

**WORK CLIMATE IMPROVEMENT
AND PRODUCTIVITY
ASSESSMENT IN IRINGA AND
MTWARA REGIONS OF
TANZANIA**

DRAFT



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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMO	Assistant Medical Officer
BMAF	Benjamin William Mkapa HIV/AIDS Foundation
CCHP	Comprehensive Council Health Plan
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHMT	Council Health Management Team
CO	Clinical Officer
CTC	Care and Treatment Center
DDH	District Designated Hospital
FBO	Faith-based Organization
HIV	Human Immunodeficiency Virus
HCW	Health Care Worker
HRH	Human Resources for Health
HRM	Human Resources Management
HSSP	Health Sector Strategic Plan
MOHSW	Ministry of Health and Social Welfare
OPD	Out- Patient Department
OPRAS	Open Performance Review and Appraisal System
RCH	Reproductive Child Health
RHMT	Regional Health Management Team
USAID	US Agency for International Development
WCI	Work Climate Initiative
WHO	World Health Organization
THRP	Tanzania Human Resource Capacity Project

EXECUTIVE SUMMARY

Human Resources for Health is a crucial component of health service delivery. The government has made a deliberate effort to improve human resources in many ways i.e. to increase numbers of health professionals, to improve skills of health workers, and to improve salaries and other incentives of health workers. Despite Government efforts to improve Human Resources for Health, there are still challenges that hinder the health services delivery to the public. Besides the insufficient total number of health workers, poor management has been distorting the allocation of staff towards urban areas. This adversely affects the access to quality of healthcare in rural areas where 77% of Tanzanians lives (Primary health service development programme MMAM 2007-2017 pg 11)

To complement government efforts to improve health services in Tanzania, BMAF through THRP initiated HRH interventions in 54 districts of the regions of Mtwara, Lindi, Iringa, Shinyanga, Mara, Mwanza, Ruvuma and Kagera. The interventions strengthen the capacity of Council Health Management Teams (CHMTs) in the districts to improve Human Resource Management, and health workers' attraction and retention.

In an effort to enhance the productivity and gender equality, THRP conducted gap analysis and collected baseline data in five targeted districts in Mtwara and Iringa regions where THRP interventions have been implemented for the past three years. The objective of the analysis was to document deeper understanding of the factors contributing to low morale, low job satisfaction and poor performance in the facilities, gather baseline data on the productivity of providers at selected facilities, and develop interventions for improvement. Further, the study authors performed a gender analysis in the selected facilities to determine if gender practices affect provider performance.

The key findings of the study are as follow:

1. On average, patients had to wait for more than one and a half hour for consultation services in reproductive and child health (RCH) and out-patient departments (OPD) but had contact time ranging from 3 minutes in the RCH to 5 minutes in the OPD. Registration took 42 min in RCH and 43 min in OPD, whilst dispensing services took 48 min in RCH and 54 min in OPD. The average waiting was 43 and 42 minutes in RCH and OPD respectively. The service contact times varied across the departments. The highest contact time in the RCH department was in counselling (24 minutes) followed by lab services (23 minutes) while in OPD more contact was in lab services (22 minutes), followed by clinical assessment (14 minutes).

2. In the engagement¹ questionnaire, the study reveals that Medical Doctors, Dentists and Assistant Clinical Officers are disengaged with an average score of 3.8, 3.9 and 3.2 respectively. This reflects the fact that the ratio between the MD and population is 1:100,000 in rural areas. On gender issues, the average engagement is 3.6, which suggests that gender biases are limited in some respects, as shown by incorporation of gender issues in the plans and budget (with an average score of 3.0), awareness of gender policies (with a score of 3.0) and leadership positions (with a score of 3.5). Further, the information gathered shows that men reported having a higher rate of engagement (3.7) compared to women with lower rate (3.5)
3. Based on the direct observations of 61 health providers in 14 facilities, the assessment found that providers spent 55% of their total time on direct patient care, 9% on indirect patient care, and 10% on attending meetings or entering data on the register. Further, the assessment found 16% of time being unproductive, when providers were engaged in socializing (2%) or waiting for patients (14%)
4. When health workers were asked if “your job description presents an accurate description of the work you are actually doing each day,” 23% (45) agreed, 13% (26) disagreed with the statement, and 34% (66) did not respond because they were not provided with a job description. Providing accurate job descriptions to staff is another area where intervention is needed. All facilities needed infrastructure improvement. This ranges from renovation/painting (14 facilities) of different structures, water system repair (14 facilities), renovation of incinerators (12 facilities), renovation of placenta pits (6), installation of signage (9), and increased supply of protective gears (10)
5. When providers were asked individually if they have implemented open performance review and appraisal systems (OPRAS), 72% said no and 28% said they filled the forms but did not conduct midyear and annual evaluations. This data show that there is an asymmetrical relationship between government’s investment in the design and implementation of OPRAS, and the expectations government has for improved performance management at the local level. However, when data collectors asked to see the OPRAS forms for those who filled the forms, only 10% of could produce any, and those produced had a very low quality
6. Despite government efforts to mainstream gender issues at all levels, the level of awareness at the lower levels is very poor, with an average engagement score of 3.6 per district. It was further noted that staff were afraid to discuss gender related issues openly. Data collected

¹ Engagement is “a heightened emotional connection an employee feels for his/her organization that influences him/her to exert greater discretionary effort to the work.” The scores are classified as “engaged” (scoring 4.0-5.0) to show health workers with higher level of productivity, “disengaged” (scoring 3-3.9) health workers with less productivity and less loyal to their organization and are not having their needs met. Further, providers that are “actively disengaged” (scoring 1-2.9) have low levels of productivity, have high rates of absenteeism, feel compelled to spread their disillusionment with other colleagues, and are not loyal to their organization

revealed that an average of only 27% agreed that issues of violence against women are fully addressed in the districts plans

Based on the study assessment findings, a productivity intervention package should be prepared and shared with key stakeholders. HR and clinical indicators should be developed to measure implementation of the intervention package. Health providers should be trained on the intervention package and periodic coaching and mentoring should be conducted to assess the implementation of the package.

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1 Background and Rationale

Human resources for health (HRH) presents a major challenge for the health sector in general. Qualified health care workers are in short supply despite high demand, particularly in rural areas. According to the Government of Tanzania's HRH Strategic Plan (2006), Tanzania's public sector health facilities have a total of 29,063 out of the 82,277 needed health professionals, meaning that only 38% of the required positions are filled.

Further, health workers receive low wages, work in unfavorable conditions, and often have not received the necessary training and supplies to perform well. Health workers in these situations often become demoralized, and as a result, may leave their workplace in search of more profitable opportunities or become disengaged in their current work.

Various approaches have been tried to motivate and retain health workers; however, these approaches have shown limited impact and have not always resulted in improving motivation. Work climate improvement (WCI) initiatives offer a way of thinking about managing, retaining, and making health workers more productive. Work climate has an influence on performance. A positive work climate is a driver of performance and creates an environment conducive to developing trust and empowerment, which in the context of health services leads to higher quality patient care and improved productivity. Also, little is known about the nature and level of gender discrimination and workplace violence experienced by health workers, or what policies and reporting systems are in operation to increase workplace equity, safety, and security at district and facility levels.

The Tanzania Human Resource Capacity Project (THRP) is a four-year (2009—2013) USAID-funded initiative implemented by a consortium of partners with the common goal of improving the health and social welfare workforce in both the public and private sectors of Tanzania. Through the Benjamin Mkapa HIV/AIDS Foundation (BMAF), THRP initiated HRH interventions in 54 districts in the following regions: Mtwara, Lindi, Iringa, Shinyanga, Mara, Mwanza, Ruvuma and Kagera. The interventions strengthen the capacity of Council Health Management Teams (CHMTs) in the districts to improve human resource management, productivity, and retention.

In collaboration with the district councils, THRP intends to implement work climate improvement (WCI) in selected facilities in five targeted districts. In a health facility environment, work climate can be described as the general atmosphere experienced by health workers in dealing with colleagues, supervisors, and clients. It is thought when people are happy in their jobs, they are more productive. In this regard, THRP is conducting a baseline survey to document health workers' productivity and job satisfaction levels and performing a gender analysis in the health facilities targeted for intervention in the districts where THRP is implementing human resources management (HRM) interventions.

2 Literature review

According to the WHO definition in the *World Health Report 2006*, a well-performing workforce is one that “works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given the available resources and circumstances.” Poor performance results from too few staff, or from staff not providing care according to standards and not being responsive to the needs of the community and patients. As Hughes et al. state (2002): “Most performance problems can be attributed to unclear expectations, skills deficit, resource or equipment shortages or a lack of motivation.” These causes are rooted in a failing health system, low salaries, difficult working and living conditions, and inappropriate training.

There are many things that influence how productive a worker is. Several studies have demonstrated a relationship between health workers’ productivity and client outcomes. When the number of patients per health worker increases to a certain level, there is insufficient time to diagnose and treat all patients adequately. There is a positive correlation between qualified nursing staff and lower mortality rates. Registered nurses generally have more effective skills for in-depth assessment and surveillance of clinical changes than unskilled staff. When there are higher numbers of registered nursing staff, there is more time for them to monitor changes in patients’ conditions. This results in quicker detection of changes in health status and increases the ability to intervene before the condition deteriorates. (Aiken, et al., 2002; Needleman, et al., 2002b)

Other studies have shown that there is a clear link between job satisfaction and intention to leave a post, and some studies demonstrate that efforts to improve job satisfaction are closely related to efforts to improve productivity, competence, and responsiveness of workers (Schoo & Dunbar, 2005). Financial benefits are an important factor, especially when salaries are very low, but they are not the only - nor the most important factor (Hongoro & Normand, 2006; Dussault & Fanceschini, 2006). Other important elements are organizational and professional support, influence in decision-making regarding the medical practice and working life, career opportunities and professional development, the working environment, worker safety, and the availability of opportunities to develop skills and to grow (Dieleman & Harnmeijer, 2006).

Studies conducted by the Clinton Foundation and the Capacity Project² show one of the most critical gaps in human resources in Tanzania is improve performance management at the facility level. Overloaded health workers, understaffed facilities, and weak or nonexistent performance systems contribute to low worker productivity, a lack of engagement, and a seeming lack of ownership and empowerment regarding their jobs and responsibilities. This lack of productivity

² Clinton Foundation report on OPRAS baseline study. October 2008.

and engagement becomes increasingly severe in rural and hard-to-reach areas and becomes a serious barrier to improvement in quality of care.

Ottar Mæstad et al (2010) found no association between caseload and the level of effort per patient. The study suggests that scaling up the number of health workers is unlikely to raise the quality of health services and recommends the use of performance incentives to motivate health workers to increase productivity.

2.1 Methods for increasing health workers' productivity

Health care worker engagement and enhanced productivity relate to three things: the employee's *perception of valence* – i.e., how their work is valued; *self-efficacy*—how adequately they believe they can perform the tasks at hand; and *personal expectancy*—how much upward mobility is available to them (Dambisya Y, 2007). Mechanisms through which these three areas may be promoted go beyond reward and disincentive systems and seek to improve the overall occupational environment, facility infrastructure, resources (such as medications, diagnostics, and information packages), district level management, and recognition. A key element in the success of these mechanisms is involving employee participation in decision-making and feedback processes, which helps to strengthen worker autonomy and responsibility, building off this understanding of necessary mechanisms to improve employee productivity, Mathauer and Imhoff (2006) identify key methods to implement toward this effort³:

- Exposure to new knowledge (training, conferences)
- Team building
- Low-cost benefits that express personal appreciation (extra free time, tea during night duty)
- Development of career development plans
- Transparent and reliable promotion schemes
- Continuing professional development, training
- Supportive supervision and feedback
- Performance management tools
- Staff satisfaction surveys
- Increased staff participation in decision-making processes within the health structure
- Horizontal and vertical communication among staff
- Quality improvement teams and building a quality culture
- Participatory problem assessments and problem-solving processes
- Benchmarking and competition among facilities.

³ Mathauer I, Imhoff I. Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. *Human Resources for Health*. 2006; 4(24): 1-17.

2.2 Measuring productivity

Increasing the productivity of health workers has been identified as one of the most cost-effective ways to improve health system capacity and performance [19]. Simply put, productivity is defined as a ratio of outputs to inputs.

There is no accepted 'gold standard' measure of health workforce productivity in the literature. Health worker productivity has been measured in a variety of ways including levels of absenteeism from health facilities (Chaudhury and Hammer, 2004) or direct observation of how health workers spent their time providing health care services as compared to non-care services (Zanzibar productivity study, 2009; URC HR improvement collaborative 2010; Health Systems 20/20 project; Abt Associates Inc 2011; Kurowski et al, 2007). Other measures include the number of health services provided—doctors' visits or inpatient days—by a particular type of health worker, usually per doctor or nurse (Courtright et al, 2007; Vujicic et al, 2009). Other studies have linked productivity with improved patient outcomes such as increased access of services, reduced loss to follow up, and reduced maternal mortality rates.

2.3 Indicators for performance and productivity

Performance can be assessed by looking at the availability of staff, as well as their competences, productivity and responsiveness (Marjolein Dieleman et al., 2006). The analytical framework below compiles indicators that can be applied to measure performance (WHO, 2006; Buchan, 2005; Hornby & Forte, 2002). The framework is adopted from Marjolein Dieleman et al., 2006 and the indicators for measuring health outputs have been compiled from various sources (Peter Hornby & Paul Forte, Soumya Alva et al 200 HSSP III Indicators). This framework is adopted in this assessment.

2.3.1 Table 1.1 Indicators for measuring performance and productivity

Factors	Example of indicators based on literature review	Indicators to be collected through baseline assessment
Outcome level		
Performance	Composite of four elements mentioned under Effects. Improvement in these four elements indicates improved performance	
Effects		
Availability	Waiting time, contact time, staff ratio, overtime, staff turnover, attendance of health workers, workload	Waiting time, contact time, staff turnover, workload
	1) <i>Indicators for monitoring providers' productivity</i> <i>Number of outpatient dept. (OPD) caseload per provider, interventions provided by provider, the</i>	<i>Caseload per provider, the ratio of workers' time spent providing health care services as compared to non-care services (meetings,</i>

Factors	Example of indicators based on literature review	Indicators to be collected through baseline assessment
	ratio of workers' time spent providing health care services as compared to non-care services (meetings, travelling, reporting, etc.)	travelling, reporting, etc.),
	<p>Examples of health outputs indicators</p> <p><i>RCH services:</i></p> <p>Proportion of children under one vaccinated against measles/DPT, proportion of pregnant women who start ANC before 16 weeks of gestation, proportion of pregnant women attending ANC at least 4 times during pregnancy, proportion of deliveries attended by a skilled HCW professional, proportion of women using family planning methods, infant mortality rate, maternal mortality rate</p> <p><i>HIV services:</i> Percentage of HIV positive women receiving ARVs to prevent MTCT, number of persons with advanced HIV infection receiving ARV combination treatment, proportion of PLHIV lost to follow up, proportion of HIV positive patients screened for TB</p> <p><i>Malaria</i></p> <p>Proportion of laboratory confirmed malaria cases among all OPD visits (disaggregated under 5 and over 5), prevalence of malaria, prevalence of Malaria parasitemia (under 5 years) , use of bed nets</p>	<p><i>Indicators for monitoring outputs of health services will be selected in consultation with the facilities before interventions are implemented. For detecting changes contributed to the interventions and simplifying the data collection process, the indicators that are collected through the existing routine data collection system will be given high priority</i></p>
Competence	Prescribing practices, adherence to protocol during diagnosis and communication with patients	
Responsiveness	Client satisfaction, readmission rate, case fatality rates	Client satisfaction
Outputs		
Retention	Vacancies, posts filled, duration in post	Vacancies, posts filled, duration in post
Accountability	Level of responsiveness and adherence to rules and standard operating procedures	
Skills and knowledge	Level of skills and knowledge practices	Level of skills and knowledge
Motivation and job satisfaction/engagement	Level of job satisfaction/engagement, gender equity, level of staff motivation	Level of job satisfaction/engagement, gender equity, level of staff motivation
Working environment	Availability of infrastructure, medication and supplies, communication procedures, decision	Availability of infrastructure, medication and supplies, supervision procedures, decision

Factors	Example of indicators based on literature review	Indicators to be collected through baseline assessment
	making process	making process

2.4 Measuring employee job satisfaction/ engagement of health workers

Several measurement tools have emerged in an effort to assess levels of employee engagement and job satisfaction. The Capacity Project developed a job satisfaction survey tool with questions designed to gauge employee satisfaction as related to their relationships with coworkers, supervision, job satisfaction and salaries⁴. The Gallup Q12 is another example of a very successful tool which is widely used to assess employee satisfaction. Designed for improving business productivity, the Q12 is a survey that identifies twelve recurring themes to reflect an employee's level of engagement with his or her respective employer. The Q12 has been used among 6.5 million employees in over 70 sub-industries across 170 countries worldwide⁵. As every country is confronted with its own unique human resource constraints, the results produced by Q12 require contextualized strategies and approaches. These tools are suggested as a base model to be modified as necessary to meet the needs of HCW workers in Tanzania.

2.5 Assessment Objectives

The aim of the assessment was to examine HRM practices and working environments in health facilities in order to identify areas for interventions which would improve health worker productivity as well as the quality and efficiency of health care services. More specifically the assessment covered the following specific objectives:

- i. To create a deeper understanding of the factors (systems, physical or emotional) contributing to low morale, low job satisfaction and poor performance in the facilities
- ii. To gather baseline data on the productivity of providers at selected facilities
- iii. To perform gender analysis at the selected facilities to determine if gender practices affect provider performance

⁴ Work Climate Improvement (WCI) Initiative, Job satisfaction survey in western and Nyanza provinces of Kenya, 2008

⁵ Gallup Q12. Employee Engagement. Retrieved May 11, 2011. Available online at <http://www.gallup.com/>

- iv. To recommend simple practical interventions that will influence facilities to improve work climate conditions

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3 Methodology

The baseline includes a cross-sectional study conducted among a purposively selected sample of health worker cadres in five districts. Through direct observation of providers, data was generated showing how health workers spend their time to do productive and unproductive tasks.

Information on patient loads and flow, health workers engagement, health workers capacity to support client, client satisfaction and available support (equipment, supervisory visits, and training) essential to facilitate productivity was collected.

3.1 Data collection methods and tools

Four data collection methods were used:

- i) Interviews with health providers
- ii) Time utilization observation
- iii) Recording client flows
- iv) Client satisfaction interview
- v) Documenting status of infrastructure in the facilities

3.1.1 Interview with health workers

Interviews with individual health workers and their facility managers were conducted to assess their perception of their workload, working environment, job satisfaction, working conditions, supervision, and opportunities for advancement, performance management, motivation and training and perceptions of constraints to optimum productivity. All cadres of health workers were interviewed at each selected health facility.

3.1.2 Time utilization observation

The way service providers spend their time has a major impact on service quality and productivity. Members of the data collection team directly observed providers for one day (during working hours) in the health facilities to observe how the health workers utilize their time in service provision. The tool was applied to track services offered by health workers working in the Reproductive Child Health (RCH), Out Patient Department (OPD) and Care and Treatment Clinic (CTC).

The assessment team observed providers every fifteen minutes to identify whether they were involved in productive or unproductive tasks. Data collection started at the clinic's official opening hours and completed when the clinic closed or the service provider left for the day.

An analysis was performed to document how the providers divide their time between productive and unproductive tasks.

3.1.3 The employee job satisfaction/engagement survey

The employee engagement tool was used to assess levels of health workers job satisfaction. The tool include questions related to motivation, but goes beyond traditional definitions to include questions addressing the employee's commitment to the organization and their connection to high level job performance to help the organization advance. The tool was also used to collect gender based data. The analysis was performed to gauge the engagement levels of providers in their facilities.

3.1.4 Client flow

The assessment documented how clients move from one service to another, how long they waited for services, and how much time they spend with providers. It also documented caseload per provider per day.

The data was gathered using the client flow assessment tool. The team initiated the tool at the health provider registration. Each client who presented at the clinic registration was asked what time he or she arrived at the clinic. The client's arrival time and registration start and end time were recorded on the form. The form moved with the client to each point of service at the clinic. The staff recorded the start time and end time of the service provided. The analysis determined average time the client used to wait and receive services time.

3.2 Sampling method

Five districts were selected for this assessment. The districts were purposively sampled and were part of 54 districts covered by THRP interventions in Tanzania. District selection took into account the region coverage area, budget for the assessment and duration of project intervention in the district and remoteness of the district from the regional administration office. These districts are among 20 districts where THRP interventions were initiated in 2009. Based on these criteria, three districts were selected in Iringa and two districts in Mtwara. Selected districts include Kilolo DC, Njombe DC and Ludewa (Iringa region) and Newala and Mtwara DC (Mtwara region).

3.2.1 Selection of Health Facilities

District managers were consulted on the selection of facilities in each district. Priority was given to the facilities with challenging locations and adverse working conditions to enable easy detection of changes from the intervention. The assessment intended to cover six health facilities in each district; district hospital or designated district hospital, two health centres and three dispensaries.

In some districts, it was not possible to meet the criteria for facility selection because of the type of facilities that are available. For example, Mtwara DC and Njombe DC do not have district hospitals. To reduce significant deviation from the study design Kibena Hospital, which is owned by Njombe Town Council, was included in the assessment. This hospital provides health services to clients residing in Njombe TC and DC and was previously owned by Njombe DC.

3.2.2 Table 1.2 summary of facilities covered in the assessment.

District	Facility	Population Size
Kilolo DC	Ilula Designated District Hospital	2036
	Mtandika HC	6534
	Kibadaga HC	4359
	Kilolo Dispensary	7583
	Mazumbe Dispensary	2966
	Itungi Dispensary	5328
Ludewa DC	Ludewa District Hospital	6645
	Manda HC	4761
	Mlangali HC	7616
	Masaki Dispensary	1668
	Mawengi Dispensary	3799
	Mbwila Dispensary	1988
Njombe TC	Kibena Hospital	6780
Njombe DC	Wanging'ombe HC	12,303
	Makambako HC	5198
	Lusisi Dispensary	6035
	Igima Dispensary	3023
Mtwara DC	Kitere HC	9672
	Mahurunga HC	9275
	Madimba Dispensary	7779
	Mpapula Dispensary	5750
Newala DC	Newala DH	7654
	Chihangu HC	4567
	Kilangali HC	5589
	Mnyambe Dispensary	3425

3.2.3 Sample size for data collection tools

All cadres of health workers in health facilities were included in the assessment. The selection of respondents represents an accurate distribution of all cadres of health workers in the district. At the hospital level, at least one respondent from each cadre was included while in lower facilities with less than five staff all staff were included.

Table 1.3 Sample size for each data collection tool by district

Instrument	Number of respondents ⁶ per district						Total
	Kilolo DC	Ludewa DC	Njombe DC	Njombe TC ⁷	Mtwara DC	Newala DC	
1. Health Worker interview	23	16	16	8	12	16	91
2. Facility Manager interview	5	6	4	1	4	4	24
3. Time utilization observation	13	14	16	4	12	17	76
4. Employment Engagement & gender Questionnaire	31	26	25	5	16	19	123
5. Client flow observation	122	35	151	85	16	83	492

3.3 Data Collection

3.3.1 Selection and training of data collectors

The process of selecting data collectors is an essential component of ensuring the success of the assessment. Six data collectors were recruited. The data collectors included HRM local experts located at zonal office, district staff and BMAF staff. The data collectors selected had previous experience in data collection while implementing HRM activities at the district level.

The data collectors received one day of orientation which focused on questionnaire use and field preparations.

3.3.2 Data collection exercise

The data collectors were responsible for collecting data from health workers, documenting time utilization of health workers and tracking client flow in the facilities. In order to complete the field work

⁶ A provider can respond to multiple tools

⁷ Njombe TC covered Kibena Hospital only

in the allocated time, the data collectors were divided into two teams. Each day after field work, the data collectors submitted the questionnaires to assessment team leader for review and filing. The team leader reviewed the questionnaires submitted by the data collectors for accuracy and completeness and worked with data collectors to rectify erroneous data.

4 FINDINGS

4.1 Demographic Characteristic

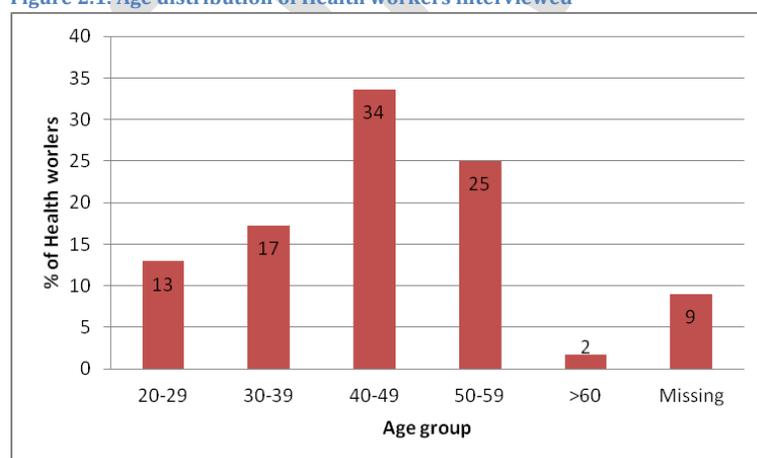
A total of 91 health workers (30% male and 70% female) were included in the assessment. The average age of health workers interviewed was 43 years, ranging from 23 to 37

The majority of health workers had worked in the health sector for 18 years and averaged 9 years at their current facility.

Table 1.4 Distribution of Health Workers by Sex

	Male	Female	Total
Kilolo DC	9	14	23
Ludewa DC	5	11	16
Mtwara DC	4	8	12
Newala DC	5	11	16
Njombe DC	4	20	24
Total	27	64	91

Figure 2.1. Age distribution of Health workers interviewed



4.1.1 Education level

Eight per cent of the health workers reported they had completed high school, the highest standard education level in Tanzania. More than half (57%) had completed ordinary secondary education level. Only one health worker completed post graduate education while the majority (42%) had acquired ordinary certificates and less than half (31%) had a diploma certificate.

4.1.2 Client Flow

Client flow is a key measure to understanding the effectiveness and efficiency of services delivered in sites. If services are being delivered efficiently and providers have high levels of productivity, clients should have fairly low wait times and have adequate contact time with providers to receive good quality care⁸. The client flow tool was used in to track 472 clients in three hospitals and 5 health centers. Morning hours were shown to have higher client loads than afternoon hours.

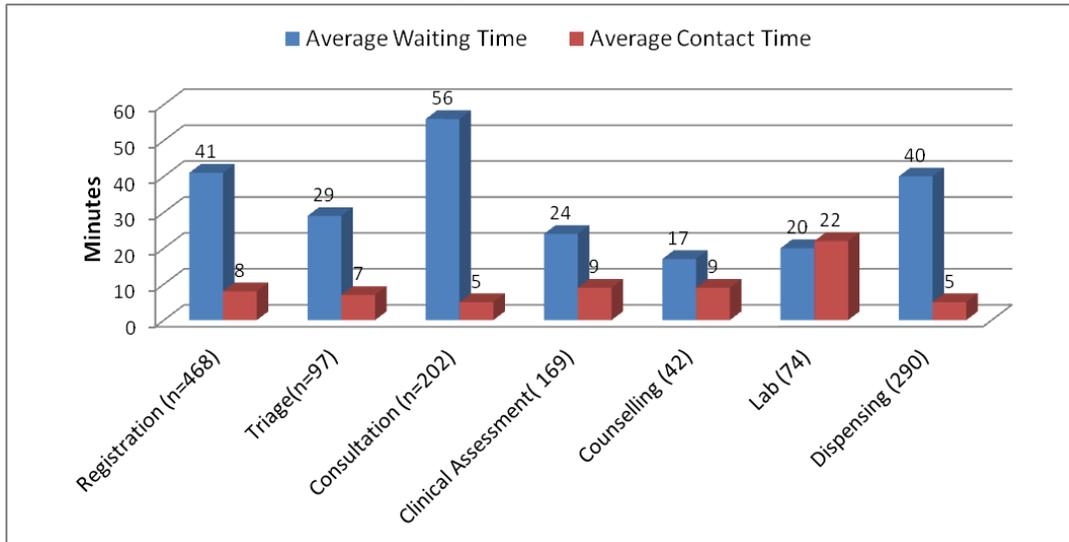
Figure 2.2 shows the average client contact time with the providers and the time the client spent in waiting for services at each stage of their visit in the three departments - Care and Treatment Centre (CTC), Orthopedic Department a(OPD) and Reproductive and Child Health (RCH) departments . The greatest wait time occurred at consultation services, where average waiting time was 56 minutes with an average of five (5) minutes of provider contact time with the client. The provider contact time was similar to the findings of Mæstad et al⁹ (5.7 minutes per client) in their study on workload and performance in Tanzania.

Clients also spent considerable time at the registration desk. On average, clients waited 41 minutes for registration and eight minutes for consultation or clinical assessment. In most stages of the process—triage, clinical assessment, counseling and lab —patients' waiting time was less than 30 minutes. In all departments except laboratory services, the average patient contact time was shorter than waiting time. The specific contact and waiting times are indicated on the table 2.2 below:

⁸ Baseline Assessment of HIV Service Provider Productivity and Efficiency in Tanzania

⁹ Overworked? On the relationship between workload and health worker performance

Figure 2.2. General - Patient contact and waiting time

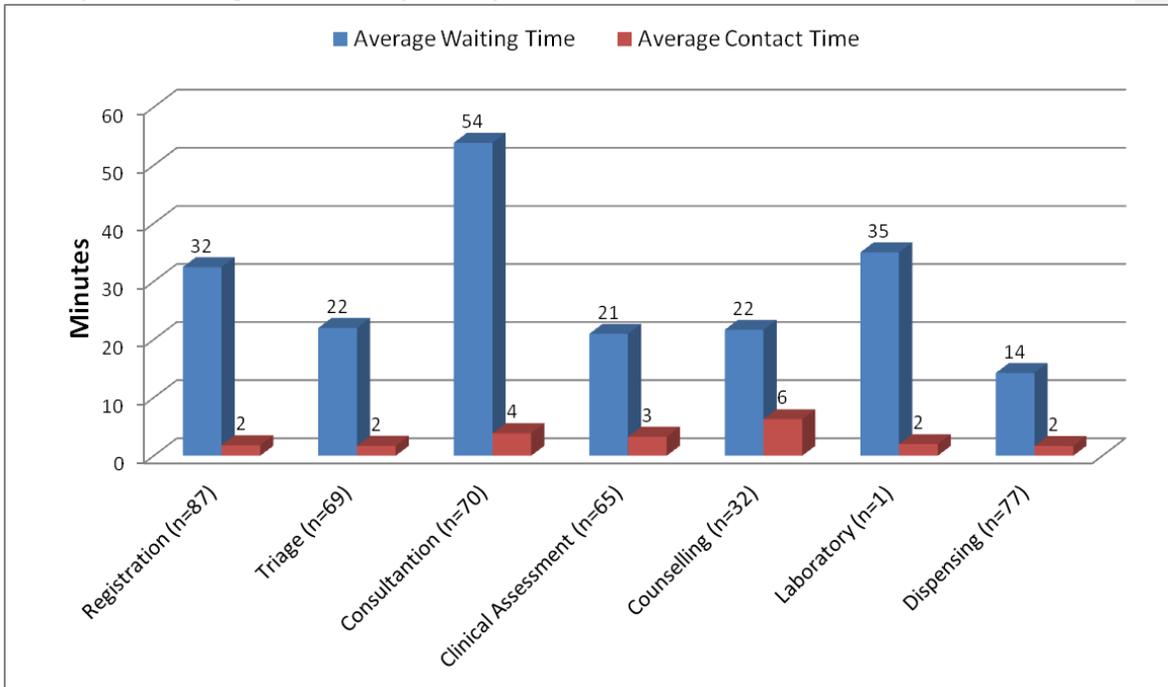


4.1.3 Client Flow in the Departments

CTC Department

The client flow component of the study assessed 87 clients seeking services in CTC departments. Consultation had highest waiting time (54 minutes) followed by laboratory (35 minutes) and registration (34) minutes. The waiting time for other services, i.e. triage, clinical assessment, counselling and dispensing – was quite reasonable at 20 minutes as indicated in Fig 2.2. The highest client contact time with providers was in counselling service (6 minutes), followed by consultation services (3 minutes). While other services contact time was 2 minutes. The longer contact time in counselling compared to other services is not surprising, because counselling involves pre and post counselling phases. Overall, the contact time with providers for all services was very short and not likely to compromise the quality of services provided.

Figure 2.3. CTC Department - Average Waiting and Contact Time



4.1.3.1 RCH and OPD

Similarly, on average, patients waited for more than one and a half hour for consultation services in RCH and OPD departments but had contact times ranging from 3 minutes in RCH to 5 minutes in OPD.

The average waiting time for registration and dispensing was 43 and 42 minutes in RCH and OPD respectively. The service contact times were much shorter in both departments (seven (7) for registration and five (5) for dispensing). The highest contact time in RCH department was in counselling (24 minutes) followed by lab services (23 minutes), while in OPD, more contact was in lab services (22), followed by clinical assessment (14). Figure 2.4 and 2.5 summarizes patients' waiting and contact time at RCH and OPD departments.

Figure X. Average client waiting and contact time, RCH

Figure 2.4 Average Waiting Time and Average Contact Time in RCH

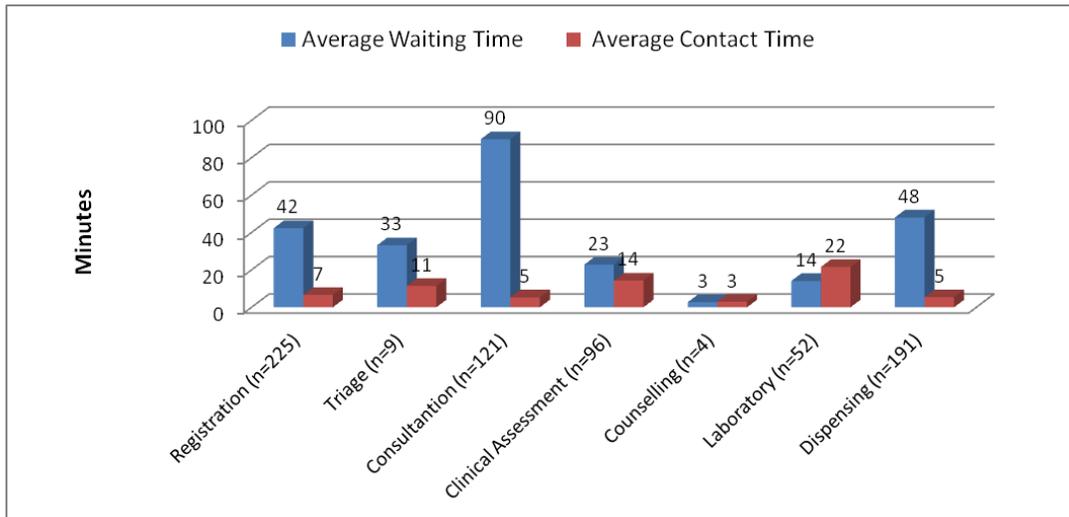
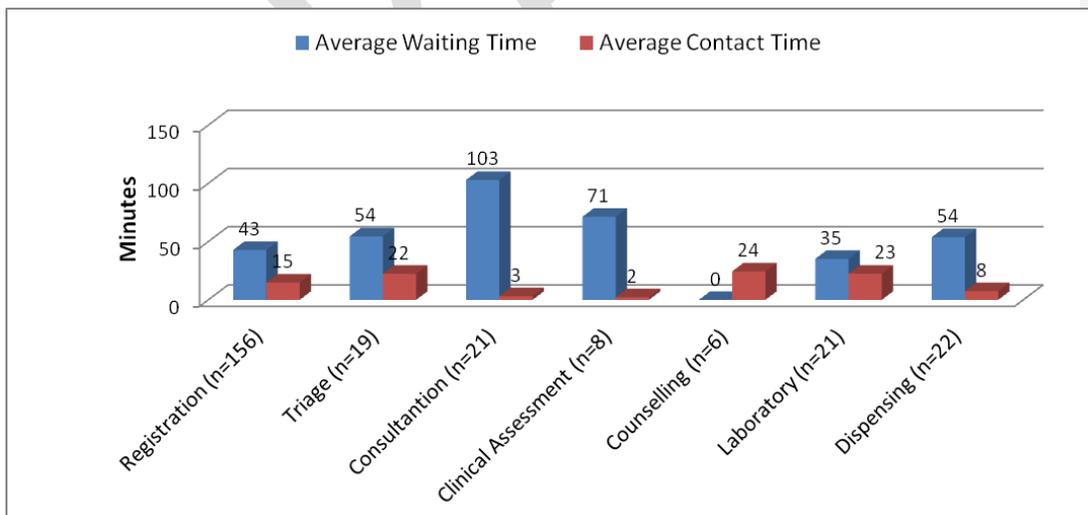


Figure 2.5 . Average Waiting Time and Average Contact Time in OPD

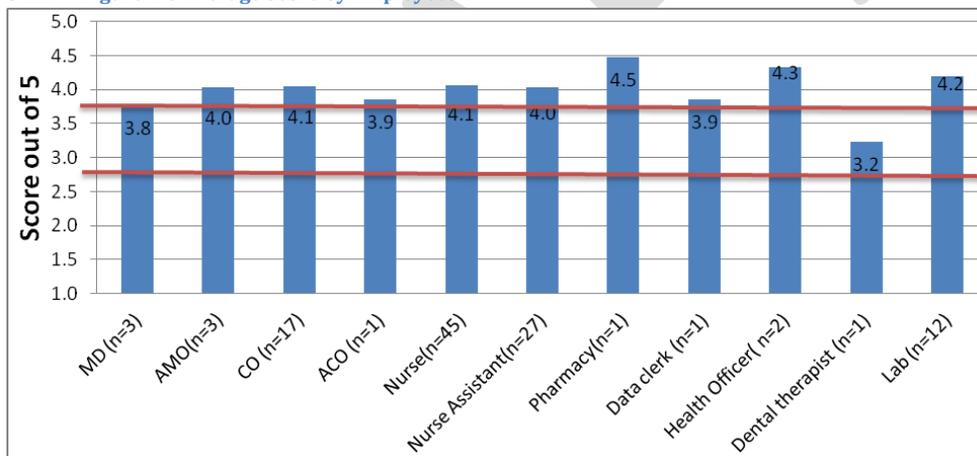


5 Employee Engagement

The measure of employee engagement gauges how workers feel about their job and the environment in which they work. Research has shown that health workers that are “engaged” (scoring 4.0-5 on the questionnaire) in their work have a higher level of productivity, are more loyal to their organizations, tend to perform better, and are absent less often. Employees that are “disengaged” (scoring 3-3.9) are less productive than engaged employees, are less loyal to their organization, and are not having their needs met. Further, providers that are “actively disengaged” (scoring 1-2.9) have low levels of productivity, have high rates of absenteeism, feel compelled to spread their disillusionment with other colleagues, and are not loyal to their organization. To ensure high rates of efficiency and productivity, providers need to be engaged in their work.

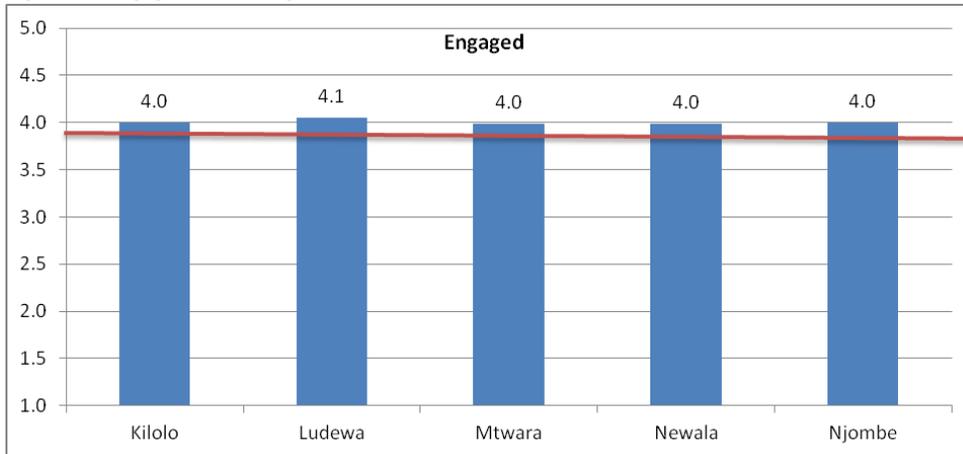
Results from the employee engagement questionnaire were analyzed by type of provider, site, and question. When overall average scores on the employee engagement questionnaire were analyzed by provider, there was little variation in scores, as can be seen in Figure 5.1.1 below. Pharmacists, AMOs, COs, Nurses, Health Officers, and Lab Techs were engaged to a higher degree. Scores for other cadres fell below the engagement threshold, at 3.9 signaling they were somewhat disengaged.

5.1.1 Figure 2.6 Average Score by Employees



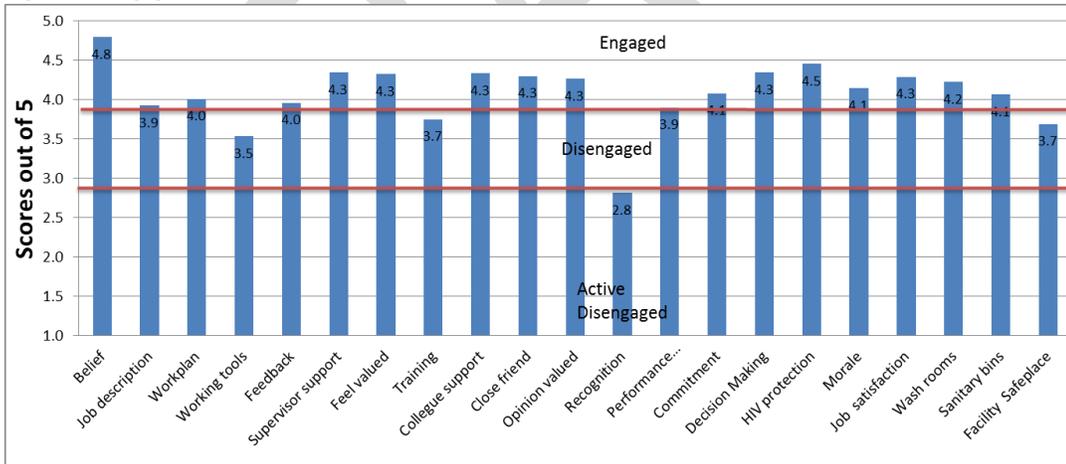
The engagement questionnaires were also analyzed by site. There was little variation in scores between sites with average scores ranging between 4.0 – 4.1 as seen below:

Figure 2.7 Engagement average scores



The analysis of employee engagement by question reveals more detail on specific areas where engagement was low. The figure below shows that recognition (2.8) and working tools (3.5) scored lowest, highlighting areas where improvements can be made. Other areas scored quite high, such as belief in their job being important (4.8) and HIV protection (4.5), signaling areas of achievement.

Figure 2.8 Engagement flow chart



6 PRODUCTIVITY

To draw a connection between HRM interventions and productivity, 76 health workers in 14 sites were observed every 15 minutes for one full work day. Their time was assessed for levels of productivity. Productive time included time spent in direct contact with patients as well as indirect patient care—preparation, review and updating of charts; consultation with other providers; management tasks such as meetings and routine maintenance; and off-site activities such as trainings and outreach. Unproductive time included time spent waiting for patients, lunch breaks, social visits and conversation, personal errands, and absences not related to client care or service delivery. It is important to note that each health worker was only observed during one day in each health facility. Due to logistical challenges, the observers were unable to keep the day of the week constant (some observations on Monday, Tuesday, etc.). Patient load varies on different days of the week, thus findings on other days might be quite different.

Based on the direct observations of health providers in 14 facilities, the assessment found that providers' productive time included 55% of their total time on direct patient care, 9% on indirect patient care, and 10% for others as shown on the figure below:

Table 1.5 productivity levels

Activity Category		Observed Time (Average %)
Productive	Direct patient care	55%
	Indirect patient care	9%
	Meeting	8%
	Cleaning	2%
	Outreach	0%
	Training	0%
	Total	74%
Unproductive	Waiting for patients	14%
	Social visits	2%
	Unexplained absence	5%
	Other breaks	2%
	Total	23%
Others	Missed Observation	3%
	Total	3%

Comment [AH1]: Is there somewhere I can check this table? With some of the lines deleted the percentages don't add up... I left the track changes in for that reason.

The study found that at urban facilities or those close to tarmac roads, health providers spent more time on productive activities (Newala, makambako etc) compared to health workers in hard to reach areas as indicated in the figure below:

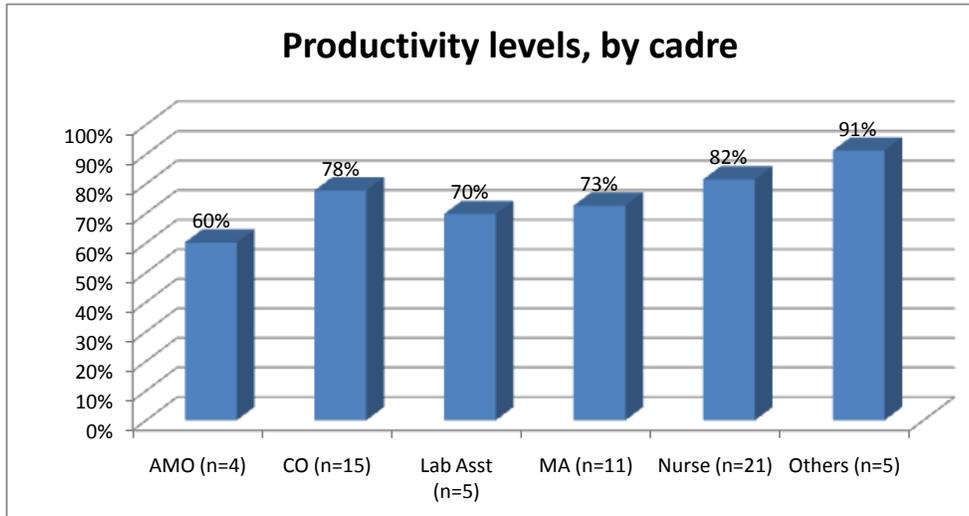
Table 1.6 Health worker productivity levels in terms of time use

District	Facilities	% Productive Time	% Unproductive Time	% Others Time
Kilolo	Ilula DDH	63%	33%	4%
	Kidabaga HC	46%	53%	1%
Ludewa	Ludewa Hospital	68%	14%	18%
	Mlangali HC	51%	40%	9%
Mtwara	Kitere HC	84%	13%	2%
	Mahurunga HC	67%	29%	4%
Newala	Chihangu HC	58%	40%	3%
	Kitangare	77%	20%	1%
	Kitangare HC	61%	32%	6%
	Newala Hosp	87%	13%	0%
Njombe	Kibena Hospital	71%	25%	4%
	Makamboko HC	73%	24%	3%
	Wanging'ombe HC	68%	30%	2%

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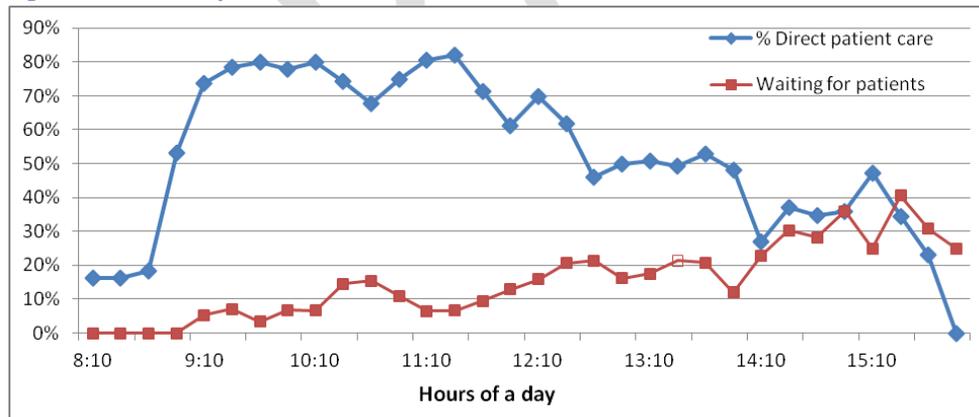
The average assessment of productivity by cadre reveals that Assistant Medical Officers were less productive in terms of time usage compared to other cadres as shown in fig 2.9. The trend indicates health workers with the higher education level were less productive in lower cadres, compared to staff with lower education level.

Figure 2.9 Productivity levels by cadre



It was observed in all facilities that providers were highly engaged on direct patient care during morning hours when patients are many, compared to the afternoon time. During the afternoon time when patients were few as shown on fig. 3.0, providers were engaged on other productive work such as filling the registers, cleaning the office or preparing supplies or medicine.

Figure 3.0 Productivity of health workers



7 PERFORMANCE MANAGEMENT

The availability and quality of staff appraisal systems are fundamental to many aspects of the HRH in the districts. Performance appraisal is a significant component of performance management, which sets

a framework for the senior staff or supervisors and their juniors or subordinates to agree with and review priorities, goals, objectives, activities, as well as results within the overall framework of public service provision. To manage performance, the Government introduced the use of Open Performance Review and Appraisal System (OPRAS) in July 2004, through Establishment Circular No.2 of 2004. It was designed to enhance public servants' accountability and efficiency with the ultimate aim of improving services delivered to the public. The system derived its policy orientations from the Public Management and Employment Policy (1998), The Public Service Act (2002), revised in 2008, and its attendant Regulations (2003)

All district councils interviewed acknowledged familiarity with OPRAS. When providers were asked individually if they have filled and implement OPRAS, 72% said no and 28% said they had filled the forms. However, the quality of the filled forms remains unknown, as no forms were physically checked. Further it was observed that no midyear and annual evaluations were conducted. This data shows that there is an asymmetrical relationship between government's investment in the design and implementation of OPRAS, and the implementation of the initiative as well as the expectations the government has for improved performance management at local level

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Figure 3.1 : Showing staff who completed OPRAS forms

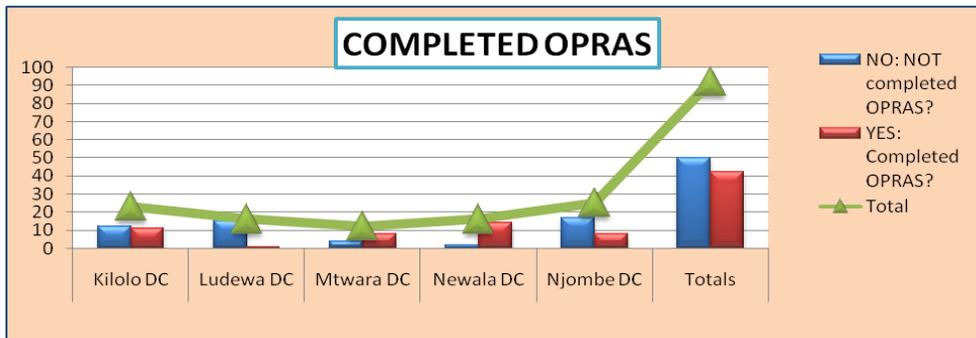
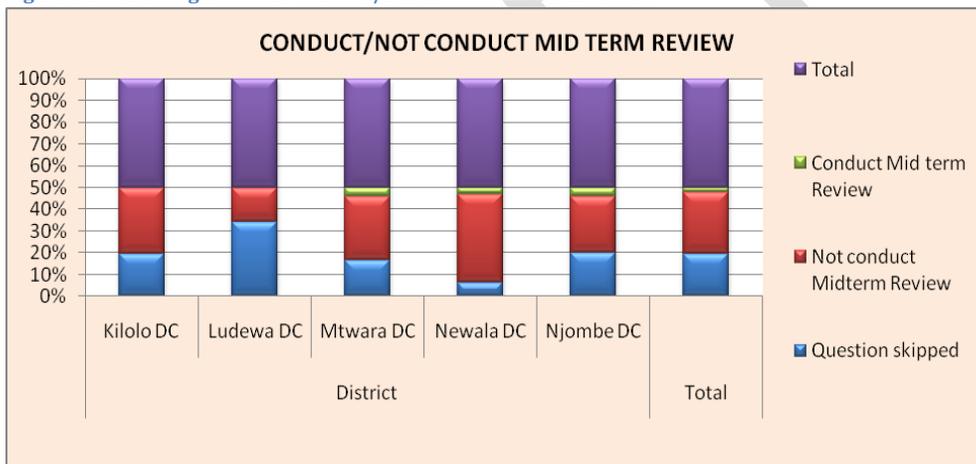


Figure 3.2 : Showing staff who conduct/not conduct midterm review



8 JOB DESCRIPTIONS

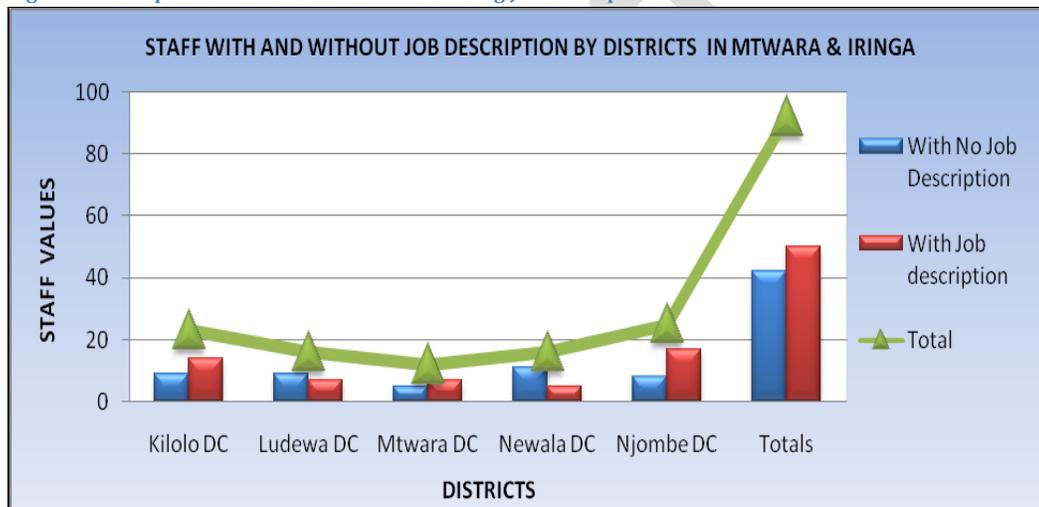
Written job descriptions with clearly aligned goals and tasks are a cornerstone to ensuring the existence of strong performance management. Job descriptions are essential because they allow providers to know what specific tasks they are responsible for, and they provide a basis/standard against which providers can be given feedback about performance and evaluated.

In this study, all councils have generic job descriptions for most cadres. Five (38%) councils namely Kilolo DC, Ludewa DC, Mtwara DC, Newala DC and Njombe DC said job descriptions were available for only some staff such as medical doctors, nurses, and clinical officers. Four (31%) councils said all staff

had generic job descriptions, and four (31%) councils reported all staff had specific job descriptions that reflect local needs like workload and related responsibilities. It was widely observed in this study that medical attendants play the role of clinical officers and assistant clinical officers, but their job descriptions have not been adjusted to indicate the same. Further, in many district councils, only a few staff members have copies of generic job descriptions.

It was reported that Mtwara DC district council have started adjusting the job descriptions to accurately describe employees' responsibilities. In Njombe district council, the revision of job descriptions has been completed for senior district staff, and the district plans to adjust the job descriptions for all staff is ongoing.

Figure 3.2 : Responses of Health Workers on Having Job Descriptions



When health workers were asked if “your job description presents an accurate description of the work you are actually doing each day,” 23% (45) agreed, 13% (26) disagreed with the statement, and 34% (66) did not respond because they had not been provided with a job description. The other staff members neither agreed nor disagreed with the statement.

There was inconsistency in the answers provided by council managers (CHMT members) and health facility managers regarding the availability of job descriptions. Although all districts said that generic job descriptions are available for all staff, 61% of public facilities and 44% of FBO facilities agreed.

The analysis therefore concludes that generally 77% do not have the job descriptions and about 23% had job descriptions. Further, the responses showed that most of the job descriptions are generic and do not reflect what they are particularly doing at their site.

Performance based rewards

Rewards are an important factor in the process of recognizing and acknowledging good staff performance. The study sought to determine if health workers are provided with monetary or non-monetary rewards based on an annual performance evaluation.

All district councils reported that there was no formal mechanism for rewarding health workers based on their performance. The only award provided on annual basis is the Best Worker Award offered during Workers' Day celebrations. The majority of facility managers felt that the recognition of staff only through the Best Worker Award is not sufficient and demoralizes other staff.

Furthermore, about 92 (79%) of facilities assessed reported that there is no mechanism established in the district councils to reward staff based on performance. The majority said they provide non-financial rewards such as appreciation and acknowledgment of good accomplishments. Similar findings were observed in both public and private facilities.

9 HEALTH FACILITIES STAFFING PROFILE

Tanzania has an estimated 29,000 health workers, many of whom are unskilled. The ratio of doctors to population is 1:20,000 people. (Ministry of Health Annual Sector review, 2006). The average staff vacancy rate in the assessed facilities is 38%. The staffing levels in the facilities assessed are higher than average national level statistics. Makambako and Mparura dispensaries have more staff than 2009 establishment requirements. Makambako HC exceeded the staffing level because of higher population size of Makambako DC. Plans are underway to upgrade the facility to hospital. Myambe dispensary have highest vacancy rate at 67%. Table 1.8 summarizes staffing level in the facilities assessed.

Table 1.8. Staffing level by districts

Facility Name	Population ¹⁰	Required	Available	Vacancy Rate
Kilolo DC		142	85	40%
Ilula DDH	2036	107	60	44%
Itungi Disp	5328	5	2	60%
Kidabaga HC	4354	10	8	20%
Mazumbe Disp	2966	5	3	40%
Mtandika HC	6534	15	12	20%
Ludewa DC		213	92	57%
Ludewa Hospt	6645	151	66	56%
Manda HC	4761	17	9	47%
Masaki Disp	1668	5	2	60%
Mawengi Disp	3799	7	3	57%

¹⁰ District CCHP 2011/12

Mbwila Disp	1988	4	2	50%
Mlangali HC	7016	29	10	66%
Mtwara DC		53	37	30%
Kitere HC	9672	22	14	36%
Libobe Disp	9665	5	3	40%
Mahurunga HC	9275	21	14	33%
Mpapura Disp	5750	5	6	-20%
Newala DC		42	21	50%
Chihangu HC		17	7	59%
Kilangali HC		19	12	37%
Mnyambe Disp		6	2	67%
Njombe DC		53	75	-42%
Igima Disp	3023	5	4	20%
Lusisi Disp	6035	5	3	40%
Makambako HC	5198	24	58	-142%
Wanging'ombe HC	12,307	19	10	47%
Grand Total		503	310	38%

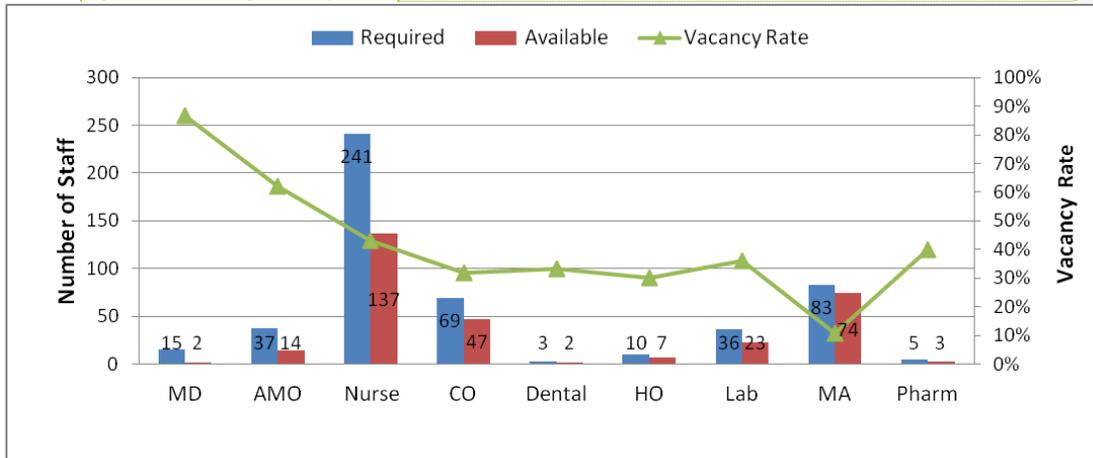
9.1 Distribution of staff by cadre

Compared to non-professional cadres, the shortage of professional cadre health workers is very high. Medical doctors have highest vacancy rate of 87% followed by AMO (69%) and nurses (42%). The medical attendant cadre has the highest staffing percentage with a vacancy rate of only 9%. According to a 2009 scheme of service, medical attendants are tasked with cleaning their facility, preparing medical supplies, and assisting clients. Unfortunately, due to the extreme staff shortage, the medical attendants in some of the facilities visited provide health services such as prescriptions, deliveries, and drug dispensing without receiving proper training. This compromises the quality of service provided to clients. To overcome this situation, the Government has introduced the public service pay and remuneration policy in 2010 for enabling Local Government Authorities to attract and retain professional staff in the underserved areas.

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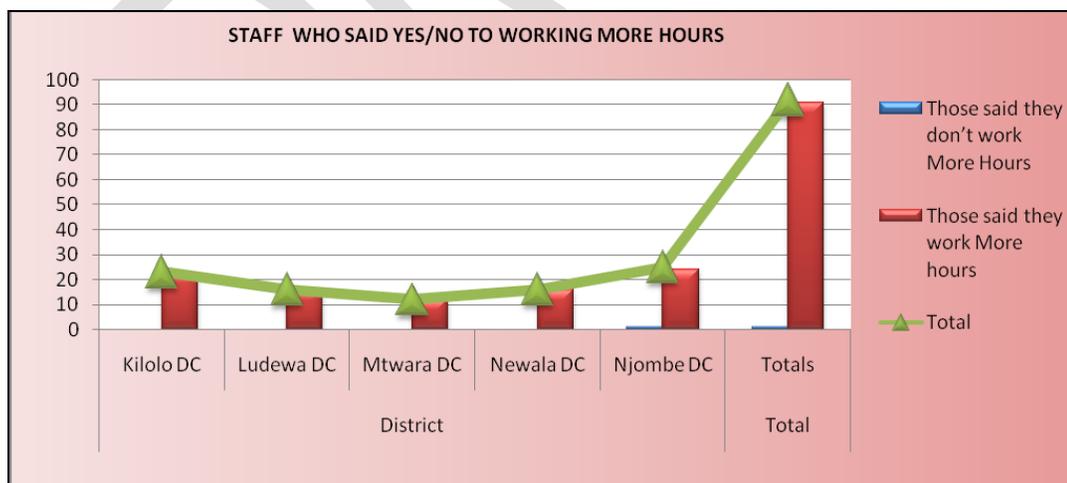
9.1.1 Figure 3.3 Staffing level, by cadre

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Working Hours

Shortage of staff has a great impact on working hours especially during child clinics or scheduled patient appointment days for CTC or RCH patients. The study revealed that health workers work more than the normal working hours (8 hours/day) for an average of 9 working hours. A total of 91 staff responded to have been working for more than the usual working hours. However the analysis shows that Njombe DC has the highest rate of staff (24 staff) working more than working hours followed by Kilolo DC, Ludewa, Newala and Mtwara DC as shown by the figure below:



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9.2 FACILITY INFRASTRUCTURE CONDITION

All facilities need infrastructure improvement support. The support ranges from renovation/painting (14 facilities), water system repair (14 facilities), renovation of incinerators (12 facilities), renovation of placenta pits (6), installation of signage (9), and protective gear (10). The table below shows specific details on infrastructure support for each facility.

Table 1.9 . Areas need infrastructure improvements, by facilities

District	Facility Name	Renovation /Painting	Water system (storage/drainage)	Transport (Outreach)	Latrines	Incinerators	Placenta Pit	Signage /Noticeboard	Protective gears	Other
Kilolo	Itungi disp		X			X	X	X		
	Kidabaga HC				X	X			X	
	Ilula Hospital	X	X							
	Mazombe disp	X				X	X			
Njombe	Makambako					X	X			
	Kibena Hosp	X	X					X	X	
	Wanganing'ombe		X				X		X	
	Igima Dispensary		X			X	X		X	
	Lusisi Dispensary					X	X			
Ludewa	Ludewa Hospt		X		X				X	
	Masasi disp	X			X	X		X	X	
	Mbwila disp	X	X					X		Solar
	Mawenge disp	X	X		X					Delivery MVA
	Mlangali HC	X		X	X	X		X	X	Invertor
	Manda HC	X	X		X	X				
Mtwara DC	Libobe disp	X		X		X			X	Solar
	Mparura disp	X	X	X		X		X		
	Kitere HC	X	X	X	X			X	X	
Newala	Mnyambe disp	X	X			X		X	X	
	Chihangu HC	X	X	X	X			X		
	Newala Hosp	X	X	X						
	Kilangali HC			X						Data Management
Total		14	14	7	8	12	6	9	10	5

9.2.1 Waste disposal systems

Waste disposal systems ensure that all waste products are properly destroyed to eliminate hazardous risks to the health workers, children and all community members served by the facility. The waste disposal systems in most of facilities are in poor condition. Improper disposal of waste is very dangerous for the health of community members using the facility. Poor waste disposal can cause transmission of diseases such as diarrhea, cholera and bad odor in the surrounding.

9.2.2 Incinerator

Only hospitals have modern incinerators. Health centers and dispensaries use pit holes for burning the hazardous waste and sharp objects such as syringes.

The incinerators in 12 facilities were in very poor condition and needed major renovation to prevent hazardous effects to the communities using the facilities. Itungi dispensary is near a primary school and imposes risks of student exposure to hazardous substances.



Manda HC, Ludewa

9.2.3 Placenta Pit

Anatomical waste such as placentas are difficult to burn and when burned, consume a lot of fuel. All facilities said they discard placentas in a pit or latrine where they can naturally decompose. A placenta pit should be built according to national standard to ensure that the hazardous effects are minimized. Six facilities did not have a placenta pit, and as a result deposit the placenta directly in the latrine. The latrines in these facilities are in poor condition, producing a bad odor which is disagreeable to users of the latrines.

Domestic Waste Non – risk HCW or domestic waste is made of all waste that is not contaminated with infectious or pathogen agents (food residues, paper and plastic wrapping). All facilities have constructed pit holes for disposing domestic waste. In Mparura dispensary and Kitera HC Mtwara the waste overflowed in the pits. Generally, the disposal of domestic waste was very poor in majority of facilities visited. The facilities'



Mparura Dispensary, Mtwara

surroundings are not maintained properly due to shortage of staff.

Latrines

Every facility needs a latrine to protect patients and health staff from infectious diseases such as cholera, diarrhea, etc. The latrines in eight out of 22 facilities we visited were in very poor condition and need renovation.

In Ludewa hospital, the latrine was very old and was frequently blocked. In Manda HC, the latrine was located in an open space outside facility area. Anyone passing near the hospital had access to the latrine. The latrine in Mawenge dispensary was in very poor condition and did not have a door. There was no privacy to users.



Mawenge Dispensary

9.2.4 Renovation of buildings/painting

Fourteen facilities required renovation and/or painting. The renovation needs ranged from repairing staff housing, painting of walls, repairing windows, replacing iron sheets and ceiling board and repairing flooring. The staff house in Manda HC had been evacuated because of its condition. The clinical officer had resorted to renting a house outside of the clinic compound. Unfortunately, this prohibits emergency service provision beyond the health facility's service hours. In Masisi dispensary, the ceiling boards were damaged and the staff house did not have a latrine or bathroom. The new CTC building in Mlangali HC needed painting. Chihangu HC required renovation of the staff house and health facility roof. The Myambe dispensary needed repainting. The Libobe dispensary needed window repairs and the offices painted.



Libobe Dispensary



Mparura Dispensary



Manda Health Centre

Water supply and drainage systems needed improvement. Respondents at 14 health facilities indicated the water systems are not working well. There was no water supply in Itungi and Mbwila dispensaries. The health workers fetch water from the well. This reduces productivity and compounds problems of staff shortage. The water system in Newala hospital needed renovation. The septic tank in Ilula hospital required renovation. Mnyambe and Itungi dispensaries did not have a water storage system. The water storage systems in Chihangu HC, Manda HJC and Libobe dispensaries needed renovation.

In addition, nine facilities had an irregular supply of functioning medical supplies, especially gloves. Gloves protect the health workers and clients from being infected with diseases during service provision, and can protect patients from transmission of infection by the provider. Libobe dispensary and Masasi dispensary did not have a source of electricity. The staff faced very difficult working conditions when they provide emergency or delivery services at night.

10 GENDER

Approximately 60 percent of women in Tanzania live in absolute poverty. This is a result of the increasing poverty amongst the overall rural and urban populations. The gap continues to increase between the rich and poor; women and men; and amongst women. In the rural areas and poor urban suburbs, women carry a heavy burden of tradition and lack of knowledge which impacts their access to property rights and credit facilities. Due to the low education level of many women, they generally struggle with reduced levels of knowledge and skills on how to manage their work. Most women also depend on poor technology, which consumes their time and energy¹¹.

The 2002 Tanzania National Census estimates that women provide 80 percent of labour force in rural areas and account for 60 percent of food production. Though they are the main producers of cash crops, their culture does not allow them to own their own wealth. Women do not have the power in their marriage to make reproductive decisions. For example, most women cannot decide on the number of children they would like to produce though they are the ones giving birth and playing a big role in child rearing.

The government is in the process of making sure that gender issues are integrated in program planning and budgeting. In 1998, the government passed a law on sexual assault, to address assault, rape and incest. The law criminalizes spousal rape, but only if the couple is legally separated. Rape is now punishable by life imprisonment or by 30 days in prison with corporal punishment; offenders must also pay financial compensation to their victims. Despite these measures, rape remains a serious problem. More than 10 per cent of Tanzanian women are thought to have suffered a sexual assault, but this figure may be low because very few women register complaints. Large numbers of women in Tanzanian refugee camps have been victims of rape and sexual abuse perpetrated by other refugees.¹²

10.1 Gender and Employment in Tanzania

Worldwide, women and men have been found to enter the labour force in different ways, and on different terms. Differences in employment are found between women and men, as well as among different groups of women (rural-urban; rich-poor; educated – non-educated) and men. Certain kinds of work have been stereotyped as being 'male' or 'female', because of the socialization process on the division of labour which stipulates different roles for men and women.

Gender assumptions, however, contribute to a process whereby most women are allocated low paying, unskilled or lesser skilled work in both the formal and the informal sectors of the money economy. The terms upon which women and men compete for employment are set by wider social relations, including cultural, economic and political arenas. These include the assumption that a woman's

¹¹ <http://www.tanzania.go.tz/gender.html>

¹² http://www.mcdgc.go.tz/index.php/publications/more/gender_equality_and_social_intitutions_in_tanzania/

primary commitment is to care for a family at home, in the 'reproductive' sphere of life; and that each woman depends on a male provider for cash needs.

10.2 Gender Opportunities

Apart from the gender policy that serves as the foundation for gender equality, Tanzania currently enjoys a political environment that recognizes and practices gender equality. Tanzania is a signatory to the Beijing Platform of Action, and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), and an active implementer of the two conventions. The Ministry of Community Development, Gender and children has gender focal persons in all Ministries, Government Departments and all Local Government Authorities who oversee gender issues and ensure that gender related activities are mainstreamed in the plans and budgets.

Further, the Tanzania Labor and Industrial Relations Act (2004), Public Service amendment act (2007) and regulations together with the Government standing orders (2009) set the legal ground for equality between men and women in all work related issues and guaranteed privileges to women at the time of recruitment, leadership positions and during pregnancy and maternity leave.

10.3 GENDER BASELINE DATA

10.3.1 Gender Engagement Scores

The gender engagement questionnaire was administered across 27 sites to assess provider satisfaction on various gender related issues. Eleven questions were administered and the results are classified as follows: "engaged" (scoring 4.0 – 5 on the questionnaire) indicating that there is equal play between men and women in all aspects in the districts. Employees that are "disengaged" (scoring 3-3.9) indicates less equal pay than engaged employees, are less treated equally and are not having their needs met basing on gender expectations. Finally, those providers that are "actively disengaged" (scoring 1-2.9) report high rates of discrimination in all aspects of gender issues.

1. Unfortunately, equal pay or unequal pay cannot be determined by perception. You have to study occupational segregation and actual way data.

2. What is the relationship between the equal pay introduction, and the general term used below "gender satisfaction?" What were indicators of "gender satisfaction?" Why not just use the term positive or negative "engagement"?

10.3.2 Average gender satisfaction level by district out of score of 5

The study reveals that the average engagement rate in all five districts is 3.6, which indicates that gender equality is limited in some respects. Further, the information gathered shows that men (n=87)

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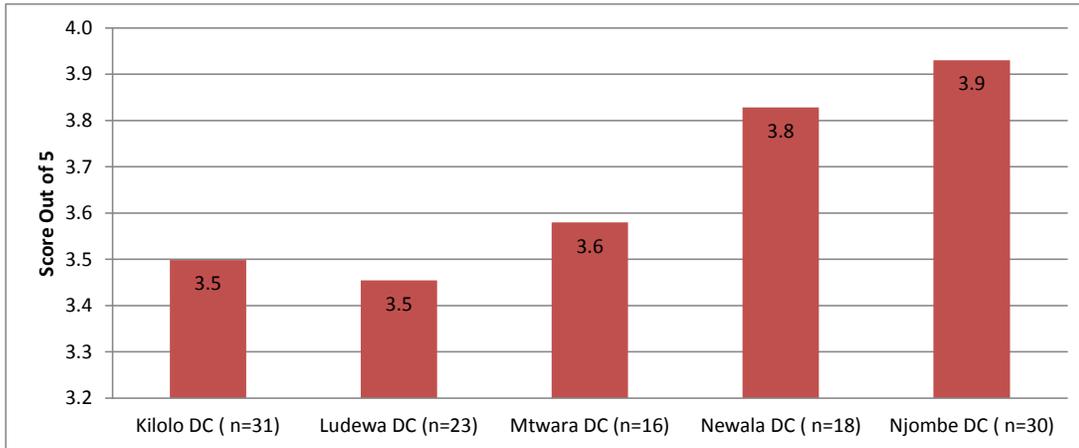
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have higher rate of engagement (3.7) and women (n=34) have lower rate (3.5). The average engagement by district is shown in fig 3.4

Figure 3.4 Average engagement by District

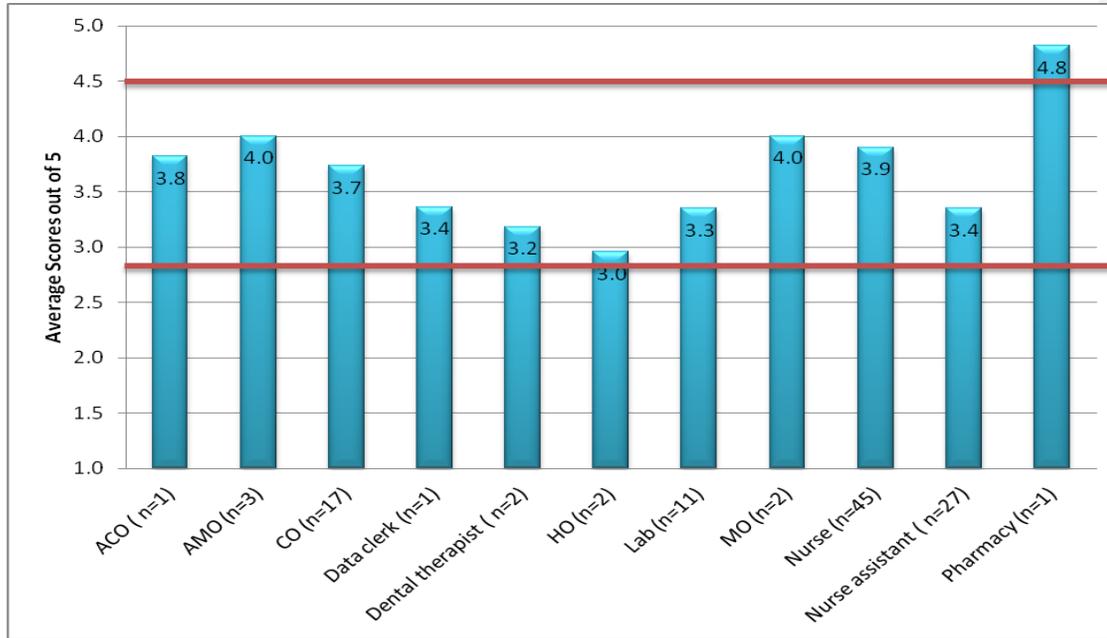


Average gender satisfaction level by cadre (out of score of 5)

Data on gender satisfaction by cadre reveals that pharmacists, assistant medical officers and medical officers are highly engaged with scores between 4.0 – 5.0, while the remaining cadres are less engaged with an average score of 3.4, as shown in fig 3.5 below.

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Figure 3.5 Average scores by cadre

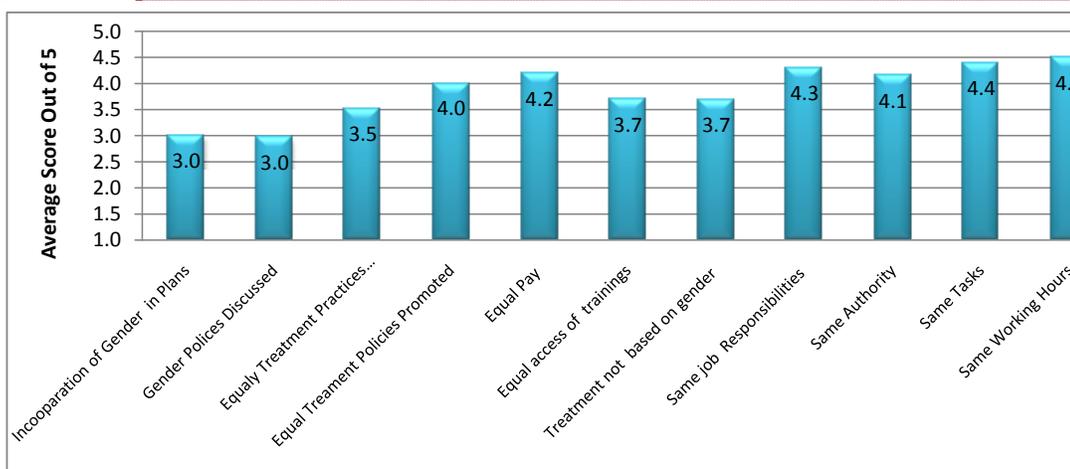


Avarege gender satisfaction level by questions(out of score of 5)

The analysis of gender satisfaction reveals details of the responses to each question. Lower scores reflect areas where interventions should be focused. Figure 3.6 below shows that incorporation of gender issues in plans (3.0) and discussing gender issues in the district (3.0) scored lowest, highlighting specific areas where improvements can be made. Such as? Other areas scored quite high, such as having the same working hours between men and women, same tasks and same job responsibilities, signaling areas of achievement as indicated on the background of this section.

Figure 3.6 Incorporation of gender issues in plans. See spelling. What is the difference between “Equal treatment practices (3.5) other indicators of equal treatment such as equal pay (4.2), treatment not based on gender” (3.7)?

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10.4 OTHER GENDER SURVEY

Violence against women and women’s poverty in the districts

As mentioned at the beginning of this chapter, women in Africa have been segregated and left in poverty for many years. The baseline assessment found that women in poverty were not taken into consideration during the planning process and hence not integrated into the CCHP. This has affected awareness of various gender issues and issues related to violence against women that need to be addressed. Fig 3.7 shows “Response to violence against women or women’s poverty taken into account during planning in your facilities activities.”

Figure 3.7 Addressing of violence issues against women Can you show the analysis across all districts?

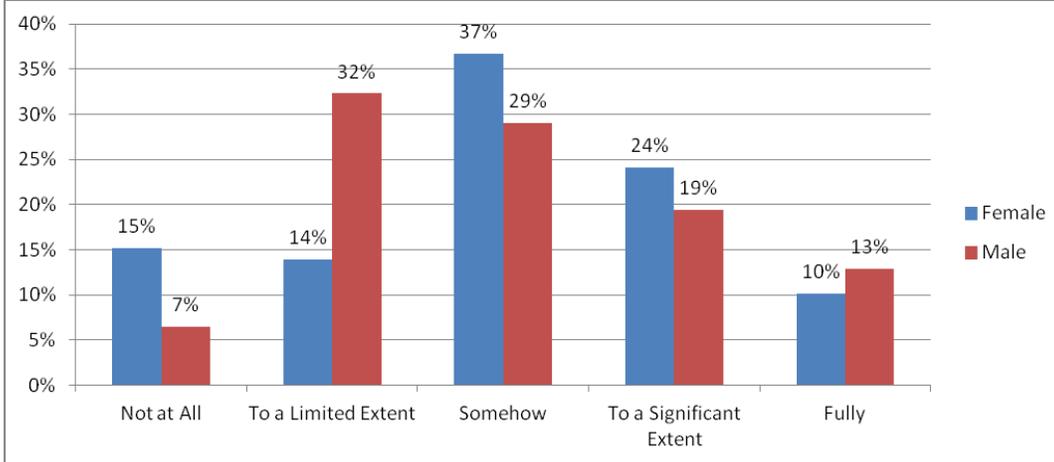


Table 2.1 shows that Kilolo District has created a more favorable environment for issues related to violence against women and incorporating women and gender issues into the CCHP (27% fully agreed). The remaining 4 Districts have less than 10% of the polled population who fully agreed that violence against women or women's poverty has been addressed during organizational planning. Can you explain why Kilolo has a more favorable environment? This suggests that gender issues are not a priority for districts and more work to improve gender awareness needs to be done.

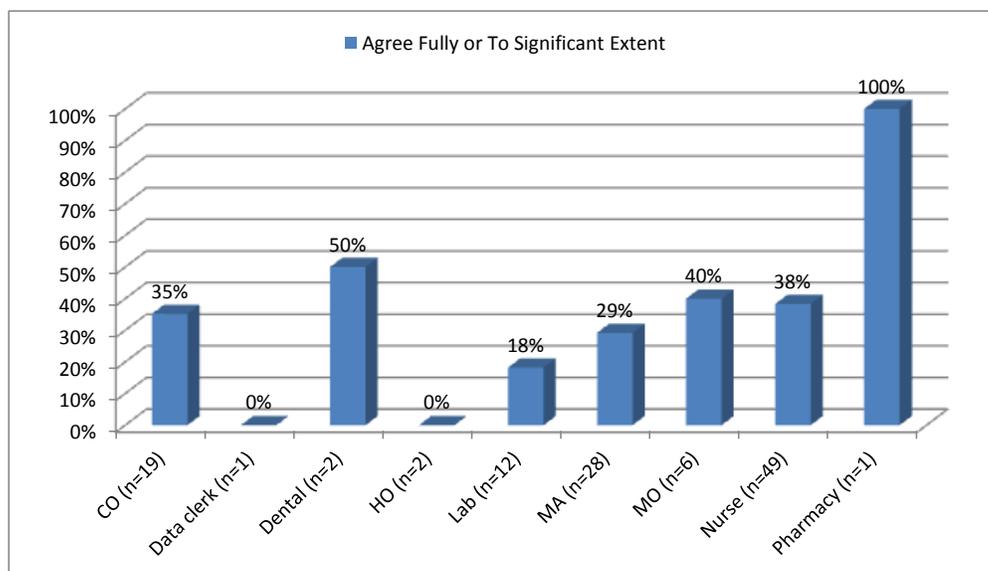
Table 2.1 Violence against women

Is response to violence against women or women's poverty taken into account during planning of your organization's activities?					
District	Not at All	To a Limited Extent	Somehow	To a Significant Extent	Fully
Kilolo DC (n=31)	10%	17%	30%	17%	27%
Ludewa DC (n=23)	20%	20%	30%	25%	5%
Mtwara DC (n=16)	21%	21%	50%	0%	7%
Newala DC (n=19)	19%	31%	25%	19%	6%
Njombe DC (n=31)	3%	13%	40%	40%	3%

The analysis of the same question by cadre reveals that nurses (n= 49) and clinical officers (n=19) are **not fully engaged** in gender related interventions. Which interventions? The figure below shows that level of involvement is below 50% for most of the cadres.

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Figure 3.8 Are issues of violence against women or women's poverty taken into account during planning of your organization's activities?



11 RECOMMENDATIONS

The baseline assessment identified several areas where human resource management systems can be improved to strengthen provider efficiency and productivity and improve the quality of service delivery. The specific interventions are as follows:

- Put in place/ review service delivery processes from time to time in order to reduce unproductive time.
- All health workers should be provided with both generic job descriptions and specific job descriptions that align their current tasks in the facilities. The service delivery process can be used to identify key responsibilities for each staff in the facility
- The districts should have a localized incentive package to attract and retain staff in the hard to reach areas where engagement and productivity is very low.
- The cross functional matrix (modeling of services delivery process) should be used as an effective means to develop individual performance contracts in the OPRAS form. Further, PO-PSM should develop a guideline that outlines sanctions or incentives that would enforce the usage of OPRAS in LGAs both at the level of management and lower cadre facilities.

Comment [JM6]: I'm not sure why two job descriptions are needed.

- e. Gender issues should be integrated in the District plans and budget and a mechanism established for reporting and addressing gender violence in the LGAs. Awareness programs should be conducted to increase awareness on gender issues at all level in the Districts.

11.1 WAY FOWARD

The results of this assessment should be discussed and shared with the sites and key partners. In addition, the baseline report should be disseminated to the sites, the CHMT and RHMT in Mtwara, Iringa and all other key partners.

The productivity tool kit should be prepared for key interventions observed in this study. After finalizing the tool kit, training on the key components should be provided with periodic coaching and mentoring visits.

DRAFT

Tool 2: Time use observation form

Facility Name: _____ District: _____

Cadre: _____ Date: _____ (dd/mm/yy)

		Productive time					Non productive time					
		Direct patient care	Indirect patient care	Outreach	Meeting/Administration	Training	Cleaning/preparation, personal hygiene	Waiting for patients	Unexplained absence	Social visit/contact	Others	Missed observation
Hour	Min											
8	10											
	25											
	40											
	55											
9	10											
	25											
	40											
	55											
10	10											
	25											
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14	10											
	25											
	40											
	55											
15	10											
	25											
	40											
	55											
16	10											

	25											
	40											
	55											

Tool 3. Job Satisfaction/Engagement Survey

Dear staff member

This survey is designed to get information from you regarding your experiences at work. The data gathered using this tool will enable us to determine how well the health care organization you work with is meeting your needs and identify areas that may need improvement. Neither your supervisor nor anyone else will know how you responded to this survey. The results we get from this survey will be reported in general terms and will not identify individuals. Your participation is greatly appreciated!

Section A

1. Facility Name: _____

2. Provider type (please tick)

<input type="checkbox"/>	a. Medical Officer
<input type="checkbox"/>	b. Clinical Officer
<input type="checkbox"/>	c. Nursing (RN/EN)
<input type="checkbox"/>	d. Nurse assistant/attendant
<input type="checkbox"/>	e. Lab personnel
<input type="checkbox"/>	f. Pharmacist
<input type="checkbox"/>	g. Other specify _____

3. Sex Male _____ Female _____

4. Number of years with organisation:

5. Number of years in this working station

Instruction for the health worker:

Please complete this survey by selecting one response for each statement that reflects how much you disagree or you agree with the statement. Indicate the extent of your agreement on a scale 1 to 5, where 1=strongly disagree, 2=disagree, 3 = not sure, 4=agree and 5=strongly agree. Please respond honestly by circling the number that best represent how you feel about the statement today.

Choose only one response for each question below

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	I believe what I do as health worker is important					
2	My job description is accurate and up to date.					
3	I have a current work plan developed with my supervisor with clear performance expectations and priority areas (I know what I am supposed to do).					
4	I am provided with tools necessary to do the job.					
5	I get clear feedback from my supervisor about how well I am performing on my job.					
6	My supervisor helps me to solve problems in a positive way.					
7	I feel that the organization values my work.					
8	I feel that the organization provides me with the essential coaching and training to do my job.					
9	When I face problem in my work, I am able to solve them with others					
10	I have a close friend at work with whom I share ideas or problems					
11	My colleagues open listens to my ideas and opinions.					
12	In the last 7 days, I have receive praise or recognition for doing good work					
13	I believe I am evaluated based on quality of my work					
14	My co-workers are committed to doing quality work.					
11	I can make meaningful decisions about how I do my work					
15	This facility takes specific measures to prevent and protect me from HIV infection.					
16	Overall, the morale level at my department/section is good.					
17	I am satisfied with this facility as a place to work.					

Tool 4: Health Worker Interview

The Tanzania Human Resource Capacity Project (THRP) is conducting a baseline assessment of human resource systems, working environment and productivity of health workers working in health facilities in Iringa and Mtwara regions. The information from the assessment will be used to design intervention to improve working climate and productivity in the regions. Your responses will remain anonymous and confidential. May I proceed with the interview?

Facility name		
District:		
Section 1: Respondent's Background		
1.	Sex of worker/ <i>Jinsi ya mfanyakazi</i>	1=Male 2= Female
2.	Year of birth / <i>Mwaka wa kuzaliwa</i>	19_____
3.	What is the highest level of formal education	1= Primary School (Standard 7) 2=Secondary School (Form four) 3= High School (form six) 4= University
4.	What is your highest level of professional education	1=Untrained 2=Certificate (please specify) _____ 3=Diploma (please specify) _____ 4=Advance Diploma(specify) _____ 5=Degree(Please specify) _____ 6=Postgraduate (please specify) _____
Section 2: Employment status		
5.	For how long have you worked in this facility?	Years _____ Months: _____
6.	2. For how long have you worked in the health sector?	Year's _____ Months _____
7.	3. What cadre of health care worker are you? (Tick the one that apply)	1. MD_____ 2. AMO_____ 3. CO _____ 4. EN_____ 5. RN_____ 6. NA/MA_____ 7. Lab Tech_____ 8. Pharm Tech _____ Other _____
8.	What is your position in this facility?	1=In charge of facility 2=In charge of department 3=Ordinary health workers 4=Other specify _____

MD=Medical Doctor, AMO=Assistant Medical Officer, CO=Clinical Officer, EN=Enrolled Nurse, RN=Registered Nurse, NA/MA=Nurse Assistant/Medical Attendant

1. Do you have a written job description that clearly defines your tasks and responsibilities?
1= Yes 2=No

(If no, go to question #1d)

1a. If yes, can you show me a copy (mark X only when you see the job description)? Mark _____

1b. Do you know the tasks in your job description? Please describe the tasks

1. c Do you feel that your job description is an accurate description of the work that you actually do each day? Describe any difference

1.d Has anyone discussed your job description with you? Yes ___ No ___

If yes, who discussed with you?

- a. Supervisor
- b. Facility manager
- c. MO/CO
- d. Coworker
- e. other please specify _____

2. Do you ever work more than your scheduled hours? Yes No

(If no, go to question #4)

3. If yes, what are the reasons?

- a. High number of patients
- b. Coordination meetings
- c. Administrative matters
- d. Other: please specify _____

4. Do absences of your co-workers occur on a regular basis at this facility? Yes No

(If no, go to question #9)

4a. Which of the following reason(s) accounts for the majority of staff absences? **(check all that apply)**

- a. Vacation _____
- b. Sick leave _____
- c. Maternity leave _____
- d. Training _____
- f. Other (specify) _____

5. How often do you have to work more than your scheduled hours?

- a. Once a month
- b. Once a week
- c. More than once a week
- d. Other: please specify _____

6. Do you ever work less than your scheduled hours? Yes No

(If no, go to question # 7)

6.a If yes, what are the reasons?

- a. Low number of patients
- b. Worked more than scheduled hours on another day
- c. Other: Please specify _____

7. How do you describe the number of health workers in your facility?

- a) More than enough
- b) Just enough
- c) Not enough
- d) Severe shortage

(If no shortage of staff or heavy workload, goes to question # 9)

8. How do you current cope with shortage of health workers and/or heavy workload (circle all that apply)

- a) I delegate my work
- b) I leave some tasks undone
- c) I work beyond office hours
- d) I turn some patients away
- e) I reduce the thoroughness of my patient care (hurrying up the patients)
- f) I take over the duties of another staff within my cadre
- g) I take over the duties of other cadre (i.e lab to nurse)
- h) Others specify _____

Part 2: Training

9. Are there times in which you find yourself performing activities which you have no training?
Yes _____ No _____ (if yes, please describe)

(if no go to question # 10)

10. How often do you find yourself performing the activities for which you were not trained?

- 1=all the time
- 2=Most of the time
- 3=Sometimes
- 4=rarely happens
- 5=Never happens

10. Have you participated in any training in the past 12 months? Yes ___ No ___

(If no, go to question #11)

10a. If yes, please note the theme(s) of the training(s) you attended:

Theme of training (circle all that apply)	Duration of training in days
3a) STI	
3b) OI	
3c) VCT	
3d) PMTCT	
3e) ART	

3f) Other 1: specify	
3g) Other 2: specify	
3a) STI	
3b) OI	

11. Do you know how health workers are selected to attend trainings? (Prompt: By whom? On what basis?)

12. Do you feel that you receive adequate training on a regular basis? Yes No
(If yes, go to question #13)

12a. If not, in which areas are you lacking?

Part 3: Supervision

13. Do you have a supervisor? Yes No
(If no, go to question #14)

13a. If yes, who is your supervisor? (circle all that apply)

- a. Facility manager
- b. Medical Officer
- c. Clinical Officer
- d. Nurse/Midwife
- e. Other: specify _____

14. When was the last time you received supervision?

- a. Within the past 7 days
- b. Within the last month
- c. Within the last 3 months
- d. I don't remember
- e. I never receive supervision visits

15. What happens when you are supervised? (circle all that apply)

- a. Records are examined
- b. Work observed
- c. Feedback given
- d. Discuss problems encountered
- e. Administrative updates given
- f. Other: please specify _____

Part 4: Performance Management

16. If you have been working at this facility for at least one year, did you complete Open Performance Review Appraisal System (OPRAS) in 2011? Yes___ No___

(if yes, ask for copy of filled OPRAS form and mark X) Mark _____

(If no go to question # 19)

17. Did you do midterm reviews with your supervisors? Yes ___ No___

17.a. If yes, did you feel that you were evaluated fairly? Yes ___ No___

Please briefly explain why or why not:

18. Did you do annual performance reviews with your supervisors? Yes ___ No___

18. a. If yes, did you feel that you were evaluated fairly? Yes No

Please briefly explain why or why not:

19. Do you have opportunities for promotion in your position? Yes___ No___

(If no, go to question #21)

20. If yes, how were you informed about these opportunities?

Part 5: Incentives and Motivation

21. Aside from salary, do you receive any financial or non-financial incentives? Yes___ No___

(If no, go to question #23)

21. a. (If yes, describe and circle all appropriate)

Non-financial

- a. Verbal recognition
- b. Written recognition
- c. Time off
- d. Other: please specify _____

(Please describe non financial incentives provided in your facility below)

Financial

- a. General Bonus

- b. Salary increase
- c. Hardship payment
- e. Performance based incentive
- d. Other: please specify _____

26. What are some important factors that you think influence health worker motivation? **(circle those mentioned by provider)**

- a. Living and working conditions
- b. Incentives
- d. Supportive supervision
- e. Possibility for professional advancement/growth
- f. Ability to influence decision-making
- g. Other: please specify _____

Part 5: Work environment

27. How do you rate your satisfaction with your work?

- 1=very satisfied
- 2=Satisfied
- 3=Dissatisfied
- 4=Very dissatisfied

28. What satisfies you in your job? **(tick all that apply)**

- a. I like to take care of my patients
- b. My salary is enough
- c. Non salary benefits I receive in my position
- d. The community support me
- e. I receive privilege and recognition because of my work

29. What dissatisfy you about your job? (rank in order of importance; 1=most important, 2=2nd etc)

- a. My salary is too low
- b. This place is too remote
- c. No supplies and equipments
- c. Too many complaints from the community
- d. Too much work
- e. No time for myself and family
- f. This work is too risky
- e. No good relationship among colleagues

Part 6: Recommendation

Please provide three recommendations to improve your working environment and performance

Tool 5: Facility Managers questionnaire

The Tanzania Human Resource Capacity Project (THRP) is conducting a baseline assessment of human resource systems, working environment and productivity of health workers working in health facilities in Iringa and Mtwara regions. The information from the assessment will be used to design intervention to improve working climate and productivity in the regions. Your responses will remain anonymous and confidential. May I proceed with the interview?

Part 1: Staffing level

1. How many health workers are available in your facility?

Required staff: _____ Available staff: _____

1b. please indicate the distribution of staff in your facility by cadre

Cadre	Required	Available

Part 2: Task and workload

2. Do all employees working at this facility have a written job description that clearly defines roles? and tasks for their position? Yes No

2a. Briefly describe how job descriptions are developed and disseminated to healthworkers

2b. Are job descriptions updated regularly? Yes No

How do you describe the number of health workers in your facility?

- e) More than enough
- f) Just enough
- g) Not enough
- h) Severe shortage

(If no shortage of staff or heavy workload, goes to question # 9)

8. How does your facility current cope with shortage of health workers and/or heavy workload? Please describe

Part 3: Training

9. How often do health workers in your facility receive training?

- a. Monthly
- b. Quarterly
- c. Yearly
- d. Other: please specify _____

10. How are staff members chosen for trainings?

11. Are the training conducted based on the needs identified by the facility? Yes ___ No ___

(if no go to question 12)

I1.a. how do you assess the training needs for staff members at your facility?

Part 4: Supervision

A: Supervision from the district

12. Do you receive supervision from the district? Yes ____ No ____

(If no go to question 13)

13. How often does the district supervise staff in your facility? (Check that apply)

- 1. Weekly _____
- 2. Monthly _____
- 3. Quarterly _____
- 4. Other: _____

14. Do supervisors have supervision guideline or checklist? Yes No

(If no, go to question #22)

14a. if yes, ask to see form _____ **(mark with an X if seen)**

15. What happens during supervision? Please describe

B: Supervision within the facility

16. Who supervises the health workers in the facility? *(Circle all that apply)*

- a. Facility Manager
- b. Medical Officer
- c. Clinical Officer
- d. Nurse/Midwife
- e. RHMT/CHMT
- f. Other: specify _____

13. How often are staffs supervised? (Check that apply)

- 1. Weekly _____
- 2. Monthly _____
- 3. Quarterly _____
- 4. Other: _____

15. What happens during supervision? Please describe

Part 5: Performance Management

16. Is there a process to assess and appraise health workers? Yes ____ No ____

(If no go to question #17)

16a. if yes, can we see an example of a performance evaluation form? _____ **(mark with X If form was seen)**

17. If yes, how often are performance evaluations and reviews done?

- a. Once a year
- b. twice a year
- c. No set time-frame for evaluations exists

d. Other: please specify _____

18. What are performance evaluations of health workers based on?

- a. Job descriptions
- b. Performance goals of health facility
- c. Health outcome indicators
- d. Performance objectives
- e. Other: please specify _____

19. Are there any opportunities for staff promotion at this site? Yes No

20. If yes, please describe:

21. How often can staff receive performance-based incentives?

- a. Never
- b. Once a month
- c. Once every six months
- d. Once a year
- e. Other: please specify _____

22. Is retention of health workers a problem in this facility? Yes ___ No ___

23. If yes, what are some of the reasons retention is a problem? (tick those mentioned)

- a. Remote area
- b. Leave for position in the private sector
- c. Lack of supervision
- d. Burnout
- e. Migration to another country
- f. Lack of professional advancement opportunities
- g. Other: please specify _____

Incentives and Motivation

24. Aside from salary, do health workers in your district receive any financial or non-financial incentives? Yes No

(If no, go to question #25)

24. a. (If yes, describe and circle all appropriate)

Non-financial

- a. Verbal recognition
- b. Written recognition
- c. Time off
- d. Other: please specify _____

(Please describe non financial incentives provided in your facility below)

Financial

- a. General Bonus
- b. Salary increase
- c. Hardship payment
- e. Performance based incentive
- d. Other: please specify _____

(Please brief describe the financial incentives provided in your facilities)

25. Do you think these incentives motivate staff to perform well? Yes No

25. a. Why do you feel this way? Briefly explain

26. How do you rate the productivity of health workers in your facility?

- 1= very productive
- 2=productive
- 2=unproductive
- 3=very unproductive

Please describe your ranking

Part 5. Work environment and productivity

27. How do you rate satisfaction of health workers in your facility working condition?

- 1=very satisfied
- 2=Satisfied
- 3=Dissatisfied
- 4=Very dissatisfied

Please describe your ranking

Recommendations:

Part I:

28. Please recommend three (non infrastructure) areas that need to be addressed to improve the working environment in your facility?

27. Please provide three areas that need to be address to improve productivity of health workers in your facility?

Part II:

28. What physical infrastructure should be supported to improve working environment in your facility? Please complete the gap analysis tool below

Area of intervention	Specific intervention	Service delivery bottlenecks	Impact of bottlenecks on the service delivery	Any expected support from Government or other partners	Current or proposed District initiatives to the problem	Specific support needed from BMAF	Cost estimates (to be verified)
Staff accommodation Improvement activities							
Employee working environment/safety needs	Latrines						
	Incinerator						
	Protective gears						
	Signage						
	Notice board						
	office conditions (painting)						
	Transport to conduct outreach activities						
	water storage systems						
OTHERS							

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