

**Regional Network for
Equity in Health in east
and southern Africa**

**DISCUSSION
Paper
NO. 61**

Non-financial incentives and the retention of health workers in Tanzania

Michael A Munga and Deogratius R Mbilinyi
National Institute for Medical Research (NIMR), Dar es Salaam

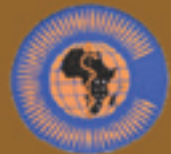
University of Namibia, Training and Research
Support Centre, University of Limpopo
With the Regional Network for Equity in Health
in East and Southern Africa (EQUINET)
in co-operation with the East, Central and Southern
African Health Community (ECSA-HC)

EQUINET DISCUSSION PAPER 61

July 2008

with support from SIDA Sweden

Valuing and Retaining our Health Workers



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EXECUTIVE SUMMARY

The Tanzanian public health sector is losing its workers to internal migration (from poorer, rural areas to richer, urban areas), migration from the public sector to the private sector and international migration, usually to wealthy, developed nations in the north. Non-financial incentives are one way of encouraging workers to remain in their posts. In this paper, the authors examine the implementation of policies to govern non-financial incentives to retain health workers, to fill a gap in the literature dealing with non-financial incentives and health worker attrition in Tanzania. This study was undertaken within the Regional Network for Equity in Health in East and Southern Africa (EQUINET), in co-operation with the Regional Health Secretariat for East, Central and Southern Africa (ECSA) as part of a multi-country programme to explore the incentives that encourage workers to stay in African health systems and work in underserved areas. It was co-ordinated by the University of Namibia, with support from the Training and Research Support Centre, University of Limpopo and the ECSA Regional Health Secretariat.

The paper examines a range of non-financial incentives including: training; leave; promotion; housing; and a safe and supportive working environment. It also examines the systems for managing personnel and the implementation of incentives as a factor in retention, including the participatory personnel appraisal system; worker participation in discussing their job requirements and welfare; supervision; recognition and respect.

Examining health worker retention and migration issues calls for a broader and a more comprehensive perspective, not only considering push and pull factors, but also macro-factors, such as the growing global economy and labour market. In this study, three approaches are used, namely, a literature review, and the collection of primary qualitative data and quantitative data in a field study. The literature review covered policy documents, published and grey literature concerning Tanzania from the mid-1980s to 2007, when most of the country's major health sector reforms (HSR) started. These reforms, in one way or another, might have contributed to the success and/or failure of efforts to make the Tanzanian health care labour market more attractive to professionals. Data for the field study was collected from seven districts, including five underserved districts with fewer health workers per capita based on the latest health workforce census, randomly selected from a list of ten districts.

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The literature review presents evidence of a number of policy recommendations that, if implemented, particularly in combination, may improve health worker retention in the public sector, particularly for health facilities in rural areas, which face a critical shortage. These include:

- Providing extra payments, such as hardship allowances.
- Proactively increasing the health budget in hard-to-staff districts over time.
- Improving general infrastructure, particularly health facility infrastructure.
- Providing more, useful training opportunities for health workers.
- Facilitating the acquisition of staff loans for personal development.
- Ensure that salary increments and promotions are implemented more vigorously and quickly for health workers working in disadvantaged rural districts.

Even though non-financial incentives are institutionalised by government policies and standing orders, their sustainability is eroded by the absence of special earmarked funding for their implementation. Decentralised districts also lack adequate powers and authority to manage health workers weakening their ability to implement non-financial incentives. There was general consensus from health workers and managers that interventions such as training and education, promotion and the provision of safe working and living environments can be strong motivators if implemented in an effective and sustainable manner. In contrast, health workers interviewed pointed to the demotivating effect of poor implementation of available non-financial incentives.

Participants in the field study observed that the major weakness with implementing non-financial incentives was the district authorities' inability to implement policies such as promotion and training. With regard to promotion, it was pointed out that districts have limited powers and authority to ensure that the process can be effected on time (when the employees' time for promotion is due). It should take two years for a deserving worker to be promoted but, in practice, it often takes three, four or more years. Training is a problem in two respects: employers fail to set enough funds for training and staff shortages prevent employees from going on study leave. Managers also perceived some staff as unwilling to go for further training on long courses because they did not want to be separated from their families or inconvenienced. Staff preferred to go on short courses with allowances. More than 60% of all health workers who attended short- and long-term training courses assessed them as useful in improving the efficiency and

effectiveness of their day-to-day tasks, compared to only about 25% who said the training was not useful. There was no significant difference across gender. Disaggregated by type of employer, only about 10% of private not-for-profit and 8% of the public sector employees described the type of training they attended as not useful.

Health workers interviewed in the field study also pointed to a lack of transparency in the implementation of programmes, such as those for promotion and training. Available non-financial incentive policies were felt to not match well with the reality in health facilities, due largely to the shortfall in resources for these. For example, senior officers are entitled to housing, but houses (reasonable decent houses) are not always available. The priority given to senior officers was also felt by some to be unfair, as all workers need adequate housing. Favouritism was seen as a problem in appointing people who go for training, especially short courses. Health workers reported inadequate feedback from employers and supervisors (especially when things have gone wrong), poor or inadequate assessment of staff training needs and delays in promotion, without information to workers on the causes of delays. Managers, on the other hand, reported that the heavy workload due a critical lack of adequately qualified health workers makes it difficult to release health workers for leave and training as it affects service delivery. Participatory mechanisms are in place for workers to discuss matters affecting their welfare, but are reported to be inadequate. It was also noted that the monitoring and evaluation of incentive regimes is weak or absent.

Health system development does not live in isolation from development of other sectors and systems. For efforts to ensure that the available policy measures and strategies can be implemented and produce the desired effects, strategic efforts are needed to address (in a holistic way) critical health worker issues ranging from recruitment, placement and retention, taking the needs of specific cadres, levels of the health system and areas.

Analysis of issues driving retention needs to take into account both individual and structural factors that shape individual health workers' preference structures and the complex nature of the health care labour market. A trivialised pull and push factors framework in analysing complex problems like retention, will not guide sustainable solutions. This needs to examine factors that not only guide the design of incentive regimes, but also the resources, management systems and other factors that enable their implementation in practice.

1. INTRODUCTION

Tanzania is one of the poorest countries in the world, with more than 30 million people, and its health indicators have been consistently poor for many years, despite well-documented, effective health interventions (UNDP, 2002; World Bank, 2006). The health sector is seriously overburdened: two major diseases in Tanzania are malaria and HIV/AIDS. In 2006, the Ministry of Health and Social Welfare (MoHSW) estimated that 30% of the total disease burden in Tanzania was acute febrile illnesses, mainly malaria, which mostly affects children under five years of age. One in seven children dies before reaching the age of five, and 75% of these deaths are preventable (MoHSW, 2006). HIV/AIDS also poses a public health threat and affects individuals, communities and the health system at large. Many health workers also die of AIDS, and the loss of these skilled workers is a major blow to the health sector (Muhondwa and Fimbo, 2003). In addition, the workload for the remaining health workers increases, compromising the quality of health services (Ngalula, Urassa, Mwaluko, Isingo and Ties, 2005).

The health system problems described above have their roots in the mid-1980s and 1990s, when most developing countries were forced by the World Bank, International Monetary Fund (IMF) and other bilateral lenders to decentralise their health systems as part of the so-called structural adjustment programmes (SAPs). These policy changes have undermined the structure of the health care labour market, as well as health workers' individual choices (Dussault and Franceschini, 2006). Many developing countries now suffer severe staffing shortages and have incurred incalculable losses to their economies in terms of the investment their governments made by subsidising the education and training of health professionals, only to have them leave the public sector or the country (ibid). Tanzania is no exception.

A few years after Tanzania's independence, policies were designed in line with ideals of the Arusha Declaration of 1967, which emphasised building a self-reliant socialist state, in which free, quality health care would be available for all. In this vision, the government would centrally manage the production and provision of all social services, such as health. The implementation of these policies initially led to significant investments in infrastructure and training of health professionals (Wyss, 2004). However, due to macro-economic constraints at the time, the investments quickly became financially unsustainable. Tanzania's economic problems reached crisis proportions in 1970s and 1980s. In 1993, under pressure from the IMF and World Bank, the government introduced, a public employment freeze', Many public employment posts, including health posts, were frozen up to

the year 1993/1994, after which the posts were opened (ibid). From the mid-1980s and throughout the 1990s, Tanzania was forced to implement huge economic, social and political reforms, some of which are still under way (ibid). Currently, there is no adequate evidence of the effects and implications of these reforms on the management of non-financial incentives and the general management of health worker motivation.

The policy shifts and twists as identified above, as well as new demands created by structural changes in the health care labour market as a result of globalisation, trade liberalisation and a revitalised private health sector, are contributing to the current health human resources crisis. Tanzania is unable to attract and retain an adequate and qualified health workforce to effectively implement health interventions, reverse the negative health status trends and ultimately achieve Millennium Development Goals (MDGs). This inability is partly due to inadequate resources for the health sector. According to the World Health Organisation (2007), Tanzania's total health expenditure as a percentage of its gross domestic product (GDP) is 5%, three times less than the Abuja commitment, where African countries agreed to allocate 15% to health.

The situation described above may go some way towards explaining why so many health workers are leaving their posts in the Tanzanian health sector. The attrition of the health workforce in developing countries is a growing trend, as workers are lost to external migration (by moving to other countries, mostly developed) or internal migration, where they move from rural to urban areas or from the local public sector to the private sector (Dussault and Franceschini, 2006). Various researchers have identified the push and pull factors responsible for this trend in developing countries (Dussault and Franscenshini, 2006; Mathauer and Imhoff, 2006; Zurn, dal Poz, Stilwell and Adams, 2002). Push factors are those negative factors that 'push' workers out of their jobs, such as poor pay, working conditions, management and governance, while pull factors are the advantages offered by new jobs, such as higher pay and better working conditions that 'pull' workers towards the new jobs (Paradath, Chamberlain, McCoy, Ntulli, Rowson and Loewenson, 2003).

The recent Human Resources for Health Census (MoH, 2002) estimated that Tanzania has around 48,000 health workers, many of whom are unskilled. Health workers are also unevenly distributed between urban and rural areas, with rural and remote places being more disadvantaged (Dominick and Kurowski, 2004; Wyss, 2004). Tanzania has the lowest ratio of highly trained health workers (physicians) per capita in the world (Joint Learning Initiative, 2004). The shortage is further compounded by low productivity (Mæstad, 2006), ineffective financial and non-financial incentives (such as

poor pay), a poor working environment (Dominick and Kurowski, 2004), lack of supportive supervision (Manongi, Marchant and Bygbjerg, 2006), poor career schemes (Dambisya, 2007), migration to other attractive health care labour markets in Africa and the developed world (Dussault and Franceschini, 2006), and absenteeism and the loss of health workers due to AIDS (Ngalula et al, 2005).

Due to a lack of research in this area, the Regional Network for Equity in Health in East and Southern Africa (EQUINET), in collaboration with the East, Central and South African Health Community (ECSA), has launched several initiatives to generate regional-specific evidence on the migration and retention health workers, particularly on the role of non-financial incentives in motivating health workers to stay. These initiatives are based on an emerging consensus that financial incentives (though still useful) are not enough to attract and retain a motivated health workforce in situations of extreme resource scarcity (Mathauer and Imhoff, 2006). In 2005, all participants in an EQUINET regional meeting adopted a resolution to focus on policies and strategies that reward health personnel by using financial and non-financial incentives (Dambisya, 2007). In addition, the February 2006 ECSA-HC Ministerial Conference emphasised that member countries need to develop financial and non-financial incentives to improve health worker retention and, therefore, need to generate evidence on the implementation of effective retention strategies. The secretariat agreed to support country research teams in collecting evidence (Dambisya, 2007).

In this study, we will examine how the structural aspects of the healthcare labour market, such as continuing health sector reforms, trade liberalisation, privatisation and globalisation, might have made health workers more mobile to sell their labour anywhere. Using quantitative and qualitative approaches, we will analyse individual health workers' perceptions on the ability of their employers to, for example, offer a good working environment, effectively manage training programmes and promote deserving health workers, particularly in underserved areas.

The main objective of our research was to assess the availability and effectiveness of non-financial incentives in Tanzania, and gaps in their implementation. Specific objectives were to:

- identify policy regimes and institutional mechanisms on the types, nature and implementation of financial incentives in both the public sector and the private sector;
- map the retention incentives currently being applied;

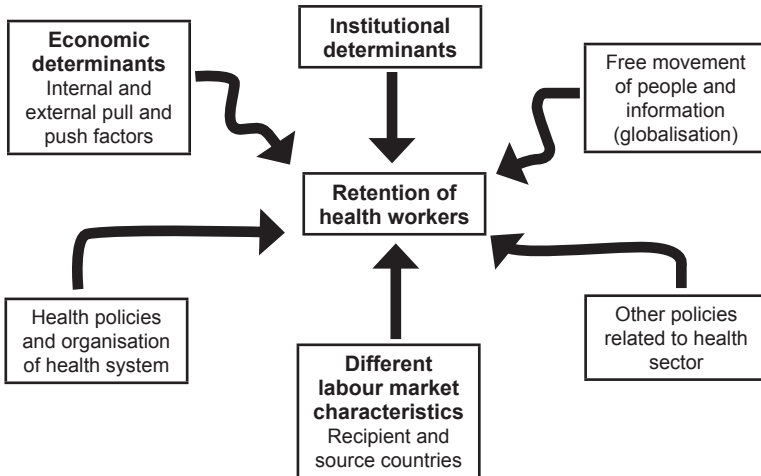
- ascertain strengths, weaknesses, opportunities and threats (namely, conduct a SWOT analysis) of the implementation of the current non-financial incentives in the public and private health sector in Tanzania, in terms of design, introduction, implementation and sustainability;
- assess the role and impact of existing non-financial incentives in improving health worker retention and reducing health worker migration in health care sub-markets (rural to urban or public to private) and migration to other countries;
- ascertain the sustainability of existing non-financial incentives in the health sector;
- assess the mechanisms used for monitoring and evaluating incentive systems; and
- provide evidence-based recommendations for formulating, implementing and evaluating non-financial incentive policies and operation guidelines to cover existing policy gaps, improve health worker retention, attract those working in the diaspora (health workers who have already emigrated) and curb further migration.

In addition to the conventional pull and push factors, we also looked at more general determinants such as:

- the management of health workers;
- mitigating factors for internal and external migration, including how national actions and plans for improving health services are affected by policies outside the health sector and international policies and institutions; and
- the implementation of policies and incentive programmes (particularly regarding non-financial incentives).

Figure 1 shows how the determinants listed above fit together into a framework that can help analysts and policy makers to identify the main determinants of poor health worker retention and the shortage of health workers. We adopted the framework because some characteristics of Tanzania's health sector labour market may be a response to the effects of international labour markets. Globalisation and the free movement of goods, people, services, information and technology may all impact on the country's health system and its labour market, including health workers' individual choices (preferences) about which labour market is most attractive. The push and pull factors framework is not discarded, but instead other crucial determinants have been added.

Figure 1: A conceptual framework for analysing health worker retention



Adapted from: Dussault and Franceschini, 2006; Paradath et al, 2003; Zurn et al, 2002, 2004

The framework in *Figure 1* links health worker retention to both macro- and micro-level factors. The macro-level factors are those outside the health sector, including other development policies related to health (both international and national policies), socio-economic developments and technological changes that occur globally (globalisation and international pull and push factors), and the governance issues related to management and enforcement of policies and programmes aimed at improving human resources for health (institutional factors). Other policies related to health sector may also have an impact on retention of health workers. In contrast, micro-level factors are those that operate within the health sector, such as the working environment.

According to the adopted framework, factors such as the inadequacy of human resources management policy and poor organisation of health system can partly explain why retention mechanisms aren't working effectively. So, if the local labour market and differences in the sub-markets (rural-urban, public and private) are not properly managed, health worker retention may become a problem.



2. METHODOLOGY

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In this study, we used three methodological approaches, namely, a literature review and the collection of primary qualitative data and quantitative data. For the literature review, we consulted Tanzanian policy documents and other published and unpublished materials within the time frame of the mid-1980s to 2007. The timeframe was chosen because this is the period during which most of the major health sector reforms (HSR) started. These reforms, in one way or another, might have contributed to the success and/or failure of efforts to make the Tanzanian health care labour market more attractive to professionals. In instances where best practices were important, we also considered theoretical literature and studies done outside Tanzania.

Data for the focused study was collected from seven districts. Five underserved districts were randomly selected from a list of ten districts, which have fewer health workers per capita based on the latest health workforce census (MoHSW, 2002). In addition, two urban districts that are relatively better off were included. Quantitative data was collected from a convenient sample of 152 health workers in private and public sectors, as well as from 21 key informants.

In the field, data from in-depth interviews and documents was also analysed. An analysis of qualitative data from a focused study followed the principles of grounded theory, in which coding categories reflected the content of the data rather than the questions in the interview guide (Barbour, 2001). Commonalities and differences as reflected in the data were systematically analysed to identify response patterns across key informants' diverse, albeit subtle, characteristics. Data from the documentation was synthesised by grouping documents into different categories and identifying general and specific issues as they were related directly or indirectly to the implementation of non-financial incentives and their effect on the retention of health workers.

Quantitative data was entered into an Epi-Info database before being tested for errors and consistency. Identified errors were corrected, inconsistencies were fixed and the data set was transferred into STATA version 9.2 for analysis. Simple cross-tabulations were performed and the generated descriptive statistics were presented in tables and histograms. Prior to the study, ethical clearance was sought from the National Institute for Medical Research (NIMR). In addition, informed consent was sought from potential interviewees and key informants.

3. RESULTS OF THE LITERATURE REVIEW

3.1 The international and national policy context

The Oslo Ministerial Declaration, signed in 2007 by France, Norway, Indonesia, Thailand, Senegal, South Africa and Brazil, acknowledges that:

...the current global shortage and maldistribution of trained health workers, particularly nurses, represents a major barrier to preparedness and to national and global health security. The shortage of human resources is influenced by the global economy, incentives for migration, and global negotiation on services. Such influences go beyond the health sector and can only be modified through political action at the national, regional and global level. At the same time, human resources for health is situated within the broader health development and systems agenda, with financing and stewardship issues as key related matters.

Source: Støre et al, 2007:1376

Recommendations for tackling the global shortage of health workers included implementing monitoring and accountability mechanisms, tracking recruitment from countries with health worker shortages and developing national plans to manage health worker flows, including the use of alternative models for care that reflect the standards set by WHO, through the Global Health Workforce Alliance (GHWA) and related initiatives. Governments in developing countries should also undertake to support ethical health research, build research capacity, improve access for researchers to innovation and to global knowledge networks, and find ways to benefit from the diaspora. More health workers need to be trained and collaborative partnerships should be built with other institutions to exchange technical expertise, especially between countries in the South, as well as more regional collaborations (Støre et al, 2007).

Some international initiatives have called for basic health interventions to be scaled up or implemented to improve people's health. They include the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis, the Highly Indebted Poor Countries (HIPC) initiative (whose debt relief and cancellation efforts are aimed at strengthening health sector services in developing countries), the Stop TB Partnership and the Global Alliance for Vaccines and Immunisation (GAVI). The 2006 World Health Report has also highlighted that the lack of staff in resource-poor settings has reached crisis proportions and needs effective short-, medium- and long-term strategies

to reverse the trends (WHO, 2006). The World Bank has also recently supported Tanzania's Health Sector Development Project and approved a US\$60 million loan to the government to improve health services and build institutional capacity (World Bank, 2007). One can only assume that building "institutional capacity" will also include health workers.

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In its Countries Co-operation Strategy (2002–2005), WHO has pledged to support the Tanzanian government by helping to develop an institutionalised programme for upgrading managerial skills in the health sector, guiding the formulation of human resource policies and plans, addressing the issues of retention and equitable distribution, and ensuring an appropriate skills mix (MoH, 2003). However, we could find no documented evidence regarding the implementation and effectiveness of these plans, which were meant to be a collaborative effort between WHO, the Ministry of Health and other partners in the health sector.

Schwerzel (2006) also had recommendations, such as increasing the number of trainees from MoHSW institutes and university graduates, including the Public Service Reforms of the MoHSW as a beneficiary of the newly introduced accelerated Salary Enhancement Scheme (SASE), motivating staff and their performance in an improved working environment, promoting more staff (to increase staff production by up to 50%) and collaborating between the MoHSW and other sectors, such as the Prime Minister's Office-Regional Administration and Local Government (PMO-PRALG), the Ministry of Finance and the Department of Public Service Management.

In 1996, the Ministry of Health put in place a five-year Human Resources for Health (HRH) development plan to address a number of critical concerns, among which is the issue of retaining more health workers in the public sector. An internal evaluation of this plan five years later indicated that, while many aspects were accomplished as expected, there remained serious challenges that were not adequately tackled. Critical to our review and the need to improve the implementation of human resource policy, is the lack of a comprehensive plan for the rationalisation of staff, including adequate distribution of personnel in rural and less-desirable areas (MoH, 2003).

The Tanzania Development Vision 2025 and the National Strategy for Growth and Reduction of Poverty (NSGRP) have identified health as one of the country's priority sectors. The two policies highlight the need by all stakeholders in the health system to ensure that quality health services through proven health care interventions are accessed by all Tanzanians. These interventions include quality primary health care and reproductive health services, a reduction in infant and maternal mortality rates of 75%, and gender equality and the empowerment of women. Despite the noble intentions of these policies, recent evaluations (for example, HERA/MoH,

2006) and a series of Poverty Reduction Strategy Papers have singled out a lack of adequate skilled workers as central to the country's failure to meet its health goals as they are stipulated in the two policies. The monitoring and evaluation (M&E) of joint efforts by national stakeholders in the health sector (and other sectors), mainly financed by international development partners such as the World Bank, is affected by both inbuilt M&E mechanisms within the Ministry and the externally commissioned partners, such as research institutes and academic think tanks.

The Health Sector Strategic Plan (2003–2008) also recognises the crucial role that health personnel play in improving access to quality health care services. It acknowledges the need to improve retention strategies and aims to develop health personnel by improving their skills and building management capacity at all levels of the health system. The Ministry of Health and Social Welfare expects that access to quality health services will be improved and that efficiency in the delivery of these services will be strengthened (HERA/MoH, 2006).

The National Health Policy of 1990 and its review in 2002 both highlight the importance of human resources for the health system to realise its goals. The strategic vision of the policy is 'to improve the health and well being of all Tanzanians, with a focus on those at risk, and encourage the health system to be more responsive to the needs of the people'. Its policy mission is 'to facilitate the provision of equitable, quality and affordable basic health services which are gender sensitive and sustainable, delivered for the achievement of improved health status'. The policy clearly stipulates the importance of flexible and responsive HR planning in both the public and private sectors and singles out HR development and management as a priority in the health sector (MoH, 2002).

Dominick and Kurowski (2006) have indicated that, since 2000, Tanzania has not had a comprehensive strategy of addressing human resource challenges, including that of staff retention. Recognising this gap, the Ministry of Health established a National Human Resources for Health Working Group in 2003 (Schwerzel, 2006). Under the auspices of this group and with support from the Ministry, a number of initiatives have been launched. For example, there have been deliberate efforts to involve research institutes, such as Tanzania's national institute for medical research, in collecting and synthesising important information related to human resources for health. A Tanzanian action plan, which prioritises recruitment and retention strategies, has been developed (ibid). Block grants and basket funds guidelines for the public and private sector were revised in 2006. In fact, the MoHSW is currently drafting new guidelines, which will address adjusted modalities for allocations for bed grants, salary grants/personnel emoluments, as well as other charges

and basket funds, to the public health sector, the district-designated hospitals (DDHs) and other voluntary agency (VA) hospitals (Schwerzel, 2006). It is hoped that different grant modalities will be improved to address a number of problems, including human resources issues in the health sector.

3.2 Financial incentives for health worker retention in Tanzania

In July 2005, the government implemented a special accelerated salary package for health workers in the public sector and for seconded health workers working in DDHs and VA hospitals. In these efforts, the gross salaries of the selected health workers were increased substantially, on average by 36% (ibid). Salary increases were 37% for medical doctors, 45% for assistant medical officers, 32% for clinical officers, 37% for nursing officers and 31% for pharmacists (ibid). A specific incentive package for public health workers has been developed, which offers improved promotion systems for health workers, financial loans, a housing allowance of US\$80 per month for medical doctors, a hardship allowance for remote areas and non-taxable allowances (for example, car allowances and overtime pay) (ibid). Since 2006, the government of Tanzania has undertaken various measures to strengthen the available six zonal training centres (for better pre-service training), improve continued education and decentralise pre-service training and continued education, with a focus on training support for national HIV/AIDS care and treatment programmes (ibid).

After the government allowed the private sector to provide health care services in the form of public-private partnerships, it instituted some flexibility by allowing health workers to run a private practice while working in public health facilities (Mogedal and Steen, 1995). This flexibility may well act as a form of non-financial incentive to improve job performance and health worker retention.

The implementation of Selective Accelerated Salary Enhancement (SASE) for health workers in managerial and management cadres was one of the strategic measures used to retain health workers in the public service. However, many health workers in the frontline service are unfortunately not covered by this plan and they expressed discontent about this inequitable situation (Kombo, Mutema, Mwakilasa, Pemba and Petis-Mshana, 2003).

3.3 Non-financial incentives for health worker retention in Tanzania

The Tanzanian government recognises the importance of non-financial incentives for all civil servants, including those working in the health sector. The Tanzania Government Circular No. 1 of 2004 and its Public Services Regulations of 2003, which came after the enactment of the Public Services Act, No. 8 of 2002, all specify the types of non-financial incentives to be administered to civil servants and highlight the modalities of their administration.

Similarly, the Government Standing Orders of 1994 clearly specify issues related to health workers, namely:

- training
- leave
- participatory personnel appraisal system
- worker participation in discussing their job requirements and welfare
- promotion
- supervision
- recognition and respect
- housing
- a safe and supportive working environment.

It is clearly stipulated in clause 103(1) of the Public Services Act that ‘every employer shall be responsible for training and development of [their] staff’. The Government Standing Orders of 1994 also provide guidelines that prescribe how to implement training programmes for public servants. The above responsibility by the employer to ensure training and development of staff follows the government’s recognition that staff development aims at developing individuals in the skills required for the performance of the duties they are currently assigned to or their future jobs following promotion to senior posts. The policy seems to recognise that promotion and training are mutually reinforcing. In other words, training may lead to promotion and/or promotion may trigger the desire for more training to effectively accomplish new, and sometimes more difficult, tasks.

It is on the basis of the above provisions that clauses 103(5) and 103(6) of the Public Services Regulations prescribe to all public service employers that adequate funding for training programmes should be set aside by all appointing authorities and that employers should prescribe terms and

conditions for public servants' attendance of various training courses and put in place an effective management system for co-ordinating and monitoring to avoid unwarranted disparities within the public sector. The policies recognise the importance of the sustainability of these non-financial incentives. Yet, these non-financial incentives are ultimately just financial incentives because they have to be paid for (Dussault and Franceschini, 2006). So financial sustainability here means always earmarking adequate funds for so-called non-financial incentives, such as training and staff development - an approach by all public agencies and departments have taken for many years during budgeting. Almost always, funds are limited and priorities have to compete, so there is usually a failure to implement training programmes as first envisioned.

While leave is more of an entitlement than an incentive, it can be managed to make it appear as an incentive. If managed in a fair and transparent way, leave can become a great motivator. Conversely, if poorly managed, it may become a de-motivator. By law, every public servant is entitled to annual leave, which is granted once during the two-year leave cycle (Public Services Act 8 of 2002). They have the benefit of free transport in the form of a cash grant, calculated on the basis of the prevailing fare rate charged for the cheapest public transport for themselves, a spouse and a maximum of four children/dependants under the age of 18 (Public Services Regulations, 2003, clause 97[1, 3&5]). The Public Services Act is meant to serve all employees in the public sector and, except under special circumstances, it does not discriminate between benefits and obligations due to all public servants. In the private sector, the benefits of employees are managed through a separate legal arrangement and their contracts of employment are protected by law.

Apart from normal leave, the policy is also clear on such issues as leave without pay, which is normally initiated by the employee's desire to work outside his or her organisation for a maximum period as restricted by the law, with the aim of gaining new skills and experiences from a different working environment with quite different organisational arrangements (for example, in the private sector, NGO sector or in an international organisation). Clause 99(1) of the Act provides that 'the permanent secretary may grant leave without pay to a public servant, provided [they are] satisfied that it is in the public interest to do so'. The discretionary powers vested in the permanent secretary to decide what is in the 'public interest' and what is not needs to be taken into account when analysing the implementation gap inherent in this kind of non-financial incentive.

Moreover, maternity leave is also legally constituted as a basic right for female public servants in Tanzania. Clause 98(1) of the Act provides that 'a female public servant shall be granted paid maternity leave of 84 days

once in three years from the date she completed her last maternity leave'. Maternity leave does not include normal annual leave for the calendar year in which the maternity leave is taken.

Section 3 of the same clause further prescribes that 'a female public servant shall, within a period not exceeding six months after maternity leave, be allowed to leave office two hours before the end of office hours every day to breastfeed her child'. The same Act gives directions for the management of sick and convalescent leave (clause 100[1&2]) and sabbatical leave (clause 101[1&2]). In a nutshell, all these types of leave are instruments used by the government to send out the message that it values the welfare of its employees. The effectiveness of the measures that have been taken remains to be critical analysed.

The Government Standing Orders, Public Services Act and Public Services Regulations all recognise the importance of housing civil servants, including those working in the health sector. While the law restricts the right to housing to few executives, it also emphasises that 'each employer may facilitate the process for [their] employees to secure housing accommodation'. In places where there are extra houses, non-entitled health workers may secure them (key informant, Kongwa district).

The assurance of a safer and better working environment is another form of non-financial incentive. With regard to safety, the law holds both employers and employees responsible. On the one hand, clause 63(1) of the Public Service Scheme of 2003, pursuant to section 7 of the Public Services Act, states that 'every employer shall take all reasonable precautions to ensure occupational safety standards in order to avoid unnecessary cause of health hazards and shall facilitate annual medical check-up for public servants within this jurisdiction'. On the other hand, section 2 of the same clause confers some responsibility to individual workers themselves when it stipulates that, 'notwithstanding the provision of sub-clause 1, every public servant shall take reasonable precautions in accordance with modern health practices for proper protection of [their] health'.

The two sub-clauses sound impressive, but the realities of working environment in the public service, especially in hospital settings of most developing countries like Tanzania, do not provide enough room for such reasonable precautions to be taken. There is enough evidence pointing to a lack of appropriate equipment to perform even the most basic procedures in health facilities, especially those found in rural areas (Leonard et al, 2005; Manzi et al, 2004; Mæstad, 2006). Limited funding of the health budget does not always allow facilities to purchase state-of-the-art medical equipment or hire appropriately qualified health workers.

The Government Standing Orders, which set out the way in which the day-to-day activities in the civil service are run, the Public Services Management Policy of 1999 and the Public Services Act recognise the importance of promotion for deserving public servants. The decision whether or not an employee deserves promotion depends on the results of an open appraisal system between the employee and the employer and is effected in the context of the existing scheme of service relevant to the respective cadre's career development. The Government Standing Orders address the implementation of the promotion policy, which is very much dependant on workers' and supervisors' adherence to performance contracts. Clause 22(3) of the Public Services Regulations clearly states how the performance contracts can help with promotion: 'Information obtained through performance appraisal should be used in awarding or withholding increments, planning job rotation and training programmes, and in making appointments to higher posts or in demotions or termination of appointment to that particular post' (URT, 1994; URT, 1999; URT, 2003).

Like other non-financial incentives, supervision, particularly supportive supervision, is clearly specified the by laws and regulations governing all public servants in Tanzania, including health workers. The Public Services Act and the Public Services Regulations specify the expected relationships between public servants and their supervisors to increase the efficiency and effectiveness of public service delivery. Supervision as a non-financial incentive is included in performance contracts, which supervisors and supervisees must sign each year. The contracts are ideally supposed to be executed in a an open, fair and participatory way to ensure that workers' strong values are rewarded and weak points identified and corrected accordingly. To ensure that supportive supervision actually occurs, the Public Services Regulations provide that 'public servants shall be given feedback at regular intervals of not less than six months on their performance against the objectives, and shall be given advice and support to improve any shortcomings'(see clause 22[5]). Again, whether or not this is actually happening needs to be answered by future critical studies.

Tanzanian law recognises the importance of recognising the work and value of the country's health workers. Clause 40(3) of the Public Services Act stipulates that 'relationships in the public service shall observe that every public servant is entitled to recognition and respect for [their] dignity, regardless of hierarchy in the service'. Section 4 of the same clause goes on to emphasise the importance of co-operation in the workplace by clarifying that 'every public servant shall respect and co-operate with [their] fellow public servant at work or elsewhere within the public service in order to achieve the objectives of the public service'.

A participatory appraisal system has been cited to be an effective quality management tool, which is in line with the New Public Management Models (Russell, Bennet and Mills, 1999). In the context of this review, it is taken as a form of non-financial incentive. The Public Services Regulations stipulate that ‘there shall be operated an open appraisal system by every organisation within the public service in accordance with the procedures as shall be provided for in the Public Services Regulations’. With other important ingredients, an appraisal system that has been executed in a fair, open way is a stepping stone to a fair and deserving promotion. It may further be argued that, if promotions are perceived by other co-workers and supervisors as fair and deserving to the person to whom they are granted, they may act as a strong non-financial incentive. As yet, there has not been concrete evidence on the gap between what is specified by the policy and what actually happens on the ground. However, anecdotal evidence (for example, Manzi et al, 2006) highlights dissatisfaction and lack of trust among health workers about how the appraisal and promotion of health workers is managed.

Related to the open appraisal system, an important ingredient of participatory management in the public service, is workers’ direct participation or through representation in discussions of their work and their general welfare. Clause 64 of the Public Service Regulations states that ‘the representation of public servants in the discussions with employers on matters of employment and welfare in general shall be through workers’ councils and joint staff councils.’ By the time this study was conducted, evidence on the presence and/or performance of these councils in the workplaces could not be found. The Public Service Management Policy of 1999 also recognises the importance of good relationships between workers and management and among workers themselves through participation. Workers may participate as members of trade unions or through workers’ councils (URT, 1994; URT, 1999; URT, 2003).

The policy directives as stipulated in the above-mentioned legislation provide evidence that the importance of non-financial incentives in retaining public servants, including health workers, has been recognised by government. Yet, there might be gaps between expected outcomes and actual outcomes, which have yet to be measured. These discrepancies are largely being caused by factors related to health workers themselves and the local health system (micro factors), as well as factors that are beyond the control of individual health workers, such as the national economy, policies and the health system (macro factors).

We need to integrate the micro-level analysis with the macro-level analysis in a multilevel health system analysis, like the framework illustrated in *Figure 1*. In other words, an understanding of the effectiveness and implementation

gaps of non-financial incentives can best be reached if analysis moves beyond perceiving health workers as utility maximisers towards incorporating (in a holistic way) more structural factors that operate both nationally and internationally to effectively re-organise the health sector.

3.3 Effectiveness of current incentive policies and implementation gaps

As has been highlighted in the policy documents we reviewed, non-financial incentive policies do not treat different public servants separately. Their implementation is supposed to cut across all sectors in the public service. There are, however, regulations governing specific cadres such as health workers and teachers, but they all must take into account that the existing foundational laws and regulations take precedence.

Under the current decentralised scheme, districts have very limited powers over their health personnel because of the overriding powers of different central government agencies on matters related to human resources management at the district level. For example, the stringent financial regulations by the Ministry of Finance (MoF) on how to spend locally mobilised resources and central government allocations reduce the potential flexibility that health managers can exploit to motivate their health workers. Moreover, the positions of the Civil Service Department (CSD) and the Public Service Commission as (PSC) the ‘top organs’ in approving the promotions of health workers allow them to regulate the mandates that local authorities (decentralised districts) are given by the law to manage their workers. To this extent, one may conclude that, despite the laws, the implementation of all non-financial incentives at the district level renders most of them to be perceived as ‘low-powered incentives’ (Leonard et al, 2005). Supervisors have little say in hiring and firing staff, as well as salaries and the type and numbers of clinicians who work for them, and little financial independence.

The review of limited literature on this subject has identified significant gaps between what is specified in the highlighted non-financial incentive policies and what actually happens on the ground. Manzi et al (2006), for example, have documented a lack of supportive supervision in some of the health facilities by interviewing a cross-section of health workers. The interviewed workers pointed out that, instead of supervisors acting as supervisors, they presented themselves as employers. In other words, it was more of a question of ‘policing’ workers than supervising them. The same study also pointed out how effective community interaction can be and how workplace trust between employees and management, and among workers themselves, can motivate workers.

A study by Bryan et al (2006) and an internal evaluation by the Tanzanian Ministry of health (MoH, 2004) have both identified some weaknesses in implementation of non-financial incentives among health workers in Tanzania. In both cases, low pay, poor working conditions and the poor state of health facilities and medical equipment were singled out as factors responsible for decreasing health workers' morale.

A study conducted at Muhimbili National Hospital by Muhondwa and Fimbo (2004) has noted a huge decline in worker morale due to dissatisfaction on a number of issues. The majority of nurses and doctors (around 50%) were not satisfied with their working conditions. The decline in morale was largely related to lack of clear job descriptions, absence of quality performance management tools, limited opportunities to participate in decision-making bodies, poor information flow between management and staff, lack of supportive supervision, low salaries and poor staff welfare. Similarly, a study by Manzi et al (2006) pointed out more or less the same causes of declining health worker morale in public and faith-based health facilities.

Another study done by Manongi et al (2006) on worker satisfaction in the northern part of Tanzania identified two crucial problems related to both health worker motivation and retention, namely poor or inadequate supportive supervision and a lack of adequate diagnostic equipment, which led to health workers feeling like they were 'gambling' with patients' lives.

Frontline health workers and district medical officers (DMOs) seem to be discouraged by the promotion system because they say it took too long to be implemented. They also lamented that it takes up to ten years working without being promoted (ibid). District Medical Officers pointed out that their role is very limited in the process of promotion (ibid). In other words, they only send recommendations to higher (central) authorities and do not make the final decision. It is logical to connect this observation with Tanzania's ongoing decentralisation reforms, where experience from many countries, has shown that managers at local government levels have been given a lot of responsibilities but few powers (administrative and financial). They have authority to implement some of their tasks but sometimes they are confused about accountability to different central government authorities, whose relationships are unco-ordinated. In addition, it was pointed out that supervisors at district level had very limited time to perform their duties effectively because their workloads were too heavy (mainly DMOs) (ibid).

3.4 Proposed recommendations to improve health worker retention

In general, most of the studies and reports on the evaluation of the status of health workers motivation and retention have highlighted a number of policy recommendations that, if implemented, may improve health worker retention in the public sector, particularly for health facilities in rural areas, which face a critical shortage:

- Give an extra payment, such as a hardship allowance.
- Implement an affirmative strategic action plan to increase the health budget for hard-to-staff districts.
- Improve general infrastructure, particularly health facility infrastructure.
- Provide more, useful training opportunities for health workers.
- Facilitate the acquisition of staff loans for their personal development.
- Ensure that salary increments and promotions are implemented more vigorously and quickly for health workers working in disadvantaged rural districts.

In particular, Mæstad (2006) has recommended that empowering employers with the necessary resources to attract workers, in the health sector in general and into rural districts in particular, may be a powerful deployment strategy that may also help to retain health workers once they are deployed. In this case, it's crucial to have the institutional and financial resources necessary to make the public service labour market attractive. Mæstad further argues that, in order to improve retention of health workers and, indirectly, address the problem of geographical imbalance in the distribution of health workers, the government should use pull measures, such as providing incentive packages to health workers like hardship allowances and adequate (decent) housing, and push measures, such as implementing coercive instruments like bonding agreements, and influencing health workers' preferences for rural vs urban life by letting them get used to a rural life.

So far there is no evidence whether or not government has succeeded in influencing health worker preferences for rural over urban posts. There is, however, limited evidence that the MoHSW has not yet effectively implemented these pull and the push measures to ensure the retention of health workers in the country in general, or in rural districts in particular (ibid; Manzi et al, 2006).

An innovative strategy currently implemented by the Mkapa Fellowship Programme combines bonding agreements and incentive packages (Mæstad 2006, Dambisya, 2007). In essence, it looks more like voluntary bonding than compulsory bonding, which, according to anecdotal evidence, had failed to help retain health workers due to a number of implementation weaknesses ranging from corruption and nepotism to poor monitoring and evaluation. The Mkapa programme operates in such a way that qualified and willing fellows are posted to some selected rural districts, which have high prevalence of HIV/AIDS and are reported to have relatively fewer health workers per capita. Before being posted, fellows are provided with intensive training in health systems management and how to administer anti-retroviral treatment to AIDS patients. They are trained to evaluate whether or not the set objectives of the initiative are met. In addition to a regular government salary, fellows are paid a monthly stipend and, at the end of their service, they receive a bonus. They also receive regular on-the-job training as part of a skills enhancement programme (Dambisya, 2007). At time of writing this report, no data was available on the impact of this programme in improving the effectiveness of health worker retention.

In 2006, the Christian Social Services Commission (CSSC) commissioned a team of international and national consultants to design an incentive package for health workers that is relevant to voluntary faith-based health facilities in Tanzania. A mix of financial and non-financial incentives was perceived to be the most effective strategy for improved retention of health workers (Schwerzel, 2006). Accordingly, the following recommendations were made for the proposed incentive package to be used by faith-based health facilities under the umbrella of the CSSC: Facilities should offer:

- A Rural Area Allowance (RAA): For health workers and staff members [who] work in VA hospitals [and] have been selected based on the remoteness classification criteria. This is ideally meant for all categories of health workers [who] will be working in remote and hard-to-staff facilities. The aim of this support is to make it more attractive for health workers to work in rural areas for a longer period of time in those particular VA hospitals. It is assumed that this will apply to 75% of the VA hospitals. This percentage equals to a total of 45 VA hospitals and, on average, 9 VA hospitals per zone.
- A Health Worker Recruitment Fund (HWRF): for a selected number of key health workers (all the required health workers as per establishment of Voluntary faith based organisations) to assist VA hospitals that meet the remoteness classification criteria.

- Continued Professional Development (CPD) opportunities: Can become available to all VA hospitals. Both internal M&E systems and external mechanisms through the use of training and research institutions and other stakeholders are expected to be instrumental in facilitating the implementation of this objective, but also in assessing whether there are any successes or failures.
- Improved social security arrangements: Will need to be followed by all VA hospitals.
- A Utility Support Fund (USF): For VA hospitals that meet the remoteness classification criteria. It is assumed that this will apply to 50% of the VA hospitals. This is a total of 30 VA hospitals and, on average, 6 VA hospitals per zone.
- A Rural Health Workers Savings and Credit Scheme: For all VA hospitals (Schwerzel, 2006).

No data is available as yet on the effectiveness of the proposed package or if the Christian Social Service Commission had any plans implement the proposed recommendations.

3.5 Cost implications of the proposed recommendations for retaining workers

The fact that non-financial incentives need to be financed cannot be underestimated. Thus, a strong and efficient economy is crucial in making sure that enough resources are set aside for the health sector to be able to finance its human resources needs, including financing health workers' salaries and their incentives. In addition, good governance is essential to ensure that allocated financial resources from government internal sources and development partners are spent as efficiently as possible, without diverting them to other non-health objectives. Consequently, if the implementation of any non-financial incentive policy has a cost, this is a justification for conducting comprehensive and holistic costing studies to assess the cost-effectiveness of the available alternatives and also to assess what is feasible.

To date, there is no concrete evidence regarding the financial costs of implementing any of the non-financial and financial incentives as a way to improve health worker retention. Despite major increases (around 30%) in Tanzania's health budget in recent years (Mæstad, 2006), little or no evidence is available on how the health budget has been able to accommodate the projected increased costs of additional training, as well as implementing the incentive packages. Very few studies give the cost estimates of implementing

financial and non-financial incentives. One is McKinsey's 2004 study, which estimated the costs of implementing an incentive package that will ensure the availability of medical supplies, the implementation of team performance incentives with a 20% increase in salaries and strengthening of continuous education, including upgrading zonal training centres. McKinsey's estimated annual total cost for this package was roughly 27 billion Tanzanian shillings for recurrent expenditure and around 75 billion for a one-time capital investment. Implementation of the proposed incentive package needs tremendous financial resources to be earmarked from government tax sources, as well as also support from development partners in the health sector.

Currently there is no evidence on the effectiveness of implementation of these measures. It is, however, important to note that sustainability of their implementation needs clear political will and strategic efforts by the government to mobilise the resources needed for implementation, monitoring and evaluation. Government also needs to resurrect the prioritisation debate by starting dialogue with other sectors and stakeholders to ensure that the status conferred to health as a priority sector becomes a reality and not just an empty promise. The importance of revitalising the debate around priority sectors lies in the fact that the health system does not operate in a vacuum. Its survival is dependent upon other sectors and systems, which also depend on the same sources of funding as the health sector.

Table 1 summarises the evidence found of Tanzania's existing non-financial incentives, their effectiveness and implementation gaps.

Table 1: Tanzania's non-financial incentives: Effectiveness, implementation gaps, and monitoring and evaluation, 2007

Non-financial incentive	Target category of health workers	Effectiveness in improving morale, and retention	Implementation gaps	Monitoring and evaluation	Remarks
Selected Accelerated Salary Enhancement (SASE)	Health workers in management and administrative positions (frontline workers are not covered by this scheme)	No evidence, but some evidence of discontent and dissatisfaction among low-cadre health workers	Low-cadre workers feel neglected or not valued by their employer – corrective action needs to be taken	Internal Ministry of Health and Social Welfare M&E system, with other external partners contributing	SASE is a discriminatory mode of financial incentive, which has caused dissatisfaction and discontent among those who are not covered by it.
Promotion	All health workers	Effective	Poorly managed with some evidence of discontent/ dissatisfaction	As above	No available evidence
Training	All health workers	Theoretically effective but, if poorly managed, can cause discontents among health workers	Health workers complain about missing training opportunities and testify to implementation gaps	As above	Poor monitoring and evaluation of the training programmes and training outputs can very largely be the cause of this failure (training programmes and training outputs should be informed by training needs, and training outputs should sufficiently address the original problems)
Leave	All health workers, but law is not clear about sabbatical leave, which is available to senior lecturers in health training institutions	As above	No evidence available	No available evidence	No available evidence

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Non-financial incentive	Target category of health workers	Effectiveness in improving morale, and retention	Implementation gaps	Monitoring and evaluation	Remarks
Participatory personnel appraisal system	All health workers	Theoretically effective	Delays in promoting deserving staff point to implementation failure	Internal Ministry of Health and Social Welfare M&E system, with other external partners contributing	Improving M&E mechanisms may help alleviate problem of delays
Safe and supportive working environment	All health workers	Effective	Health workers complain about poor working and living conditions	As above	Improving M&E mechanisms may help alleviate problem of poor working and living conditions
Supportive supervision	All health workers	Effective, according to theoretical and policy literature	Lack of effective feedback mechanisms between supervisors and their staff, as well as complaints by health workers of being "policed" instead of being supervised, point to implementation failure	As above	Improving management skills for health workers in management and administrative positions will get them in line with ongoing health sector reforms, especially decentralisation of health services
Recognition and respect	All health workers	In the framework of new public management practice, this is effective	The concept of SASE, which is considered discriminatory and has led to discontent among health workers, points to a lack of critical research before implementing government interventions	As above	None

Non-financial incentive	Target category of health workers	Effectiveness in improving morale, and retention	Implementation gaps	Monitoring and evaluation	Remarks
Housing	All health workers, especially executives, who are entitled to a housing benefit	In hard-to-staff areas (remote, rural facilities), decent housing is instrumental in retaining health workers, and this incentive should be supported by other incentives like a rural allowance, supportive supervision and a good working environment	There are implementation gaps	Internal Ministry of Health and Social Welfare M&E system, with other external partners contributing	Only executives are entitled to a housing benefit, but employers still need to help employees find reasonable housing
Worker participation in determining their job requirements and welfare	All health workers	Effective, according to theoretical literature	No evidence	As above	None

••••• Non-financial incentives and the retention of health workers in Tanzania

4. RESULTS OF THE FIELD STUDY



4.1 Characteristics of respondents

The study included 152 respondents, who were conveniently selected during facility visits. Of these, 39% (59) were men and 61% (93) were women. Respondents were drawn from different employers as follows: 78.29% (119) were working in the public sector, 2.63% (4) were working in the private health sector (for-profit) and 19.08% (29) were working with non-profit private organisations. The mean age for all respondents was 38.9 years (minimum of 37.5 and maximum of 40.5 years). Overall, 71% (108) were married. In the remaining 29% (44) of the total sample, 6.58% were cohabitating (10), 20% were single (31) and 1.97% were divorced (3). On average, respondents had a mean age of 13.1 years of working in their respective health facilities/employers (minimum of 10.3 and maximum of 14.52).

Table 2 below shows the different cadres of health workers who were involved in the field study, according to gender.

Table 2: Cadres of health workers in the field study by gender, 2007

Cadre	Men	Women	Total
Assistant medical officers	2	0	2
Clinical officers	21	13	34
Dental therapists	0	1	1
Health officers	1	0	1
Lab technicians	4	0	4
Medical attendants	28	37	65
Nurses	2	42	44
Surgeons	1	0	1
Total	59	93	152

As indicated above, the difference in composition of health workers by gender in all study sites is statistically significant, with some cadres being overwhelmingly dominated by women. For example among men, only 4% were nurses, compared to 45% for women. For clinical officers, the opposite is the case where there are more men (36%) than women (14%).

Overall, untrained health workers constituted a significant majority (43%) of the interviewed health workers. This is typical of the Tanzanian health workforce, as other studies have indicated that more than 40% of health workers fall under the category of medical attendants with very little or no formal training at all (Mæstad, 2006).

4.2 How do workers perceive the implementation of non-financial incentives?

In the qualitative study, most of the informants we interviewed (over 80%) had a basic understanding of non-financial incentives. The most frequently mentioned incentives were promotion, training and education, leave, participation in discussion of matters related to the welfare of workers, supervision, housing and feedback from supervisors. Respondents answered questions about:

- promotion
- training and education
- leave
- housing
- their work environment
- work-time flexibility and workload
- supportive supervision
- recognition, support and respect
- the effectiveness of feedback mechanisms
- their participation in discussions of matters related to worker welfare
- their perceptions of the adequacy and effectiveness of incentives.

The questions were intended to elicit their levels of satisfaction regarding the implementation of these incentives. Let's take a closer look at their responses. Please note that *Tables 5* and *6* are continually referred to in the discussion below, and they may be found at the end of section 4.2.

4.2.1 Promotion

According to existing policies, an employee is supposed to wait two to three years to be promoted or re-promoted after meeting all the necessary prerequisites. However, workers were not aware of this fact, as different answers were provided to the question, 'How long does it take after fulfilling the requirements for one to be promoted?' In total, the answers ranged from one year (5.26%, 8) to six years (17.11%, 26). A large proportion

(67.77%, 103) of respondents got the answer right. Of the remaining respondents, 2.63% (4) said one has to wait for four years while 7.24% (11) said one has to wait for about five years. There were no significant differences between genders and between the types of employers (152). Workers' experiences of the implementation of promotion policies point to a gap between what is specified in the policy and what actually happens on the ground. It is specified in the promotion policy that, upon fulfilling the necessary performance criteria and acquiring the necessary educational and professional qualifications, an employee is entitled to be promoted after every three years of satisfactory service.

In all districts, it was observed that there is a policy in place guiding promotion of health workers from one grade to another. The open appraisal system, level of education and job performance were mentioned as the main criteria for promoting health workers. In practice, the district technical officers, in collaboration with the human resources officers, are only responsible for providing *recommendations* for the promotion of health workers, as it is for workers in other sectors. Central government, through the President's Office, Civil Service Department, makes the final decision on whether or not promotion should be granted. Informants told us that, even if health workers meet all the requirements for promotion, the process does not happen instantly and it normally takes more than three years for one to be promoted. However, it was revealed that, since 2002, when the new promotion system was introduced, the process has been going relatively faster, and education has been an important determinant in promotion.

Most informants from private (for-profit) and non-profit organisations revealed that their institutions have a policy for promoting health workers and the main criteria are job performance, personal skills and experience. A good level of education may help someone to enter the organisation but employers do not offer chances for long-term training or study leave and employees cannot ask for promotion on the basis of their education, only according to performance and skills. One interviewee, for example, said:

I have been working with this organisation for three years. I have already had three promotions. As you can see I am now a manager for this region, so it really encourages me and other workers who also got promoted.
(Informant, Mbeya urban district).

Regarding the effectiveness of promotion in motivating health workers, it was learnt that health workers feel recognised and appreciated from the job they are doing:

When promoting someone, even if you do not add much to [their] salary, [they] still feels that [they have] made a great step in [their] career or profession and a recognisable contribution in the organisation.
(Informant, Mbeya Urban District).

It was also explained that promotion helps in retaining health workers from migrating because low salaries and other financial incentives are not the only reasons pushing health workers to migrate.

It was further pointed out that the promotion process for health workers is a sustainable process aiming at motivating health workers, especially those in lower cadres. However, the process is probably not transparent because some of the health workers did not know how the process is implemented. For instance, one key informant pointed out that the open appraisal system, which has just been introduced as a new system for promoting health workers, seems to be very complicated and not well known to most health workers. Favouritism was also identified as a problem regarding promotions.

The situation becomes more complicated when managers deal with old employees who do not have educational qualifications and cannot go for training because of their age or family commitments:

To be promoted you need to attend some long-term training. It is not easy for some of health providers who fall in groups, like the old or those who cannot afford education cost sharing or those with strong family commitments, to start attending long-term training. This is a difficult group to deal with, especially when they perceive themselves as people deserving promotion. (Informant, Iringa urban district).

Lack of funding was consistently identified as undermining the promotion process. There have often been delays in changing health workers' grades because of constrained budgets at the district level. As one informant complained:

Normally, promotion goes with other benefits, such as increase in salary and other financial incentives. Therefore, before planning for promotion, you need to have enough money in place. We always face difficulties in promoting workers because of a shortage of funds. We always expect a kind of 'natural' response from the Treasury during the personnel emoluments budgeting process. (Informant, Bukombe district).

4.2.2 Training and education

While, on average, respondents had worked with their employers for 10 to 14 years and were aware of the existence of long- and short-term training programmes, 52.3% (80) had never attended any long course (six months or longer), even when they deemed it necessary. The differences in the numbers of students attending long training programmes disaggregated by type of employer were not significant. *Table 3* summarises the number of times that health workers have attended training, according to gender.

Table 3: Health workers attending long-term training programmes by gender, 2007

How often have workers attended programmes?	Men (59)	Women (93)	Total (152)
Never attended	37.30% (22)	62.36% (58)	52.63% (80)
Attended once	35.59% (21)	22.58% (21)	27.63% (42)
Attended twice	22.03% (13)	9.68% (9)	14.47% (22)
Attended three times	3.39% (2)	4.30% (4)	3.95% (6)
Attended four times or more	1.69% (1)	1.08% (1)	1.32% (2)

Pearson Chi² (5) = 12.6201 P < 0.027

For short-term on-the-job training, there have not been significant differences between the genders, nor types of employers. Only 53.23% (87) of respondents reported having attended short-term programmes. The number of attendances ranged from one to twelve times for both men and women and between all types of employees, with no significant differences.

Overall, the majority of respondents were aware of the existence of some form of policy or programme on training in their workplaces. Of the 72 who attended long-term training courses, 45 (65.5%) said that their attendance was as a result of their own personal initiative, by first finding the relevant training institutions and then requesting financial support and permission from their employers. Only 25% (18) had attended training because of employers kick-starting the process. Meanwhile, 12.5% (9) could not remember who initiated the process resulting in their attending training courses.

While there are no significant differences when the analysis is disaggregated by type of employer, 28.57% (34) of respondents in the public sector had initiated their own training while 12.61% (15) had the process started by their employers and 5.04% (6) could not decide who was the initiator. In the private not-for-profit, it was reported that 17.24% (5) had initiated the process themselves, while 24.14% (7) attended the training in response to their employers' efforts. In this category, 6.9% (2) could not establish or remember who was the initiator of the process. The private for-profit employees constituted a relatively small proportion of the total respondents. It was accordingly found that almost all respondents (75%, 3) reported that their attendance was wholly initiated by their employers and 25% (1) reported to have not attended any long-term training.

A stratified gender analysis showed significant gender differences ($P < 0.03$) and that 35.59% (21) of men compared to 22.58% (21) among women said that their attendances were self initiated while 22.03% (13) of men and 9.68% (9) of women respectively said their attendance was initiated by their employers. Only 5.08% (3) of men and 5.38% (5) of women were undecided about who initiated the process.

It was revealed that guidelines exist for the short- and long-term training of health workers. It is normally the responsibility of health workers themselves to apply for the relevant course, subject to their employer's endorsement. In some instances, training institutions bring advertisements for training opportunities to the council and workers are encouraged to apply for short- and long-term courses.

Regarding the question of who foots the training costs, normal practice has been that long-term training costs are borne through cost sharing between health workers and employers. The council annually allocates a specific budget amount for training, but due to a shortage of funds and higher demand from health workers who need training, the council covers only one third of total expenses. As one informant from Mbeya commented, 'We have 15 health staff from this council who are now attending long-term training and the council is paying one third of the expenses for each worker'

Key informants from NGOs revealed that they offer no long-term training. However, their health workers have been through a number of tailor-made short-term courses offered on the job. These institutions receive substantial donor support from their trustees within the country and their international networks to cover the costs of short-term training, among other expenditure items. This helps to attract and motivate health workers because they are given additional skills and money in the form of training allowances. In NGO facilities, it was learnt that health workers who wish to attend long-term training must first terminate their employment contracts, involving a huge sacrifice to acquire further skills and qualifications.

In public health facilities, training and education were mentioned to be one of the strongest motivator because health workers can still earn their salaries while on study leave and retain their jobs. Moreover, they get additional skills for their jobs and are implicitly assured that they will get promoted once they finish their studies. However, a number of problems have been acting as obstacles in implementing training. Due to lack of funds, not all health workers can be financially assisted, even if they are accepted for a course. Locally mobilised funds are insufficient and donor funds (such as the basket fund) are often not earmarked for the training costs of health workers, but are spent on supplies, such as drugs.

Also, due to an extreme shortage of health workers, some health workers who wish to attend training cannot be granted study leave. This problem is typical in most rural and remote districts, where the shortage of health workers is more severe. Under such circumstances, granting study leave to health workers has always been a difficult management decision and had always been associated with discontent from workers who want to improve their knowledge and skills. One key informant in the Bukombe district pointed out that:

This district faces a serious shortage of health workers. It is a rural district, so most health workers do not want to come and work here. I always face problems when it comes to granting leave because I can't allow many health workers to go for study leave.

Figures 2 and 3 below show that more than 60% of all health workers who attended short- and long-term training courses assessed them as useful in improving the efficiency and effectiveness of their day-to-day tasks, compared to only about 25% who said the training was not useful. There was no significant difference between genders. Disaggregated by type of employer, about 10% of private not-for-profit and 8% of the public sector employees described the type of training they attended as not useful.

Figure 2: Health worker perceptions of their training by gender, 2007

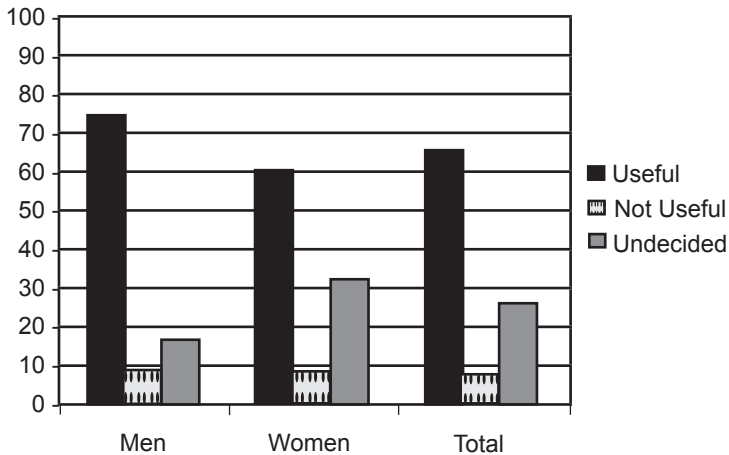
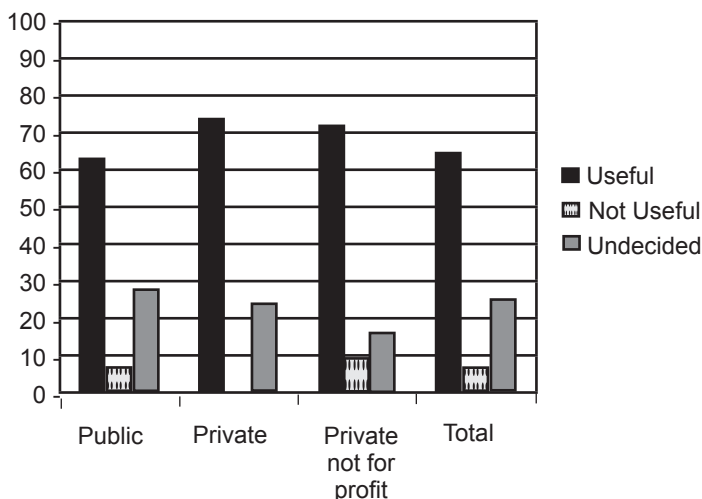


Figure 3: Health worker perceptions of their training by type of employer, 2007



Apart from extrinsic factors, such as company policy, available training programmes and financial resources, in determining levels of attendance to training courses, we also modelled intrinsic (personal) factors in a logistic multivariate regression analysis, including gender, age, marital status, type of employer and number of years in the service. The results are shown in *Table 4*. Attending these courses was emphasised by the employment policies as crucial for career and professional advancement.

The logistic regression model indicates that the gender of an employee and length of service are significant determinants ($P < 0.05$) in increasing the probability of attending long-term training. While these factors are highlighted for long-term training, the smaller R^2 (19%) indicates that gender, length of service and other factors in the model are only capable of explaining a fraction of variations in the probability of attending long-term courses. Other factors, such as employer training policies/programmes, type of rewards after training (or lack of thereof), that are not considered in this study might explain the variations better and will need to be tested in future studies.

4.2.3 Leave

We also explored how health workers' leave and other related benefits have been functioning and how they motivate health workers' performance. One key informant from the Iringa urban district succinctly pointed out that:

Annual leave alone cannot motivate health workers. The most important thing is the presence of leave allowances and other types of leave, such as sick and emergency leave.

Table 4: Probability of workers attending future training courses according to selected intrinsic factors, 2007

Independent variable (intrinsic factor)	Coefficient	Standard error	P-value	Confidence interval
Short-term training (one to six months)				
Marital status	0.0563937	0.1917827	0.769	-0.3194935 – 0.4322809
Age in years	0.0422463	0.0302414	0.162	-0.0170256 – 0.1015183
Gender	0.1429224	0.358295	0.690	-0.5593228 – 0.8451677
Type of employer	0.3192497	0.2323167	0.169	-0.1360827 – 0.7745821
Length of service	0.0182003	0.0295404	0.538	-0.0396979 – 0.0760985
R ² = 6%				
Long-term training (six months or more)				
Marital status	-0.2550917	0.1861363	0.171	-0.619912 – 0.1097287
Age in years	0.0304427	0.0312004	0.329	-0.030709 – 0.0915944
Gender	-1.007199	0.3911717	0.010*	-1.773881 – -0.2405162
Type of employer	0.1045418	0.2363494	0.658	-0.3586945 – 0.5677782
Length of service	0.0991529	0.0321281	0.002*	0.0361929 – 0.1621229
R ² = 19% * = significant at 0.05%				

We discovered that health workers from all cadres were entitled to annual leave. Almost all surveyed districts and health facilities have a leave roster, indicating who will be taking annual leave when. Also, health workers, especially in the public sector, are entitled to study leave, sick leave and emergency leave, as well as transport costs and allowances during their leave.

The interviewees also indicated that sick leave and emergency leave are rarely given by private sectors employers:

The advantage of working in the public sector is that when you get sick you can just rest until you get better, while still receiving your salary and other entitled benefits (Informant, Bariadi district).

However, another informant argued that leave should not be viewed as an incentive because health workers know that it is their right and should be granted annually, as the law specifies.

From the private sector, it was reported that health workers are entitled to annual leave but not prolonged sick or emergency leave. There is no study leave because employers prefer tailor made, in-house short-term training to long-term training outside the workplace. (For more details on leave, see *Tables 5 and 6.*)

4.2.4 Housing

Respondents were asked to provide their opinion on the extent to which their employer supports them to get adequate housing. More than 50% disagreed with the statement that their employers “always support them” to secure housing (see *Tables 5 and 6.*)

In the private sector, it was observed that health workers have been receiving monthly housing allowances:

Even if the amount is not that much, it still helps to reduce the burden of housing cost. Whoever gets employed here is entitled [to a] housing allowance. The amount differs, depending on one’s job position, but still most of workers are happy with it. (Informant, Mbeya urban district).

In the public sector, particularly in the Mbeya and Iringa urban districts, a few workers receive free housing. The government decided to build houses close to health facilities to enable staff to respond quickly to emergencies, such as those occurring at night. The public sector has a regulation that specifies who is entitled for housing and who is not. In this respect, very few health workers (mainly DMOs and other senior officers) at the district level are entitled to housing.

Workers who are not entitled to housing do not receive any housing allowance and this has been one major complaint from workers. One informant from the Iringa urban district said:

In several meetings workers raise the housing issue and we don’t get proper answers for this since we also don’t have a special vote to budget for major projects, like housing for each and every worker. Housing really affects workers. Can you imagine, with the low salary they get, they have to pay for housing that is expensive. Also, housing has been acting as an excuse issue when someone gets to work late. Several times, when you ask a worker why [they are] late, [they tell] you that [they live] very far from the workplace and transport is a problem. And they stay far from the town centre because that is the only place where they can get relatively cheaper houses for rent.

4.2.5 Work environment

The perceptions of health workers of their working environment was largely negative, as analysed by gender and employers strata (see *Tables 5 and 6.*) While there was no significant difference among employers, 51.26% (61) of

public employees disagreed that the working environment allowed them to unleash all their potential. The same answer was provided by 41.37% (12) of workers in the private not-for-profit sector. All four respondents in the private for-profit sector believed that their working environment allowed them to be productive, but this result should be interpreted with great care because the sample is so small and probably not representational.

4.2.6 Work-time flexibility and workload

Flexibility in a health worker's work-time schedule has well been documented to be an important non-financial incentive and good for the overall motivation of health workers. In the field study, the majority of respondents remarked on inflexible time schedules, as well as a heavy workload. Among public sector employees, 57.98% (69) had the perception that there is not enough time flexibility for them to effectively accomplish their work and do other private work, while 3.36% (4) were undecided and 38.65% (46) said that their time was flexible enough for them to accomplish their job requirements and at the same time engage in their other private work.

4.2.7 Supportive supervision

The analysis, as disaggregated by gender, indicates that, between men and women, more than 15% of respondents had a negative attitude towards supportive supervision by their supervisors from both within and outside their workplaces. While 76.27% (45) of the men, and 66.66% (62) of the women had a positive attitude towards supportive supervision, this finding should be interpreted with care due to the possible problem of lack of a clear understanding of what supportive supervision really entails among the interviewed respondents. Among the three types of employers, it was found that more than 16% of all interviewees had a negative attitude towards the type of supervision they received. However, significant differences in terms of perceptions (whether positive or negative) on the functioning and effectiveness of supportive supervision (as a non-financial incentive) between genders and among the three categories of employers were not observed. *Tables 5 and 6* provide more details on workers' perceptions of supervision.

From the interviews, we found that there is a schedule for doing supervision in all dispensaries and health centres in the public sector. In all surveyed districts, council health management team members are the ones who supervise the health facilities below the level of district hospital and they are supposed to bring feedback to these facilities in their following supervisory visits. Consistently in almost all districts, DMOs are not often engaged in supervision, as they are always busy with administrative duties, and more often attending to unexpected guests from the Ministry of Health, research organisations etc. One key informant said:

I would really like to visit those health facilities for supervision but I am always busy with administrative work. Right now I just came from the meeting with the city director and tomorrow I have another meeting with CHMT. If I remember, last time I went for supervision was two months ago, and I managed to visit just a handful of facilities. (Informant, Mbeya urban district).

Generally, almost all participants acknowledged that good supervision play a big role in motivating health workers, especially those in rural areas. Apart from improving the health care system, supervision makes health workers feel part of the system and not isolated. One interviewee commented that “I would always be happy to see my boss visiting my office and listening to my problems” (informant, Iringa urban district). In the private sector, especially not-for-profit, it was revealed that government health officials are indirectly involved in supervision of the projects managed by the DDHs. Most of these projects are collaborative efforts between donors and the government.

In Mbeya, Bukombe, Bariadi and Meatu districts, a lack of transport facilities was seen as undermining the supervision of lower-level health facilities in the public sector:

You know, everything (funds, cars and what you have) is under the city director. So sometimes we don't go for supervision even if our department has got a lot of cars. This is because sometimes all cars are used by other offices or departments, like education, works, agriculture etc. And it is the discretion of the city director to decide, not the DMO. (Informant, Mbeya urban district).

4.2.8 Recognition, support and respect

Evidence suggests that the absence of recognition, support and respect at workplace and from the community may be a potential de-motivator and reduce a health worker's efficiency and effectiveness. As shown in *Tables 5 and 6*, our analysis reveals that the interviewed health workers (stratified by gender and type of employer) have positive perceptions on how their fellow workers, their supervisors and community around them value their contribution in the provision of health services. While interpreting the meaning of this finding, it is also imperative to consider the mediating effect of other variables, such as a poor working environment, which can offset the positive contribution of recognition, support and respect.

4.2.9 Effectiveness of feedback mechanisms

A well-functioning and effective feedback mechanism between the workers and management is the backbone of supportive supervision. Our analysis indicates that, overall, workers had a positive perception regarding day-to-day supervision and feedback. While this is the case, there is concern that

the positive contribution of a good feedback mechanism between workers and management may be diluted or offset by inadequacies in other forms of non-financial incentives, such as a poor working environment and limited flexibility with work-time.

There were mixed responses in the interviews as to whether there is an effective feedback mechanism or not. According to some informants, there are good feedback mechanisms, especially in the public sector. Council health management teams hold monthly meetings to discuss different health workers' issues and provide explanations or seek solutions from the responsible authorities. One informant pointed out that:

I think we do have good feed back mechanism here. However, due to a number of problems, things are not 100% okay. There are some problems here and there, and sometimes workers complain, but it is beyond our reach. You know, sometimes, giving feedback involves a lot of money. We need vehicles, fuel, stationery, allowances etc to strengthen the feedback mechanism. However, management should work hard to make sure that feedback related to the output of supervisory visits is provided to health workers. (Informant, Iringa urban district).

4.2.10 Health worker participation in discussions about their welfare

In the field study, we found that there is high level of participation in matters relating to employment among public sector health workers, from the level of dispensary to district hospitals, in the form of monthly meetings. The agendas from dispensary and health centre meetings are forwarded to the district executive director by the DMO. It was, however, learnt that not everything discussed and agreed in the meeting regarding the improvement of workers' welfare is implemented. The only excuse that has been frequently provided by the health management at the district level is a shortage of funds. For example, it was revealed by one key informant that:

Even if health workers complain that some of the things are not fulfilled as was agreed in the meetings, the only reason is that the government does not have enough funds to fulfil everything on time. Quite often we budget, but the government does not give us the required amount of money. Therefore, we always have to divert some funds to other expenditure responsibilities, which in turn affects the implementation of what was agreed to in the meeting. (Informant, Mbeya urban district)

It was also pointed out that sometimes health workers are given feedback instead of participating in planning. This normally happens when donors give directives on how, for example, financial resources should be spent. So, vertical programmes, which normally come with strict modalities of

implementation and expenditure procedures, including health worker participation, have little or limited participation. One respondent also argued that:

In implementing plans from the Global Fund, we normally don't change anything because there are directives for that fund. Health workers are just given some directives and plans on how to implement. So, in practice, health workers do not participate in everything. (Informant Mbeya urban district).

4.2.11 Perceptions of the adequacy and effectiveness of non-financial incentives

In the field study, we wanted to find out respondents' general perceptions of the adequacy and effectiveness of the existing non-financial incentives. More than 70% of all respondents (working for all three types of employers) had a perception that the functioning of available non-financial incentives was not enough to motivate them to remain in their posts. This was also the case when a gender-stratified analysis was performed. In both cases, there were no significant differences between men and women and among the three types of employers in terms of the above-mentioned perceptions (see *Tables 5 and 6*).

In general, a lack of funds was consistently mentioned in the interviews to be an obstacle to implementing a number of non-financial incentives. Some common and specific problems mentioned in each district include lack of transport for health workers, poor housing, delays in salary and allowances (especially leave allowance) and delays in promotion. Also, poor working conditions (bad infrastructure and lack of supplies) were demotivating workers. It was also added that most health workers do not know their rights or the regulations governing them and sometimes they complain because they do not know these.

It was also mentioned that bureaucracy and unnecessary "red tape" in public offices cause a lot of problems. One informant said that:

Some of the officers cause a lot of problems and delays when it comes to things such as leave allowances etc. You know this tendency of 'Come tomorrow, come tomorrow' has never ended despite efforts to stop them. It really demoralises health workers. Instead of spending their valuable time working in the hospitals, they spend much time following up administrative tasks and calling accounts offices for such things as leave allowances. (Informant, Bariadi district).

Respondents recommended that education should be the primary criterion for promotion. It was further emphasised that the health sector should be allocated more funds because it has long been recognised as a priority

sector. Sufficient funds will help to solve a number of problems relating to general human resources issues and, in particular, to ensure effective implementation of the non-financial incentives.

Moreover, housing should be improved so that many workers can have decent housing close to their workplaces. The existing management system should be improved to better work relationships. Related to the earlier suggestion, it was further recommended that, in order to reduce delays in promotion, decentralised district authorities should be given full mandate in the management of their health workers. The promotion process should be managed from start to finish by the district authorities themselves, and the central government should just be given a report of the decisions that were taken. In addition, it was recommended that health workers should be assisted in burial and funeral services when they are bereaved:

It is very expensive to handle these funeral ceremonies. Nowadays, and especially with the problem of AIDS, we always receive news from co-workers that they have lost [members of] their families and relatives. This makes us obliged to contribute some money for [them] to ensure that the funeral ceremony is effected. With these low salaries that the government pays us, we are forced to spend a big part of it on contributing for funerals. I urge the government to allocate some funds and help on this. (Informant, Iringa urban district).

Tables 5 and 6 show elicited attitudes and perceptions of health workers towards implementation of some non-financial incentives, disaggregated by gender and type of employers. Overall, there are no significant differences between genders and type of employers regarding employees' attitudes towards implementation of non-financial incentives. Only for a few aspects were there significant differences by gender and type of employer. For example, there was a significant difference ($P < 0.002$) between men and women in assessing the fairness and transparency of the process of worker promotion. While 42.4% of men (24) agreed that the process was fair and transparent, 28% of women disagreed. A stratified analysis by type of employer (see Table 5) showed that 39.5% (49) of health workers in the public sector agreed that the system is transparent and fair, compared to 25% (1) in the private sector and 41% (12) in the private-not-for-profit sector ($P < 0.05$).

4.3 Some critical issues for the implementation of non-financial incentives

4.3.1 Monitoring and evaluation of the implementation of non-financial incentives

After identifying a number of implementation gaps, in both the literature review and field study, we also wanted to point out existing M&E mechanisms for the effective implementation of existing non-financial incentives, as

institutionally supported by laws and a number of establishment circulars. The budget and planning process at the district level was mentioned by a number of informants at the district level as one of the M&E mechanisms. Through the budgeting process, for example, it was possible to know if, in the previous financial year, there were sufficient funds set for such non-financial incentives such as training and paying the costs of those whose annual leave was due. Through these processes, it is possible to conclude whether the training programmes are realistic and focused or not. In aspects such as promotion, complaints channelled to representatives of health worker trade unions may provide a rough picture of whether employers do enough to address health workers' welfare problems. However, this study did not manage access data from trade unions on the M&E of non-financial incentives.

4.3.2 Budget to implement incentives and sources of funds

All districts that were involved in this study receive money from the central government. They also mobilise their own local resources through taxes. In addition, they get donor support from a consolidated pool of funds known as a basket fund. There is no specific budget vote for improving non-financial incentives. In most cases, the government, through its district councils, provides specific guidelines for improving some of the non-financial incentives, such as housing for senior officers.

Funds from central government are always delayed, without explanation, and this causes a lot of problems in terms of performing district daily activities, including those in the health department. The only reliable source of funds is basket funds, although these funds have very strict expenditure guidelines. As a respondent from Iringa argued:

We have never had problems with receiving money from basket funds. They send money on time but with very strict expenditure guidelines. You can't use this money for improving health workers' welfare and other things, which are out of their guidelines. (Informant, Iringa urban district).

Even though non-financial incentives are institutionalised by government policies and standing orders, their sustainability is eroded by the absence of special earmarked funding for their implementation. Also, decentralised districts' lack of adequate powers and authority over the management of human resources on their disposal might go some way to explaining the observed ineffectiveness of the non-financial incentives.

4.4 Strengths, weaknesses, opportunities and threats (SWOT analysis)

The study conducted a SWOT analysis of the implementation of non-financial incentives in Tanzania. There was general consensus that interventions, such as training and education, promotion and the provision of safe working and living environments, can be strong motivators if effective and sustainable ways of implementation are in place. The complaints by interviewed health workers on poor implementation of available non-financial incentives are a testimony that these incentives are really useful in motivating health workers to remain where they are posted.

The major weaknesses identified by the interviewed participants were related to districts authorities' inability to implement such policies as promotion and training. With regard to promotion, it was pointed out that districts have limited powers and authority to ensure that the process can be effected on time (when the employees' time for promotion is due). One informant said:

We, at the district level, do our best to ensure that, if an employee is due for promotion and has fulfilled all the performance requirements, [they are] recommended for that effect. But the problem is caused by those authorities above in the central government. It takes too long; sometimes up to three years when the recommendation has been sent to the time a letter of promotion for a particular employee is sent to us. (Informant, Kongwa District)

Training is a problem in two respects: employers fail to set enough funds for training and staff shortages prevent employees from going on study leave, as one respondent argued:

Every year you may have more than 10 employees who need training, as per the training needs analysis seen in our training programmes. But the problem is funding to cater for all. However, even when funds are available, you cannot just release all who want to go for training because if you do that some facilities will remain without health workers. In this case, the shortage of health workers forces us to fail to give our employees right for further training and sometimes they are forced to postpone their annual leave for up to the next two to three years. (Informant, Bukombe district).

Another informant added:

Moreover, employees themselves may wish to reject a training programme as a result of many excuses. For example, staying away from their families for one to two years is perceived to be a problem to some of them. They only prefer to go for short courses with allowances, even if the courses have no relevance to their day-to-day performances of their jobs. The same people want promotions. So we face some difficulties in dealing with these issues. (Informant, Meatu district).

Table 5: Perceptions of frontline health workers on the implementation of non-financial incentives by gender, 2007 (sample size = 152)

Statements regarding perceptions of health workers	Men (59)			Women (93)			P-value
	Agree	Undecided	Disagree	Agree	Undecided	Disagree	
In case of problems in implementing NFIs, workers are adequately involved in seeking solutions	57.6%	17.0%	25.4%	49.5%	19.4%	31.2%	0.535
There is clear and transparent policy for implementing non-financial incentives (NFIs)	62.7%	8.5%	28.8%	44.1%	18.3%	37.6%	0.071
There have never been substantial problems in implementing NFIs to ensure fairness	32.2%	10.2%	57.6%	18.3%	20.4%	61.3%	0.098
I am adequately involved or represented in meetings discussing workers' welfare and NFI-related issues	55.9%	10.2%	33.9%	50.5%	16.1%	33.3%	0.278
The process by management of selecting workers to attend short- and long-term training is fair and transparent	59.3%	11.9%	28.8%	41.9%	25.8%	32.3%	0.151
The process by management of promoting workers is fair and transparent	42.4%	15.3%	42.4%	28.0%	30.1%	42.0%	0.002
The working environment is conducive enough for me to unleash all my potential	39.0%	13.6%	47.5%	46.2%	5.4%	48.4%	0.177

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Statements regarding perceptions of health workers	Men (59)			Women (93)			P-value
	Agree	Undecided	Disagree	Agree	Undecided	Disagree	
There is sufficient time flexibility for me to effectively accomplish my work and do other private activities	30.5%	5.1%	64.4%	43.0%	4.3%	52.7%	0,201
I always get supportive supervision from my superiors, both within and outside working place	76.3%	8.5%	15.3%	66.7%	14.0%	19.4%	0,186
There is a strategic and clear training programme for advancing health workers' skills	49.2%	25.4%	25.4%	36.6%	28.0%	35.5%	0,583
There are clear and effective feedback mechanisms between workers and management	52.5%	28.9%	18.6%	61.3%	11.8%	26.9%	0,112
I am supported, recognised and respected by co-workers, management and the community around me	94.9%	5.1%	0%	88.2%	8.6%	3.2%	0,302
My employer always helps/supports me to secure adequate and conducive housing accommodation	36.7%	5.1%	55.3%	22.6%	6.5%	71.0%	0,077
The workload is not as heavy, as there are adequate health workers	11.9%	6.8%	81.4%	17.2%	5.4%	77.4%	0,411
The available NFIs are enough to motivate me and dismiss any intention to find another job elsewhere	6.8%	15.3%	78.0%	6.5%	12.9%	80.6%	0,907

Table 6: Perceptions of frontline health workers on the implementation of non-financial incentives by type of employer, 2007 (sample size = 152)

Statements regarding perceptions of health workers	Public sector (119)			Private for-profit sector (4)			Private not-for-profit Employees(29)			P-value
	Agree	Un-decided	Dis-agree	Agree	Un-decided	Dis-agree	Agree	Un-decided	Dis-agree	
In case of problems in implementing NFIs, workers are adequately involved in seeking solutions	49.6%	21.9%	28.6%	50%	0%	50%	65.5%	6.90%	27.6%	0.587
There is clear and transparent policy for implementing non-financial incentives (NFIs)	44.5%	18.5%	37.0%	75%	0%	25%	75.9%	0%	24.1%	0.074
Never been substantial problems in implementing NFIs to ensure fairness	19.3%	17.7%	60.5%	25.0%	25%	50%	27.6%	13.8%	58.6%	0.077
Im adequately involved or represented in meetings discussing workers' welfare and NFI-related issues	51.3%	14.3%	34.5%	75%	0%	25%	55.2%	13.8%	31.0%	0.431
The process by management of selecting workers to attend short- and long-term training is fair and transparent	49.6%	25.2%	25.2%	75%	0%	25%	41.4%	3.5%	55.2%	0.03
The process by management of promoting workers is fair and transparent	39.5%	21.9%	38.9%	25%	75%	0%	10.4%	27.6%	62.1%	0.037
The working environment is conducive enough for me to unleash all my potential	40.3%	8.4%	51.3%	100%	0%	0%	48.3%	10.3%	41.4%	0.374

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Statements regarding perceptions of health workers	Public sector (119)			Private for-profit sector (4)			Private not-for-profit Employees(29)			P-value
	Agree	Un-decided	Dis-agree	Agree	Un-decided	Dis-agree	Agree	Un-decided	Dis-agree	
There is sufficient time flexibility for me to effectively accomplish my work and do other private activities	38.7%	3.4%	58.0%	75%	0%	25%	31.0%	10.3%	58.6%	0.042
I always get supportive supervision from my superiors, both within and outside working place	72.3%	9.2%	18.5%	100%	0%	0%	58.6%	24.1%	16.4%	0.232
There is a strategic and clear training programme for advancing workers' skills	44.9%	31.1%	24.7%	50%	0%	50%	27.6%	13.8%	58.6%	0.001
Clear and effective feedback mechanisms exist between workers and management	55.5%	21.0%	23.5%	75%	0%	25%	65.5%	10.3%	24.1%	0.563
I am supported, recognised and respected by co-workers, management and the community around me	90.8%	6.7%	2.5%	100%	0%	0%	89.7%	10.3%	0%	0.921
My employer always supports me to secure adequate, conducive housing	30.3%	4.2%	65.5%	75%	0%	25%	20.7%	13.8%	65.5%	0.128
The workload is not heavy, there are adequate workers	16.0%	3.4%	80.7%	25%	0%	75%	10.4%	17.2%	72.4%	0.162
The available NFIs are enough to motivate me and dismiss any intention to find another job elsewhere	5.9%	16.8%	77.3%	25%	0%	75%	6.9%	3.5%	89.7%	0.025

A number of weaknesses/problems with the implementation of non-financial incentives were identified by health workers who were interviewed in the field study. They pointed to a lack of transparency in the implementation of programmes, such as those for promotion and training, inadequate feedback from employers and supervisors (especially when things have gone wrong), poor or inadequate assessment of staff training needs and delays in promotion, without being told the causes of such delays. A heavy workload due a critical lack of adequately qualified health workers makes it difficult for the management to release health workers for leave and training because otherwise services will collapse. Participatory mechanisms are in place for workers to discuss matters affecting their welfare, but they are inadequate. Significantly, they noted that the available non-financial incentive policies do not match well with the reality in health facilities. For example, senior officers are entitled to housing, but you may find that houses (reasonable decent houses) are not available. The provision of housing was seen to be discriminatory because senior officers are provided with housing, yet junior health workers are not, even though they need adequate housing just as much.

Favouritism was seen as a factor in appointing people who go for training, especially short courses. A lack of tools, resources and infrastructure to implement the available non-financial incentives means that, for example, the policies that are intended to help health workers, to give them good housing and a safe working environment, cannot be put into practice because there are no funds to support training programmes, no adequate housing facilities and no sufficient funds to equip facilities with equipment that ensure a safe and conducive working environment. A lack of effective M&E programmes was identified as a final weakness.

With regard to opportunities that the current arrangement can exploit to effectively implement NFI, the general pattern that emerged during interview sessions was that the revitalised and the emergency of private health sector players can be a good place to learn what works and what does not, and if possible adopt and adapt the best practices. Also implementation of decentralisation policy can be a better place to streamline the mobilisation of resources at district levels to make them capable of implementing flexible and context specific incentives for their health workers. One informant explained:

What we are seeing is basically partial decentralisation. They talk too much of decentralisation of powers and authority to the district level, but in reality there is much left to the central government and very little given to the local levels as far as human resources management are concerned (including promotion, training and development). (Informant, Ngara District).

Consistently, it was mentioned by the majority of key informants in all surveyed districts that the current wave of globalisation which has gone hand in hand with easiness of information flow about different labour markets characteristics both within and outside Tanzania can both be an opportunity and a challenge (if not a threat) in improving the effectiveness of non-financial incentives in Tanzania. They can be an opportunity to policy makers to work and correct the weaknesses that make health workers move from, for example, public sectors to private sectors, from rural to urban health care labour markets, or from Tanzania to other health systems abroad.

The trend can be a threat in terms of losing a reasonable number of critical mass of health personnel moving from public sector to other employers in the country. It may even be worse when a large number of qualified workers migrate to other health systems outside Tanzania.

4.5 Key informant and health worker recommendations

Based on their practical experiences in the management of health personnel in general and non-financial incentives in particular, a number of proposals were recommended by interviewed participants as summarised below. They pointed out that there is a need for the government to increase more health workers to the underserved districts or support the district to employ them to reduce the burden of workload shouldered by fewer health workers (which discourage the remaining fewer workers as they are given low pay and work in poor environment). Government should strengthening the existing mechanisms to ensure adequate participation of health workers in decision-making bodies and ensure that mechanisms are built such that laws and regulations governing implementation of promotion and training programmes are respected in order to eliminate the potential problem of favouritisms and general corruption in implementing non-financial incentives. In collaboration with representatives of health worker trade unions, human resources officers at district level should educate health workers on their rights and obligations regarding the implementation of non-financial incentives. There is also a need to strengthen mechanisms for monitoring and evaluation of non-financial incentives to ensure fairness.

5. DISCUSSION OF RESULTS

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Despite the noble intentions of non financial incentive policies such as promotion and provision of continued education to workers, the limited evidence that we gathered in this study showed a definite dissatisfaction among health workers with regard to the implementation of financial and non-financial incentives in Tanzania. The policies are not motivating health workers as they were supposed to. This failure can partly be attributed to emerging trends, such as the globalisation of health care labour markets, within the country and globally. Differences in working conditions between rural and urban health facilities, between the public sector and private sector, and also between Tanzanian health care labour markets and those in other countries can partly explain this gap.

The disparities in health care labour markets can also be translated into differentials in pay structures, prospects for career advancement, lack of working equipment and supportive supervision, among others. As Dussault and Franceschini (2006) have argued, it is these differences that increase the opportunity costs of health workers to remain and serve where they are deployed. Furthermore, globalisation and the free flow of information over the internet about other countries' health care systems has catalysed the desire for health workers in low income countries to opt for migration to other attractive markets. National and international pull and push factors can work together and reinforce each other to complicate the management of health workers' retention in resource poor settings.

Despite the apparent distinction between financial and non-financial incentives, non-financial incentives are ultimately financial because they have to be paid for. Critical costing studies ought to be undertaken before any of the existing or proposed incentive packages are implemented. Estimating the implementation costs of any programme is a good starting point to judge the sustainability of the programme and can also help to determine the feasibility of the recommendations in the policy – if they are more attractive on paper than in reality remains to be seen.

Implementation of the said efforts need to be evidence based and as of now, there are either no or very limited evidence of what works and what does not work with regard to Tanzania's health care labour market. Evidence from frontline health workers, health managers and policy makers (at district level) on the practical limitations of the current incentive regimes can help researchers and analysts to decide on how best these can be done to ensure that the available incentive policies are effectively implemented, monitored and evaluated.

Though limited by unavailability of published documents on the subject matter, our cross-sectional analysis has been able to elicit lived experiences from health managers at district level on whether the available incentives work or not, and if not, what are the reasons for this and what are the suggested ways to deal with the identified obstacles. For example, through the key informant interviews we have been able to shed light by pointing to the fact that, although funding was consistently perceived to be a major obstacle for effective implementation of non-financial incentives, weak management styles (partial decentralisation of health service management) and opportunities offered by an ever-expanding and diverse health care labour market, are also responsible for imposing obstacles to the effective implementation of the available non-financial incentives in the health sector. The negative perceptions and attitudes towards implementation of some of the non-financial incentives as indicated by this analysis are a clear testimony that their institutional sustainability as provided by government laws and standing orders is offset by employers' inability to fund their implementation.

Unnecessary delays due to complex and bureaucratic procedures by civil service department to effect promotions (even when there are funds set for this aspect) is another setback that is beyond the control and management of health sector. From the analysis of quantitative data collected from the health providers, it was also highlighted that the general attitudes and perceptions of the effectiveness of available non-financial incentives was negative and that they can not effectively motivate health workers to remain where they are deployed in the contexts where labour markets offer diverse employment opportunities. Thus, strengthening the implementation capacity both financially and institutionally, is a sine qua non for effective and sustainable outcomes of the non-financial incentive policies in settings where health care labour markets are perceived unattractive.

The indication that some training courses that workers attend are perceived not to be useful raises fears and eyebrows. There is a cause for concern especially with reference to the design or implementation of the available training policies and programmes. Thus, while the training programmes may have good intentions, its implementation must very well be informed by a well designed training needs assessment. The findings that some health workers attend a number of recurring long-term trainings while others do not, is a further indication of serious implementation problems in existing training policies and programmes. One potential explanation for this shortcoming is the highlighted health workers perceptions and attitudes on the fairness and transparency in selecting candidates to attend training courses. It has been shown in the quantitative data analysis that a significant

proportion of interviewed health workers exhibit a negative attitude towards this aspect. Thus, corruption, favouritism and nepotism may be surrounding the selection process, rendering it to be unfair.

The responses on the attitudes and perceptions from the interviewed health workers on implementation problems and ineffectiveness of non-financial incentives indicate that, if properly implemented the non-financial incentives can be valuable tools to motivate health workers. Their negative attitude on the transparency and fairness of the process of selecting health workers for promotion, and how promotion is conducted point to the underlying reality that health workers are serious about incentives, which suggests that incentives may be a powerful tool for helping to retain health workers where they are needed most.

6. CONCLUSION AND RECOMMENDATIONS

The inability to recruit and retain a motivated health workforce in Tanzania is a crucial policy concern for which urgent and effective interventions are to be implemented. Approached in a broader health system framework, it is important to note that the causes for Tanzania's health system failure to retain motivated health workers are many, and are not limited to individual based choices as trivialised by the pull and push factors framework.

Though individual health workers' preferences are important, they are also influenced by macro factors in the health care system and factors from other sectors and systems. Moreover, the international policy context and perceived attractiveness of other health care labour markets are crucial in influencing health workers to practise location choices and hence, negatively affect poor countries' efforts to attract and retain a motivated health workforce. The comment by one informant that decentralisation of health services management to the district level has partially been effected, may provide logical explanation in addressing this problem. That is, if districts are given sufficient powers, authority, (financial and other) resources and management capacities to address human resources issues in the health sector, they could potentially be innovative enough to provide context specific solutions for effective implementation of non-financial incentives.

It is important to emphasise that health system development does not live in isolation from development of other sectors and systems. Any efforts to ensure that available policy measures and strategies can be implemented and produce the desired effects, require strategic efforts to address (in a holistic way) the critical human resource issues ranging from recruitment, placement and retention. Specific policies and strategies for specific cadres and places need to be designed and implemented, taking into account that the health sector is just a small part of the bigger social system.

In this case, any useful analysis, given availability of resources, must take into account both individual and structural factors that shape individual health workers' preference structures and the complex nature of the health care labour market. A trivialised pull and push factors framework in analysing complex problems like retention, will not help the research and policy communities provide sustainable solutions. Thus, a more comprehensive analysis (than that used in this report) is needed to help researchers and policy makers design health sector-specific and multi-sectoral interventions to ensure that new and current policies are effective in motivating health workers and therefore, reverse the emerging migration patterns.

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
CSSC	Christian Social Services Commission
CSD	Civil Service Department
DDH	District-designated hospital
DMO	District medical officer
GAVI	Global Alliances for Vaccination and Immunisation
GHWA	Global Health Workforce Alliance
HERA	Health Research for Action
HIPC	Highly indebted poor countries
HIV	Human immunodeficiency virus
HSR	Health sector reform
HRH	Human resources for health
HWFR	Health Workers Recruitment Fund
IMF	International Monetary Fund
MDG	Millennium Development Goal
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
MoF	Ministry of Finance
NFI	Non-financial incentives
NSGRP	National Strategy for Growth and Reduction of Poverty
PPFF	Pull and push factors framework
PORALG	Presidents Office-Regional Administration and Local Government
PSC	Public Service Commission
RAA	Rural areas allowance
RHW-SCS	Rural Health Workers Saving Credit Scheme
SAPs	Structural Adjustment Programmes
SASE	Selected Accelerated Salary Enhancement
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
USF	Utility Support Fund
VA	Voluntary agencies
WB	World Bank
WDI	World Development Indicators
URT	United Republic of Tanzania

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

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