thus people should respect and value your contribution, By being employed you do not become enslaved. One cannot decide to come to the facility at any time s/he feels like. There must be specified time so that we can have time to rest. It is not fair to dis-regard health workers' freedom. We are not employer 24 hours. People here have a tendency to start self-medication at home and when they find that their conditions*

become worse it is then they decide to come to the dispensary. That can even be in the middle of the night. When you ask them why they decided to come at such hours they would tell you that the illness has no specific time to start! That is really irritating. When the same interviewee was asked if he had additional comments, he said *'Yah! The worst thing about this behaviour of late treatment is that most of these people are living very close to the dispensary. It is really surprising to see that they come at odd hours while they have the opportunity to have come earlier! Had they been coming from away that would have been something else. We could be considerate about that!'*

Importantly, the relatively common discourse across health workers about poor health seeking behaviour may point to a basic level of dis-trust between them and their patients. It seems that health workers feel that patients either deliberately, or because they are uneducated, use health care inappropriately and so make unfair demands on them. However, one health worker noted the problems but simply commented that living in a rural area brought special demands that just have to be accepted.

At another level, health worker interactions with the community occur around organisational issues. In one church dispensary, for example, the community wanted the dispensary to offer immunization services so together with the in-charge they went to the CHMT. It was agreed that the CHMT would provide the fridge and the community would construct a place for the gad bottle. The facility in-charge reported his appreciation of this joint action, and the improved trust in the facility as a whole that resulted. In contrast, in another case, a government health worker reported that she was disturbed when summonsed before village leaders to explain her conduct, in response to complaints.

In most sites, interaction over organisational issues occurred through the broader leadership structures routinely established within Tanzanian villages. However, one, government, facility had a functioning clinic committee through which the relationships between health workers and the community were mediated. Interestingly, in this site, most health workers themselves identified the chair of the committee as one of their supervisors. They all also expressed considerable trust in this person, seeing him as someone who was good, honest, committed and hardworking, and who visited them often. Like other supervisors their trust was also founded in his own personal behaviours – being supportive (through helping to solve problems), being participatory and fair in decision-making and being a respectful person, a good communicator and willing to listen. Yet despite this trust, several health workers also expressed fears about the committee's possible power over them. However, villagers felt that the committee was powerless to address their concerns about the dispensary's operations.

Understanding the complexity of motivational influences

The individual-level analysis so far presented suggests that:

- ◆ salary is never the sole motivator, but may have particular importance for some individuals in specific circumstances;
- ◆ levels of trust in colleagues and the in-charge are generally high and are seen to be particularly important to motivation;
- ◆ the level of trust in an external supervisor, if received, is often fairly high and so can be important to motivation, but it is not always experienced as a strong influence and is sometimes seen as policing rather than support;
- ◆ the level of trust in the employer is variable and generally has a weak or negative influence based on the extent of problems experienced with the employer: where it has a negative influence it can be a significant de-motivator even for those people who clearly have intrinsic motivation, where it has a weak influence it is perhaps experienced more as a lack of negative influence than as a positive motivator;
- ◆ the influence of the community over motivation is generally strong and can either sustain or undermine motivation;
- ◆ although working conditions do influence motivation, they are generally not a major influence;
- ◆ people's personalities and personal situations clearly have an important and variable influence over motivation, but are not enough by themselves to sustain motivation in the face of a weakly supportive environment;
- ◆ the wider context, in the form of rural location, for example, also influence worker motivation.

Although this analysis has so far considered the possible influences over motivation levels independently of each other, it is nonetheless clear that the various factors are inter-woven in complex ways. The following three vignettes outline the experiences of three health workers of different motivation levels (real names not used).

Vignette 1 high motivation: Mzee Dominiki is nearly sixty years old and has been working as an ACO at his (government) facility for 21 years. Although not initially from the village he has made his life there, marrying a local woman and obtaining a farm there. He is widely praised by colleagues and villagers as a model of performance: first to report to work, concerned to see people are well attended, supportive to colleagues and friendly to all. He is clearly motivated by the nature of the work itself and is confident in it: *'My profession is good and I enjoy helping people. I am confident and comfortable with my work. I know it quite well...Some of the things that make me like my job include the feeling that I am helping people. I like it when am doing examinations to know how a patient is suffering*

from. And I treat them and see them recover, I become very glad. If a patient could not recover, normally I become very sad'. He also appreciates the respect accorded to him as a health worker, *'Also the word doctor as they call us here gives me respect I would never have been given elsewhere'*, and enjoys overcoming the challenges of working in rural areas. This intrinsic motivation sustains him despite his concerns about the burden of work, in particular having to work all hours because that's what villagers demand, and despite the relatively low salary received for this level of work, as well as a past experience of being unfairly accused by the community. There are also problems with working conditions that undermine good care as well as (e.g. around staff housing) act as personal frustrations. However, he enjoys the support and cooperation he gets from colleagues, which allows sharing of experiences, and the back up of supervisors. Although district staff don't visit often he is particularly appreciative of their support: *'You know, that is our office, It is a focus of every staff under the DMO. Now, you visit that place and end up being mistreated, it would have made us feel left out and not valued. The good treatment we receive from the office further encourages us to take ahead in our work with a good working spirit'*. Although expressing some concerns about the employer's tendency to ignore employees after they have been employed for a while, he also says *'Aaa, I have not seen any significant mistreatment directed purposefully towards me. I think I have trust in my employer'*.

Vignette 2 mixed motivation: Bwana Charles is the in-charge of his church facility and is widely appreciated for his skills and attitudes towards patients. He is also appreciated as a leader and colleague, providing hands-on support for colleagues and treating them with respect. He feels motivated by patient appreciation of his work, and enjoys good relations with his colleagues. Supervision visits from the nearby government facility also contribute to his performance. However, he also finds it difficult working with less skilled colleagues and in an environment which undermines patient care (e.g. because of the lack of drugs or equipment). Most critically, however, his motivation is affected by the lack of support received from the employing organisation, which fails to address problems identified by staff, uses decision-making procedures that are neither transparent nor fair, fails to keep its promises about supporting staff training and, most critically, often fails to pay salaries. He simply has no trust in the employer. Given the failure to pay salaries he is often out of his work station doing other work, and patients complain about his absences, and given the broader set of experiences is also actively searching for alternative employment.

Vignette 3 low motivation: Mama Aziza, a Public Health Nurse, is an experienced health worker who has been based in her current (government) facility for only two years leading the RCH section. The services of this section are spoken of positively by patients, although the researchers also observed Aziza being a bit rude and impatient towards her patients. She says she likes her job and is motivated by it: *'It is because I like serving people and this work gives me that opportunity. I get so much satisfaction when I see I have been able to help people'*. She also seems to have confidence in her

skills, appreciates being provided with housing near the facility and feels that her working environment largely allows her to do a good job. In addition, she appreciates the support she has received from some village leaders, and essentially trusts her employer - both because she has the security of knowing she will be paid whether or not she is sick and because it provides her with training to do her work. However, her motivation is undermined by two main factors that, together with long hours and the physical demands of her work, lead her to experience her work as very stressful. The first is that she has experienced being criticised by villagers for a patient's death, although she feels the problem was caused by the mother's late arrival at the facility during her labour. This experience made her feel that *'People in this village are not kind. They are not grateful, they would re-pay kindness with hatred. They do not value one's humanity. They like spreading rumours that we do this and that'*. Her second complaint is that she does not get adequate support from her colleagues, including the facility in-charge. She feels that she bears the biggest burden of work because she does most of the after hour duties and often stays late to finish work. Although she says she trusts her colleagues, she still feels let down by them and as in the past complained about their lack of cooperation and support.

The experiences of the case study dispensaries (as summarised in Table 10) also highlight the complexity of motivational influences.

As noted, there are mixed performance and motivation patterns in all facilities, and only in one church facility are there aspects of high motivation across all staff and largely positive patient views about staff attitudes. Patient judgements of performance are, however, also, and sometimes, more strongly, linked to drug availability and the presence of cost sharing arrangements.

Across facilities, however, all staff are clearly embedded in their communities, whether or not they like it. Some, like Mzee Dominiki above, have lived for many years in their village, own land there and have close relations with community members (his wife is from the village). Many, even those who dis-like rural life, feel positive about community appreciation and feel touched by the difficulties of villagers' lives: *'Aaa, you know, rural life is tough, most of the villagers have low income, have limited earnings. Now, if a facility like ours cannot serve them by ensuring that drugs are available it is going to be difficult for them to purchase every kind of medicines from shops. And we don't feel comfortable to consult a patient and fail to provide him/her with appropriate medicines. In that sense I don't feel that I have done my job in the way I would like it to be done. That is why I say that the availability of drugs would improve my work performance'* (government health worker). All, however, also feel the pressure of community demands, recognising that their positions mean that they are often the subject of village gossip – positive and negative. Their personal reputations are, thus, bound up

with their professional practices and, not surprisingly, health workers often suggest that they respond to community demands to avoid being criticised.

These shared experiences may also help explain the importance of team spirit and teamwork within facilities. Subject to villagers' criticism and far from supervisors, health workers have to rely largely on themselves to do their work and cope with the demands they face. By sharing tasks and experience they support each other. By respecting and behaving politely to each other, they sustain this teamwork by creating a positive working atmosphere. Although health workers may not associate with each other out of the workplace, their trust in each other is clearly important in ensuring cooperation and sustaining performance. In one case it even encouraged a health worker to stay in post despite concerns about her working conditions.

The health workers in-charge of church facilities also seem to play particularly important roles in sustaining trust and cooperation among colleagues. By establishing working rosters, sharing tasks and experience, as well as maintaining good relations with the community, they support and motivate their colleagues. In contrast, the leadership offered in the two government facilities was quite weak. In one instance, staff were largely left to organise and support themselves. In the other, the in-charge himself acknowledged the greater experience of several of his colleagues. Although being supportive to others, he largely left them to provide after hour care and manage relationship with the community. The different experiences are summed up by the following comments from health workers at different facilities:

'To be frank his decisions are not that much good. That fact is that when there is something to be communicated to us, he wouldn't do so practically. He never gives clear clarifications. We all look at him as our leader and if he fails to show us that way where else would we go to seek professional advice and clarification';

'I care very much to have trust to my leader for otherwise I would feel very uncomfortable to work under a person whom I question a lot'.

Table 10: Overview of facility experiences		
	government	Church
District 1	<p>Facility 1 <u>Staff performance:</u> mixed views in general; concerns about curative care competence, staff availability, staff rudeness; broader concerns about lack of diagnostic equipment & cost sharing implementation</p> <p>Motivation: 1 low, 2 mixed, 1 high</p> <p>Salary unimportant to staff with training for competence & co-operation more important</p> <p>Some trust problems among staff & with in-charge Variable trust in external supervisor Passive trust of employer</p> <p>Working conditions reasonable, except staff houses Cost recovery some problems</p> <p>Facility health board</p>	<p>Facility 3 <u>Staff performance:</u> mixed views across staff & yet broadly positive assessment; some concerns about lack of drugs & cost sharing</p> <p>Motivation: 2 high & 1 low (1 other mixed)</p> <p>Salary unimportant to staff with intrinsic motivation, training for competence & employer behaviour more important</p> <p>High trust among colleagues & in-charge Varying trust in external supervisor Active dis-trust of employer</p> <p>Working conditions poor Cost recovery problems</p>
District 2	<p>Facility 2 <u>Staff performance:</u> mixed views across staff with some strong concerns about attitudes; broader concerns about lack of diagnostic equipment & lack of drugs</p> <p>Motivation: 1 high, 3 low</p> <p>Salary unimportant to staff with intrinsic motivation and training for competence more important</p> <p>Reasonably high trust across colleagues & with in-charge Most trust supervisors Largely passive trust of employer, with some criticisms</p> <p>Working conditions quite poor</p>	<p>Facility 4 <u>Staff performance:</u> positive views & observation of staff attitudes, but concerns about availability, competence; and broader lack of trust due to drug shortages & cost sharing</p> <p>Motivation: 2 mixed (2 other also mixed)</p> <p>Salary important because not getting paid, but also intrinsic motivation</p> <p>Trust in colleagues & in-charge tempered by some concerns about competency Government supervisors seen positively, church supervisors negatively Active dis-trust of employer</p> <p>Working conditions poor Cost recovery problems</p>

A further layer of support is that provided by supervisors at each facility. However, across facilities, the experience of support varies between individuals, with nurses often complaining that supervisors do not specifically support them or that they experience supervision as policing rather than supportive. In part, this response seems to reflect the largely technical (and sometimes quite time-constrained) nature of supervision, as well as the manner of the supervisor. Positive views tend to be associated with direct personal experiences as well as being treated with respect and politeness. Views of supervisors are also influenced by their effectiveness in addressing facility problems. Church health

workers speak positively about government supervisors' support in direct contrast with the ineffective response of church supervisors (the two health workers specifically indicating lack of trust in their supervisor were based in church facilities).

In all facilities, moreover, some external supervisors represent the face of the employer and so are influenced by health workers' views of their employer. It is in these views that the greatest differences between facilities were noted. Although seven out of eight health workers employed by churches expressed little or no trust in their employer, seven out of nine government health workers expressed weak or full trust in their employer. For government health workers, trust in the employer was essentially rooted in two things: job security and never having been treated poorly. Job security was, in turn, associated specifically with being assured of a salary, even when sick, and of pension rights. One or two, nonetheless, hint at the possible fragility of this trust – with complaints about the lack of training for nurse auxiliaries or the unfairness of people at the same grade earning different levels or the failure to get promotion. *'My employer is a good one particularly at the time when you start your job and depending on your level of qualification. However, later on, you get a feeling of being ignored'*.

In contrast, church employees all complained about low salaries, salary insecurity, and the lack of training opportunities. *'To work with missionary as an employer is just because of poverty, but there is no incentive as salaries are small; what we enjoy is gaining work experience'*. Where government staff commonly compared their situations favourably with that of church health workers, church health workers were actively seeking government appointments. Church health workers often complained about the unfairness and weak transparency of their employers' decision-making practices, and the lack of care offered to health workers. Several spoke about the employer breaking their contractual promises to health workers – such as promises to raise salaries annually or to provide upgrading training. For many, these experiences had actively destroyed their trust in the employer and undermined their motivation, leading them to resign or contemplate resignation. Those who chose to stay with the employer essentially had little choice (because of their inadequate training).

In both church facilities the employer's lack of care is well demonstrated by the health workers' experiences of the cost sharing and drug revolving funds introduced to compensate for the employer's funding shortfalls. In one site, the dispensary only ever received a small proportion of the promised initial capitalisation grant and the employer routinely failed to pay health worker salaries. As a result, staff were forced to use the very limited level of cost sharing revenue to pay themselves rather than to buy drugs. The lack of drugs only undermines community trust in the dispensary and its staff. Yet the health workers' appeals to employer for help were ignored. In the other site, the employer had threatened to make deductions to staff salaries to cover the cost of unpaid patient bills. The staff took

the matter to the village government and then to court, were it was ruled that people were just too poor to pay that year due to drought. Eventually the employer withdrew the threat to claw back lost revenue from staff salaries, and continued to pay salaries and provide drugs.

4. CONCLUSIONS

This preliminary report of a small-scale study of health worker motivation in Tanzania offers a range of insights.

The links between motivation and performance, and key influences

Although the available data do not allow firm judgements of the links between patient perceptions of performance and motivation levels at a facility level, this initial analysis suggests that at an individual level, more caring behaviour is not solely associated with higher levels of motivation and at lower motivation levels caring attitudes and behaviours can also be combined with other behaviours that are judged as poor, such as absences from work.

In addition, the analysis suggests that:

- salary is never the only influence over motivation;
- poor working conditions influence motivation but seem to be less important than other factors;
- the notion of workplace trust offers useful insights into the factors influencing motivation;
- community interactions are an important influence over motivation.

Finally, it is clear that full understanding of the links between motivation and performance and of the factors influencing motivation requires a contextualised interpretation of health workers' and patients' views and experiences. Although what health workers think, feel and do today, for example, are partly influenced by personal factors, they are also, and often more importantly, influenced by the social contexts of rural health facilities and by current experiences in the workplace and society. The task of motivating health workers, thus, requires strategies that acknowledge and work with these contextualised understandings, even as they seek to change them.

The relevance of workplace trust as an influence over motivation

As noted, many of the central factors that appear to influence motivation can be understood using the three elements of workplace trust.

Trust in colleagues:

Good relations with colleagues are common and important. However, health workers sometimes trust each other on work matters, but not personally

Trust in the supervisor:

Trust in the health worker in-charge of the dispensary is also common. But if the health worker in-charge is viewed as not being supportive, consultative and/or transparent, his colleagues' motivation may be undermined. Even where the in-charge is himself perceived to be a competent health professional, poor management style can undermine trust in his leadership. Low trust can, in turn, generate anxiety and disputes and so impact negatively on motivation.

The influence of the external supervisor is variable. Whilst often positive, current practices are not always motivating. There may be room to change the nature of supervision in ways that better support motivation.

Trust in the employing organisation:

For church health workers, dis-trust in the employing organisation appears to mean that health workers see themselves as working in a very uncertain and fragile context, which can have unexpected impacts on their personal and professional lives. It is hard to remain motivated when you are unsure what will happen next and so church staff have resigned. For government staff, the weak influence of the employer is perhaps just an indicator of the lack of negative experiences, rather than of a more positive influence.

Trust judgements

Feeling trusted and cared for is a central basis for trusting both supervisors and the employer, and is demonstrated by fair and transparent decision-making and good consultation/communication around decisions.

Thinking about future plans and actions

The initial findings presented here suggest that:

- health care provision is influenced by health worker motivation and behaviour problems;
- there is potential to strengthen motivation and behaviour through changed management practices, as motivation is not solely a function of salary;

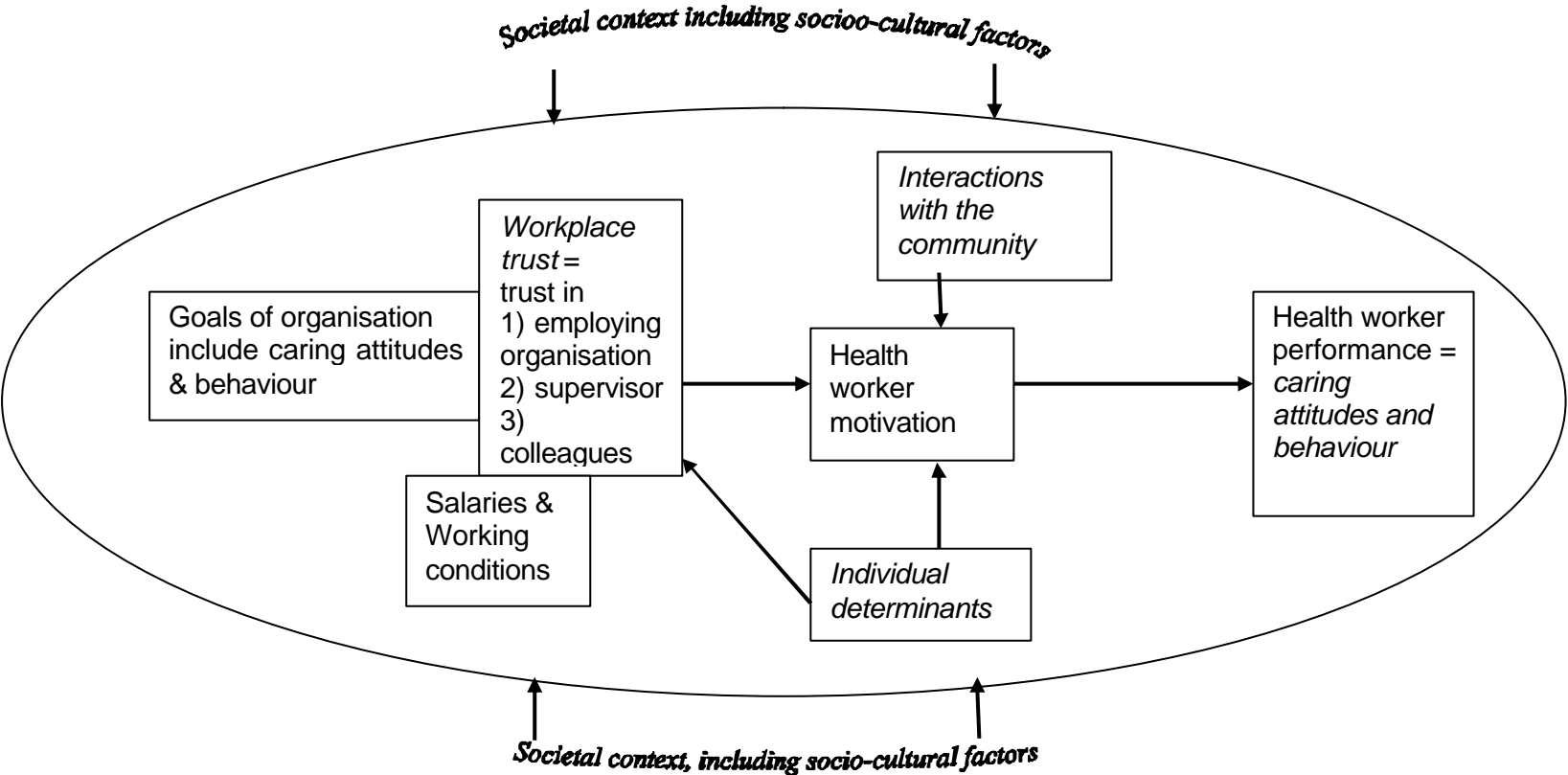
- strengthening the management and leadership skills of those health workers in charge of facilities is essential;
- given the currently relatively weak influence of external supervision and government-as-employer, there may be potential for strengthening government health worker motivation by strengthening external supervision and management in relation to primary care facilities;
- the management decisions apparently of particular importance to motivation are those influencing routine facility operations (associated largely with the health workers in-charge of dispensaries) and those associated with basic human resource management practices (training, appraisals, salary increases, promotion) and implemented outside the health facilities
- the apparent weakness of government appraisal and disciplinary procedures, in particular, suggests that strengthening these may offer opportunities for actively influencing motivation - but such actions should be sensitive to the real potential to have negative rather than positive impacts;
- as the way in which management decisions are implemented is a critical influence how they impact on motivation, particular attention needs to be paid to communication and consultation, transparency and fairness, and responsiveness;
- given that primary care facilities managed by churches are often the sole health care providers in remote communities and that church organisations face a funding crisis, it might be important for government to consider whether and how it can support these organisations and their facilities – for example, complementing the current support offered for routine operations by opening up training opportunities to church staff, or perhaps even taking over the employment responsibilities of these staff.

Finally, although some factors influencing motivation lie outside the control of district managers, these managers may at least be able to lessen their negative impacts on health worker motivation. This might be by strengthening their own management processes and/or by seeking to intercede with other bureaucratic levels.

Annex 1: Aspects of management that influence workplace trust

Aspect of management	Examples
1) Trust in employing organisation	
<i>Leadership</i>	<ul style="list-style-type: none"> ➤ Ensure clear and wide communication of organisational goals and management procedures ➤ Inspire workers to share organisational goals and co-operate in achieving them ➤ Demonstrate personal values that reflect organisational goals
<i>Recruitment</i>	<ul style="list-style-type: none"> ➤ Recruit people whose skills and values match organisational goals and tasks
<i>In-service training</i>	<ul style="list-style-type: none"> ➤ Provide training that supports workers to implement tasks assigned to them in workplace, in manner required by organisation (ensure multi-skilling) ➤ Select people for training on basis of clear, appropriate and consistently-applied procedures, that reflect organisational goals
<i>Staff appraisal & award system</i>	<ul style="list-style-type: none"> ➤ Ensure appraisal, reward and disciplinary criteria are linked to organisational goals, well communicated and applied fairly and consistently ➤ Reward people who share organisational values and goals (such as respectful behaviour to others, client orientation etc) ➤ Limit degree of resort to sanctions, as opposed to use of rewards
<i>Defining jobs</i>	<ul style="list-style-type: none"> ➤ Allow multi-tasking, do not specify jobs too narrowly, or rigidly
<i>Degree of worker autonomy allowed</i>	<ul style="list-style-type: none"> ➤ Allow workers to adapt and expand job definitions in response to their understanding of patient needs ➤ Encourage debate and discussion among workers about organisational goals and activities ➤ Limit extent of monitoring and measurement of worker performance
2) Trust in supervisor	
<i>Supervision</i>	<p>Demonstrate personal values and behaviours that build inter-personal trust:</p> <ul style="list-style-type: none"> ➤ Implement management procedures consistently and fairly ➤ Take action to tackle abuse or breakdown of trust within workplace ➤ Clearly explain reasons for decisions ➤ Treat those affected by decisions with dignity and respect
3) Trust in colleagues	
<i>Promoting teamwork</i>	<ul style="list-style-type: none"> ➤ Establish and support self-managed worker teams ➤ Reward group performance not individual performance ➤ Reward adherence to norms of professional groups

Annex 2: Study conceptual framework



Annex 3: Staff interview guidelines

FIRST STAFF INTERVIEW (USING THE CRITICAL INCIDENT APPROACH)

Logistic issues:

Conduct interviews either in a private place within the facility during the quieter hours of day, or interview outside facility.

If there are only a few staff in the facility, conduct the interview with each of them.

If there are many staff, then conduct the interview with the staff member in-charge and a selection of staff of different cadres (including non-professional staff), and include some staff with more and less positive attitudes/behaviours.

Tape record the interview, if possible.

Even if you do tape record the interview, remember to keep separate notes of key issues that strike you as you conduct the interview.

Key issues being sought through interview:

- The aim of the interview is to get the interviewee talking freely about the events/things that they feel have impacted on them and their work over the last years. Then the interview moves on to asking more detailed questions about some of these events/things.
- Clearly we are most interested in events/factors that have influenced their approach to work, and their behaviour and attitudes at work. These could be things in their personal life, but you will need to encourage them to tell you why and how personal issues affected work and workplace issues. They could also be things about how the facility functions, or how the community interacts with the facility, or factors/events outside the facility.
- In order to get the interviewee talking freely, you may need to try several approaches or ask several different questions to elicit a full response right at the start of the interview. Which question will work may depend on how long the interviewee has been working in the facility, or what captures their attention.
- You should not lead the interviewee to any of these issues nor select for the interview the issues discussed in most detail.
- To aid discussion, you could draw a line on a piece of paper with today's date on one end and the time at which the respondent joined the facility (/became the in-charge etc) at the other end. Then ask the respondent to work backwards from today's date to the earlier date, identifying major events or issues. Mark the events on the timeline as they are raised by the respondent. Allow the interviewee to identify events without prompting for specific issues.

Respondent characteristics

Before you begin assign a code to the interview, and only use the assigned code in subsequent notes about the interview. Also make notes of:

- the person's position (type of staff)
- gender
- age (roughly)
- length of appointment in the facility
- date and place of the interview

Introducing the interview

Thank you for agreeing to meet with me. I'd like to talk with you about the clinic/dispensary and your work there. As you know I'm talking to your colleagues as well – and I'm also talking to other primary care workers in other facilities. We are trying to understand the challenges you face at work, as well as how feel and think about your work.

All these interviews are confidential. Although we will use your interview in developing our broader understanding of the life of a clinic nurse, we won't be telling other people what you said specifically and we won't link anything you have said to your name in our reports.

However, we will be talking to [choose correct titles] *district/regional/provincial/national* managers about the views and experiences of all those we have interviewed, with the aim of identifying ways to provide a more supportive management environment for you and your work.

I would like to try and ensure that I have a good record of the interview, gathering your views as accurately as possible. So may I tape-record this interview? May I ask you to sign these two confidentiality forms to confirm your agreement to talk to me. I will leave you with copies of each too.

Beginning the interview

Question Set 1:

When did you first join the staff of this facility (or become the in-charge of this facility)?

Since that time, what have been the main events that have impacted on you and your work here in the facility? **OR** Since that time, what are the big issues you have had to deal with?

OR

When was the current in-charge of the facility appointed?

What have been some of the big changes in this facility since s/he was appointed? **OR** What are the big issues you have had to deal with since then?

OR (for in-charges)

When did you become in-charge here?

What are the big issues you have had to deal with since then?

Question Set 2:

Out of all these events, which three or four do you think were most important to you and your work?
For each event/issue, please explain why you have selected these events.

Note to interviewer:

Allow the interviewee to identify events without prompting.

Investigating each key event/issue in more detail

Question Set 3:

Can I now ask you to go back to each of these events/factors, and to tell me more about them.
Taking the first event, please tell me what happened.

Note to interviewer:

Allow the respondent to tell the story of each event/issue in their own words. Try not to interrupt too much but encourage the interviewee to tell everything about the story by prompting with questions like:

- What happened next?
- Why did it happen?
- How did it happen?
- Who was involved?
- How did it influence your work environment and your work - both in the short and long term?
- What did you feel?
- What did you think?
- What did you do?

Question Set 4+:

What about the second event? [and so on]

Conclusion

Thank you very much for your time. It's been really interesting to hear about your experiences.

Do you have any questions at this stage?

Again thank you. And let me just remind you that, as I said at the start, this interview will be confidential – no one will know what you personally have said, although we will use what you have said to help us get a broader picture of the life of a clinic staff member!

I would also like to make another appointment to talk to you again later – would that be ok? At the next interview I'd like to ask you some more specific questions about your experiences.

SECOND, DETAILED STAFF INTERVIEW

Logistics:

Conduct interview either in a private place within the facility during the quieter hours of work day, or outside facility.

Aim to conduct with all staff in facility, including non-professional staff. But if there are very large numbers of staff, you may need to select a majority to interview – including the staff member in-charge and a selection of staff of different cadres (including non-professional staff). Interview more people than in the first staff interview.

This is a long interview. You may need to split it in two and conduct it over two sessions.

You should try to conduct it as a conversation as much as possible. You may need to move between topics in a different order to the approach listed here. That's fine, but you need to cover all the sections and all the issues raised in each section. And remember to ask the direct trust questions only at the end of each section. The words in italics are notes to you, the questions are in bold and the prompts are either in brackets or in boxes.

Key issues sought through interview:

In contrast to the initial interviews, this interview seeks specifically to investigate how health workers view their jobs and workplaces in general, and then focuses down on the issues that we have identified as being likely to influence workplace trust, health worker motivation and health worker attitudes and behaviours towards patients.

Please note that there are no direct questions on health worker attitudes and behaviours towards patients – rather this issue is an important area for prompting during the conversation. But please be sensitive in prompting on this point!

Respondent characteristics:

Before you begin assign a code to the interview, and only use the assigned code in subsequent notes about the interview. Also make notes of:

- the person's position (type of staff)
- gender
- age (roughly)
- length of appointment in the facility
- date and place of the interview

PART 1. INTRODUCTION

Remember to adapt for those you have interviewed before

Thank you for agreeing to meet with me. I'd like to talk with you about your work. As you know I've already talked to some of your colleagues and I will also be talking to staff in other facilities. We are trying to understand how clinic staff feel and think about their work and what influences them in their views.

All these interviews are confidential. Although we will use your interview in developing our broader understanding of the life of a clinic nurse, we won't be telling other people what you said specifically and we won't link anything you have said to your name in our reports.

However, we will be talking to district/regional/national managers about the views and experiences of all those we have interviewed, with the aim of identifying ways to provide a more supportive management environment for you and your work.

OR

Thank you for agreeing to meet with me again. I'd like to have a more detailed discussion with you about aspects of your work than when we last met. As you know, we are trying to understand how clinic staff feel and think about their work and what influences them in their views.

AND FOR ALL

I would like to try and ensure that I have a good record of the interview, gathering your views as accurately as possible. So may I tape-record this interview? May I ask you to sign these two confidentiality forms to confirm your agreement to talk to me. I will leave you with copies of each too.

PART 2. INITIATING THE INTERVIEW

Try to set the person at ease by asking the following types of questions as in a conversation. Adapt the questions to what you already know about the person

I understand that you have worked here for quite a while/only a short time?

Do you live locally (or where)? How do you like being here? Are you involved in any community activities in the surrounding community?

After the initial chat, move on to investigate ...

PART 3. FEELINGS ABOUT WORK

Note that the intention here is to get the interviewee to focus on their work (rather than the workplace, the clinic/dispensary), that is, the job itself, the activities and tasks that it involves. However, in discussion, issues to do with the workplace (management, lack of resources, colleagues etc), might come up. Let the interviewee talk about all issues initially, but try and get them to focus on the work itself before going on to discuss workplace issues in more detail in the next section.

Across all answers to this next set of questions look out for and when appropriate, prompt for:

- If and how things like supervision, salary level, payment timeliness influence feelings about work (personal hygiene factors)
- If and how things like the work itself, achievement, recognition, advancement, personal growth influence feelings about work (personal motivation factors)
- What is the relative importance of these two sets of motivating factors
- To what extent self-fulfillment is influenced by the specific tasks that make up job, and/or by ability to determine those for self
- What personal values (e.g. strong work ethic, concern for others etc) underlie views of work and satisfaction derived from it
- Interviewee views/feelings about patients and wider community (perhaps linked to specific actions directed towards patients and wider community)
- If and How views/feelings/experiences influence attitudes/behaviours towards patients/community (and how other factors influence these)

3.1 How do you like your work?

>>>Prompt for:

- a) things most like; things least like – and specific examples of these things
- b) why like or dis-like these things?

3.2 On balance, would you say you liked your job? (why/why not?)

3.3 Ok and on balance, would you say that you got satisfaction from your job? (in what way/why not?)

3.4 What are the key factors influencing your work?

>>>Prompt for:

- a) How does each influence your work: can you give me examples?
- b) How do you cope with each of these things?

3.5 What, if anything, would enable you to do your work better? (why?)

3.6 What, if anything, would enable you to enjoy your work more? (why?)

3.7 What would you say are your personal goals in life? and work?

PART 4. FEELINGS ABOUT WORKPLACE

The primary focus of this section are the workplace issues. If some issues have already been raised by the interviewee, then just pick up on them and ask additional questions from the set below. If workplace issues have not yet been raised, then seek to get the interviewee to talk generally about them. The idea of this section is to get the interviewee to identify the workplace issues that they see as most important, before going on to discuss specific issues we see as important in more detail.

4.1 Please tell me what you like most about your workplace and what do you like least?

>>>Prompt for: Examples? Why do you like/dis-like these things?

4.2 What are the key factors influencing your workplace?

>>>Prompt for resource related issues e.g. drugs, equipment availability, transport

4.3 Can you tell me how each of these factors influences your workplace?

>>>Prompt for: Examples?

4.4 How do you cope with each of these factors?

4.5 What other action would help you cope with the negative factors?

PART 5. INVESTIGATING FEELINGS AND BELIEFS ABOUT COLLEAGUES WITHIN FACILITY

From this point of the interview, the intention is to focus on the specific issues we have already identified as being interesting to us. But where possible, try to link the questions back to issues already raised by the interviewee.

In this set of questions look out for/Prompt for:

- whether supervisor/facility in charge gets involved in teams, and how that affects work
- whether there are sub-groups within facility based on personal friendship, ethnicity, common training, shared values etc, and how that affects interviewee and work
- if and how team work/reliance on colleagues influences attitudes and behaviours towards patients/community

In relation to factors influencing team work/reliance on colleagues, look out for/prompt for:

- bases of inter-personal trust: is it rooted in personal connections, friendships etc OR skills, competence of colleagues OR shared values
- reliance on each other not so much about trust, but more because have no choice but to depend on each other
- role of facility in-charge/external supervisor in building/undermining relationships with colleagues and trust

Try to use an easy opening question, e.g.:

5.1 You've already indicated that your colleagues are an important influence over your work.

Can we talk more about how you work together? OR Who do you work most closely with in this facility?

5.2 Do you feel there is a good team spirit among staff in this facility? (why/why not? examples?)

>>>Prompt specifically for:

- a) Would you say you rely on your colleagues in this facility in any way? In what way? (For professional/personal reasons? Which colleagues?)
- b) Does working with your colleagues in this way help you to achieve personal or work goals? (which goals; why/why not?)

5.3 What factors encourage or discourage you to rely on other colleagues in the facility?

5.4 Would you like to be able to rely on your colleagues more?

>>>Prompt for: Why/why not? What would encourage you to rely on them more?

5.5 Trust focus:

- **Would you say you trust your colleagues?**

>> Prompt for: In what way/in relation to what things? Work or personal matters?

- **Would you say you didn't trust anyone for some reason?**

>>>Prompt for: in relation to what things? Why?

- **What influences your trust/dis-trust in your colleagues?**
- **Does it matter to you that you trust/dis-trust your colleagues? (Why/why not?)**

PART 6. INVESTIGATING FEELINGS AND BELIEFS ABOUT SUPERVISOR

The intention here is to focus on the person seen by the interviewee as their main supervisor. Although this may be the in-charge of the facility, it could also be someone on the district management team or outside the facility. Clarify who is the main supervisor as the first point.

Try to use an easy opening question, e.g.:

6.1 You've already mentioned that xxx influences your work: are they your main supervisor?

OR Of the people you've already spoken about, is one the main supervisor of your work?

Which one?

6.2 What influence do they have over you and your work?

6.3 Do you generally agree with your supervisor's decisions? (Why/why not?)

Prompt for:

- influence over job definition and tasks
- appraisal, reward and discipline roles
- influence over training opportunities
- inspiration, guidance, support at professional and personal levels
- arbitrary, unclear, inconsistent

6.4 Would you say you have a good relationship with him/her?

>>>Prompt for: Why/why not?

6.5 Would you say others have a good relationship with him/her?

>>>Prompt for: Why/why not?

In answers to these questions, prompt for:

- Personal characteristics of supervisor: honesty, integrity
- Technical competence of supervisor
- Supervisor's attitudes towards individual workers: respect, fairness
- Supervisor's behaviour towards individual workers: consistency, listening, support
- Communication practices
- General attitudes: fairness and firmness

6.6. Trust focus:

- **Would you say you trust your supervisor?** (In what way/in relation to what things? Work or personal matters?)

- **Would you say there are some things you don't trust you supervisor about?** (what things? Why not?)
- **What influences your trust/dis-trust in him/her?**
- **Does it matter to you that you trust/dis-trust him/her?** (Why/why not?)

PART 7. INVESTIGATING FEELINGS AND BELIEFS ABOUT HIGHER MANAGEMENT/EMPLOYING ORGANIZATION

Note to interviewer: If possible, start here with some sort of opening comment. For example, ok, can we now move outside this facility and talk a little about your employer.

7.1 Who is your employer? (Who pays your salary?)

7.2 Can you tell me which person or people in your employer's organisation gets involved in the following tasks and areas of decision-making in relation to primary care workers:

Task	Response
Recruitment	
Job descriptions	
What in-service training is provided and who is chosen to receive it	
Performance appraisals and career development advice	
Salary levels and salary increases	
Disciplinary procedures	

7.3 Can we talk a little more about specific issues (prompts in italics):

- Recruitment: Do you think the organization choose the right people for the job? (*In what way yes/no?*)
- Worker autonomy/job description: Are you allowed to make your own decisions about any aspects of your work? If yes or no: does your level of decision-making influence how you feel about your work/workplace?
- In-service training: Have you ever received in-service training? How were you chosen? How are people usually chosen? What do you feel about these procedures?
- Appraisal: Do you have a regular discussion with a supervisor about your work and work performance? (*With whom?*) What do you feel about these discussions /about not having such discussions?
- Salary and salary increases: Do you normally get your salary on time? How are salary increases normally awarded in this organisation? (*Have you ever had one? Who decides you should get one and on what basis?*) How do you feel about these experiences/procedures around salaries?
- Discipline: Who makes disciplinary decisions in the organization and on what basis? How do you feel about these procedures?

7.4 Overall, do you think xx is a good employer? (Why/why not?)

7.5 Do you think your employer cares about you? (In what way yes or no? Give examples)

7.6 Does your experience of your employer influence the way you do or feel about your work? (how? Give examples?)

In these questions, prompt for:

- Communication practices: Do you think the communication practices within the organization are strong or weak? How do they affect how you feel about your work?
- Fairness: Do you think the way decisions are made about employees in this organization are generally fair or not? Explain/give examples
- Organisational goals: How would you describe the main goals of your employer? Do you value these goals? (Why/why not?) Do you think these goals are reflected in your experience of working for them? (Why/why not?)
- Senior managers/leaders: Do you know much about senior managers/leaders within the organization (at local, provincial/regional or national levels)? Do you think that they provide good guidance to the organization? (why/why not? Examples?) What sort of system/policy changes have influenced your work here recently? Do you think the senior managers/leaders have managed these changes well? (Why/why not?)

7.7 Trust focus:

- **Overall, would you say your trust your employer/employing organisation?** (In what sense do you trust and in what sense do you dis-trust?)
- **What influences your trust/dis-trust in your employer?**
- **Does it matter to you that you trust/dis-trust your employer/employing organisation?** (Why/why not?)

PART 8. INVESTIGATING CONTEXTUAL INFLUENCES

Note to interviewer: If possible, start here with some sort of opening comment. For example: thanks, let's now move outside the workplace altogether.

8.1 Are there events, factors or people outside this facility and your employer that influence you and your work? What?

>>>> Prompt for:

- a) How do they influence you and your work?
- b) How do they make you feel about your work?
- c) How do you manage them?
- d) Can anything be done to help you cope with them?

Prompt also for:

- Societal level actors e.g. professional groups, politicians
- Community level actors e.g. leaders, community committees etc
- Society level factors e.g. conflict within community, economic constraints, political factors
- Policy changes
- How these factors influence attitudes and behaviours towards patients/community

8.2 Does the community that the facility serves influence it at all? (the services and the people working in it? How? Give examples.)

Prompt also for:

- Society level factors e.g. conflict within community, economic constraints
- Attitudes and behaviours towards patients/community

CONCLUSION

Thank you very much for your time. It's been really interesting to hear about your experiences and views.

I've asked so many questions, do you have any further questions?

Again thank you. And let me just remind you that, as I said at the start, this interview will be confidential – no one will know what you personally have said, although we will use what you have said to help us get a broader picture of the life of a clinic staff member!

Annex 4: Patient and key informant interview guidelines

COMMUNITY KEY INFORMANT INTERVIEW

Note to interviewer on logistics

Interview in a private place

Select as interviewees 3-5 people from:

- Local political leaders (e.g Tanzania: street leaders , Diwani)
- Leaders within local burial or credit societies
- Leaders of local health or women's NGOs/CBOs
- Members of clinic committee (if exists)
- Some from community closeby to facility and some from community further away but served by facility
- People /patients with particularly strong views identified from observation

Respondent characteristics:

Gather information about the respondent before the interview and assign a code to him/her. Only use the assigned code for the interviews in the notes / transcripts, together with notes about gender, age etc

Introducing the interview

Thank you for agreeing to meet with me. I'd like to talk with you about health facility xx, and the other facilities /providers available to this community. We are also talking to other people in this community about these issues in this community and other communities.

All these interviews are confidential. Although we will use your interview in developing our broader understanding of the functioning of clinics, we won't be telling other people what you said specifically and we wont link anything you have said to your name in our reports.

However, we will be talking to health systems managers about the views and experiences of all those we have interviewed, with the aim of developing ways to strengthen clinic operations.

I would like to try and ensure that I have a good record of the interview, gathering your views as accurate as possible. So may I please tape-record this interview? May I ask you to sign these two confidentiality forms to confirm your agreement to talk to me. I will leave you with copies of each too.

Setting interviewee at ease

Can you tell me how long you've lived in this community?

[if relevant] And am I right in thinking that you are xxx [state position understand interviewee to hold]? How long have you held that position?

Comments on xxx facility

1. Have you ever visited xx facility (*how often? When last?*)
2. What services are available there?
3. Are some better than others? (*Which ?why?*)
4. Is the facility generally well used by the community or do people prefer to use other facilities? (*if they use other facilities which ones and why?*)
5. What do people like/dis-like about the facility? (*how does it compare with other facilities/providers used by the community*)
6. If not already discussed please say something about :
 - The training and skills of the staff working there
 - The attitudes and behavior of the staff towards patients and the community
 - Whether necessary supplies and equipment are available
 - How long people have to wait to be seen
 - How long people ever complain about the services there what about?
 - Can they influence how services are provided in any way? How? (probe for formal and informal mechanisms) Does it get results?
 - Whether the facility gets visitors and support from elsewhere?
7. What suggestions would you make to improve the facility?
8. What factors do you think have most influence over how the facility and its staff function?

Investigating community mechanisms that influence health worker performance

1. Has there ever been a situation whereby the community had an influence on the clinic?
What/why/who/how brought about?
2. How does the clinic respond to community needs ? Can you give examples?
3. If you want to lay a complaint who do you go to ? how do you do it? do you get response?
4. Are there different mechanisms for different types of complaints?
5. Does a clinic have a clinic committee? (*note : not to ask this question to a clinic member*)
6. If yes, how many members does it have?
7. It is composed of what sort of people?
8. How are these people chosen?
9. What are the roles of the committee?
10. Do you trust the clinic committee to address your needs and concerns? (*note: not to ask this question to a clinic committee member*)
11. If no why not? If yes why? If yes ask for examples (*note: not to ask this question to a clinic committee member*)
12. IF NO to any of above:
 - Do you think that it would be a good thing if the community could influence the clinic? Why? Over what issues? what sort of a mechanism?
 - Would you like a structure where by the community in this village would be represented in terms of their needs?
 - How much influence would you like that structure to have?

Trust and xx facility

1. Would you say that people in this community trust the services provided by facility xx?
2. In what way do they trust it or dis-trust these services?
3. What leads them to trust or dis-trust?
4. If not already discussed , please comment whether these issues are important in relation to trust/dis-trust in the services :
 - The range of services provide
 - The training and skills of the staff working there
 - The attitudes and behavior of the staff towards patients and the community
 - Whether necessary suppliers and equipment are available ?
 - How long people have to wait to be seen
 - Whether people can influence the services provided in any way
 - Whether the facility gets visitors and support from elsewhere?
5. Do you think people in this community think it is important to trust the facility ? (*why/why not ? examples?*)

CONCLUSION

Thank you very much for your time, it's been really interesting to hear about your experiences and views.

I have asked so many questions, do you have any further questions?

Again thank you. And let me just remind you that, as I said at the start, this interview will be confidential no one will know what you personally have said.

IN-DEPTH INTERVIEWS WITH PATIENTS

Note to interviewer on logistics:

Interview away from the facility, and in a private place.

Selecting interviewees:

Choose a mix of those living nearby and those living further away.

Using facility records/other relevant approaches, choose 4 mothers attending for ANC, 4 patients attending for chronic services, 4 patients attending for acute services.

Respondent characteristics:

Gather basic information about the respondent before the interview and assign a code to him/her. Only use the assigned code for the interviewee in the notes/transcript, together with notes about gender, age etc

Introducing the interview

Thank you for agreeing to meet with me. I'd like to talk with you about your experience of the xx services provided by yy facility. We are also talking to other people in this community and other communities about their experiences with this facility.

All these interviews are confidential. Although we will use your interview in developing our broader understanding of the functioning of clinics, we won't be telling other people what you said specifically and we won't link anything you have said to your name in our reports.

However, we will be talking to health system managers about the views and experiences of all those we have interviewed, with the aim of identifying ways to strengthen clinic functioning.

I would like to try and ensure that I have a good record of the interview, gathering your views as accurately as possible. So may I tape-record this interview? May I ask you to sign these two confidentiality forms to confirm your agreement to talk to me. I will leave you with copies of each too.

Investigating knowledge and experience of xx facility

1. Can you tell me for how long you have lived in this area?

2. I understand that you have been using xx services at yy clinic. How long have you been using these services?
3. Do you regularly/frequently attend clinic yy for other services? (*Why/why not?*)
4. Have you used other health care providers for service xx or more generally? (*Why/why not?*)
5. Please tell me something about the xx services at yy clinic:
 - What do you like about them?
 - What do you dislike about them?
 - How do they compare to similar services at other clinics?

Investigating community mechanisms that influence health worker performance

11. Has there ever been a situation whereby the community had an influence on the clinic?
What/why/who/how brought about?
12. How does the clinic respond to community needs? Can you give examples?
13. If you want to lay a complaint who do you go to? how do you do it? do you get response?
14. Are there different mechanisms for different types of complaints?
15. Does a clinic have a clinic committee? (*note : not to ask this question to a clinic member*)
16. If yes, how many members does it have?
17. It is composed of what sort of people?
18. How are these people chosen?
19. What are the roles of the committee?
20. Do you trust the clinic committee to address your needs and concerns? (*note: not to ask this question to a clinic committee member*)

12. If no why not? If yes why? If yes ask for examples (*note: not to ask this question to a clinic committee member*)

13 IF NO to any of above:

- Do you think that it would be a good thing if the community could influence the clinic? Why? Over what issues? what sort of a mechanism?
- Would you like a structure where by the community in this village would be represented in terms of their needs?
- How much influence would you like that structure to have?

Investigating trust in providers

1. Do you think that the clinic provides good [*type of service*] services? (*Can you give examples?*)
2. What aspects of how the staff behave and do their work are good and what bad? (*Can you give examples?*)
3. What other features of the xx service do you think are good and what bad? (*Can you give examples?*)
4. If use other services at this facility, How does this service compare with the other services at xx facility?
5. Given your experiences, When you're ill do you go there believing the staff are going to do the right thing for you? (*Why/why not? Examples?*)
6. Given your experiences:
 - Would you say that you trust the staff providing these services? (*Why/why not? What leads you to trust/not trust?*)
 - Do you trust other health care providers, perhaps working in other clinics, more? Why/why not?
 - Does it matter to you that you (dis)-trust the staff in this facility?
 - Does that (dis)-trust in staff influence when and if you use service xx/ the services more generally? Or your overall satisfaction with the services? (*Why/why not?*)

7. Does any other aspect of your experience at this facility influence your satisfaction with services at this facility? (*What and why? How does it influence your views?*)

Investigating trust in health system [either government or xx church]

1. In general, would you say trust government [xx church] health facilities and how they are organized/managed as whole? (*Why/why not?*)
2. What influences your level of trust in these facilities and their general organisation?

Prompt for:

- Role of health workers specifically
 - How health workers are managed (e.g. disciplinary/promotion systems; training and skills; level and form of provider payment etc)
 - General management systems in government [xx church]
 - Potential for community in general to influence government [xx church] health system
 - Links/Differences between what patients want from health system and what see as government [xx church] goals for health system
 - Leadership and vision within health system
3. Does it matter to you that you trust/don't trust government [xx church] facilities in general? (*How/Why/why not?*)
 4. Does your (dis-)trust influence your use of its services or how you experience the care they provide or your overall satisfaction with services? (*How/Why/why not?*)
 5. Does your (dis-)trust influence your trust in government [xx church] in general? (*How? Why?*)

Annex 5: National level interview guidelines

1. What do you see as the key goals of the health system?
2. What are the key expectations of health workers in achieving these goals?
3. Is there a role for caring attitudes and behaviours in these goals/expectations?
4. What recent health system reforms have been introduced – and how do they address health system goals, and expectations of health workers?
5. In your view, what are the key strengths and weaknesses of public primary care provision in this country? Do you have any concerns about health worker attitudes and behaviours?
6. In your view, what factors influence health worker performance in general –and with specific respect to attitudes and behaviours?
7. What are the roots of these factors?
8. How can they be tackled to allow performance improvements?
9. Can you tell me something about levels of health worker motivation in the public system?
10. Do you think health worker motivation is currently influencing the performance of primary care facility? In what way?
11. In your view, what are the key factors that influence motivation of health workers in primary care facilities? how do these factors influence motivation?
12. What other factors influence provider performance at this level?
13. How does the provision of primary care differ between public and church organisations?
14. In your view, does the level of health worker motivation influence the patient's perception of/satisfaction with primary care services?
15. Do communities influence health care delivery? How? if not, why not?
16. Can you clarify for me the main human resource management practices that affect primary care workers?

Annex 6: Documents reviewed during course of national level work

TITLE	AUTHOR	YEAR
National Health Policy	Ministry of Health -Tanzania	1990
Draft Inception Report and Indicative Work Programme	Ministry of Finance - Tanzania	1993
Strengthening of Budgeting and Planning In Health and Education	Ministry of Finance - Tanzania	1994
Proposal for Health Sector Reform	Ministry of Health	1994
Donor Financing for Local Government Health Services	Mtei, O.P.S	1995
Capabilities of Public, Voluntary and Private Dispensaries in Basic Health Service Provision	Ahmed, Abdullahi M Urassa, Davip P Gherardi Eugenio and Game Nigussie Yitagesu	1996
Comprehensive Summary of the Sectoral Review	United Republic of Tanzania	1996
Guideline Standards for Health Facilities	United Republic of Tanzania Ministry of Health	1996
Demographic and Health Survey 1996	Bureau of Statistics and Planning Commission - Tanzania	1997
The National Employment Policy	Ministry of Labour and Youth Dev. -Tanzania	1997
A Baseline Service Delivery Survey for Rural Tanzania	Tanzania Dev. Research Group	1997
Managing Public Sector Reform: The Case of Health Care	Economic and Social Research Foundation	1998
Economic Analysis of an Emerging Mixed Health Care System and Implication for Management and Regulation: Initial Themes and Issues of Research Design	Mackintosh, Maureen and Tibandebage, Paula	1998
Public Service Medium Term Pay Policy	President's Office -Tanzania	1998
Challenges facing private sector health providers: The Mbeya experience	Dyauli, Seth	1999
Cost sharing in Education and Health	Maliyamkono, TL and Ogbu, O (TEMA Publishers Company Ltd., Dar es Salaam)	1999
Community Health Fund (operational guidelines and district health plan model)	MOH, URT	1999
Public Service Management and Employment Policy	President's Office - Tanzania	1999
Tanzania Development Vision, 2025	President's Office: Planning and Privatization, URT	1999
Institutional Cultures and Regulatory Relationship in a Liberalizing Health Care System: a Tanzania Case Study	Tibandebage, Paula and Mackintosh, Maureen	1999
The Health Sector Reform Programme of Work	United Republic of Tanzania	1999
Medium Term Strategic Plan 2000 - 2004	MOH, URT	2000
Situation Analysis of 45 councils under phase II of the joint Health Sector/ Local Government Reform	National Institute for Medical Research and Ministry of Health	2000
Operationalisation of the Selective Accelerated Salary Enhancement Scheme	President's Office - Tanzania	2000
Public Policy and Public Sector Investment in Tanzania	Tibandebage, Paula	2000
Current issues in sector-wide approaches for health development: Tanzania case study	Brown, Adrienne	2001

TITLE	AUTHOR	YEAR
The health sector-wide approach and health sector basket fund, Unpublished ESRF working paper	Hobbs, Brian	2001
Public Service Reform Programme 2000 -2011	President's Office - Tanzania	2001
National Policy on HIV/AIDS	Prime Minister's Office - Tanzania	2001
Private Sector Development: The Case of Private Health Facilities	Tibandebage, Paula A Semboja, Haji H. Mujinja, Phare and Ngonyani Henock	2001
Component Description: Health Sector Programme Support, Phase II: SASE Component	United Republic of Tanzania	2001
The State of Tanzania's Social Sector in the Development Context	Wangwe S. and Rweyemamu D.	2001
Client Service Charter	Ministry of Health - Tanzania	2002
Capitalization of Hospital Pharmacies and a Drug Revolving Fund (operational manual)	MOH, URT	2002
Managing and Regulating Mixed Health Care Systems: A Tanzania Case Study	Tibandebage, Paula and Mackintosh, Maureen	2002
The Public Service Act, 2002	United Republic of Tanzania	2002
Tanzania Assistance Strategy: Tanzania Country Profile Vol I	United Republic of Tanzania	2002
Tanzania Assistance Strategy: Appendix: Priority Areas Vol II	United Republic of Tanzania	2002
Revised National Health Policy	MOH, URT	2003

Annex 7: District level interview guidelines

IN-DEPTH INTERVIEWS WITH DISTRICT MANAGERS AND PRIMARY SUPERVISORS OF CASE STUDY FACILITIES

Interviewees: should include both government district manager and any key supervisor of primary care clinics; also, in Tanzania, church managers

Introducing the interview

Thank you for agreeing to meet with me. I'd like to talk with you about health worker motivation and performance, with specific reference to attitudes and behaviours, and the key factors influencing it.

All these interviews are confidential. Although we will use your interview in developing our broader understanding of how clinics operate, we won't be telling other people what you said specifically and we won't link anything you have said to your name in our reports.

However, we will be talking to regional/national managers about the views and experiences of all those we have interviewed, with the aim of identifying ways to strengthen clinic operations.

I would like to try and ensure that I have a good record of the interview, gathering your views as accurately as possible. So may I tape-record this interview? May I ask you to sign these two confidentiality forms to confirm your agreement to talk to me. I will leave you with copies of each too.

Respondent characteristics

Note to interviewer:

Gather basic information about the respondent before the interview and assign a code to him/her. Only use the assigned code for the interviewee in the notes/transcript, together with notes about gender, age etc

Can I just check that I have understood your position correctly? You are xx [position].

Organisational goals and health worker performance

Tell me about primary care provision in this area...

>>> *Prompt for:*

- *what works, what doesn't work, and why?*

What do you think of the performance of health workers?

>>> *Prompt for:*

- *why is it good /bad?*
- *what are factors influencing this?*
- *what motivates health workers?*

Follow on, Have there been any initiatives to tackle these issues in this area recently?

[In Tanzania only]: Do you think there is a significant difference in motivation/ behaviour between public sector health workers and private/NGO workers? If so , why?

Check that you have covered – and if necessary prompt for:

- Community perceptions of facilities and health workers
- Attitudes and behaviour of health workers
- Motivation of health workers
- Things that have been done to try and tackle problems with health workers
- Do interviewees think health workers are an issue? In what way?

Human resource practices/processes

Do you find that you spend much time on human resource issues in your job?

Can you clarify for me your specific responsibilities with respect to the following HR procedures:

- Recruitment procedures
- Placement procedures
- Job definitions and task allocations (*Do staff have any scope for discretion in deciding what they do?*)
- In-service training opportunities
- Personnel appraisal systems
- Discipline/promotion systems
- Procedures for re-locating
- Procedures for salary increases

On what basis do you make your decisions?

>>> Prompt for:

- *What discretion do you have in making decisions?*

From your perspective, would you say that these procedures worked well on the whole?

>> Prompt for:

- *Why/why not?*
- *Are some bigger problems than others?*
- *Generally implemented consistently and fairly? Why/why not?*

Follow on, Are there any you would change? (why?)

How do staff see these procedures?

>> Prompt for:

- *Do staff see some as bigger problems than others?*
- *What underlies their views?*
- *Do channels of communication with staff work well? Why/why not?*

How do you think these staff views/experiences affect staff motivation and performance?

(Examples?)

Contextual influences

Other than the issues we've already discussed, what, in your view, are the types of factors that are influencing public primary health care provision not only in your district/area but also across the country at present?

Do these factors influence patient/community experience of care? (how?)

How does the public [church] sector compare with other providers?

Conclusion

Thanks very much for your time.

I've asked so many questions, do you have questions for me?

Are there any key documents on the health system's performance, health workers or HR issues that you would recommend we read? Can you tell us how to get hold of them?

Annex 8: Government human resource management functions: national and district interviewee perspectives on practices, problems and reforms

Function	Practices, Problems and Reforms
Recruitment	<p><i>Practices:</i> Districts determine needs, submitted to PO-RALG for onward consideration by Public Management Service and approval of Ministry of Finance</p> <p><i>Problems</i> due to cumbersome and slow process</p> <p><i>Reforms:</i> Districts can hire staff selves, but must then be based in district for five years before transfer</p>
Job definitions	<p><i>Practices:</i> Clearly stated and available; limited flexibility</p>
Staff transfers	<p><i>Practices:</i> decisions to re-allocate with district easily made by district managers</p> <p><i>Problems:</i> re-allocation across districts very difficult as needs district managers to make joint decisions</p>
In-service training	<p><i>Practices:</i> Training and development programmes based on Ministerial human resource plans District authorities plan and budget for their training needs, submitting requests through PO-RALG to MOH MOH responsible for qualification-based training programmes; PO-RALG responsible for short on-the-job training, but some collaboration with MOH</p> <p><i>Problems:</i> Training not clearly linked to work improvements Weak selection process, based on favouritism</p>
Appraisal	<p><i>Practices:</i> Annual appraisal forms completed annually, but face to face interaction only every 3 years; submitted to CHMT who make recommendations to District Council</p> <p><i>Problems:</i> Poor record-keeping so information sometimes lost Current system poorly managed, subjective and not participatory</p> <p><i>Reforms:</i> OPRAS to be implemented across public sector, with appraisal linked to performance contract; and with periodic reviews</p>
Salary increases	<p><i>Practices:</i> currently cost of living increases automatically given each year; other increases supposed to be linked to appraisal</p> <p><i>Problems:</i> Salary increases recommended through appraisal process take long time to be implemented</p> <p><i>Reforms:</i> in future (under OPRAS) will be linked to performance</p>
Promotion	<p><i>Practices:</i> All employees first employed in specified period of years promoted at the same time, regardless of performance; managed by PO-RALG for more junior district health staff, and MOH for more senior staff</p> <p><i>Problems:</i> failure and delays in promoting, together with failure to include merit as criterion, seen as a key problem by national respondents</p>
Discipline	<p><i>Practices:</i> CHMT recommends disciplinary actions to District Council with final decisions taken by District Executive Director</p> <p><i>Problems:</i> rarely implemented</p>

Annex 9: Health worker experience of human resource management functions

	Govt District 1	Govt District 2	Church District 1	Church District 2
Recruitment	Recruitment by DED; generally seen that right people recruited; 1 concern about favouritism	All feel recruitment procedures are acceptable	All happy with recruitment procedures	Not asked.
Job definitions	Most staff feel they have some autonomy in decision-making about how carry out assigned tasks	Most staff feel they have some autonomy in decision-making about how carry out assigned tasks, but only over small decisions	Most staff feel they have some autonomy in decision-making about how carry out assigned tasks	No staff feel comfortable with their level of decision-making
In-service training	all have received some training, and think decisions about who gets training are appropriate	most have received some training	None have received training	None have received training
Appraisal	Most raise concerns about process because few appraisals conducted and because salary increases resulting from appraisal slow	Limited clarity about appraisal process across staff, with some seeing supervision visits as appraisal	None have been appraised	None have been appraised
Salary increases	Problems of slow payment of salary and delays in receiving increases	No problems identified	One identifies problems with getting salary on time	None get salary on time
Discipline	Only one staff member says knows the procedure and is comfortable with it (because several people involved)	Only two staff members not familiar with procedure; but no indication that know it is applied	Only one staff member does not know procedure; not clear if applied	All know procedure; not clear if applied
Communication with employer	All staff see communication as reasonably good and link this to supervision visits and training sessions	All staff view as weak	Two staff view as good, and two as poor	All staff view as poor
Fairness of employer decision-making	Only one staff member said decisions were not fair	Two staff fair; two staff not fair/weak; one staff member not respond	Three staff view as not fair, one of whom links this judgement to the lack of communication	All staff view as not fair
Organizational goals	Two staff members say not know these goals; two present general statements based on their training	All staff not familiar with goals	All staff do not know these goals	All staff not familiar with goals