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Exploring the Influence of Workplace Trust over Health Worker Performance Preliminary National Overview Report: South Africa

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Voices
by Gugu Khumalo

Like words rising from a storm,
and falling on the ears of the deaf
Many voices rose from the depths of hearts,
and remained unheard as usual

They do not care about us,
Can it be that they do care but they often fail to show it?
They do not care about us, can it be that the measurement for caring or uncaring that they use is unclear?
They do not care about us, can it be that the only way for these voices to be shown that they are cared for is through financial incentives?
If so… what about non-financial incentives?
What about intrinsic motivation?
What about the calling?

Is there such a thing as "the calling"
Is there such a thing as intrinsic motivation?

They are not supportive, can it be that they themselves need support?
They do not consult when taking decisions, can it be that they themselves are overloaded with tasks and responsibilities so that no time is left for consultation

Like the words rising from a storm,
and falling on the ears of the deaf:
Many voices rose from the depths of hearts,
and remained unheard as usual

They make promises but they often fail to deliver, can it be that the intention is to deliver but because of government's bureaucracy, restructuring, reforms …
delivery takes time?
They promised us 25% but now we are demoted, we are demoralized we do not care about our work any more

Is there an ear to listen to these voices?
Is there a person to show them they are cared for?
If not there is no hope that these voices would ever appreciate their work
There is no hope for AN effective health systems' response to health care needs
For it is through these voices health care is delivered for the community
Maybe there is an ear or maybe there isn't,
Either way, no one will know for sure.

Like the words rising from a storm,
and falling on the ears of the deaf,
Many voices rose from the depths of hearts,
and remained unheard as usual.

1. OVERVIEW OF STUDY

A study exploring the influence of workplace trust over health worker performance at primary care level was undertaken in South Africa and Tanzania in 2003. The study aimed to: -

a) review the policy environment and contextual factors influencing primary care delivery and health worker motivation;

b) explore the managerial and organizational influences over workplace trust at primary care level;

c) consider the influence of workplace trust over health worker motivation and performance, with particular regard to attitudes and behaviours towards patients;

d) draw preliminary recommendations for improving primary care management

e) establish a foundation for future investigation of the workplace trust and health worker performance.

As summarised in Annex 1, the notion of workplace trust is comprised of three elements, trust in colleagues, trust in supervisor and trust in employing organisation; each of which is assumed to be based on specific behaviours and procedures. Human resource management practices are an important influence over workplace trust, including how such practices are implemented and how people in different positions within an organisation relate to each other. As the nature and perception of financial rewards may influence trust in the employing organisation, the study sought to explore the importance of salary relative to other factors as a driver of health worker motivation and performance. It did not, however, consider the level of financial rewards.

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

- How do health workers behave towards their patients and does motivation, and the influences over motivation, influence that behaviour?

- How important are financial incentives as a motivating factor in comparison with non-financial incentives?

- Is workplace trust a relevant and useful concept for investigating motivation and behaviour towards patients? Which elements are more or less important as an influence over motivation and caring performance?

- What influence do interactions with the wider community have over health worker motivation and behaviour towards patients?

- What managerial action is relevant and necessary in order to strengthen motivation and performance?

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

<u>This preliminary national overview report</u>

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

2. STUDY DESIGN AND METHODS

The South African researchers all participated in the study preparation workshop, held in May 2003 with Tanzanian and British colleagues. This workshop discussed the overall study design and finalised site selection criteria, discussed initial drafts of data collection tools and planned the logistics of each country study. Data collection and initial analysis was then undertaken during the latter half of 2003 and into early 2004, with the study analysis workshop of April 2004 providing an opportunity to discuss the initial analyses. The study's conceptual framework guided all data collection and analysis activities.

Permission was obtained from South African government authorities to conduct the study, and ethics approval was secured from the Ethics Committee of the Faculty of Health Sciences, University of Witwatersrand, as well as the London School of Hygiene and Tropical Medicine, UK. In accordance with the stipulation of the government approval authority, no patient records were used in the study nor observations made during consultations with patients. Either written or verbal informed consent was obtained for every interview conducted, and, in accordance with the stipulation of the LSHTM Ethics Committee, every effort has been made to protect the anonymity of respondents in data collection and analysis.

The South African study was conducted with the support of colleagues in the Health and Population Division of the School of Public Health, University of Witwatersrand. We are particularly grateful to Christina Qhibi and Fred Gooloba-Mutebi for their role in community-level data collection and initial analysis, and to Mark Collinson, Obed Mokoena, and Mildred Shabangu for their overall support of the project. We also thank Ian Couper for his comments on an earlier draft of this report.

Site selection

A case study design was adopted within each country study, involving in-depth inquiry in and around four primary care facilities using rapid ethnographic approaches.

All four South African case study facilities were purposively selected from one health district located in the rural North-East part of the country. Given the lack of routinely available information on performance, and the importance of engaging managers early in research activities, the District Manager's assistance in site selection was important.

The three main selection criteria were to:

1. include two larger (health centres) and two smaller (clinics) health facilities, to allow exploration of the influence of facility size/type over health worker motivation and behaviours (on the assumption that size of staff complement and scope of service provision may influence morale and performance);

2. include, in each pair of facilities of the same size/type, one that had better and one worse performance, judged in terms of managerial knowledge of staff and facility performance (to allow exploration of the possible links between motivation and performance);

3. ensure inclusion of facilities located in peri-urban and more remote rural areas (to allow exploration of the possible links between geographical location, motivation and performance).

Table 1 summarises key details about each facility included in the study.

Table 1: Case study dispensaries		
	Health Centre	Clinic
Better performing	Relatively new building Fairly good working environment An old ambulance is available for emergency cases Referral hospital far from the health centre Drug availability is good Two telephones lines Water availability problems Open 24 hours Has 3 wards, including labour ward Out-patient department estimated to serve on average between 190-200 patients per day Relative high daily rate of deliveries Posts for 24 health workers and 19 non-medical staff (some vacant). Based in a peri-urban area	Older building Fairly good working environment No ambulance available within the clinic The clinic is located next door to its referral hospital. Drug availability is good One telephone line Water availability problems Open 24 hours Estimated to serve on average between 150-170 patients per day Patients' choice as facility 8 health workers and 4 non-medical staff. Staff posts all filled. Based in peri-urban area
Worse performing	Older facility Poor working environment No ambulance available for emergencies Referral hospital far from the health centre Drug supply problematic One telephone line Water availability problems Open 24 hours Has labour ward OPD estimated to serve on an average between 130-170 patients per day. Relatively low daily rate of deliveries By-passed by patients 18 health workers and 18 non-medical staff. Based in rural area	Housed in temporary accommodation, itself in poor condition Poor working environment No ambulance available for emergencies Referral hospital far from the clinic Drug supply problematic No communication equipment Water availability problems Open 8 hours Estimated to serve on average between 20-90 patients per day. By-passed by patients 5 health workers, 2 volunteers and one non-medical staff. Some staff posts vacant. Based in rural area

Data collection in case study sites

Khumalo and Qhibi conducted fieldwork across all facilities. Khumalo was also primarily responsible for health worker interviews, and Qhibi conducted patient and community interviews. Following an initial period of general preparation by Khumalo and Gilson, Khumalo and Qhibi received a one week period of fieldwork training, in which they also piloted (and adapted as appropriate) the data collection tools. Subsequently, the field team visited each selected facility for a period of three weeks.

The first week of data collection in each site involved observation in and around the facility, including informal discussions with staff and patients. During the second and third weeks individual in-depth interviews were then conducted with staff members, patients and community key informants. The fieldworkers taped the interviews, with consent, and also kept field notes of their observations and informal conversations. Following completion of each site visit, Khumalo prepared a brief initial site summary note, with input from Qhibi, as the basis for a de-briefing discussion with Erasmus and Gilson. This discussion allowed early reflection about the key contextual features of each facility, the experiences of health workers and patients, and the implications of these experiences for each element of the conceptual framework; as well as about the experience of using the study tools and approaches.

Health worker interviews were conducted in a language with which the interviewee felt comfortable. Interviews were conducted with every staff member involved in patient care in each clinic (the smaller facilities) and, given the much larger staff complement, with a sample of health workers in health centres. The sampling approach in health centres sought primarily to ensure that all nurses from all cadres of staff involved in patient care, and at least one administrative staff member, were interviewed. In addition, some respondents were chosen because they had particularly interesting or relevant experiences (such as planned resignation, or commendation for services). In practice, due to differences in the ease of accessing staff, 15 out of 24 (63%) posts in the relevant staff categories were interviewed in one health centre and 17 out of 20 (85%) in the other[1]. To ensure confidentiality, interviews were conducted outside the facility in the smaller facilities and in the larger facility, in closed offices. It was intended to conduct two interviews with each respondent. In practice, however, it proved

impossible to conduct both interviews with all respondents, particularly in the larger facilities, due to workloads, the pattern of shift working, unexpected staff absences and the fact that the researchers were staying at some distance from the facilities (making them unavailable for evening interviews).

The first interview, the critical incident interview[2], was quite open and sought to elicit key events or issues of concern to the health worker, as well as to provide an opportunity to build trust with the interviewee. The second more detailed interview also adopted a fairly open approach in its initial stages, but also included questions specifically soliciting the health worker's views about each element of workplace trust as an influence over motivation (Annex 3). To support managerial analysis and action wider experience suggests that is acceptable to investigate the conditions leading to trust without specifying the precise dimensions of the construct of trust (Butler, 1991). The detailed interview, therefore, began with a series of exploratory questions about each element of workplace trust, to elicit the respondent's views about the nature of that particular relationship. Only after these questions was the respondent specifically asked whether she trusted colleagues / supervisor / employing organisation, why and whether that trust mattered to her. In addition, specific questions were generally asked about the respondent's experience of several human resource management functions[3] and of interaction with the community surrounding the facility.

All health worker interviews were initially transcribed into English from tapes by a total of 3 transcribers (including Khumalo), and then all transcriptions were checked by Khumalo before being used in the preparation of site reports. The English translation of words used in any direct discussion of trust was specifically double-checked to ensure appropriate understanding. As the fieldwork was conducted continuously over a period of four months, the majority of this transcribing was undertaken after the fieldwork was completed.

Interviews were also conducted, in Shangaan, in each site with 15 patients and 3-4 community key informants. Given the possibility that patient experience and views differs by condition or

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[1] Equivalent to 37% and 47%, respectively, of the total staff establishment in each facility; as a few posts were vacant the proportions of staff-in-post interviewed were slightly higher.
[2] The critical incident approach has been used previously to study trust relations (Butler, 1991) and is useful in the early stages of an investigation to access links between context and outcomes. It also avoids the early imposition of a set research agenda by allowing interviewees to identify things that they define as important to their work experiences.
[3] There was, however, some variation between respondents in which questions on human resource management functions were asked, due to time and other constraints.

service used (Mechanic and Meyer, 2000), the patients were selected to include people from three groups: those attending for acute curative care, those attending for maternal and child health care and those attending chronic disease clinics. All patients were selected through an initial screening process, involving interviews of a random sample of patients as they left the facility to identify those willing and appropriate for inclusion in the study. Key informants were selected from among local community leaders and those more directly connected to the life of the health facility (such as members of clinic committees, as well as people involved in running TB DOTS and HIV home based care support groups). All interviews were conducted in the respondents' homes.

The guidelines for these interviews (Annex 4) allowed exploration of respondents' views about the services provided by the facility of focus, and in comparison with other facilities. As with the staff interviews, only after an initial, open discussion about their views and experiences were respondents asked whether they trusted health workers, the facility and the owner organisation, and why. The fieldworker who conducted these interviews (Qhibi) also transcribed all interviews into English, both during and after fieldwork was completed. Another Shangaan speaker then reviewed these translations, and revisions were made as appropriate. Any direct discussion of trust was specifically translated into English to identify the Shangaan words used and ensure common understanding.

Table 2: Interviews conducted by site		
	Health Centres	Clinics
Better performing	Total interviews: 39 15 health workers (21 interviews) 15 patient interviews 3 community key informant interviews	Total interviews: 35 10 health workers (17 interviews) 15 patients interviews 3 community key informant interviews
Worse performing	Total interviews: 41 17 health workers (22 interviews) 15 patients interviews 4 community key informant interviews	Total interviews: 30 5 health workers, 2 volunteers (12 interviews) 15 patients interviews 3 community key informant interviews

In total, as summarised in Table 2, 145 interviews were conducted with 49 health facility staff, 60 patients and 13 community key informants.

National and district data collection activities

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

National level data collection activities involved two components. First, interviews with six respondents, purposively selected because of their position and experience of health human resource management issues. Four of these respondents worked in national government departments, but not all in the Department of Health. The interview (Annex 5) explored respondents' views about primary level health worker performance and the key issues influencing it, as well as the human resource management practices of government. Interviews were conducted in English, taped and then transcribed. Second, a review of key policy and other documents around the issues of primary health worker motivation, human resource management practices and influencing factors was undertaken. Documents were identified through the key informant interviews and informal discussions with other knowledgeable people.

A total of seven in-depth interviews were also undertaken with purposively selected respondents at district level, including facility supervisors and district staff involved in human resource management functions. These interviews (Annex 6) sought to elicit respondents' views on primary level health worker performance and the key issues influencing it, as well as on the human resource management practices of the different management authorities. Interviews were conducted in English, taped and then subsequently transcribed, or notes were taken during the interview and subsequently written up.

Data analysis

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

First, preliminary analysis was undertaken by the South African research team, with Khumalo and Gilson leading the case study analysis, Erasmus, the district level analysis, and Mbatsha and McIntyre, the national level analysis.

For each case study site, Khumalo prepared a site report summarising the key findings and drawing on observation data, fieldnotes, staff and patient/community interviews. These reports were prepared in a common format for all sites, and considered all of the issues

incorporated within the conceptual framework. They included discussion of each staff member interviewed, as well as the experience of the facility as a whole. They also included important commentary from field teams about key elements of health staff and community experiences, the discussion of trust and the main problems experienced in the field. National level data were also summarised against key themes in an overview report. The draft reports were initially reviewed by Gilson (overall study leader) for comprehension and comprehensiveness, and then finalised.

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

In particular, it was agreed that:

♦ the main health facility performance variable of focus in the study would be health worker behaviour and attitudes towards patients, rather than the broader performance of the facility as a whole;

♦ following Franco et al. (2002), motivation would be understood in this study as 'an individual's willingness to exert and maintain effort towards organizational goals' and the motivational outcomes of focus would include those associated with:

a) what workers feel: job satisfaction (with pay, co-workers, supervisors, management) and organisational commitment (shared values, pride in workplace);

b) what workers think: satisfaction with autonomy, progress towards professional goals, recognition as a professional by superiors; and

c) what workers do: such as conscientiousness, getting along with others, punctuality and absenteeism, focus on work;

♦ three specific issues drawn from the conceptual framework would be explicitly explored through qualitative judgements, focussing on:

  ♦ The importance of salary as a motivating factor at different levels of motivation, compared to other motivating factors

  ♦ The overall level of workplace trust at different levels of motivation

  ♦ The overall influence of community interaction as a motivating factor at different levels of motivation

♦ analysis would be undertaken at both the individual and facility level.

Third, drawing on the data and initial judgements of the case study reports, additional analysis of case study site data was undertaken to:

♦ determine the motivation level of each staff member interviewed;

♦ test, for each individual, the two hypotheses:

    ♦ H1: at high/mixed motivation levels, salary is less important than other motivating factors; at a low motivation level, salary is more important than other motivating factors;

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

♦ assessment of the third specific issue was not possible as the available data were inadequate (only a few staff spoke directly about the direct influence of community interactions over their motivation levels).

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

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

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

reflection:

♦ by fieldworkers during data collection in each case study visit and across visits, both amongst themselves and with members of the wider South African team;

♦ on case study facility reports by the South African research team and wider study team during analysis workshop;

triangulation in analysis:

♦ where possible, across interviews for each staff member;

♦ across interviews for all health workers based in the same facility;

♦ across all patient and key informant interviews associated with the same facility;

♦ across observation, staff interview, patient and key informant interview data for each facility;

♦ across case study facility reports;

triangulation across analysts in relation to judgements about:

♦ motivation levels of staff members;

♦ staff experiences against hypotheses;

♦ the pattern of site experiences.

Data collection and analysis issues

An important foundation for all data collection and analysis activities was the initial period of general preparation by Khumalo and Gilson, which involved review of literature on qualitative methodologies, how to conduct interviews, and how to analyse qualitative data. This preparation was then followed by fieldwork training around the specific tools used in data collection.

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

♦ some problems in how questions in the critical incident interviews were understood by health workers, with a primary focus on patient incidents reported to supervisors as the basis of performance appraisals, rather than health management issues – addressed either

by following up with the second interview, or only using the guidelines for the detailed interview with some respondents;

♦ the complexity of translating into Shangaan patient/community key informant interview guides initially developed in English, and using them appropriately – addressed through fieldworker training and supervision;

♦ in some sites, health workers were initially reserved in the fieldworkers' presence, due to some misperceptions about their role (and, specifically, a fear that they were there to monitor staff) - but this problem was largely overcome by the relationships fieldworkers built up over the initial week of observation, before any interviews were conducted, as well as by assuring respondents that confidentiality would be maintained;

♦ greater difficulties in observing health worker behaviour towards patients in health centres than in clinics, due to the size of the facility and the decision not to observe consultations directly (as required by the government approving authority) – partially addressed by observing interactions between health workers and patients in public areas;

♦ greater difficulties in building relationships with staff in health centres than in clinics, due to staff workloads as well as the size of the staff complement – partly addressed through careful attention to building relationships during the first week of observation (and, nonetheless, took care to avoid only interviewing those staff with whom initially had built a relationship);

♦ difficulties in completing both interviews with all health worker respondents – in some sites addressed by expanding the number of respondents interviewed at least once;

♦ discomfort among some health workers in talking about trust, particularly for those respondents involved in conflicts with colleagues - addressed by building good relationships with respondents during the initial observation week and ensuring respondents that confidentiality would be maintained;

♦ difficulties in tracing some patients after they had agreed to be interviewed during the initial screening process – addressed by replacing selected respondents with others of similar characteristics who could be traced.

In terms of data analysis, the key issues were:

♦ the use of transcribers who had not been involved in conducting health worker interviews led to some problems of translation and transcription – addressed by ensuring that the sole interviewer checked all transcriptions before they were finalised;

- ♦ that qualitative judgements were made about the motivation level of each individual and in testing hypotheses – but these judgements were made through a process that involved: two researchers (Khumalo and Gilson) assessing each person independently, using a common framework; comparing the resulting assessments; and, where differences were identified, discussing the judgements among themselves until a final, agreed judgement was made;

- ♦ the ability only to partially identify changes over time in motivation levels and influences, due to the cross-sectional nature of the study design;

- ♦ as some health workers had problems in answering the question about trust in employer, apparently due to the abstractness of the term and concept, judgements about whether or not such trust existed were sometimes based on assessment across a range of questions around the employer.

3. FINDINGS

National perspectives

Current human resource problems and explanations

Human resource (HR) issues are recognised to be among the key priorities for the South African health sector at this time (Department of Health 2004a). The key HR problems bedevilling public health care provision, in particular, include inappropriate and inequitable training opportunities, inequitable personnel distribution, migration and low staff morale and weaknesses in skills and attitudes towards patients (Lehmann and Sanders 2004). The challenges of HIV/AIDS are also important to note, and include both the increased mortality and morbidity borne by the health workforce itself and the burdens of caring for the infected and affected population.

However, many of the current problems are themselves legacies of the apartheid era. Pick (1995) noted that 'In South Africa, human resources for health care have developed in an ad hoc and fragmented manner. The ideology of apartheid not only compounded the inherent inequality in the provision of health care along race, gender and class lines but also entrenched the development of human resources along these lines'.

Inequitable personnel distribution, for example, is partly a function of the public/private fragmentation in health care delivery that was deliberately fostered in the early 1980s through a process of privatization and de-regulation. The private health sector, however, serves less than one-fifth of the population and private providers are heavily concentrated in the urban areas where the more wealthy groups primarily using this sector live. Migration of health professionals from the public to the private sector thus, also, engenders an urban bias in personnel allocations. In addition, health workers are inequitably allocated across provinces. In 1998, there was nearly a three-fold difference in the population per nurse between the best and worst served provinces and just under a two-fold difference in the population per public sector nurse (van Rensburg and van Rensburg 1999). There is also a mal-distribution of personnel by level of care (Lehmann and Sanders 2004) . These sorts of distributional inequities have only been exacerbated in recent years by an increase in the out-migration of health personnel. Although precise figures are not known, available data suggest that nurse emigrants in 2001 were roughly equivalent to almost 20% of the total number of nurses working within the public sector (Lehmann and Sanders 2004).

The main results of these various forces are unfilled public sector posts (ranging from 13.4 to 67.4% of total posts across provinces) and staff shortages. Patients perceive the problem of staff shortages in terms of long queues and waiting times and, in some instances, early closing (Klugman and McIntyre 2000). For health workers, staff shortages are perceived as a problem in terms of heavy patient loads, leading to poor patient care and an inability to perform all tasks (Ijumba 2003).

In recent years there has also been growing documentation of, and concern about, staff discourtesy towards, and even abuse, of patients (Jewkes and Mvo 1997; Klugman and McIntyre 2000; Oskowitz et al., 1997; Schneider et al., 1998; Tint et al. 1996). Such behaviour effectively creates an additional barrier to service access (Palmer et al., 2000; Gilson et al., forthcoming). These problems are thought to be closely related to working conditions, including staff shortages, as well as concern about staff safety (Department of Health 1997), remuneration levels (McIntyre and Klugman 2000), a lack of resources with which to provide care and training that does not adequately equip staff to work in rural and under-resourced areas (interview data).

Two other factors that have been identified as important influences over health worker motivation and behaviours in the last ten years are the speed and process of change, and the lack of supportive management.

The speed and breadth of transformation within the public health system has been dramatic. Although it has been essential in order to tackle the apartheid legacy, it has also occurred at a speed and in a way that has led to what has been termed 'transformation fatigue'. Health workers and managers are 'tired of change' and frequently complain that are never consulted or communicated with before, during or after a new policy change is announced or implemented (Leon et al., 2001; Walker and Gilson, 2004). The result has been considerable uncertainty, particularly at primary care level, about tasks, organisational structures and even job security (Klugman and McIntyre 2000). This concern is, in turn, linked to the long period of uncertainty (only resolved with passing of the 2004 National Health Act) about which level of government (provincial or local) would ultimately have responsibility for primary care. Other important influences are the lack of a supportive environment, adequate encouragement and appropriate supervision. One interviewee commented that 'many of the nurses themselves don't feel important and cared for, so if I don't think we have succeeded in making our staff feel important and cared for. I think our patients bear the consequences of that; they feel the consequences if themselves not getting the kind of care they want.' Another also noted that it is important to make workers feel happy in order to encourage them to treat their patients better.

However, a key obstacle to treating health workers better remains the tradition of bureaucratic, rule bound and authoritarian management in the public sector. Before 1994 public servants were trained to adhere to directives, administering services rather than managing them. Despite efforts to decentralise health system management, the experience of working within the health system remains, for many, one of working within 'a top heavy and rigid management hierarchy that imposes multiple and often conflicting demands' (Local Government and Health Consortium, 2004). The attention paid in transformational efforts to legal frameworks, structures, organograms and technical skills development has simply not been matched by the necessary efforts to strengthen human resource management or build strong relationships between people working together (Local Government and Health Consortium, 2004). These problems have, moreover, been exacerbated by the fiscal environment which has required new policy initiatives and resource re-allocations between

geographical areas to be implemented in a context of stringent budget limits (Gilson et al., 1999). These limits have both precluded the resource re-allocations necessary for decentralised management, particularly in previously under-resourced areas.

A final factor identified as influencing health worker motivation is that of relations with patients. A 1997 Department of Health policy document notes that 'the rights of health care workers should be defined and respected, so that an ethos of caring is nurtured, and not undermined or exploited'. However, there is a widespread view among public sector workers that whilst patient rights have been established and protected since 1994, nurses' rights have been ignored and whilst public expectations of care have increased, nurses' ability to provide that care has been constrained (McIntyre and Klugman 2003; Walker and Gilson 2004)[4].

Policy responses
Recent policies that impact on health workers have been developed both by the Department of Public Service Administration (DPSA), applying to all civil servants, and by the Department of Health, specifically for its own employees.

DPSA policies
A key policy framework of the DPSA (1997a) is the 'White Paper on Human Resource Management in the Public sector'. The vision of this policy is to create a "diverse, competent and well-managed workforce, capable of and committed to delivering high quality services to the people of South Africa" and the mission "is to become a model of excellence in which service to society stems from commitment instead of compulsion" (DPSA 1997a). It explicitly recognised the important relationship between the management environment and public servant motivation: "Transforming the Public Service into an instrument capable of fulfilling its role in bringing about the new South Africa depends on the commitment and effectiveness of its employees, which in turn depend on the way in which those employees are managed" (*ibid)*.

The White Paper placed considerable emphasis on the responsibility associated with human resource management and the need for professional skills to fulfil this responsibility. It envisaged that human resource management would be decentralised and that "… line

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[4] Patient dis-satisfaction may also have been partly fuelled by the shift to a nurse-based system, given patient beliefs that doctor-provided care is better care (Public Service Commission 2000).

managers will have increasing freedom, within the limits of their budgets, to determine the number of staff and the levels and skills they need to deliver the required results. They will, however, also have greater responsibility for the performance management, conduct and career development of their staff" (DPSA 1997a). This responsibility also extends to 'leading by example': "The key to ensuring good conduct on the part of employees is to create an environment where a high standard of professional behaviour is the norm. While every employee is responsible for his or her own conduct, most employees will take their cue from their seniors. Managers therefore have a particular duty to set and maintain high standards of honesty, ensure responsible use of resources, courtesy, punctuality, and conscientious performance of their duties. This applies, above all, to managers who are ultimately accountable for their employees' conduct" (*ibid*).

The White Paper provides an indication of the dramatic changes in the expectations about the way public servants should be managed and should conduct themselves compared to what existed before 1994. The paradigm shift expected from public servants is huge; from a rule-bound, centralised administrative system to one of decentralised responsibility, accompanied by accountability, in management and from obedient servant to public service provider. The transformation of public service and the new way of functioning are at the centre of this policy document.

While the above document placed the emphasis on human resource management issues, another DPSA policy document (the Batho Pele White Paper) released in the same year focused more on the *service* aspects of public sector employment (DPSA 1997b). It sought to introduce a fresh approach to service delivery: "an approach which puts pressure on systems, procedures, attitudes and behaviour within the Public Service and reorients them in the customer's favour, an approach which puts the people first" (*ibid*). It recommended that staff performance in their interactions with customers should be monitored and that a 'zero-tolerance' approach for poor performance in this regard be adopted. It also recognised the necessity to provide adequate training opportunities and support for staff that deal directly with the public. It also suggested that "An important aspect of encouraging customer-focused behaviour is to provide staff with opportunities to suggest ways of improving service and for senior managers to take these suggestions seriously" (DPSA 1997b). Thus, the Batho Pele policy document speaks about the need for every government department to take all of their clients seriously and to serve them with all the respect and dignity they deserve.

The Batho Pele White Paper provides a strong basis for addressing challenges in relation to health worker attitudes. There have been Batho Pele initiatives to create a more caring ethos amongst staff in public sector health facilities. However, it is unclear whether these objectives have been met. Some stakeholders have expressed concerns that initiatives like Batho Pele serve to increase the expectations of consumers and to place more demands on public service providers, while health workers' rights are not being protected nor their needs addressed. However, the DPSA is responsible for the welfare of public servants and is there to serve their interest. The White Paper on Human Resource Management is a critical policy document in this regard as it provides the framework for ensuring that public servants are adequately supported and rewarded on the basis of their performance. In addition, civil servants are able to lodge complaints with DPSA if they feel their rights have been infringed. Thus, the DPSA has put in place the policy instruments to address many of the challenges facing public service providers in South Africa. However, it remains to be seen how effectively these policies have been implemented in general, and within the health sector in particular.

Department of Health policies

The sentiments of the DPSA policies are echoed in the White Paper for the Transformation of the Health System in South Africa (Department of Health 1997). In particular, the need for health workers to "develop a caring ethos and commit themselves to the improvement of the health status of their communities" is stressed. At the same time, it recognises that this can only be achieved in a context where the rights of health care workers are respected. The health White Paper also concurs with the DPSA policy of decentralisation of management authority and that appropriate training to support effective decentralised management is required. It further notes that "a participative, democratic management style and management by objectives should be engendered".

The concerns about poor communication that had been expressed by front-line workers in the early stages of the transformation process, particularly after the rapid implementation of the free care policies, seem to have been taken to heart by senior health department officials. The 1999-2004 Strategic Framework stressed that "Health personnel must be involved in decision-making as appropriate and all health personnel must be informed timeously of decisions taken. In addition, appropriate strategies must be established to keep lines of communication

open to enable management to obtain feedback from health personnel (Department of Health 1999).

The national Department of Health (2000) has also developed a policy on "Quality in Health Care in South Africa". The ongoing efforts to improve quality are contributing to changes in the way in which health services are organised. Many health care workers are taking on new roles and responsibilities, which could contribute positively to health worker motivation through the new opportunities created. However, this could also create insecurity for some, who may feel unsure about whether their training has adequately prepared them for the dramatic changes that are taking place. This potential problem is recognised in this policy document, which notes that "Training and professional development on a continuous basis are required to obtain competent and skilled health professionals." It recommends that there are facility or district quality teams which have to ensure that the needs of the customer are focused on, that proper consultation with providers is ensured at all times and that good leadership skills are developed. The document also recommends that both consumer and carer/provider satisfaction surveys be regularly conducted, in order to understand challenges to quality of care from both sides. Emphasis is also placed on issues of supervision, and supervisors are expected to agree with junior health workers the number of formal supervisory visits that will occur each year. Supervision is intended to include: providing support in solving problems, training to help improve performance, reviewing individual performance, monitoring services and inspecting mandatory or statutory functions.

Another key document of relevance to interactions between health workers and patients is the Patients' Rights Charter, developed by the national Department of Health. It broadly speaks to issues of access to health care and makes reference to the quality of service that patients must expect from the providers. In particular, patients have a right to "a positive disposition displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance". While the charter also speaks to the interests of providers by referring to the responsibilities of the patient as "to respect the rights of other patients and health providers", as discussed earlier, some health workers do not feel that this has been given sufficient prominence. For example, an interviewee in Walker and Gilson (2003) commented: "They have a patient's charter. Where is ours?".

These nurse reactions to the patients' rights charter may, again, partly reflect some legacies from the apartheid era. First, the patient-orientation underlying the charter goes against the grain of the apartheid system, in which patients accepted whatever service was given to them without challenge. Second, it also goes against the grain of nursing as a profession, which was linked to authoritarian attitudes towards patients and which sought to create a status difference between nurses and patients. Van der Walt (2002) notes 'Nursing was, at that time, one of the few career options that offered young colours [and other black] women the opportunity for professional qualification. A nursing qualification, often obtained with great determination and sacrifice, represented an 'upliftment' out of the situation of the average patient … [This] frequently manifested in a top-down relationship in which nurses would set themselves up as critical authority figures in relation to their patients' (see also Marks 1994). In challenging these inherited attitudes, the Charter may threaten nurses' understanding of themselves as professionals and their perceptions of their status relative to communities, creating further uncertainty in their working lives.

The chapter of the National Health Act 2004 that deals with human resources, mainly refers to empowering the National Health Council to develop policy and guidelines that will monitor the provision, distribution, development, management and utilisation of human resources within the national health system. Section 52 of the Act deals specifically with regulations relating to human resources. It gives power to the Minister of Health to ensure the availability of adequate resources for the education and training of health care personnel. The Minister is also required to prescribe strategies for the recruitment and retention of health care personnel and ensure that adequate human resources planning, development and management structures exist at all levels of the health system.

A key component of the National Health Act is the definition of the responsibilities of the three spheres of government. The national Department of Health must ensure that national health policies, as far as they relate to the national department are implemented, and provide guidelines for the implementation of national policy in the other spheres of government. The Director-General of the national department must make and promote adherence to, norms and standards on health matters. He or she must co-ordinate the provision of health services at national and provincial level and provide additional health services as may be necessary to establish a comprehensive national health system. Chapter 4(25) gives power to provincial health departments to facilitate and promote the provision of port health services,

comprehensive primary health services and community hospital services. The provincial department must also control the quality of all health services and facilities. Municipal health services are defined in the Act to include: water quality monitoring; food control; waste management; health surveillance of premises; surveillance and prevention of communicable diseases, excluding immunisation; vector control; environmental pollution control; disposal of the dead; and chemical safety. Municipalities may also render services that are the responsibility of the province, if a service level agreement is established between the respective provincial Department of Health and municipality. While this is the first time that there is clarity on the definition of municipal health services, there remains uncertainty about whether comprehensive primary health care services will be provided by provincial health departments, or will be provided by municipalities in terms of a service level agreement. This decision will be left to provinces. As indicated earlier, this continued lack of clarity on whether primary health care health workers will be employed and managed by provincial or municipal health departments, and hence their remuneration packages, contributes significantly to staff morale challenges.

A very recent policy document outlines overall government and Department of Health's strategies for addressing the challenges of health services in rural areas (Department of Health 2003). These include the government's Integrated Rural Development Programme, as well as Department of Health efforts to improve clinics and hospitals located in rural areas and to increase the number of health providers working there, partly through introducing additional allowances. Although first mooted and publicised in 2003, the Minister of Health formally announced the introduction of such allowances in late January 2004. Certain health professionals, including doctors, dentists, pharmacists and professional nurses, will be entitled to the rural allowance, ranging from "8% to 22% of annual salary, depending on area and occupational category" (Department of Health 2004b). In addition, a scarce skills allowance of between 10-15% was introduced for "medical officers, dentists, medical and dental specialists, pharmacists, radiographers, various types of therapist and nurses specialising in the areas of operating theatre technique, critical or intensive care and oncology", irrespective of where they work. These allowances will assist in retaining key professionals within the public health sector and hence addressing relative shortages and associated workload problems. Most importantly, they should make a considerable contribution to attracting staff to rural areas. For example, a public sector doctor would earn 37% more than s/he is currently earning if s/he agreed to relocate to a rural area.

While the newly introduced allowances will undoubtedly go some way to addressing some of the human resource challenges facing the public health sector in South Africa, as indicated previously, remuneration packages are not the only factor influencing health worker motivation. Strategies like Batho Pele and efforts to improve human resource management within the public sector are in many ways more difficult to implement successfully than introducing salary changes. Although the range of DPSA and DoH policies provide a solid foundation to address existing challenges in relation to health workers, it remains to be seen whether they will achieve their commendable goals.

Patient and community views of case study facilities

General experiences of care

Patient and key informant interviews across case study sites indicate that two key factors commonly influenced facility choice and patient satisfaction. These were:

- the conduct and empathy of the health workers, with positive attitudes towards patients (e.g. respectful, confidential behaviour) being seen positively;
- the performance of clinical work according to patient expectations, for example, thorough and comprehensive examinations and getting relevant drugs are seen positively.

Both are clearly linked to patients' trust in individual health workers, as discussed below.

Two other factors mentioned by patients and key informants as being sometimes influential are distance and speed of service. Patients may choose to use a facility because other facilities are located further away, whatever their perceptions of the care offered in it. Slow service is identified as an issue of concern across facilities, either because long queues mean long waits, or because staff are criticised for taking long breaks and so slowing down service delivery. In addition, patients identify high workloads and understaffing as affecting health worker performance in three out of the four facilities[5]. The clinic located close to its referring facility is specifically liked by patients because referral is easy. Some complaints about equipment and drug availability are made across facilities.

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[5] Those facilities which Table 1 also suggests had the higher workloads among the four assessed.

Patient/community member views are, however, also influenced by various personal factors that shape their own choices and experience of health facilities. These include: lack of facility choice (leading patients to use a particular facility, or, commonly, government over private facilities), beliefs about the cause of illness and relevant treatment, perceived competence (with expressed preferences for traditional care, or for specific types of drugs), age (with some complaints that older people are treated less well) and illness condition (with specific facilities praised for particular services used by patients, but no common pattern across facilities and services).

Across facilities, both positive and negative patient/community views about health worker performance were expressed at both the individual and facility levels. In other words, patients express a mixture of confidence in the services provided, together with concerns about health worker performance. These views and experiences, therefore, provide examples of both good and poor health worker performance.

Patient/provider trust

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

Second, patient and key informant interviews suggest that there are two dimensions of such trust that stand independently of each other as well as influence each other. They are:

1. trust and dis-trust in government clinics in general[6], influenced by:
   - their being owned by government:
     - generally a positive influence, either because patients are simply not used to using private providers or because government ownership is actively seen as a signal of good care;
   - their being free of charge
     - generally a positive influence, given levels of household poverty;
   - the performance of health staff

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[6] Although some patients do talk positively about private primary care providers, most appear not to use them. The common preference for free government care suggests that the costs of using private care are themselves a deterrent.

- a positive and negative influence, depending on health worker behaviours and attitudes (see below);
- drug availability
  - a positive and negative influence, depending on the patient's experience of availability;
- the experience of getting better after treatment
  - a positive and negative influence, depending on the perceived success of treatment in curing illness.

2. trust and dis-trust in health workers, influenced by:
   - attitudes towards, and treatment, of patients where:
     - where positive attitudes and behaviour include: being nice and friendly to patients, demonstrating care for patients, organising the queuing system so that sick people are seen first, providing quick care;
     - and negative attitudes and behaviour include: shouting and being disrespectful to patients, treating patients like children, taking long breaks, making patients queue even when sick, making patients wait without providing care;
   - perceived competence and thoroughness of practices where:
     - positive practices include: complete physical examinations, getting medicines that treat illness, giving good explanations (and so, in some instances, motivating patients to continue with chronic care), being careful in giving injections
     - negative practices include: changing medicines without explanation, not giving drugs, not offering services on week-ends, failing to do physical examinations,
     - and training level is important, with auxiliary nurses sometimes specifically criticised as being less competent than professional nurses
   - personal knowledge of nurses' good behaviour.

The complexity of experience is demonstrated by the fact that some patients express trust in nurses in general but not in the specific health workers with whom they regularly interact. In addition, whilst patients sometimes express strong concerns about some health workers, these concerns do not necessarily undermine trust in other health workers. Personal experience appears to be central to patient judgements, although reputation and rumour can sometimes be influential. A common theme across patient interviews is the risk of being treated badly that is

associated with seeking care – as some nurses are caring and others not, and some nurses are caring on some days but not on other days. Personal knowledge of nurses' behaviour, and sometimes nurses' reputation, thus, offers some certainty to patients seeking care.

Third, across sites, patients clearly have mixed views about health workers. Out of the total of 60 patient respondents:

♦ 13 said that they did <u>not</u> trust health workers at the nearby facility;

♦ 11 said they trusted these health workers only sometimes;

♦ 34 said they trusted these health workers.

The mixed pattern of performance across individuals was confirmed by observation. Positive behaviours observed included caring responses to patient problems, and health workers doing more than required of them in providing patient care. In contrast, negative behaviours observed included rudeness towards patients, and taking long tea-breaks whilst patients waited.

Finally, these data on trust in health workers hint at a site effect. There was an almost unanimous set of positive responses for the initially 'better performing', smaller facility in comparison with a greater proportion of clearly negative responses for the other, smaller facility; but for both larger facilities (health centres), there was a positive but slightly ambivalent set of responses.

The ambivalence of patient responses for the larger facilities seems to result from the greater uncertainty (and so, risk) that accompanies health centre use compared to clinic use. Given the larger size and staff complement of larger facilities, patients appear to have less personal knowledge of the full range of staff. They often express caution about the care received because they have been, or fear they will be, treated badly. In addition, the larger facilities are always busy and so patients are likely to wait longer to be seen, undermining their views of the care received. In clinics by comparison they tend to be able judge in advance what sort of reception they will get, good or bad, from health staff because they have more personal knowledge of them. However, the very small respondent sample sizes indicate that these data must be used with great caution. There were also particular difficulties in conducting observations of health worker performance within health centres.

Motivation and performance

Motivation assessments were only possible to determine for 36 out of the 49 health workers interviewed, given limitations in interview data for some respondents. Of these, 8 and 5 came, respectively, from the better and worse performing clinic; and 11 and 12 from, respectively, the better and worse performing health centre.

Out of the 36 staff for whom motivation assessments were made, 19 (53%) were judged to have low, 10 (28%) mixed and 7 (19%) high motivation levels. There seemed to be some potential for higher motivation levels among professional nurses than auxiliary/staff nurses. Six out of fifteen professional nurses were judged as having a high motivation level (40%) and six, a low motivation level (40%), compared to only one auxiliary/staff nurse judged as having a high motivation level (6%) and nine, a low motivation level (56%).

It is important to note, however, that both sets of findings appear to be influenced by a site-effect. First, the health workers judged to be of a high motivation level all came from two of the four facilities (those initially assessed as 'better performing'), and these facilities also had the lowest proportions of health workers judged to be of a low motivation level. Second, the two other (initially 'worse performing') facilities not only had relatively high proportions of health workers judged to be of a low motivation level but also higher proportions of auxiliary/staff nurses were included in this assessment in these sites. The apparently lower motivation level of auxiliary/staff nurses may, thus, be a reflection of experiences in the particular facilities.

At facility level it is, however, difficult to judge conclusively if there are links between performance levels (judged as caring behaviour) and motivation levels. Comparison of the two clinics' experience does provide some indications of such a link. In the initially better performing clinic not only were health workers assessed by patients to be more trustworthy than those in the other clinic, but also to be, in general of higher motivation levels[7]. However,

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[7] In the initially better performing clinic, 3 staff were assessed to have low, 3 mixed and 2 high motivation levels; whereas, in the other clinic, all staff (5) were assessed to have low motivation levels.

although there were fairly clear differences in motivation levels across the two health centres[8], there are less clear-cut differences in performance judgements. In part the lack of difference in performance assessments may reflect methodological weaknesses, given the limited sample sizes for patient interviews and difficulties in conducting observations. But in part, as already noted, it may also reflect the greater patient uncertainty linked to being treated in facilities with larger staff complements. In some way, therefore, facility size may influence patient assessments of performance and the possible links to motivation.

Health workers with high motivation levels generally stated that they liked their job and gained satisfaction from it, indicating that they derived intrinsic motivation from the nature of their work[9]. *'I know for a fact that in spite of it all I'm still ready to serve and am prepared to give me all for the people. I have come to love the people and the profession and have come to accept it with its challenges'* (professional nurse). *'The thing is when I wake up in the morning I feel the need to go to work inside me, no one forces me to go to work. Knowing I serve the community makes me feel good inside'* (professional nurse). The underlying commitment seemed, however, to be to the nature of the work involved in their jobs rather than (as inherent in Franco et al's (2002) definition of motivation) to their organisation's goals, as very few health workers were familiar with those goals (Annex 7). Some highly motivated staff expressed a desire to learn more to be able to provide better care and others suggested that the challenges faced in their working environment simply had to be confronted as part of daily work. These health workers were also identified as generally doing more than expected of them in relation to caring for patients and supporting colleagues. Although only some were observed interacting with patients, these few were seen to be friendly and polite. In addition, the interviews themselves, or discussions with colleagues, indicated that these respondents often did things beyond their duties for colleagues and patients (such as providing social assistance to patients, coming to work out of hours without being asked, delaying off-duty time to cover for colleagues). Interviews with five of these seven health workers suggested that they were people with generally positive attitudes, in the other two

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[8] In the initially better performing health centre, 4 staff were assessed to have low, 2 mixed and 5 high motivation levels; whereas, in the other health centre, 7 staff were assessed to have low and 5, mixed motivation levels.

[9] Although one of these health workers specifically stated that she was dissatisfied with her job, she was nonetheless assessed as having a high motivation level on three grounds. First, this dissatisfaction (specifically associated with the refusal of a request for transfer) appeared to be fairly recent and so, perhaps temporary; second, throughout most of her interview she appeared positive; and third, her colleagues largely spoke of her as a positive person, a colleague to whom they specifically referred patients for counselling.

cases respondents expressed greater levels of dissatisfaction with their jobs and working environment (see also Annex 8).

Only one of the health workers assessed to be of mixed motivation clearly stated that s/he liked the job and was satisfied by it. This health worker was also spoken about very positively by other colleagues, and provided evidence of initiating activities beyond the call of duty. However, partly in response to frustrations at work, this respondent had recently resigned in order to take up an overseas posting and so was judged to be of mixed motivation. Others assessed as of mixed motivation combined statements about liking their job and being satisfied with it, with discussion of a series of concerns and complaints that clearly expressed dissatisfaction with their work, and undermined their motivation. These concerns included factors undermining patient care (e.g. workloads, lack of equipment, lack of training) and experiences of poor treatment in the workplace from patients, colleagues, and managers. However, where information on behaviour and actions was available, most appeared to demonstrate positive behaviour towards patients and/or colleagues.

Only two of those health workers assessed as being of a low motivation level stated unequivocally that they liked their jobs, but both were observed to behave rudely towards patients and one had been found drunk on duty. Other health workers of low motivation commonly complained about the stressful nature of their jobs due to high workloads[10] and problems with working conditions[11], and about the lack of support and care they receive in the workplace. *'For example, with me I just wake up in the morning with no motivation whatsoever because I know there is nothing that I will do because we do not have medicine'* (auxiliary nurse). *'It's sad because we hate our profession. I think a nurse can never motivate her children to become nurses, because it has not helped anyone. Most nurses feel as though they are dumped thus they are not comfortable with their profession. This has really affected the nurses in this clinic. You need to motivate them and to encourage them to take nursing'* (professional nurse).

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[10] However, some health workers raising workloads as a factor undermining their motivation came from facilities with lower workloads than others included in this study whilst highly motivated health workers tended to be based in the busier facilities (Table 1). The issue of workloads is, therefore, as much an issue of perception rather than fact.
[11] Such conditions generally relate to levels of resource availability: e.g. of staff, drugs, equipment, water, referral transport.

Of the fifteen (out of 19) lowly motivated health workers for whom some judgement could be made about their behaviour and actions, only two were explicitly identified as behaving with politeness towards patients. A few staff also demonstrated positive behaviour at work, such as being conscientious and being prepared to cover for colleagues taking leave. The majority of the others were identified as being rude to patients and/or taking long breaks. Five specifically stated that they had wondered about resigning, and several spoke about being 'burnt out' by the stresses of their jobs. In addition, several individuals themselves spoke about the links between low motivation, and its underlying causes, and behaviour towards patients (see Box 1).

Box 1: Low motivation and patient treatment

'because of these problems we do not cope. Every time when we work we are not in a good mood, you will find that they will say that nurse so and so is not good to patients. They forget that when they come to work they are also mistreated by their colleagues (staff nurse)

Employer's lack of trust and respect ….'That's why even the patient does not get enough love from us. Why I say that, there are personal issues that affects me and makes my morale not to be good. Sometimes I tried to force myself to be good to the patients because we don't have any problem with the patient' (staff nurse)

'It looks as if the work we do is not enough and the management does not appreciate whatever we do and thus the nurses become less motivated. I guess that is why many nurses are no longer caring anymore, as the public would love them to be. I think due to frustration of what the nurses go through with their work they express their anger by becoming nasty to the patients of which this is not something that is supposed to be happening. If the department of health can change the way they operate I reckon nurses attitudes will change. By getting the recognition they deserve, their negative attitude will definitely change'. (professional nurse)

In general, the features of the working environment that were experienced as de-motivating included poor working conditions (see Table 1) and lack of training, the feeling of being treated badly by supervisors and employer and patient demands and poor attitudes towards health workers. These are linked to three important underlying themes of personal experiences, also reflected in the poem presented on page 1:

1. *The risks of health care provision:* nurses across motivation levels provide compelling testimonies of the hardships of life in their communities and workplaces, and have themselves often to deal with death and disease, in situations where their power to offer help is constrained by factors beyond their control (such as poverty, or the lack of ambulances and medical equipment) or by their sense of limited skills (a specific concern of auxiliary nurses).

2. *The problems of hierarchy and bureaucracy:* nurses across motivation levels complain about the length of time it takes for managers to make decisions, poor communication across bureaucratic levels and provide indications of the limited decision-making power assigned to lower levels (see Box 2).

3. *A sense of powerlessness:* this is linked to the sense of being unable to assist patients in some situations, to the problems of hierarchy and to the fear that the bureaucracy and society in which they work seeks to punish health workers for mistakes rather than support them in their difficult task (a strong fear of being disciplined unfairly is expressed by many nurses)[12]. This feeling is linked to the common statements that 'patients have rights but not nurses', and that 'no-one listens to the nurses' side of the story', as well as to the complaints that lack of transport and equipment often hinder nurses from doing their work properly, whilst staff shortages require auxiliary nurses to undertake tasks outside their scope of practice (making them vulnerable to disciplinary action). In all cases there is also a strong sense that health workers function under strict regulations (such as about the tasks different cadres of staff can perform, or about transferring patients to hospital) that limit what they are allowed to do but may be inappropriate for the contexts in which they work (with staff shortages, working in remote areas where few ambulances are available) (see Box 2).

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[12] Interestingly, this fear is also recognised by supervisors and managers and linked to powerful organisations that can influence nurses' lives, such as the Nursing Council (even if in practice, relatively few disciplinary cases lead to sacking).

Box 2: The powerlessness of nurses

'That's why you find that we blame our supervisors meanwhile they are not the ones. Even themselves they are controlled by managers up there. So we look at them. That's why we look at them to see if they can make a push to make things happen, meanwhile they are not doing it themselves. They go through procedures. Things in our department causes us problems because it goes through procedures. So myself I'm looking at my senior and the senior won't do that before she goes to her seniors. She also had stress because I am busy pushing her to do the thing that she can't. When she goes there they also answer her things that frustrate her. That's why I say in our department we are living with stress just because of the way we are working. We at the bottom we just want to see things happen but how we don't know. So how to explain to you, you will see that everyone in his /her rank has a problem' (staff nurse)

'You see working under these conditions is very strenuous because it's above our scope. If a patient can die on me they would say I have ignored him and didn't look after him. I could even lose my job for that' (auxiliary nurse)

'You find that because you are a nurse when they tell you something or you have done a mistake they tell you as if they are telling someone they meet on the street who can not make decisions about other things. Who does not think that when she answer me she answer me generally, she no longer explains according to the procedures of things. I won't say I trust them when it comes to the personal things, I won't say they are wrong, maybe it is the way nursing has to be done. 'We don't know. We end up so used to it that sometimes when they call you into the office you know that you are going to cry because the things that they will tell you. You won't answer it because she is my senior and if I answer she will say I don't respect her. And I feel that when I answer her she won't like it because she thinks as if you do not reason and because she is senior to you she is going to say whatever she wants to. It frustrates me that.' (staff nurse)

As already noted in the section on 'National Perspectives', some of these experiences may themselves reflect tensions between new policies and new expectations of nurses, and past practices and understandings. In the apartheid era, the nursing profession was one of the few professional employment opportunities available to women from disadvantaged communities and one associated with status and prestige within the community. For some nurses, policies such as the Patients' Rights Charter, as well as broader societal changes, may cause discomfort and uncertainty more because they challenge this status, than, for example, because they are truly subject to greater disciplinary threat than in the past. Similarly, the

experience of hierarchical control within the workplace may reflect the continuing influence of professional and civil service management practices left over from the apartheid era.

Other features of the broader societal context as well as a range of personal factors also seem to affect motivation and performance. For example, crime within the community has led some nurses to feel insecure in their workplace and so has negatively affected their motivation. As individuals, nurses also face personal demands that influence their attitudes to their work. These demands range from living away from home and so wanting transfers to be closer to their family members to needing to meet families' financial needs and so being disappointed in salary levels.

'When the patient comes to you as a nurse and you treat them badly, you will realise that you have mistreated them. You also come from your own home having family problems and they will affect your work and you will act out your anger towards your patients, even though they do not know anything about your family problems' (staff nurse).

Financial and non-financial motivating factors

<u>How important is salary as an influence over motivation?</u>

Table 3: Testing hypothesis 1: importance of salary as motivational influence[1,2]			
	Against data, hypothesis was:		
Motivation level	proven	not entirely proven	not proven
high	4	2	1
mixed[3]	4	2	3
low[3]	10	1	7
Note: 1. H1 = at high/mixed motivation levels, salary is less important than other motivating factors; at a low motivation level, salary is more important than other motivating factors; 2. This assessment was made using all available interview data for each respondent and represents an overall assessment of their position based on what they spontaneously discussed as personal motivating factors and how they spoke about financial and non-financial factors. 3. In each group, for one person it was difficult to judge whether or not the hypothesis was proven from the interview material.			

Table 3 summarises the test of hypothesis 1 against the available individual-level data. It indicates not only that, as expected, salary is <u>not</u> the most important motivating influence for

around half of those with higher motivation levels, but also, surprisingly, that this conclusion holds for a significant minority of those at the low motivation level (when the hypothesis was not proven). At the same time, and as expected, among those at the low motivation level and even, surprisingly, for some at other motivation levels (when the hypothesis was not proven), salary is likely to be an important motivational influence.

The three issues raised specifically by those of mixed and high motivation for whom salaries mattered to some extent also have more general relevance. First, and across motivation levels, discussions of salary generally centred on concerns about the current low level of salaries: *'I think if salaries were decent I don't think nurses would be leaving their positions'* (professional nurse). Second, low salaries were identified as signaling that the employer does not care for health workers. Complaints about low salaries, thus, reflected health workers' concerns to have their basic needs met[13] as well as the need to be recognised (with relatively low salary levels seen as a signal that health workers are not highly valued by their managers or society). Third, the recent experience of not getting a promised pay increase only exacerbated these concerns (see later discussion).

'When we first heard about it [the promised pay increase] we were excited, because I thought that at least for the first time the government is thinking for us. It was like they were actually taking the load off our shoulders. It was going to motivate us to put more effort into our work. We felt we were going to deliver more services to our patients… We are not happy about our salaries. They are paying us peanuts and the job is too much. It is not an easy task to work with people because they have different personalities and we are exhausted. We always try to control our temper and not to argue with the patients and that causes depression for us. I try to speak myself about self-control and not to lose it when I am with patients' (auxiliary nurse).

The range of non-financial factors influencing health workers included another extrinsic factor, a wide-ranging sense of job insecurity. Uncertainty around the future actions of the employer was high, as past actions appear to have demonstrated to health workers both the employer's lack of care for employees and its capricious and unreasonable decision-making. This feeling is also linked to the broader sense of powerlessness among health workers, itself

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[13] Such motivating factors are sometimes called hygiene factors (Franco et al., 2002).

tied to concern about the riskiness of the job, and, specifically, to discussions about trust in the employer (see later discussions).

'I know with this work that there is no security, I have to pray everyday that I do not make a mistake' (auxiliary nurse).

'I feel that there will come a time whereby we will have to beg for work, our employer is not good' (staff nurse)

Other non-financial incentives affecting people of all motivation levels included training and working conditions, both of which might be seen as influencing extrinsic and intrinsic motivation[14]. Having or not having access to training might be linked to opportunities for advancement and higher salaries, or to a desire to feel confident in one's skills for the job and able to provide the best care possible. Concern for working conditions may, similarly, be linked to the desire to feel confident and capable. In practice, in both cases, the most common issues raised were the lack of opportunities to upgrade skills and be promoted, particularly for auxiliary nurses, and the ways in which poor working conditions undermined health workers' ability to do their jobs.

Finally, clearly important to people of all motivation levels were the non-financial incentives associated with feeling cared for and supported by colleagues, supervisor and employer (i.e. workplace trust). For people with higher levels of motivation, such feelings may only contribute to the intrinsic motivation derived from work: thus, one highly motivated health worker said that salary was not as important to motivation as job security, trust in the supervisor and feeling cared for.

Most health workers, however, experienced a lack of care and support in the workplace, with consequences for motivation. Negative experiences of relationships were explicitly identified as important to all of the 7 lowly motivated people for whom hypothesis one was not proven. These health workers' views suggested that being treated badly by some combination of colleagues, supervisor and/or employer was as important an influence over their motivation as

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[14] Extrinsic motivation is derived from factors external to the task of focus and individual, such as salary, which allow people to satisfy their basic needs indirectly (and so are linked to hygiene factors); intrinsic motivation,

salary levels. *'I think they need to treat all of us in a human manner. You know if you are treated nicely at work then you will do your job in a satisfying way. And now I do not know anything anymore and I always feel that I am not doing everything ok. I feel that whatever I do is wrong because I know these people do not trust me, and I do not trust them'* *(auxiliary nurse)*. For many people, therefore, and particularly the less motivated, feeling a lack of care acts as an important de-motivating influence[15].

Although important where identified, the relationship between health workers and patients was less often identified as an influence over motivation than initially expected. Only 21 out of the 36 health workers for whom motivation assessments could be made discussed interactions with the community in any way, and of these, only nine specifically identified these interactions as a factor affecting their motivation. The majority of the respondents generally discussing these interactions spoke about them as being problematic, and identified them as a negative influence over motivation. The few positive experiences were linked to the intrinsic motivation derived from feeling appreciated by patients. In contrast, negative experiences included the frustration of not being able to provide adequate care because of problems with working conditions; as well as to the demands made by patients on health workers and the lack of respect shown by them to health workers (see Box 3). These perceptions indicate how different factors combine and have a cumulative impact on motivation.

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however, is derived from the task itself and is linked to factors internal to the individual (as when a task is undertaken for its own sake).
[15] Health workers' experiences of key human resource functions, summarised in Annex 8, are linked to these experiences. For example, some health workers specifically stated that they are currently not getting appraisals, but to have an appraisal and get feedback on performance would be a positive motivating influence.

For a few respondents a range of other personal factors also appeared to act as a filter encouraging them to see their workplace experiences as de-motivating. For example, one lowly motivated health worker felt almost victimised and under threat from all around her because she had been allocated to work in a facility quite far from her home, where she felt herself to be a stranger. Other individual factors influencing motivation included being frustrated as a man by having to work for women and, in the particular case of administrative staff, having boring jobs.

Overall, however, salary levels do have some influence over motivation across respondents. For more lowly motivated staff this may at least partly be because salary matters more at lower than higher motivation levels. The lower salary levels of auxiliary nurses may also be important in this possible association. For others, the failure to get the recently promised salary increase and the lack of care implied in relatively low salaries also underlies the influence of salaries on motivation.

'Other than work related frustrations I do get satisfaction. Ja, mostly when you interpret it is a calling. With me reward for doing this job is not only monetary. You know making a humble contribution to people's lives. That makes it different. It makes our job satisfying. But again there is that element of dissatisfaction, ja well that aspect I mean we are human we need to

have a better lifestyle. So when the money is not there, and mostly when you compare with other professions it can become frustrating. It is a point because I know many nurses who are victims to loan sharks. Come month end they have to take sick leave because they want their money. So let me say financially the profession is not rewarding. You know actually most of the frustrations or some of the frustrations that nurses encounter are because of financial frustrations. We need to look at nurses holistically, not professionally only but as a complete human being. If some of your affairs are not settled you cannot be happy. It is a fact that there are nurses who become aggressive to clients. The reason being that they harbour their own anger. So they relieve their anger towards the wrong people.' (professional nurse)

At the same time, the evidence also strongly suggests that health workers are driven by a mixture of extrinsic and intrinsic motivations. Although the specific mixture differs between people, common concerns raised in addition to salaries were about job insecurity, lack of training opportunities, poor working conditions and not being cared about.

Does workplace trust influence motivation?

Table 4: Testing hypothesis 2, influence of workplace trust over motivation[1]			
	Against data, hypothesis was:		
Motivation level	proven	not entirely proven	not proven
high	3	4	0
mixed	7	0	3
low	12	1	6
Notes: 1. H2 = at high/mixed motivation levels, relatively high levels of workplace trust are evident; at a low motivation level, a relatively low level of workplace trust is evident			

Table 4 summarises the test of hypothesis 2 against the available data. Across motivation levels there is, again, a mixed picture. The hypothesis is proven for around a half of the more highly motivated workers and for around two thirds of the least motivated. These cases suggest that there may be some association between workplace trust and motivation levels, with higher levels of workplace trust identified at higher levels of motivation.

However, there also appear to be fairly high levels of workplace trust among about a third of those with low motivation, as well as less workplace trust than expected for about a third of those with mixed motivation levels and for just over a half of those with high motivation. The common theme of experience across these individuals is that fairly widespread trust in facility

managers (often combined with at least some trust in colleagues) is set against other problems experienced at work. Perhaps the most important problem identified was distrust in, or negative feelings about, the employer. Other problems include those already mentioned, such as poor access to training opportunities and poor working conditions, and concerns about patient complaints and demands. All these factors are also linked to the sense of powerlessness already noted as important to health workers' experiences. However, those of higher motivation seem to be able to sustain their motivation despite these problems, whilst these problems seem more likely to undermine those of lower motivation even for those who trust their managers.

These different experiences around components of workplace trust are also highlighted by Table 5 (see also Tables 6 and 9). Of those with low motivation levels, most have little or no trust in colleagues, manager or employer. In contrast, most of those with mixed or high motivation levels trust their manager and rely on colleagues, even though most do not trust their employer.

Table 5: Motivation levels by component and level of workplace trust[1]						
Trust in:	colleagues			manager		employer
	least[2]	middle[3]	most[4]	least[5]	most[6]	least[7]	most[8]
Motivation level							
Low	11 (58%)	8 (42%)	0 (0%)	11 (65%)	5 (29%)	11 (69%)	2 (13%)
Mixed	1 (10%)	6 (60%)	3 (30%)	1 (11%)	6 (67%)	5 (56%)	1 (11%)
High	0 (0%)	6 (86%)	1(14%)	0 (0%)	6 (86%)	3 (60%)	0 (0%)

Notes:
1. Excluded external supervisor because not seen as equally relevant across respondents in all four sites.

Totals derived by using following responses by item:
2. none/little trust plus trust some only/not fully trust
3. rely on (mostly trust)
4. trust most (even on personal matters)
5. no trust in supervisor
6. yes, trust supervisor
7. not trust plus trust a little, not fully
8. trust somehow

How does workplace trust influence motivation?

Table 6 provides more individual-level data across the components of workplace trust most likely to vary by facility: trust in colleagues, trust in the manager and trust in the external supervisor. Although the conceptual framework only identified one 'trust in supervisor'

variable, the findings indicate that some health workers see their primary supervisor as the facility manager rather than a supervisor external to the facility, particularly junior staff in the larger facilities.

<u>Colleagues</u>

The data on trust in colleagues clearly show that the main theme of experience is the sense that you can rely on your colleagues – if only at work. The extent of stronger or more personal trust is quite limited across motivation levels. As noted, although the numbers are small, there is also a hint that lower motivation may have some link to lower trust, and higher motivation, to the sense that you can, at least, rely on colleagues.

The role of reliance on, or trust in, colleagues in sustaining motivation is generally expressed as allowing the co-operation in work tasks that underpins the provision of good care and sharing of work burdens. *'Trust is important for a collective effort in providing health care'* (professional nurse). Not being able to trust colleagues, thus, undermines patient care and causes tension. *'Yes, when you do not trust the people you are working with who are you going to trust?… you will be forced to carry all the responsibility of your work alone'* (professional nurse). *'Yes there is this person that I told you about that I specifically don't trust…. She operates between us and the matrons and other people as well. I am scared that this might close opportunities for us'* (auxiliary nurse).

Table 6: Elements of workplace trust, analysed by motivation level across individual-level data				
	Motivation level			
	low	mixed	high	*total*
1. Trust in colleagues				
none/little	3	0	0	*3*
trust some only/not fully trust	8	1	0	*9*
rely only (on most)	8	6	6	*20*
trust most (even on personal matters)	0	3	1	*4*
total	*19*	*10*	*7*	*36*
2. Trust in manager[1]				
no	11	1	0	*12*
yes & no	1	2	1	*4*
yes	5	6	6	*17*
total	*17*	*9*	*7*	*33*
3. Trust in external supervisor[2]				
no	5	6	1	*12*
yes & no	2	1	0	*3*
yes	1	0	1	*2*
total	*12*	*7*	*2*	*17*
Note: 1. Responses from three in-charges not relevant 2. 19 respondents do not identify external supervisor as having relevance to their work				

Although some suggest that they can only rely on colleagues of a similar rank, in one facility there are clearly indications of teamwork across cadres. Here, trust in colleagues of whatever category specifically provides the basis for staff with less training to learn from those with more training. The riskiness of work is thus tackled by developing greater skills and more confidence in using them.

Where it exists, trust in colleagues is underpinned by specific personal characteristics and behaviour, such as: being faithful, responsible, honest, having sympathy and integrity; as well as keeping confidences, giving good advice, providing assistance even on personal matters, communicating well and treating each other well. Being competent in work is also sometimes important.

However, caution about, and even distrust of, colleagues is common and this appears to be largely due to a concern about gossip and the breaking of personal confidences. In addition there are clear examples of conflict among colleagues, either where some disapprove of others' behaviour (e.g. in terms of how patients are treated, being lazy or demonstrating poor discipline) or where more 'junior' staff (less qualified) feel that more 'senior' staff (more

qualified) abuse their power in the way they treat them. Indeed, there is quite often a sense of a junior/senior divide among staff. For example, in contrast to positive experience of teamwork, some health workers complain that when senior staff delegate duties to them they do so to relieve their own work burdens and then delegate tasks outside the scopes of practice of junior nurses. *'...these nurses want you to follow them. Even if they are consulting their patients they still call you to assist them. They would say register this patient there for this and that, give this medicine and do this and that. They are just abusing us. We know what is expected of us and some of the things they request us to do are above our scope of practice. But if we refuse they would say that we do not know our work. Prescribing treatment for patients and giving injections is not our work as juniors but they expect us to do that. Even for maternity cases they would still want to go with us. We do not have midwifery but they expect us to do this and that….'* (auxiliary nurse).

A few express a form of general distrust towards other people and a few have particular, personal experiences that inform their distrust of colleagues.

Manager

Facility managers are identified staff members. In small clinics their main task is to ensure good service provision, based on teamwork, with some involvement in human resource (HR) functions such as staff appraisals and decisions on when leave can be taken (Annex 9). They also continue to provide services. In larger facilities, they may have fewer service provision functions but, instead, a wider set of management functions, including more direct involvement in HR management decisions and, in some instances, budget management. However, the range of tasks taken on in larger facilities also depends on staff availability; where staff are short, managers are likely to have to take on more service delivery responsibilities than in better staffed facilities.

Views on managers are clearly divided. About one third of respondents definitely indicated a lack of trust in their managers, but over a half clearly trusted them (Table 6). There also appears to be a site-effect, as more staff in the two facilities with generally higher motivation levels deemed their managers trustworthy than in the two other facilities. There is also a hint that professional nurses may be more likely to deem their managers as trustworthy in comparison with auxiliary nurses: 12 out of 15 professional nurses indicated that they trusted their managers at least partially (10 entirely) as compared to the 8 out of 16 auxiliary nurses

who indicated that they did not trust their manager. However, not only are the numbers small but only a few auxiliary nurses were interviewed in one of the facilities where most staff expressed trust in their manager.

Judgements about trust in the manager are rooted in three sets of factors, as reflected in both positive and negative experiences: work behaviour, personal behaviour and personal characteristics (Table 7). Positive experiences of managers are associated with being supported and encouraged at work, making decisions in ways that are seen to be consultative and transparent, demonstrating personal competence and behaving with personal integrity. In contrast, those managers who are not well trusted are seen as unsupportive, unwilling to consult with others, unfair and so likely to make other staff feel bad about themselves and their work.

Although the technical skills and competence of managers can be important to their trustworthiness, more important is the way in which they treat their colleagues.

'Let's say they report you and instead of her assessing you before approaching you, she comes to you being fed up, and you find she can't communicate with you professionally. And you won't like to report on duty because of job dissatisfaction. And at times it lowers your morale' (professional nurse)

'She is a mother to me. She gives moral support and on top of it all she is a hard worker. You know she is the type of a person who likes to do her work and she would also encourage us to do our work in a correct way. You know that one she is our mother. When the clinic manager is around it becomes warm in the clinic. If there is a problem we sit down and she allows us space to talk and we try and sort things out. When we are busy in the clinic she assists us and encourages us to work even harder. She is extremely supportive. She motivates us a lot. She would tell us that if we work hard God will help us… And she would go on and on motivating us and we would feel happy about our work…' (professional nurse).

Table 7: The foundations of trust in the facility manager	
Positive experiences	**Negative experiences**
Work behaviours: ♦ *supportiveness*: encourages, commends good performance publicly and tells you off politely/privately, won't expect you to do things she can't do, wants staff to learn, guides work ♦ *decision-making*: communicates, shares information, gives explanations, consults in making decisions ♦ *competence*: sets good work example, competent, involves others in her tasks so that they know how to do them, good people management skills Personal behaviours: does not break confidences (dominant theme) reliable, shares with us gives advice, listens & assists with problems friendly, open to all, not selfish loves and respect others, shows how to respect each other, trusts others Personal characteristics: good person, good attitude, approachable, honest, truthful, has integrity, fair to us, understanding, challenging person hard worker, competent	Work behaviours: ♦ *supportiveness*: doesn't assist or help or support, no feedback on performance, demanding too much, ♦ *decision-making*: doesn't consult, takes decisions on own, poor communication, Personal behaviours: treated me badly; don't care about me; feel that whatever I do is wrong; talks behind your back; afraid to take decisions; just shouts at you Personal characteristics: closed person, moody not open, friendly, transparent or fair

Managers' influence over health workers' daily activities and working environment, as well as the part some play in basic human resource management functions (such as decisions over leave, appraisals, less serious disciplinary matters; and whether or not they intercede with higher management levels on other issues, such as transfers and training), mean that they routinely influence whether health workers feel recognised and cared for in their workplace.

Managers' own feelings about their workplaces are also likely to influence their behaviour towards others. Most have heavy workloads and yet felt unsupported in at least some ways, and expressed frustration with higher management levels; the authority of two seemed to have been undermined in the past by their superiors. Like their colleagues, they felt relatively powerless in their workplaces.

External supervisor

The external supervisors to all four case study facilities are members of the district health team and each has responsibility for a group of facilities. They act as the liaison person between the facility and the district level, and play particular roles in provisioning as well as

in basic human resource management functions (e.g. arranging for people to cover for staff on leave at other facilities, transfers, training, more serious disciplinary matters: see Annex 9). Their influence appears to be felt more strongly in smaller clinics than in the larger health centres, perhaps because of the more limited managerial authority and smaller staff numbers in the clinics. However, their influence over facilities is also likely to be linked to their relationship with the clinic manager and their own personality, and so to how active a role they take on in facility management.

Where possible to determine, views on external supervisors seem largely negative, with just a few positive experiences (Table 6). This is perhaps not surprising given that where they have an influence, the supervisors play a strong role in decisions that have a direct bearing on factors that can clearly support or undermine health worker views about their work. It is hard to make popular decisions in such positions! [16]

However, for health workers, lack of trust in the supervisor only contributes to their feeling of powerlessness. *'There is also this thing that they do and if you don't like me you will give me less marks because you don't like me. So they have got powers to oppress you whilst you have done nothing wrong'*. As Table 8 indicates, the way in which these decisions are experienced and understood is central to the lack of trust expressed. Rather than being seen as supportive, supervisors are commonly experienced as acting as obstacles to individuals either blocking their requests or delaying decision-making. Annex 7, for example, indicates that health workers commonly complain of problems in accessing training opportunities for junior staff.

Table 8: The foundations of trust in the external supervisor	
Positive experiences (few)	Negative experiences
Work behaviours: ♦ *supportiveness:* recommends me and motivates me; able to consult with her on professional matters ♦ *decision-making:* consults Personal behaviours: keeps confidences, straightforward, doing level best	Work behaviours: ♦ *supportiveness*: delays sharing information sent from elsewhere; does not tell us things we should know; not supported in front of other staff; doesn't address our problems ♦ *decision-making*: not transparent; goes back on decisions; no consultation, not sure if reliable, Personal behaviours: has negative attitudes, cold, not fair

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[16] Supervisors, however, sometimes have different views about their role and authority in decision-making on some of these issues than nurses.

However, supervisors (and district managers) themselves also express reservations about the nurses for whom they are responsible. There was a common, if not uniform, view that nurses of today do not have a calling for their work and instead are driven by material motives. This situation is seen as starkly different from the past, when nurses worked without care for themselves, sacrificing themselves for patients – in other words, worked in ways that might be called 'true nursing'. The depth of feeling expressed on this issue appears to suggest a fundamental tension in relations between supervisors and nurses that may even reflect a two-way lack of trust. It contrasts with the general view of health workers that the right people are recruited for nursing positions (Annex 7).

Supervisors themselves, and like facility managers, also express some frustrations with their superiors. The most common complaint is that they have both heavy workloads and relatively little control over what they do and are subject to the arbitrary decision-making of their superiors – called to meetings on short notice, asked to do tasks without warning etc. In addition, they, like nurses, have experience of poor employer communication (see below). Again, this is linked to a sense of powerlessness.

The employer

The employer was commonly identified as provincial or national government, and rarely, correctly, as the local District Management office.

Table 9 indicates a wide-scale lack of trust in the employer across respondents at all motivation levels, re-emphasising the earlier discussion of hypothesis two. Only 3 people indicated some level of trust in the employer, but also made both positive and negative comments about the employer.

Table 9: Trust in the employer, analysed by motivation level				
	Motivation level			
	low	mixed	high	*total*
not trust	7	5	2	*14*
trust a little but not fully	4	0	1	*5*
trust, but…	3	3	2	*8*
trust somehow[1]	2	1	0	*3*
total	*16*	*9*	*5*	*30[2]*
Notes: 1.This response reflects the greatest level of trust displayed across respondents; the phrase 'trust somehow' tries to capture the sense that while respondents do clearly express trust in the employer, this trust is not complete or straightforward 2. Difficult to assess for six respondents.				

However, around a third of the total number of respondents (those answering 'trust, but' and those not responding to the question) found it difficult to answer the direct question about trust in their employer. Those judged as responding 'trust, but ….' stated, in response to the direct question, that they trusted the employer but throughout the interview identified only complaints and concerns, raising issues similar to those raised by others as reasons for not trusting the employer. Others appeared unable to understand the question, either seeing the employer as too distant from them to allow them to make judgements about trust or suggesting that they had to trust their employer simply because it employed them.

The very few respondents who seemed to trust the employer in some way saw it as providing a general sense of support to, and trust in, them. The dominant theme of discussions about the employer was, however, that it has failed to demonstrate care for employees, and instead has shown distrust towards them (Box 4).

These perspectives are clearly underpinned by specific personal experiences (such as being refused training opportunities), a few widely known disciplinary cases and experiences that have affected all health workers. Most significant among the latter are:

1. the failure of the national and provincial Ministers of Health (announced in early 2003) to honour their 'promise' that in July of that year a new allowance (equivalent to 25% of salary) would be introduced for rural health staff[17];

2. the implementation of a national process of re-structuring staff grades to reflect available positions, involving adjusting downwards the titles of people's positions but leaving their salaries the same (so for example, the position of chief professional nurse might be renamed senior professional nurse)[18];

3. the implementation of a Patient's Rights charter as part of the government's Batho Pele (DPSA 1997b) policy, intended to promote better patient care by outlining patients rights and responsibilities.

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[17] Although no specific promise to particular health workers was made, public announcements about the allowance appear to have been seen as a general promise to health workers living in rural areas. In practice, these rural allowances only came into effect in 2004, after the data collection process had been completed.

[18] This process was implemented in conjunction with a new performance management system. In the past promotion (linked to salary increase) within the civil service was almost an automatic process linked to period of employment, with limited consideration of performance. As a result the civil service wage bill had increased considerably. Under the new system, annual salary increases will only be based on performance, and promotion between ranks will only be possible by applying for positions as they become vacant.

Box 4: Views on the employer

'I just wish our employer would consult us more as health workers because we do have a say in these issues they affect us directly. They should consult us before decision-making so that they could know our opinions, feelings and views before deciding on the things that should be done. If they do this I would trust my employer more. As it is now they decide and implement things behind our back and impose decisions on us without having consulted us first. So I don't really trust them as much as I would like to' (professional nurse)

'They fail to deliver on promises which they make. They expect to deliver and yet they are not delivering. They do not treat us as human beings and yet expect a lot from us. They do not care about our working conditions. I don't trust them. They can move you anywhere without consulting you.' (auxiliary nurse)

'Times I would get the feeling that they are more concerned about the patients than the health workers. Because you report things and the department would make your life worse rather than improving it. The response would be very slow. But if you can mistreat a patient today and the patient would report you to the department the following day. You would see the matter in the newspapers and you would be called for disciplinary hearings. The matter would be give priority if the patient reports it. But if I were to report that there is no electricity in this clinic, the windows are broken or the door does not close properly, the response to all these would take a very slow process. But if a patient was seeing all these you would see the response. So at times I get the impression that the employer cares more about what the patients say than what the health workers say' (professional nurse)

'There is unfortunately no communication between us and the management. Whenever they want do something they just do it without consulting us first. What is happening presently if anything is going to happen we will just get a circular informing you that from such a date this is what will be taking place. We are not given a platform to make queries or not even consulted before a circular comes out. In other words, our inputs are not important to them and at the end of the day you are just at the receiving end, somebody else is making the decision we must just implement. At times you find the situation does not allow you to implement but somebody has decided that this is what will be taking place and you know there are things that will prevent you from doing them. So at the end of the day you become frustrated because of the way things are done' (professional nurse)

All three policy actions are commonly seen as undermining staff motivation and trust in the employer. As a result of the first, some health workers took out loans and made payments in the expectation of this award and so ended up with debts. This policy promise was frequently

identified as just a sign of the employer's constant failure to keep its promises to its staff. Although not what was intended, the second policy initiative is widely understood as a 'demotion' process, and has caused considerable anxiety about job security and future salary levels. Finally, the third policy is frequently linked to the sense of powerlessness among health staff with the complaint that 'patients have rights but nurses do not'.

Across all three policy actions the key weakness appears to be in poor communication and consultation (see Box 5). The employer has either mis-communicated key features of the policy changes (such as the timing of the salary increase, implemented only in 2004) or health workers have misunderstood what was intended; either way they have interpreted the changes or their results as yet further examples of the employer's failure to care for them. All three policy actions are also recognised by district supervisors as having had negative impacts on staff morale, in part because of communication problems.

Box 5: Perspectives on recent policy changes

On policy 1:
'I realised that what the government wanted was to fool us, that's all. It's like at some point they did think about us and our needs. But when the time was there for them to give us that money they decided they did not want to give us any more, because to them we are just nothing.' (auxiliary nurse)

On policy 2:
'We have tried to contact the Unions, but they have informed us that they are still negotiating with our senior managers in the national department. We are confused. We do not know whom we should trust. We do not know what we must do. The same Unions told us not to sign [to confirm agreement with the new status], but if we do not they will take us out from the system [understood as make redundant], that is a serious disadvantage to us' (clerk).

On policy 3:
'As a nurse you are always wrong, even before we open our mouths we are wrong. They write about patient's rights and they don't consider writing about our rights. We do not have rights as nurses. Most of the time patients have rights over us and they provoke us knowing that nothing will happen to them. I think government has to write about nurse's rights so that patients will not walk over us. I think the first right should be respect. Patients have to respect us.' (auxiliary nurse)

These specific policy changes must also be seen in the context of the large scale and rapid transformation of the health system since 1994. Many changes have been introduced in this time that have a direct bearing on the workplaces of primary care health workers. These range from large-scale structural changes such as the removal of fees for primary care, to changes in operational practices, such as the implementation of the 'supermarket approach' in the provision of integrated service provision. As noted in the discussion of national perspectives, the amount and scope of changes, together with consistently poor communication practices, have created an unstable working environment which itself causes significant stress and anxiety among health workers. These then interact with nurses' concerns about the riskiness of jobs, the problems of the hierarchy and bureaucracy and feelings of powerlessness, as already discussed.

Understanding the complexity of motivational influences

The individual-level analysis so far presented suggests that:

- although an important influence, particularly at low motivation levels, low salaries are not always the sole or most important factor influencing health worker motivation;
- non-financial motivational influences include job insecurity, access to training opportunities and working conditions, and the presence or absence of trusting workplace relationships;
- there are generally higher levels of trust in managers than in colleagues, and there is least trust in the employer;
- trust in the manager is likely to be a quite strong motivating influence, trust in colleagues may partly motivate just by allowing work to be done, and lack of trust in the employer is de-motivating;
- patients and the wider community appear to have only a limited direct influence over motivation but do have a diffuse influence over health workers' general sense of insecurity;
- people's personalities and personal situations clearly have an important and variable influence over motivation, but are rarely determining influences over motivation levels;
- the wider context, in the form of professional understandings, accepted health system practices and current processes of health system change, also influence worker motivation.

Although this analysis has so far considered the possible influences over motivation and performance independently of each other, it is nonetheless clear that the various factors are inter-woven in complex ways. This can be seen at both an individual (see also Annex 8) and facility level.

For example, reflecting the experience of other more highly motivated staff, one highly motivated health worker was very concerned about recent moves to re-structure staff grades and the process by which the demotion was undertaken. She feared that she had now made herself vulnerable in some way, and felt her job security threatened. However, as a clearly self-motivated and relatively senior health worker, working with the support of a trusted manager, she continued to derive great satisfaction from caring for patients and from teaching her colleagues, despite the challenges of working conditions. As a result, she was widely praised for her work and treatment of patients. In contrast, even where they have trusting relationships with managers, many staff experienced the actions of the employer as de-motivating and, in some facilities, as exacerbating existing divisions between cadres. The end result was a sense of powerlessness that de-motivated even those health workers who clearly cared for their job and their patients. In some of the most extreme cases, health workers felt unsupported in every sense and yet required by the lack of staff or the needs of patients to do tasks for which they did not have the training and for which they feared they would be disciplined.

As another example, a well trained nurse felt that her repeated experiences of being uncared for over the years have led to her current lack of motivation:

'I used to like my job. I enjoyed giving care to people. But now I do not like this job any more. There are a lot of bad things happen in this job. Our employer does not care about us, they do not take us as if we are professional nurses. Most of the time you will find they prioritize the welfare and wellbeing of patients first and we are always the last people to be considered. Even if a patient can come and abuse you, as a nurse you know no one will ever sympathise with you. And if we can mistreat a patient then you will be in deep trouble. And what I also hate about my profession is that they do not want to pay us, all we get is peanuts while we are working very hard; and that is why we are not even motivated to perform more on our duties. Even if I am coming to work I do not have that interest any more. Before when someone was a

nurse, people used to respect those nurses. Now no one respects us; we do not feature anywhere'.

Working in difficult circumstances, with little trust in those around her, and with personal experiences of being forgotten or undermined, this nurse was observed to treat patients rudely and without sympathy. As noted, several of those with similar experiences suggest that their poor treatment of patients is a result of their own poor treatment. Several, even those still demonstrating positive levels of motivation and performance, are thinking of, or have, resigned.

At facility level (Table 10), it is hard to discern any links between patterns of performance (staff behaviours and attitudes) and motivation. Although staff working in the two facilities initially judged as better performing do appear to have generally higher levels of motivation than staff in other facilities, differences in patient views of performance across facilities are less clear[19].

There are, however, slightly clearer patterns around motivation levels and workplace trust across facilities (Table 10 and Annex 10). First, facility size is not a clear influence over motivation as each pair of generally more and less well motivated facilities included one health centre and one clinic.

Second, the two facilities with the higher levels of motivation across staff members also have higher levels of workplace trust (although in one there are indications of some divisions among staff and limited trust in the external supervisor). In contrast, in the two facilities with more limited trust among colleagues (within or outside the facility) there are generally lower levels of motivation. However, it is important to note that these latter two facilities are also both less well resourced than the other facilities and located in more remote rural areas. These differences clearly do have some influence over motivation. For example, although one already suffers from relatively high workloads and staff shortages[20] many current members of staff would like to be transferred to other facilities to be closer to their homes, or due to the

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[19] It was also not possible to assess any performance differences between facilities on the basis of observations, because of the difficulties experienced in conducting such observations, particularly in larger facilities.
[20] Although the available data do not allow confirmation of how high workloads were in this facility, relative to norms across the country, its outpatient workload level was among the highest of the facilities included this study; it was also unable to fill its full complement of current posts.

working conditions. In the other, the temporary accommodation in which the facility is sited provides limited space and difficult conditions in which to work. However, resource availability is not a clearly more important influence over motivation than workplace trust, indeed there are indications of some fragility in aspects of workplace trust in one of the better resourced facilities. Instead, it seems that the sets of issues are inter-twined in their influence over motivation.

Table 10: Overview of facility experiences		
	clinic	health centre
better performing (peri-urban settings, near tar roads)	**Facility 1** Staff performance: overall positive Motivation: 2 high, 3 mixed, 3 low Salary relatively unimportant to staff, with stronger concerns about training, promotion and workplace relations Cautious trust in colleagues, largely for work, with indications that junior staff feel powerless; Widespread trust in manager as a health worker and person; Little trust in employer and external supervisor Working conditions relatively good; next door to referral facility Little delegated authority	**Facility 3** Staff performance: overall mixed Motivation: 5 high, 2 mixed, 4 low Salary important to around half, but often combined with factors such as lack of training, insecurity, and workplace relations Generally high levels of trust in colleagues, even between cadres and including some personal trust; Widespread professional and personal trust in manager, including trust in management competence; Relatively limited trust in employer (little discussion of external supervisor) Working conditions relatively good; old ambulance available for patient transfers Delegated budget authority
worse performing (more remote rural settings, on dirt roads)	**Facility 2** Staff performance: overall negative Motivation: 5 low Salary fairly important, together with experience of lack of care Little trust among staff, in manager or external supervisor; Little trust in employer Poor working conditions Little delegated authority	**Facility 4** Staff performance: overall mixed Motivation: 5 mixed, 7 low Salary important to some but for most broader frustrations more important, such as lack of training opportunities, threat of discipline and general lack of workplace support Cautious trust in colleagues, largely for work, with indications that junior staff feel powerless; Variable but generally quite limited trust in manager; Little trust in employer or supervisor Poor working conditions; no ambulance available; low workloads relative to other facilities Some delegated authority but unclear

Third, the perceptions of management seemed to be a critical influence over motivation levels. In the two facilities with lower levels of motivation, trust in management (managers and supervisors) is clearly limited. In direct contrast, the managers of the two other facilities are widely praised by their staff as leading by example, for being role models to their staff. Their behaviours and practices largely, if not entirely, demonstrate trustworthiness and, in the best case example, encourage an environment of mutual support and learning in which there is also considerable trust in colleagues. For some people trust in the manager may even mediate the negative influence of the employer over individuals' motivation levels. However, this depends on the manager's own competence and confidence in handling staff and in managing upwards; the influence of the external supervisor, as representative of the bureaucracy, is anyway greater in smaller facilities. Although the two facilities with lower levels of motivation and lower levels of trust in management were also the less well resourced facilities, and poor working conditions must make management more difficult, managerial trust is not itself dependent on resource levels but rather on how managers cope with them. Again, therefore, resource levels are inter-twined with workplace (and specifically, in this case, management) trust in their influence over motivation.

Fourth, across facilities, lack of trust in the employer is generally experienced as a factor undermining motivation levels.

4. CONCLUSIONS

This preliminary report of a small-scale study of health worker motivation in South Africa offers a range of insights. These will be developed further in subsequent analyses.

The links between motivation and performance, and key influences

Although the available data do not allow firm judgements of the links between patient perceptions of performance and motivation levels at a facility level, this analysis does suggest that, at an individual level, more caring behaviour may only sometimes be associated with higher levels of motivation and those with lower motivation levels may still behave in a caring way towards patients.

In addition, the analysis suggests that:

- at an individual level, feeling uncared for or not trusted in the workplace may lead to uncaring behaviour towards patients;
- salary is rarely the only influence over motivation;
- the notion of workplace trust offers useful insights into the importance of non-financial factors as an influence over motivation and performance;
- community interactions seem less important as a direct influence over motivation than workplace relationships and conditions.

Finally, it is clear that full understanding of the links between motivation and performance and of the factors influencing motivation requires a contextualised interpretation of health workers' and patients' views and experiences. Although what health workers think, feel and do today, for example, are partly influenced by personal factors, they are also, and often more importantly, influenced by their own acquired understanding of their professional roles and practices, by other traces of history in the wider health system and by their more recent experiences in the workplace and in society. The task of motivating health workers, thus, requires strategies that acknowledge and work with these contextualised understandings, even as they seek to change them.

The relevance of workplace trust as an influence over motivation

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

Trust in colleagues:
The existence of sub-groups among staff within facilities may sometimes undermine trust between colleagues; in particular, there are often indications of a junior vs. senior staff division. Where such divisions exist, dis-trust may sometimes undermine working practices and, for example, prevent more qualified staff from sharing experience with other staff. However, there are also examples of good working relations across this division on an individual level. Health workers also often indicate that they rely on their colleagues to do their jobs, but do not see this reliance as the same as personal trust.

Trust in the manager and external supervisor:

Facility level management practices and management style are commonly highlighted as playing a crucial role in terms of informing motivation and performance. If the facility manager is viewed as being not supportive, consultative and/or transparent, nurses' motivation may be undermined. Even where a facility manager is herself perceived to be a competent health professional, poor management style can undermine trust in her leadership. Low trust can, in turn, generate anxiety and disputes and so impact negatively on motivation. Examples of positive management style (supportive, consultative, inclusive, and transparent) tend rather to be associated with higher levels of motivation.

Facility management is often seen as a joint task of the nominated manager and the external supervisor, particularly in smaller clinics. Indeed, the supervisor is often (if not always) seen as the key gatekeeper to higher levels of management, with nurses indicating that they cannot access these levels of management except through her. Supervisors are also sometimes viewed to play the central role in key human resource management decisions, although managers also do play important roles in these decisions. As these decisions have an important influence over motivation in all facilities, the manager/ external supervisor is generally seen to have a very powerful influence over nurses. Few nurses indicated that they understood the principles used in such decision-making.

Clinic managers and supervisors are, therefore, seen as the personal face of the wider bureaucracy and nurses' perceptions of the fairness and transparency of their decision-making has a strong influence over nurse motivation.

Trust in the employer

It was interesting to note that most health care workers interviewed had a limited sense of the district as an influence over their working lives. In general they see their employer as the provincial or national government, and give little indication of the role of district staff other than the external supervisor in decisions affecting them.

Several recent human resource and restructuring decisions taken outside the district were highlighted as having badly affected motivation for most health care workers. These policy changes or restructuring processes were not clearly communicated to the lower levels in the clinics. They have jointly affected health workers' sense of job security. Failure to deliver on

the 25% salary increase generated the concern that although they had been told their salaries will not be affected by the staff grade re-structuring ('demotion') process, in practice the employer will again fail to deliver on this promise.

Health workers also often expressed the concern that policies were imposed on them without consultation or communication. For example, some nurses feel that it is difficult to implement the supermarket approach to service delivery and are worried about having to provide 24 hours care with the current staffing situation. Yet they have been/are being required to implement both. These examples only emphasise the general feeling that nurses are ignored and their complaints not heard, a feeling that underlies their sense of powerlessness and fear of being punished.

In general, therefore, the employing organisation is not trusted because it is seen as not caring for nurses. As already noted, low salaries are often seen as a symbol of this lack of care; and poor working conditions can also be seen as a reflection of uncaring behaviour. Even where some action has been taken to improve working conditions, health workers simply do not believe the employer will deliver on their promises.

Dis-trust in the employing organisation appears to mean that nurses see themselves as working in a very uncertain and fragile context, which can have unexpected impacts on their personal and professional lives. It is hard to remain motivated when you are unsure what will happen next and it is certainly difficult to be motivated when you feel you have been badly treated.

Summary of influence of workplace trust over motivation
In general, health workers appear to give less less emphasis to trust in colleagues as an influence over motivation, and much greater emphasis to trust in manager / supervisor and trust in employing organisation.

The bases of trust
Trust judgements are commonly made on the basis of experience of leadership within the facility and decision-making around key human resource management functions. Feeling trusted and cared for is a central basis for trusting both manager, supervisor and the employer,

and is demonstrated by fair and transparent decision-making and good consultation/communication around decisions.

Thinking about future plans and actions

1.   Implications of findings

The initial findings presented here suggest that:

- heath care provision is affected by health worker motivation and performance problems (although some health workers are appreciated by patients and some health workers demonstrate high levels of motivation);

- there is potential to strengthen motivation and performance through changed management practices (as motivation is not solely a function of pay or working conditions);

- the management decisions likely to be of particular importance are those associated with basic human resource management practices (training, appraisals, promotion) and those influencing routine facility operations;

- the way in which management decisions are implemented is a critical influence over the impact of any decision on motivation, and particular attention needs to be paid to transparency and fairness, communication and consultation, and responsiveness – and although full consultation in decision-making may not be appropriate or feasible, effective communication is always important;

- management action needs to recognise the perceived risk and powerlessness expressed by many health workers, and seek to tackle these perceptions.

Although primary care workers do not fully understand the role of all district staff in management, it is clear that all managers at district level have important and linked roles in taking the action necessary to strengthen motivation. On the one hand, some decisions involve

groups of actors within the district and, on the other hand, the district management team is the implementor of decisions taken at other bureaucratic levels.

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

2.   *Possible opportunities for and threats to strengthening management*

The primary focus here is not on new activities to be implemented but rather on the way in which decisions are taken and implemented at district level.

- *The rural workers' allowance*: As a rural and scarce skills' allowance is now being implemented (2004), there would be value in asking: can we capitalise on this opportunity to impact positively on health worker motivation? A review of how health workers have experienced this new policy, and what factors influence that experience, would be an important basis for identifying how to capitalise on it. Initial media reports suggest some positive experiences but also a sense that its impact on motivation may be more limited than anticipated.

- *The new performance management (PMS) system*: The procedures and practices associated with this system, and how it will differ from past procedures, seem poorly understood by most nurses. Not only might it be important to provide clear communication about the new procedures to generate correct expectations, but could the implementation of the PMS provide an important opportunity for senior district managers to discuss the procedures with nurses (e.g. through general meetings)? In this way, they would not only be consulting with nurses, but also would get ideas about how to ensure effective implementation.

- *Management meetings:* There are a number of management meetings within the district, can these meetings be used to provide peer support and mentoring to strengthen management practices? When supervisors meet do they discuss how to tackle the common management situations that they face, in addition to being given information about new

procedures and practices? Could a regular series of meetings be established, at each of which a specific management problem is discussed and ideas and experiences shared about how to address such a problem in ways that take account of staff concerns and perceptions? Do clinic managers ever meet as a group to share experiences and provide support to each other? Could such meetings be arranged?

- *District performance awards*: Could the procedures for the awards be adapted to encourage teamwork within facilities, and to allow the health workers themselves to make the final judgement? (e.g. clinics might be asked to submit a motivation for why their clinic should be given such an award, where they each have to consider a specific set of criteria that include hard evidence (such as utilisation data) and their own assessments of performance; a panel of health workers drawn from across the clinics could then assess these motivations and make the final decision)

- *Strengthening communication:* Is there a district newsletter and if not, could one be started to provide a channel of communication among clinics and between district management and clinics? Would it be possible for senior district management staff (including at least sometimes the district manager) to hold meetings with staff from different clinics to allow exchange of views and a sharing of information on a face to face basis? This could supplement the supervisors' role as a communication channel and a newsletter. Such meetings could focus on new policies and/or on the criteria used in decision-making around training, for example.

- *Providing a guiding vision*: Is it possible to establish guiding visions for all facilities, that provide a framework for clinic level operations, a focus of their work and a common goal for health staff within the district? Perhaps such strategic visions could be established annually, or more often, and looking beyond the daily problems of clinic life, try to inspire and motivate staff to tackle those problems? Perhaps such visions could, as organisational goals to which health workers can commit themselves, be motivating forces?

- *Engaging provincial and national authorities:* Could the district play a stronger role in mediating between the national and provincial levels and health workers? For example, by actively communicating provincial decisions with health workers or by publicly seeking

to engage provincial/national managers in understanding the difficulties of nurses' lives (so taking the role of defender and supporter of nurses).

The *threats to motivation* that might be considered in future planning, in order to try and offset their impact on health workers are:

- the continued uncertainty and changing plans about the links between provincial and local government in relation to primary care delivery;

- the drive to establish clinic committees, which health workers may see as a further mechanism for disciplining them;

- the constraints to taking quick action on routine human resource problems, and on taking action in ways that demonstrate fairness and transparency;

- overlooking the potentially negative influence on motivation of the way in which new procedures and practices are implemented, given the many other demands of management jobs;

- overlooking the need to recognise managers at all levels for their specific role in supporting health care delivery.

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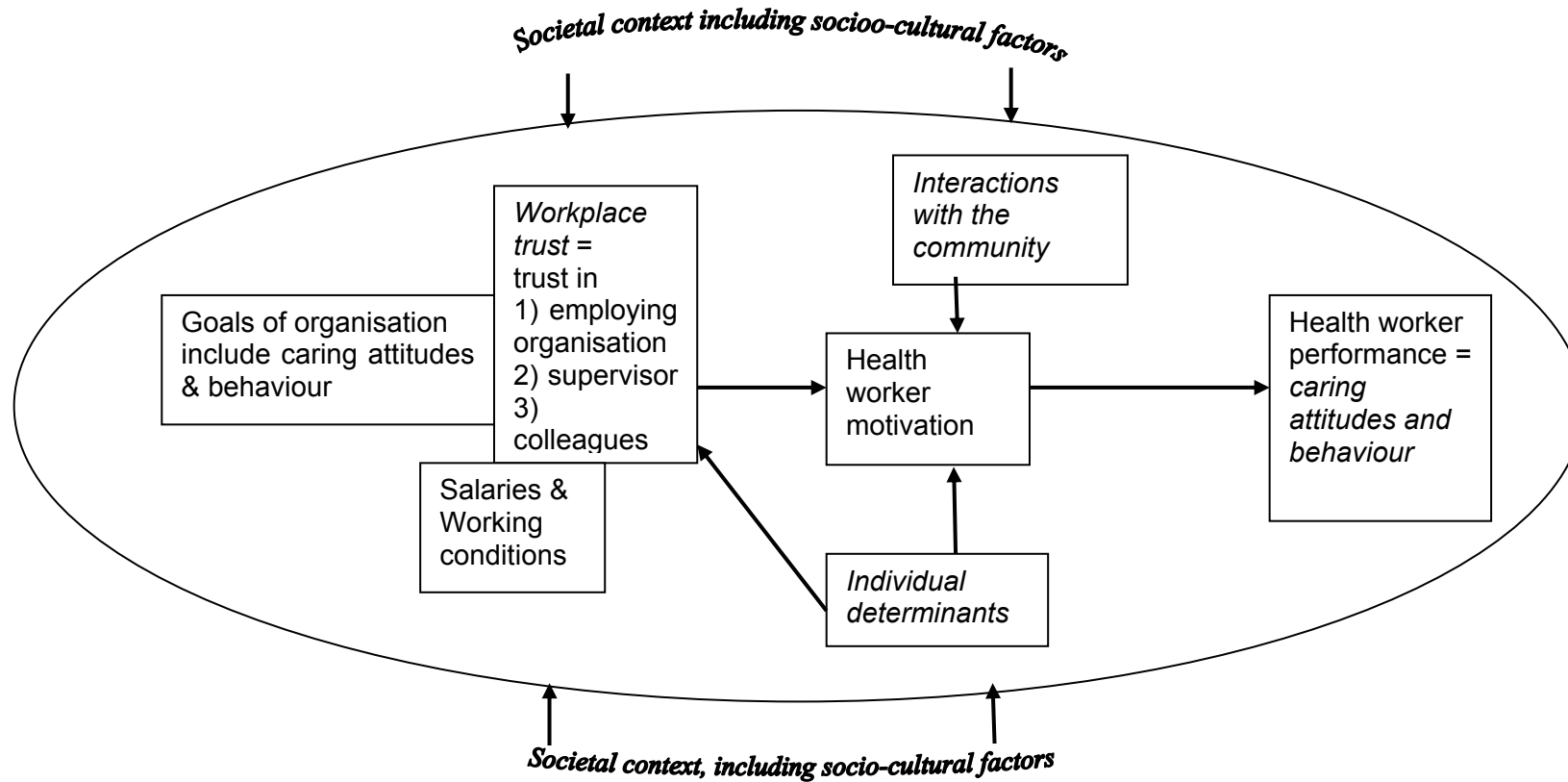
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Annex 1: Aspects of management that influence workplace trust

Aspect of management	Examples
1) Trust in employing organisation	
Leadership	➢ Ensure clear and wide communication of organisational goals and management procedures ➢ Inspire workers to share organisational goals and co-operate in achieving them ➢ Demonstrate personal values that reflect organisational goals
Recruitment	➢ Recruit people whose skills and values match organisational goals and tasks
In-service training	➢ Provide training that supports workers to implement tasks assigned to them in workplace, in manner required by organisation (ensure multi-skilling) ➢ Select people for training on basis of clear, appropriate and consistently-applied procedures, that reflect organisational goals
Staff appraisal & award system	➢ Ensure appraisal, reward and disciplinary criteria are linked to organisational goals, well communicated and applied fairly and consistently ➢ Reward people who share organisational values and goals (such as respectful behaviour to others, client orientation etc) ➢ Limit degree of resort to sanctions, as opposed to use of rewards
Defining jobs	➢ Allow multi-tasking, do not specify jobs too narrowly, or rigidly
Degree of worker autonomy allowed	➢ Allow workers to adapt and expand job definitions in response to their understanding of patient needs ➢ Encourage debate and discussion among workers about organisational goals and activities ➢ Limit extent of monitoring and measurement of worker performance
2) Trust in supervisor	
Supervision	Demonstrate personal values and behaviours that build inter-personal trust: ➢ Implement management procedures consistently and fairly ➢ Take action to tackle abuse or breakdown of trust within workplace ➢ Clearly explain reasons for decisions ➢ Treat those affected by decisions with dignity and respect
3) Trust in colleagues	
Promoting teamwork	➢ Establish and support self-managed worker teams ➢ Reward group performance not individual performance ➢ Reward adherence to norms of professional groups

Annex 3: Staff interview guidelines

FIRST STAFF INTERVIEW
(USING THE CRITICAL INCIDENT APPROACH)

Logistic issues:

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

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

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

Tape record the interview, if possible.

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

Key issues being sought through interview:

- The aim of the interview is to get the interviewee talking freely about the events/things that they feel have impacted on them and their work over the last years. Then the interview moves on to asking more detailed questions about some of these events/things.

- Clearly we are most interested in events/factors that have influenced their approach to work, and their behaviour and attitudes at work. These could be things in their personal life, but you will need to encourage them to tell you why and how personal issues affected work and workplace issues. They could also be things about how the facility functions, or how the community interacts with the facility, or factors/events outside the facility.

- In order to get the interviewee talking freely, you may need to try several approaches or ask several different questions to elicit a full response right at the start of the interview. Which question will work may depend on how long the interviewee has been working in the facility, or what captures their attention.

- You should not lead the interviewee to any of these issues nor select for the interview the issues discussed in most detail.

- To aid discussion, you could draw a line on a piece of paper with today's date on one end and the time at which the respondent joined the facility (/became the in-charge etc) at the other end. Then ask the respondent to work backwards from today's date to the earlier date, identifying major events or issues. Mark the events on the timeline as they are raised by the respondent. Allow the interviewee to identify events without prompting for specific issues.

Respondent characteristics

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

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

Introducing the interview

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

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

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

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

Beginning the interview

Question Set 1:
When did you first join the staff of this facility (or become the in-charge of this facility)?
Since that time, what have been the main events that have impacted on you and your work here in the facility? **OR** Since that time, what are the big issues you have had to deal with?

OR

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

OR (for in-charges)

When did you become in-charge here?
What are the big issues you have had to deal with since then?

Question Set 2:
Out of all these events, which three or four do you think were most important to you and your work?
For each event/issue, please explain why you have selected these events.

Investigating each key event/issue in more detail

Question Set 3:

Can I now ask you to go back to each of these events/factors, and to tell me more about them.

Taking the first event, please tell me what happened.

Question Set 4+:

What about the second event? [and so on]

Conclusion

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

Do you have any questions at this stage?

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

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

SECOND, DETAILED STAFF INTERVIEW

Logistics:

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

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

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

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

Key issues sought through interview:

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

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

Respondent characteristics:

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

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

PART 1. INTRODUCTION

Remember to adapt for those you have interviewed before

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

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

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

OR

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

AND FOR ALL

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

PART 2. INITIATING THE INTERVIEW

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

I understand that you have worked here for quite a while/only a short time?
Do you live locally (or where)? How do you like being here? Are you involved in any community activities in the surrounding community?

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

PART 3. FEELINGS ABOUT WORK

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

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

3.1 How do you like your work?

>>>Prompt for:

   a)   things most like; things least like – and specific examples of these things

   b)   why like or dis-like these things?

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

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

3.4 What are the key factors influencing your work?

>>>Prompt for:

   a)   How does each influence your work: can you give me examples?

   b)   How do you cope with each of these things?

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

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

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

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

4.1 Please tell me what you like most about your workplace and what do you like least?
>>>Prompt for: Examples? Why do you like/dis-like these things?

4.2 What are the key factors influencing your workplace?
>>>Prompt for resource related issues e.g. drugs, equipment availability, transport

4.3 Can you tell me how each of these factors influences your workplace?
>>>Prompt for: Examples?

4.4 How do you cope with each of these factors?
4.5 What other action would help you cope with the negative factors?

PART 5. INVESTIGATING FEELINGS AND BELIEFS ABOUT COLLEAGUES WITHIN FACILITY

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

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

In relation to factors influencing team work/reliance on colleagues, look out for/prompt for:
- bases of inter-personal trust: is it rooted in personal connections, friendships etc OR skills, competence of colleagues OR shared values

- reliance on each other not so much about trust, but more because have no choice but to depend on each other
- role of facility in-charge/external supervisor in building/undermining relationships with colleagues and trust

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

5.1 You've already indicated that your colleagues are an important influence over your work. Can we talk more about how you work together? OR Who do you work most closely with in this facility?

5.2 Do you feel there is a good team spirit among staff in this facility? (why/why not? examples?)
>>>Prompt specifically for:
  a) Would you say you rely on your colleagues in this facility in any way? In what way? (For professional/personal reasons? Which colleagues?)
  b) Does working with your colleagues in this way help you to achieve personal or work goals? (which goals; why/why not?)

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

5.4 Would you like to be able to rely on your colleagues more?
>>>Prompt for: Why/why not? What would encourage you to rely on them more?

5.5 Trust focus:
  - **Would you say you trust your colleagues?**
  >> Prompt for: In what way/in relation to what things? Work or personal matters?
  - **Would you say you didn't trust anyone for some reason?**
  >>>Prompt for: in relation to what things? Why?
  - **What influences your trust/dis-trust in your colleagues?**
  - **Does it matter to you that you trust/dis-trust your colleagues?** (Why/why not?)

PART 6. INVESTIGATING FEELINGS AND BELIEFS ABOUT SUPERVISOR

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

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

6.1 You've already mentioned that xxx influences your work: are they your main supervisor? OR Of the people you've already spoken about, is one the main supervisor of your work? Which one?

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

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

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

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

>>>Prompt for: Why/why not?

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

>>>Prompt for: Why/why not?

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

6.6. Trust focus:

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

- **Would you say there are some things you don't trust you supervisor about?** (what things? Why not?)

- **What influences your trust/dis-trust in him/her?**

- **Does it matter to you that you trust/dis-trust him/her?** (Why/why not?)

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

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

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

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

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

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

- Recruitment: Do you think the organization choose the right people for the job? *(In what way yes/no?)*
- Worker autonomy/job description: Are you allowed to make your own decisions about any aspects of your work? If yes or no: does your level of decision-making influence how you feel about your work/workplace?

- <u>In-service training</u>: Have you ever received in-service training? How were you chosen? How are people usually chosen? What do you feel about these procedures?

- <u>Appraisal</u>: Do you have a regular discussion with a supervisor about your work and work performance? *(With whom?)* What do you feel about these discussions /about not having such discussions?

- <u>Salary and salary increases:</u> Do you normally get your salary on time? How are salary increases normally awarded in this organisation? *(Have you ever had one? Who decides you should get one and on what basis*?) How do you feel about these experiences/procedures around salaries?

- <u>Discipline:</u> Who makes disciplinary decisions in the organization and on what basis? How do you feel about these procedures?

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

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

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

In these questions, prompt for:

- <u>Communication practices:</u> Do you think the communication practices within the organization are strong or weak? How do they affect how you feel about your work?

- <u>Fairness:</u> Do you think the way decisions are made about employees in this organization are generally fair or not? Explain/give examples

- <u>Organisational goals:</u> How would you describe the main goals of your employer? Do you value these goals? (Why/why not?) Do you think these goals are reflected in your experience of working for them? (Why/why not?)

- <u>Senior managers/leaders:</u> Do you know much about senior managers/leaders within the organization (at local, provincial/regional or national levels)? Do you think that they provide good guidance to the organization? (why/why not? Examples?) What sort of system/policy changes have influenced your work here recently? Do you think the senior managers/leaders have managed these changes well? (Why/why not?)

7.7 Trust focus:

- **Overall, would you say your trust your employer/employing organisation?** (In what sense do you trust and in what sense do you dis-trust?)

- **What influences your trust/dis-trust in your employer?**

- **Does it matter to you that you trust/dis-trust your employer/employing organisation?** (Why/why not?)

PART 8. INVESTIGATING CONTEXTUAL INFLUENCES

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

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

>>>Prompt for:

    a) How do they influence you and your work?

    b) How do they make you feel about your work?

    c) How do you manage them?

    d) Can anything be done to help you cope with them?

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

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

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

CONCLUSION

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

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

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

Annex 4: Patient and key informant interview guidelines

COMMUNITY KEY INFORMANT INTERVIEW

Note to interviewer on logistics

Interview in a private place

Select as interviewees 3-5 people from:

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

Respondent characteristics:

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

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Introducing the interview

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

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

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

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

Setting interviewee at ease

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

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

Comments on xxx facility

1. Have you ever visited xx facility *(how often? When last?)*

2. What services are available there?

3. Are some better than others? *(Which ?why?)*

4. Is the facility generally well used by the community or do people prefer to use other facilities? *(if they use other facilities which ones and why?)*

5. What do people like/dislike about the facility? *(how does it compare with other facilities/providers used by the community)*

6. *If* not already discussed please say something about :
*   The training and skills of the staff working there
*   The attitudes and behaviour of the staff towards patients and the community
*   Whether necessary supplies and equipment are available
*   How long people have to wait to be seen
*   How long people ever complain about the services there what about?
*   Can they influence how services are provided in any way? How? (probe for formal and informal mechanisms) Does it get results?
*   Whether the facility gets visitors and support from elsewhere?

7. What suggestions would you make to improve the facility?

8. What factors do you think have most influence over how the facility and its staff function?

Investigating community mechanisms that influence health worker performance

1. Has there ever been a situation whereby the community had an influence on the clinic? What/why/who/how brought about?

2. How does the clinic respond to community needs ? Can you give examples?

3. If you want to lay a complaint who do you go to ? how do you do it? do you get response ?

4. Are there different mechanisms for different types of complaints?

5. Does a clinic have a clinic committee? *(note : not to ask this question to a clinic member)*

6. If yes, how many members does it have?

7. It is composed of what sort of people?

8. How are these people chosen?

9. What are the roles of the committee?

10. Do you trust the clinic committee to address your needs and concerns? (note: not to ask this question to a clinic committee member)

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

12. IF NO to any of above:
    - Do you think that it would be a good thing if the community could influence the clinic? Why? Over what issues? what sort of a mechanism?
    - Would you like a structure where by the community in this village would be represented in terms of their needs?
    - How much influence would you like that structure to have?

Trust and xx facility

1. Would you say that people in this community trust the services provided by facility xx?

2. In what way do they trust it or dis-trust these services?

3. What leads them to trust or dis-trust?

4. If not already discussed , please comment whether these issues are important in relation to trust/dis-trust in the services :
    -   The range of services provide
    -   The training and skills of the staff working there
    -   The attitudes and behaviour of the staff towards patients and the community
    -   Whether necessary suppliers and equipment are available ?
    -   How long people have to wait to be seen
    -   Whether people can influence the services provided in any way
    -   Whether the facility gets visitors and support from elsewhere?

5.   Do you think people in this community think it is important to trust the facility ? *(why/why not ? examples?)*

CONCLUSION

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

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

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

Note to interviewer on logistics:
Interview away from the facility, and in a private place.

Selecting interviewees:
Choose a mix of those living nearby and those living further away.

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

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

Introducing the interview

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

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

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

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

Investigating knowledge and experience of xx facility

1. Can you tell me for how long you have lived in this area?
2. I understand that you have being using xx services at yy clinic. How long have you being using these services?
3. Do you regularly/frequently attend clinic yy for other services? *(Why/why not?)*
4. Have you used other health care providers for service xx or more generally? *(Why/why not?)*

5. Please tell me something about the xx services at yy clinic:

   ➤ What do you like about them?

   ➤ What do you dis-like about them?

   ➤ How do they compare to similar services at other clinics?

Investigating community mechanisms that influence health worker performance

1. Has there ever been a situation whereby the community had an influence on the clinic? What/why/who/how brought about?

2. How does the clinic respond to community needs ? Can you give examples?

3. If you want to lay a complaint who do you go to ? how do you do it? do you get response ?

4. Are there different mechanisms for different types of complaints?

5. Does a clinic have a clinic committee? *(note : not to ask this question to a clinic member)*

6. If yes, how many members does it have?

7. It is composed of what sort of people?

8. How are these people chosen?

9. What are the roles of the committee?

10. Do you trust the clinic committee to address your needs and concerns? *(note: not to ask this question to a clinic committee member)*

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

12. IF NO to any of above:

- Do you think that it would be a good thing if the community could influence the clinic? Why? Over what issues? what sort of a mechanism?

- Would you like a structure where by the community in this village would be represented in terms of their needs?

- How much influence would you like that structure to have?

Investigating trust in providers

1. Do you think that the clinic provides good [*type of service*] services? *(Can you give examples?)*

2. What aspects of how the staff behave and do their work are good and what bad? *(Can you give examples?)*

3. What other features of the xx service do you think are good and what bad? *(Can you give examples?)*

4. If use other services at this facility, How does this service compare with the other services at xx facility?

5. Given your experiences, When you're ill do you go there believing the staff are going to do the right thing for you? *(Why/why not? Examples?)*

6. Given your experiences:
   - ➤ Would you say that you trust the staff providing these services? *(Why/why not? What leads you to trust/not trust?)*
   - ➤ Do you trust other health care providers, perhaps working in other clinics, more? Why/why not?
   - ➤ Does it matter to you that you (dis)-trust the staff in this facility?
   - ➤ Does that (dis)-trust in staff influence when and if you use service xx/ the services more generally? Or your overall satisfaction with the services? *(Why/why not?)*

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

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

1. In general, would you say trust government [xx church] health facilities and how they are organized/managed as whole? *(Why/why not?)*

2. What influences your level of trust in these facilities and their general organisation?

Prompt for:
   - Role of health workers specifically
   - How health workers are managed (e.g. disciplinary/promotion systems; training and skills; level and form of provider payment etc)
   - General management systems in government [xx church]
   - Potential for community in general to influence government [xx church] health system
   - Links/Differences between what patients want from health system and what see as government [xx church] goals for health system
   - Leadership and vision within health system

3. Does it matter to you that you trust/don't trust government [xx church] facilities in general? *(How/Why/why not?)*

4. Does your (dis-)trust influence your use of its services or how you experience the care they provide or your overall satisfaction with services? *(How/Why/why not?)*

5. Does your (dis-)trust influence your trust in government [xx church] in general? *(How? Why?)*

Annex 5: National level interview guidelines

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

Annex 6: District level interview guidelines

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

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

Introducing the interview

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

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

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

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

Respondent characteristics

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

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

Organisational goals and health worker performance

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

>>>Prompt for:

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

What do you think of the performance of health workers?

>>> Prompt for:

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

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

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

- Community perceptions of facilities and health workers

- Attitudes and behaviour of health workers

- Motivation of health workers

- Things that have been done to try and tackle problems with health workers

- Do interviewees think health workers are an issue? In what way**?**

Human resource practices/processes

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

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

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

On what basis do you make your decisions?

>>>Prompt for:

> ➢ *What discretion do you have in making decisions?*

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

>> Prompt for:

➢ *Why/why not?*

➢ *Are some bigger problems than others?*

➢ *Generally implemented consistently and fairly? Why/why not?*

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

How do staff see these procedures?

>>Prompt for:

➢ *Do staff see some as bigger problems than others?*

➢ *What underlies their views?*

➢ *Do channels of communication with staff work well? Why/why not?*

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

Contextual influences

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

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

Conclusion

Thanks very much for your time.

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

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

Annex 7: Health worker experience of human resource management functions and their employer[1]

HR Function / Employer Issue	Site1 (n=13)	Site 2 (n=5)	Site 3 (n=7)	Site 4 (n=11)
Recruitment	11 respondents stated that their employer recruits right people in the clinics whilst 2 stated that they do not know.	4 respondents stated that their employer recruited right people in the clinics whilst 1 stated that the employer does not recruit right people for their jobs.	4 respondents stated that their employer recruited right people in their clinic whilst 3 had an opposite view.	3 respondents stated that their employer did not recruit right people for their jobs whilst 8 have an opposite view.
Training	All 5 senior health workers have attended various training activities whilst there are minimal training opportunities for all junior health workers.	2 senior health workers have attended various training whilst there are minimal training opportunities for all junior health workers	4 senior health workers have attended various training whilst there are minimal training opportunities for all junior health workers	All 6 senior health workers have attended various training whilst there are minimal training opportunities for all junior health workers
Appraisal	8 health workers stated that they are not appraised completely whilst 5 health workers viewed appraisal as irregular.	2 health workers viewed appraisal systems as weak whilst another 2 had an opposite view. The remaining 1 health worker was not asked the question.	Only 2 health workers were asked about appraisal systems. These 2 health workers stated that appraisals were irregular.	There were mixed views about appraisal. 3 health workers stated that there was regular appraisal especially within the clinic, whilst 8 complained that there was no appraisal system.
Disciplinary procedures	7 identified clinic manager as key person with action taken internally; 1 identified role for external supervisor; 6 didn't know or give response	Majority say, discipline person internally first then refer to supervisor; 1 not know.	Majority say discipline done internally; 1 identified role for external supervisor; 2 say don't know	All those answering identify clinic manager as main person responsible (only 2 not answered)
Decision-making autonomy in workplace	5 senior health workers interviewed stated that they could make decisions without consulting their supervisor; whilst 8 junior health workers stated that they could not	4 health workers stated that they could not make decisions without consulting their supervisor; whilst 1 had an opposite view.	4 senior health workers stated that they could make decisions without consulting their supervisor whilst 3 junior nurses said that they could not.	There were mixed views on decision making. 6 health workers stated that they cannot make decisions without consultation whilst 5 health workers said that they could.

HR Function / Employer Issue	Site1 (n=13)	Site 2 (n=5)	Site 3 (n=7)	Site 4 (n=11)
Communication with employer	10 health workers viewed communication as weak whilst 1 viewed it as strong. The remaining 2 health workers were not asked a question on communication processes.	4 health workers viewed communication as strong whilst 1 stated that she/he does not know whether it is strong or weak.	3 health workers viewed communication as weak whilst other 3 stated that it was strong. 1 health worker was not asked about communication.	10 health workers in this facility viewed communication as weak whilst 1 health worker had the opposite view.
Fairness of employer decision-making	All health workers in this facility view their employer's decision-making processes as unfair.	4 health workers in this facility viewed decision-making as unfair whilst 1 had an opposite view.	Only 2 health workers were asked about fairness. 1 responded by stating that their employer was not fair whilst another one did know whether they were fair or not.	There was a mixed viewed about employer fairness. 8 health workers viewed their employer as unfair whilst 3 had an opposite view.
Organizational goals	7 health workers were unfamiliar with their employers' organisational goals whilst 3 were familiar with them. The remaining 3 health workers were not asked any question on organisational goal.	All 3 junior health workers were not familiar with organisational goals whilst 2 senior health workers were familiar with them.	Only one health worker was asked about organisational goal and responded that s/he was familiar with the organisational goals.	6 health workers were unfamiliar with their employer's goals whilst 5 stated that they were familiar with them.

Notes: 1. Number of responses varies by question /site, due to differences in the total number of interviewees, the failure of some respondents to answer some questions and the failure to ask some questions of some respondents.

Annex 8: Health worker vignettes

1) <u>High motivation:</u>

Nurse Zethu, a professional nurse, is one of the most positive health workers interviewed. She enjoys her work despite the problems that affect patient care, and particularly enjoys working in the facility where she is based because she trusts her colleagues and her manager, and is learning a lot from them. But she does have concerns about her employer because it fails to provide the support nurses need to do their jobs well. She specifically highlights, first, its failure to provide working resources saying *'Since I like my work, these challenges do not de-motivate me. I do not feel like going away. But I think if the government can give us enough resources, then we would assist those patients holistically. The government talks about delivering quality of care and they often expect us to do that with limited resources, and then that is a big challenge we have at the moment'*. Second, she complains that the government promised rural nurses a pay increase, but this promise was never kept. *'Personally I feel upset, uncomfortable because the time they announce it the work is so difficult that you feel sometimes supported by them and the morale goes up. But when you found out that the date had come and then there is nothing that has happened, really it makes my morale go down. And I would say if I can apply and go. Because now we are working very hard now they promise things which are not happening.'*

2) <u>Mixed motivation:</u>

Nurse Buhle is a young auxiliary nurse who performs her duties with enthusiasm, is spoken of well by manager and says she likes her job. However, she also identifies a series of concerns about her working environment that undermine her motivation. Patients take advantage of her unfairly: *'Patients can take advantage any time and they are always right. If a patient provokes you, you don't have to say anything to them as a nurse. That is my fear'*. Although she speaks positively about her manager as a role model for her work and a fair person, she expresses concerns about relationships within the facility and, particularly, about being a junior nurse. *'You see that is the problem in the clinics. The seniors oppress the juniors because they have an upper hand in everything that is taking place at work'*. One colleague in particular, a professional nurse, treats junior nurses badly and tries to make them look foolish. *'It's like here in the department of nursing there's this report writing thing and if you don't like me nothing good will be written about me. Not because I'm not doing the job right. I'm doing my job right. I'm always on time. I'm doing everything correctly. But because you have personal issues with me. Then when you do a report about me you'll write all the negative things about me. There is also this evaluation thing that they do and if you*

don't like me you will give me less marks because you don't like them. So they have got powers to oppress you whilst you have done nothing wrong'. She also feels that that the employer does not make fair decisions, particularly blocking auxiliary nurses from training: *'They just don't care. It's not because they sent to me school and I failed. No. I know that I am capable, I can do it and I can make it, but I have no power you see'*. Demanding much of nurses the employer routinely fails to support them. For example, speaking about the promised pay increase for rural health workers she says, *'When we first heard about it, we were excited, because I thought that at least for the first time the government is thinking for us. It was like they were actually taking the load off our shoulders. It was going to motivate us to put more effort into our work. We felt we were going to deliver even more of our services to the patients'*. But the failure to keep this and other promises, together with arbitrary decision-making, leads her to say: *'I don't trust those people. They can do anything to us and they do not keep their promises. They expect us to deliver and yet they are not delivering. They do not treat us as human beings and yet expect a lot from us. They do not care about our working conditions. I do not trust them. They can move you anywhere you want without consulting you'*.

3) <u>Low motivation:</u>

Staff Nurse Mpho is a middle aged woman who has just completed her staff nurse training. Although she says she likes her job she also expresses clear dis-satisfaction with it: *'For example, with me I just wake up in the morning with no motivation what so ever because I know there is nothing that I will do in my work because we do not have medicine'*. Despite her recent training she feels poorly equipped to do her work and has a strong fear that staff shortages and patient demands will require her to work above her scope of practice, putting her at risk of disciplinary action: *'You see working under these conditions is very strenuous because it's above our scope. If a patient can die on me they would say I have ignored him and didn't look after him. I could even lose my job for that'*. Patient complaints about the care they receive are also hurtful: *'You would hear the community members saying that the nurses are not looking after them, that is, they are not getting any help from the clinic. That was very hurtful because they were not taking into consideration that we were under-staffed but were interpreting it as if we were lazy and we were not looking after them. This led to a mis-understanding between the community and the nurses'*. And in the face of these concerns she feels little support from colleagues, her manager or the employer. Her senior colleagues delegate tasks that require her to work above her scope of practice and do not listen to her concerns, *'..we as junior staff feel oppressed by senior staff'. They tell us what to do and do nothing themselves'*. Her manager gives little support, guidance or feedback: *'Her bad behaviour affects our work though, because we end up not relying on her'*. Her salary is

low and the employer let nurses down by not delivering on the promised pay increase. But more importantly, the employer is uncaring and more likely to discipline than reward nurses: *'If we as nurses have problems in our work they do not care to assist us. I think they want us to feel that wen made a mistake in choosing this profession. For example, if you make a mistake as a nurse they will discipline you in a very harsh manner. I feel that they have oppressed us'*.

Annex 9: Human resource management decision-making

Function	Decision-making
Recruitment	Largely district/provincial level process; supervisors mainly responsible for motivating need to fill vacant positions
In-service training	Supervisors do skills audit and prepare plan; seniority principle key to decision-making; possibly some role for facility managers in decisions on which nurses should receive training Delays in being granted study leave to limit impact of studying on workplaces; part-time study leave also possible to allow personally-funded private training Fewer problems with in-service than upgrading training
Allocation of staff relief duties	Joint decision-making by facility managers and supervisors
Staff transfers	External supervisor key decision-maker; only few requests commonly granted
Appraisal	New Performance Management System (PMS) introduced involving quarterly appraisal, in which supervisor and subordinate score subordinate's performance. External supervisors appraise facility managers; not fully clear who appraises facility staff
Salary increases	Linked to civil service procedures; under new PMS, annual notch increase based on performance decisions made through appraisal process
Promotion	Under new PMS, promotion only possible as new posts become vacant – so linked to recruitment process
Discipline	Minor cases handled by facility managers; supervisors involved in more serious cases

Annex 10: Facility experiences

Although patient judgements of performance were not clear-cut, <u>Facility 3</u> had recently received an award for good performance. One or two staff specifically identified this award, and the regular trail of visitors to the facility, as motivating. Across staff there were, in general, relatively high levels of motivation. It was clearly a well organised facility, with, for example, a functioning clinic committee and use of statistics to inform its activities. There were also a series of largely, if not uniformly, well-perceived collective processes supporting facility management, with generally high levels of consultation with, and good communication among, staff. Senior staff were regularly involved in facility administrative tasks and so gained exposure to management issues. A series of committees involving a range of staff addressed issues such as facility cleanliness, occupational health of staff, personal development and TB control, and the daily process of delegating duties was largely seen as providing support to junior staff, enabling work to be done efficiently and allowing senior staff to share experience with junior staff. Several staff members specifically described the facility as a learning environment. A key factor underpinning these positive experiences was clearly the facility manager, who was widely trusted in managerial and personal matters. There were also fewer concerns about the impact of working conditions on patient care and less staff dis-satisfaction with their posting than in other facilities, perhaps because it was better resourced and located in a peri-urban area. Nonetheless, concerns about the employer caused anxiety for all staff and for some, were sufficiently stressful to undermine their motivation.

<u>Facility 1</u> had some similar positive experiences, particularly with respect to managerial trust, better working conditions and peri-urban location. However, even in this clinic, as with the two others, motivation was threatened not only by lack of trust in the employer but also by fragile workplace relationships.

Indeed, conflicts and tensions among staff in <u>Facilities 1, 2 and 4</u> led to stress and anxiety when at work. There was a common fear that colleagues would gossip about personal matters and so few dared to trust colleagues on a personal level. Poor facility management included an inability to resolve staff conflicts or to initiate collective processes that would open spaces for dialogue, as well as a failure to control staff behaving badly. The lack of work guidance and constructive feedback from managers left staff feeling unappreciated and at risk. In some instances, the failure to offer support in times of personal crisis or success, such as after a mugging near the facility or return from training, was particularly hard to bear. Yet in some cases, it seemed that the authority of managers had itself been compromised by the actions of their superiors.

Many staff in these three facilities also spoke of problems experienced around human resource management. In one, the whole atmosphere was coloured by a nurse's treatment around a training issue, which left her feeling humiliated and angry and other nurses, concerned. In two facilities staff feel that they are routinely being denied training opportunities. A few staff across facilities complained that although they have completed relevant training they have not yet been promoted. In another facility, the way in which a senior staff member was promoted was seen by many as unfair, thus undermining her ability to play a leadership role within the facility. Several staff located in the more remote rural facilities have had transfer requests, and others, promotion requests, denied. External supervisors were quite often criticised, particularly in the smaller facilities, in relation to these experiences because they are seen either as the gate-keepers to higher levels of management, or the key decision-makers.

Although also a more general concern, staff in <u>Facility 4</u> specifically spoke of their fear of being disciplined and some staff members had been taken to disciplinary hearings around the way they had handled patient referrals. Given the numbers and training of staff working in this rural facility, it simply cannot care for all the patients that come to it and so does have to refer. But as it does not have an ambulance for patient transfers the process of transporting patients to the referral facility is often fraught with difficulties. This facility also suffers from high workloads and staff shortages, and many of the current staff would like to be transferred to other facilities to be closer to their homes or due to the working conditions. Problems of working conditions also badly affect <u>Facility 2</u>. Since a fire burnt down the clinic, staff have been providing services from temporary and inappropriate accommodation. There is not enough space to allow privacy in consultation nor an appropriate waiting area. Both of these rural facilities also experienced problems with drug and equipment availability. Not surprisingly several staff in them were worried because these conditions compromised patient care; and staff in both also identified the lack of patient respect for them as an aspect of their experience.

Across <u>Facilities 1, 2 and 4</u> staff (including managers) commonly experienced the employer as uncaring and unappreciative, and this only exacerbated the problems affecting their morale. For example, in <u>Facility 4</u>, the management response to a staff request to resolve its ambulance problem was experienced as negative and threatening. At the same time, management's failure to take seriously staff concerns about security was experienced as uncaring. Although also raised by staff in other facilities, staff in Facility 4 were also particularly anxious about the recently announced 'demotion' process. Although this was

essentially just a post re-grading exercises, with no impacts on salary levels, the staff felt that if they had not accepted the process they would have been made redundant. This experience then also led them to fear that their future salaries and job security were at risk. In this sort of environment those health workers who were able to sustain higher levels of motivation seemed to rely on their own inner motivation as well as some support from colleagues and/or managers.