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AN ASSESSMENT OF THE IMPLEMENTATION OF HUMAN RESOURCE PLANNING AND DEVELOPMENT AND ITS EFFECT ON SERVICE DELIVERY IN THE MINISTRY OF HEALTH AND SOCIAL WELFARE IN TANZANIA

BY

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A THESIS SUBMITTED TO THE FACULTY OF MANAGEMENT AND COMMERCE IN FULFILMENT OF THE REQUIREMENTS FOR THE DOCTOR OF PHILOSOPHY DEGREE IN PUBLIC ADMINISTRATION

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ABSTRACT

Public health is a major concern to a number of countries, due to its ripple impact in the economy. The aim of this study was to investigate the factors that contribute to the implementation of HRP and D in the Tanzanian health sector. To achieve this, 22 respondents from the Ministry Secretariat and Directors were interviewed, and 355 questionnaires were administered to beneficiaries of the HRP and D. A mixed method approach was utilised to analyse the data collected from the respondents. The findings of the study pointed that males dominated the sample, with the majority holding postgraduate qualification. In terms of the implementation of the HRP, 49 percent of the respondents stated that it was satisfactory. While, in terms of capacity, 67 percent were of the view that there is a shortage of skilled staff. The challenges identified include inequality in the allocation of staff, lack of skills, knowledge and experience, and oversupply of staff in certain regions. Strategies proposed for enhancing the application of HRP and D include an overhaul in the organisation structure, solving staff welfare issues, ethics and values improvement, and management of staff.

The study recommends that the government should allocate adequate budget to the Ministry of Health and Social Welfare to implement Human Resource Planning and Human Resource Development in all levels of the sector as directed by President's Office, and the Public Service Management (PO-PSM). The study also recommends on the improvement of the Human Capital Management Information System (HCMIS) to assess health workers movement. Lastly, the study recommends that there should be good coordination, cooperation, and clear lines of authority between stakeholders of health system in supervision and regulation in the implementation of HRP and HRD plans.

Keywords: Heath Sector, Private Hospitals, Public Services, Recruitment, Skills Development

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DEDICATION

This study is dedicated to my late dad Martin Rwiza. You inspire me, to aspire to the highest level of knowledge attainable.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS

AAS	Assistant Administrative Secretary
BRN	Big Results Now
CHMT	Council Health Management Team
DMO	District Medical Officer
DHS	District Health Secretary
EP	Educational Planning
ERP	Economic Recovery Programme
GDP	Gross Domestic Product
ITI	Indian Telephone Industries
RHMT	Regional Health Management Team
RRHMT	Regional Referral Hospital Team
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HR	Human Resource
HRH	Human Resources for Health
HRIS	Human Resource Information System
HRM	Human Resource Management
HRP	Human Resource Planning
HRD	Human Resource Development
LGAs	Local Government Authority
MDGs	Millennium Development Goals
MOF	Ministry of Finance
MoEVT	Ministry of Education and Vocation Training
MOHSW	Ministry of Health and Social Welfare
MKUKUTA	Mpango wa Kukuza na Kupunguza Umaskini Tanzania
MDAs	Ministries, Independent Departments, and Executive Agencies
MTEF	Medium Term Expenditure Framework
NVQ	National Vocational Qualification
NGOs	Non- Governmental Organisations
NSGRP	National Strategy for Growth and Reduction of Poverty
OECD	Organisation for Economic Co-operation and Development
OPRAS	Open Performance Appraisal System
PE	Personal Emoluments
PO-PSM	President's Office, Public Service Management
PMO-RALG	Prime Minister's Office Public Service Management
PO-PSRP	President's Office, Public Service Reform Programme

PSRS	Public Service Recruitment Secretariat
QSCs	Qualification, Skills and Competencies
RS	Regional Secretariat
RMO	Regional Medical Officer
TLTPP	Tanzania Long Term Perspective Plan
TNA	Training Needs Assessment
TCU	Tanzania Commission for Universities
UN	United Nations
VETA	Vocation Education Technical Award
WHO	World Health Organisation

CHAPTER ONE: BACKGROUND OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND OF THE STUDY

Human resource is an organization's most important asset, often differentiating highly successful organisation from those that are struggling. Countries globally have experienced shortage of this important resource due to lack of proper guidance on management of skilled health professionals (Kwesigabo et al., 2012:4). This has continued to be a challenge in most African countries (WHO, 2002:1). It is, therefore, important for the health sector to have effective and efficient Human Resource Planning and Development to ensure that they deliver quality services to the public.

Improving performance in the health sector in terms of service delivery still poses a challenge in the African continent, particularly in Sub-Saharan countries. Human resources for health sector are a vital resource to the health system (WHO, 2002:1). That means, for the health sector to be efficient and effective, it needs to have competent people and optimal number of staff to carry out required duties (Anyim, et al., 2012:68; Luzinga, 2012:1).

A country that is incapable of enhancing the capacity of its health workers and optimally utilize them will likely deliver an unsatisfactory service with the result that the national economy will be in jeopardy (Antwi and Analoui, 2007). That means HRP and HRD are the most critical ingredient of economic development. The process of economic development is nothing but the process of expanding the capabilities of people.

Health care in Africa faces challenges associated with obtaining, maintaining and managing health workers for effective and efficient functioning of the health system (Awases, et al., 2004). In addition, Martineau et al., (2002) contends that the global crisis in Human Resource for Health (HRH) has been among of factors hindering its efficiency and health promotion efforts while it is appraised that an efficacy health systems leads to more productive and functional health sectors human resource planning being a prime ingredient (Awases, et al., 2004; Martineau et al., 2002).

In view of this, the Tanzania Public Service sees Human Resource Planning and Development as a Government priority in its efforts to respond to the needs of the public in terms of service

delivery (TLTPP, 2013:1). Initiatives have been taken to develop skills, capacity-building and to make available appropriate Human Resource systems and tools that effectively enable Ministries, Independent Departments and Executive Agencies (MDAs) to have adequate number and competent staff all the time to provide service to the public. Moreover, the MDA's continue to experience inadequate number of staff.

In order to realize the Millennium Development Goals (MDGs), as advocated by the United Nations in 2000, the Tanzanian Development Vision 2025, as well as the Tanzanian National Strategy for Growth and Reduction of Poverty (NSGRP), and other sectorial strategy implementation of these programmes will depend on other factors, such as the availability of capable human capital (MOHSW, 2014:1).

Specifically, in the health sector, the government of the United Republic of Tanzania (URT) is devoted to addressing Human Resource issues by developing a number of policies and strategies (UN, 2000; MOHSW, 2014:1). Such policies and strategies call for optimizing human resources to achieve the country's vision, as well as the Millennium Development Goals (MDGs) objective number four, five and six. The aforementioned goals were aimed at reducing child mortality by two-thirds, maternal mortality rate by three-quarters, and combat Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), malaria and other diseases by controlling them (UN, 2000).

The government created the Human Resource planning section under the Ministry of Health and Social Welfare specifically to handle Human Resource Planning issues (Yambesi, 2009, Koo, 2008: vii). Reports by MOHSW (2014:4) and Answathappa (2014:100) show that the health sector still faces some challenges. They include workforce shortages, geographical imbalances in workforce availability and accessibility, understaffing of facilities, mal-distribution of skills, particularly in rural areas, concerning Human Resource Planning and Development.

Despite the government's efforts and interventions such as development of policies and strategies in the health sector, Tanzania still has a record of serious shortage of Human Resources for Health (HRH). The level of shortage varies according to particular reasons across regions and districts, such as, geographical allocation, social services, and health facilities (MOHSW, 2011:9).

In the Joint Annual Sector Review Meeting in 2005, MOHSW reported that the HRH crisis has reached emergency proportions. This is an indication that the shortage of HRH is still high due to higher demands on the health sector and higher attrition rates. To date, it is estimated that the shortage of Human Resources for Health is about 56 percent. This shortage varies across regions, districts, and facilities. According to the MOHSW data, shortage of HRH is more severe in rural areas (MOHSW, 2011:9; Kwesigabo et al., 2012:4; MOHSW, 2014:8).

Although Human Resource Planning and Development is a vital component in the management of human resources, it seems to be a difficult aspect concerning its implementation. This raised a thirst for the researcher to assess the impact of human resource planning and development with special emphasis on the MOHSW in Tanzania.

1.2 RATIONALE / MOTIVATION OF THE STUDY

Tanzania's health sector is subject to a long standing of problems. For instance, the government has been unable to ensure sufficient funding of the health care, supply of infrastructure with essential equipment (e.g state of art machines, e technology) and properly trained staff to meet the needs of the Tanzanians. Such shortcomings in the delivery of services is well documented in a number of government reports, and reflected by low absorption rates of graduate students into the health sector, persistent high rates of mortality and nationwide stock-outs of essential medicines.

While acknowledging the efforts that have been made this far in restructuring the Tanzanian health sector, we argue that a little has been done in improving the HRP and D in public sector. The study identified policy inconsistencies as a major cause of the functional fragmentation of the health sector, and unclear roles of authority, overlapping jurisdictions that are a prominent feature that characterise local governments. Furthermore, variations that exist national in terms of public health are some of the major issues that have contributed to the problems faced by HRP and D, leading to policy incoherence, which is reflected by failures in the central government to deal with a number of challenges. Policy incoherencies and inconsistencies undermine the functionality of the whole government system in its quest to deliver quality services and the ability of health care institutions to work together to improve services. The researcher found the stated problems a compelling reason to investigate the problem in detail and find lasting solutions that can help the Tanzanian government

1.3 STATEMENT OF THE PROBLEM

A report by Jannsen (2011:6) reveals that most of the African country's health sectors are in a crisis. The issue of poor service in the health sector is among the challenges facing many countries, and among others, these include poor recruitment, inadequate numbers of health workers and unequal distribution of health workers, which leads to unequal access to health services. This situation was noted in UN report (2000) that African health sectors face many challenges, which lead to poor public services while it is a legal obligation of every state to offer health services to the citizens. In addition, Dieleman and Harnmeijer (2006:1) state that lack of human Resources in poor nations is rampant, and rural areas are the most affected. This being the case, it is suggested that to rectify the situation is a priority in counterattacking such shortage.

Migration of health sector professionals is one of the problems facing management of health staff in Africa. Uneke, et al., (2007:2) claims that about twenty thousand African health professionals per year migrate to developed countries. Nigeria, being the leading country in this migration, statistics shows that about 432 nurses migrated in 2002 to work in Britain, while in 2000 about 347 migrated to other countries. lt is still an alarming indicator that Nigerian trained doctors continue to migrate in huge numbers annually (Uneke et al., 2007:1). Rakuom (2010), cited by Mugo et al., (2014:81), reports a similar situation in Kenya that health workers and facilities are normally understaffed, and dispensaries suffer shortage of nurses. For example, over 500 dispensaries suffer from a shortage of nurses. Rakuom (2010) adds that 62.8 percent of health workers are public health workers. However, the public sector is still understaffed. Statistically, Chankova, Kombe and Muchiri (2009:1) reveal that between 2004 and 2005, some provinces, districts, and health centres in Kenya reported loss of 3 percent of its workforce. According to Kilonzo (2014), cited by Mugo et al., (2014:81), the international requirements for a good health system is to have 235 nurses per every 100,000 people.

However, Tanzania is not an exceptional case because it experiencing the similar challenges of service delivery in the health sector, despite efforts made by the government to improve this sector throughout the country. It is perceived that the human capital shortage in the health sector of Tanzania is a contributing factor towards service delivery challenges, which the country is currently experiencing. Such paradoxes of challenges raised a thirst for researcher to assess the impact of Human resource planning and development in MOHSW in Tanzania.

1.4 SIGNIFICANCE OF THE STUDY

The Tanzanian health sector still needs competent, motivated, and qualified staff to carry out its mandates. This is because delivering quality health services to all citizens requires utilization of the human resource in an optimal way. Assessing the impact of Human Resource Planning and Development would help to reveal the situation and identify possible gaps that exist in service delivery of the health sector. In addition, knowing the existing infrastructure concerning Human Resource Planning and Development may open the ground for evaluating the magnitude and dimensions of Human Resource Planning and Development as per required standards in the health sector. Moreover, realising the importance and the available challenges of HRP and D will be helpful for the ministry to be more efficient and effective in service delivery in the country. Recommendations from this study targeted at the Ministry of Health and other stakeholders to improve the situation by developing and implementing useful strategies for improving the Human Resource Planning and Development in the health sector.

1.5 OBJECTIVES OF THE STUDY

The objective of this study was to the perceptions and beliefs about the effectiveness of Human Resource Planning and Development for achieving best practices in the health sector in Tanzania.

The specific objectives of the study are:

1) To assess the perceptions and beliefs of Ministry personnel about the importance of Human Resource Planning and Development in Tanzania;

2) To assess the capacity of the ministry in implementing Human Resource Planning and Development;

3) To assess the Human Resource Planning and Development infrastructure and its apparent delivery capacity at this time period;

4) To develop recommendations for improving the implementation of best practices to Human Resource Planning and Development in the ministry.

1.6 RESEARCH QUESTIONS

This study was guided by the following research questions:

1) How is Human Resource Planning and Development important in the ministry?
2) Does the Ministry of Health and Social Welfare have the capacity to implement its strategic plan for Human Resource Planning and Development?
3) How can human resource infrastructure assist to focus on Human Resource Planning and Development?
4) What should be done to improve the implementation of Human Resource Planning and Development in the ministry?

1.7 CLARIFICATION OF CONCEPTS AND TERMS

HUMAN RESOURCE PLANNING AND DEVELOPMENT

There is no universal acceptable concept on human resource planning (HRP) as far as human resource management is concerned due to the fact that there several existence of different models, outlooks, and views concerning human resource planning (Rothwell and Kazanas, 2013:2). Such confusion leads scholars to have a divergence of ideas concerning HRP. Some of them skewing their ideas on the technical side of human resource needs while others concentrate the idea on managerial wings (the way organisation handles issues concerning human resources in the respective entity. Ironically, it is more complex to make it clear (Rothwell and Kazanas, 2013:2) because some organisation focus HRP for the solely organisation while others view it from individual perspectives. However, in spite of such divergence of philosophical understanding of HRP still there are several commonalities as explained here below.

According to Armstrong (2012:210), the meaning of HRP is the process that covers a broader spectrum of activities and functions in the organisation. These include talent planning, succession planning, rewarding systems and attractive environment for working. Similarly, in the views of Andersson, Avasalu and Gabrielson (2002:11) HRP involve plans that are made across the entire workforces and their associated developmental functions and activities. Anderson et al., (2002:11) term these developmental activities as “soft issues” like organizational values, workers’ outlooks and other like incentives. In this study undertaken,

the concepts of HRP was streamlines with Taneja (2012:134-135) views on the same which involves a systematic process of revising the requirements for human resource in the organization to the extent that both quantity and quality workers are available when needed. Anyandike (2013:59) identifies four factors to be included in HRP. These are the number of employees needed, skills, knowledge, ability needed, the space where the employee is required to be placed, and timeframe required to adjust the deficit of workers. Therefore, this outlines a true picture of HRP being a systematic process of revising the requirement for HR in the organisation.

On his view, Tracey (2003) unfolds that human resource as the people who run an organisation. It is also known as workforce within the business sector economy, organisations and the likes. The same concept (Human Resource) is synonymously used interchangeably with the term "talent", "manpower", "employees" or in a narrow view, it is referred to as "Human Capital" (Aswathappa 2014:37; Tracey, 2003), to mean social being in a certain entity that make it to operate. Human resource can also be termed as an available supply that can be drawn on and be used to perform functions within the organisation. Human resource was regarded as capital assets during 1910's and 1920's and as multiplicities and complexities of functions within the organisation, misunderstandings between the employers and employees are inevitable (Bakke, 1958:1) hence human resource in modern way involve multiple functions such as human resource management.

In order for organisations to get things done, Armstrong (2012:34) points out that there must be people who provide advice and services to reach the targeted goals of the organisation. Human resource plays pivotal roles in the creation and enabling milieu that make people to utilize their capacities and capabilities in realization of their potential for the benefit of themselves and the respective organisation. The human resources function well in an integrated way from top to down as well as horizontally in the system of management involving two broad categories of activities; transactional and transformational (Armstrong, 2012:34).

Transnational activities involve human resource service delivery like recruitment or resourcing, maintaining employee relationships within the organisation, administering rewarding systems and other activities like learning and development (Rothewell and Kazanas, 2013:244). While transformational activities involve putting into practice business tactics and performing organisational activities in more strategic styles (Armstrong 2012:34). All these activities aim at preserving the interest of the organisation and its people (Pradeesh, 2011:3).

Such activities that are transactional and transformational require a well-equipped right number of people to perform such tasks in order to have conducive environment and opportunity for organisations to survive in any changing circumstances, particularly competitive environment, hence human resource planning must be on receiving hands (Taneja, 2012:134).

HUMAN RESOURCE DEVELOPMENT

The current global competitive landscape of service delivery requires organisations to adapt strategies that survive the competitive spirit in the global market. Organisations worldwide are constantly becoming aware on handling human resources in bringing meaningful outcomes. This is because no matter how the organisations have material resources like machines, equipment and other related technologies, without proper human resources in place the expected results may be in a fragile situation. This shows that the prosperity of any organisation depends on the proper utilisation of its people through the proper arrangement of human resources planning. In this respect, Human Resources Development (HRD) needs to be regarded as perceptual reposition within the organisation and not only as reactive provision of training perspective (Bernardin and Russell, 2013:275-276).

The discovery and landing process for the concept of human resource development in the organisation revealed broad meaning for improving organisational wellbeing. HRD has been posing confusion with organising training courses in the workplace, but HRD has gotten deeper and broader meaning (Gibb, 2006:1). During 1980's HRD aimed at achieving and excelling the organisation in its process and performance, this is because the on-going cut-throat struggling for better performance in the organisation call for HRD to be the focal point. Now, it is important to clarify the meaning of human resource development.

The process of modernising organisations workforces through upgrading their skills, knowledge, experience, perception and attitudes in tackling the globalisation challenges and its trends affecting the organisation performance and keeping organisation goals into competitive advantage is all what human resource development entails (Hope, 2001:124; Siudziniene, 2008:35).

The debate on internalising what HRD did not end after Sinha (2012:107) who paid tribute that it is a process of expanding and enhancing competence (Knowledge, skills, experience, talents, attitudes, abilities and creativity) of each individual in the organisation. This is done for serving

the needs of the people in a respective society in the economic, political, cultural, social, environmental, as well as technological contexts.

In view of (Meyer, 2002:2), HRD is the process of improving organisational effectiveness with training and development, organisational development and career development while improving the wellbeing of individuals in the respective organisation. The necessities for HRD comes with the fact that the current world faces several challenges on service delivery whereby employees are required to be equipped with the appropriate knowledge, skills, attitudes and experiences in order to suit the prevailing circumstances and be able to dance on the same tune of the respective challenges.

In this study, the researcher has framed her concept of HRD, along the South African Public Service Strategic Framework Vision (2015:10) that postulates that HRD are those processes and efforts undertaken by organisations in making sure that workforces are equipped to handle responsibilities and fit onto their careers, by increasing values to the outputs and outcomes as well as services of the particular organisations; increasing morale and performance of all workforces and attaining the vision of the state. In such endeavour, quality and quantity workforces can handle the responsibilities in optimal time and place. Hence, HRD is based on the idea of people as a catalyst of ensuring the organisation is performing well (Meyer, 2002:2). Therefore, HRD tends to put people on the credit side as one of the assets to be used in the organisation.

Review of the literature indicates that HRD work within the ambit of Human Resource Management (HRM) and its offspring of HRP, it differs with HRP by looking at five functions that HRP may rarely perform or not perform at all (Werner and DeSimone, 2012:9). These functions are training and development (T&D), organisation development and career development.

The research gap that this research attempt to fill is that there has been no research investigation of what relevant personnel belief and perceive as barriers to implementing best practices. It is crucial to learn this since they are charged with managing the Health Care System in Tanzania and daily face the difficulties and barriers in terms of implementation.

1.8 ETHICAL CONSIDERATION

Ethics is generally associated with morality and deals with issues of right and wrong among groups and societies (Creswell, 2014:93, 95; Brink et al., 2014:49). Ethics guide and bind

people on how to behave or conduct themselves in their everyday lives. Therefore, in this study's context, the researcher followed the ethical guidelines concerning professional research, including University of Fort Hare's standards that govern researchers based on the prescriptions in the ethical clearance certificate. Additionally, the researcher acknowledged any research resources used from different sources in order to avoid plagiarism. In line with Brink (2014:49), the researcher was sensitive to all kinds of dishonesty such as fabrications, falsification, or forging information/data/events, manipulation of design and methods and selective retaining or manipulation of data.

1.9 ORGANIZATION OF THE STUDY

The study is structured into five chapters. Chapter One provides the introduction and background of the study, and why it is necessary to have a study of this nature. Chapter Two provides the literature review pertaining the topic under study and in the process highlighting the research gap. Chapter three provides the research methodology and methods, which were used to collect data from the respondents, and how it was analysed. Chapter Four provides the results and discussions. Lastly, Chapter five concludes the study and provides recommendations, as well as, future suggestions on research.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter assess the importance of human resource planning and human resource development. Additionally, the chapter explores workability of Human Resource Planning and Development, challenges and success factors that affect its implementation in the health sector. Likewise, the chapter explores the quality of health services, performance management, professionalism, and infrastructures in Human Resource Planning and Development in the health sector.

2.2 THE IMPORTANCE OF HUMAN RESOURCE PLANNING AND DEVELOPMENT IN THE PUBLIC SECTOR

Human Resource Planning and Development is an important factor for the public sector to be more efficient and effective in the provision of services to the public. The management of human resources in the Public Sector cannot ignore HRP and D systems plans to ensure the optimal number of workforces; competences are available to provide required quality services in a dynamic environment while customer different preferences are apprehended. Failure to implement these plans, makes public sector experience over or under supply, shortage of skilled and high turnover rate of workers (Aswathappa, 2013:101). Therefore, Prasad (2015:139) illustrates the importance of putting HRP and D into action and reality in the public sector plans by identifying the total number and skills needed to implement those plans.

2.2.1 Act as an important part of Strategic Planning

HRP and D are important factors and elements in the development and implementation of strategic planning in the public sector. In fact, all activities in the work place are executed through human resource. In this view, (Aswathappa, 2013:101) argues that the strategic planning process obtains inputs on the number, skills and quality of human resources available and needed to procure for the implementation of the strategic plan. Similarly, HRP and D plans develop an integrated HR action and implementation Plan aligned with organisations' strategic objectives and goals (Horwitz, 1991:113).

2.2.2 Forecast the workforce requirement

Public Service needs to undertake Human Resource Planning and Development in order to ensure that best possible use of available human resources is made. HR Planning and Development helps to obtain information on the utilisation of existing staff, skills requirements for different occupational groups as well as forecast of human resource availability over a period of time (Prasad, 2015:139). Therefore, a well prepared HRP and D informs decision makers on the current supply and demand for human resources, as well as prioritised HR actions to be taken for the purposes of development, utilisation and retention of staff (Dessler and Varkkey, 2013:169).

2.2.3 International Strategies

HRP and HRD plans take into consideration expansion and operation of public institution across country borders. As the organisation tries to expand in an international environment, management of human resources becomes more complex and the requirement of HRP and D increase. In that manner, HRP and HRD systems tend to harmonise the situation by conducting an effective process of procurement, placement, utilisation and skills development of staff that can fit with international requirement and standards (Aswathappa, 2013:101).

2.2.4. Environmental changes

In order to delivering quality services to the public, the public sector implements different reforms and changes depending on changes in the external environment. However, people tend to resist changes introduced into an organisation (Verma, 2012:20). In this difficult situation of dynamic environment, HRP and D assist the public sector to give a clear picture and information on deficit and surplus of skills in occupations. These plans, tends to balance the situation of these disparities (Prasad, 2015:139).

2.2.5 Staff and Line Managers

Human Resource Planning and Development plans are developed from the collection, aggregation and analysing of HR information from within and outside the organisation (Armstrong, 2012:82-83). The information from within the organisation is generated from low level to upper level or from individual level to management level. In other words,

information is collected from line manager and staff manager at the department/section/unit level (Aswathappa, 2013:104). These heads of units, sections and departments have the information on HR need to facilitate the activities of their departments. Hence, HRP and D give chance for organisations to use the expertise of its leaders (Armstrong, 2012:83).

Besides, (Reilly, 1999) in Armstrong, (2012:211) further adds that the roles of HRP and D can be grouped in three scenarios:

a) Planning for proper acquisition, utilisation of workforces, impact them with required competences as well as forecasting problems associated with workforces to minimize the cost of a bad decision.
b) The plans assist to identify the present and the future of workforces, and embedded challenges for developing interconnected plans (short and long term).
c) Coordinating organisation plans (HRP and D with Strategic plan) to gain smooth control of individual and management.

Hence, the role played by these plans (HRP and HRD) in the public institutions cannot be ignored. Cherrington (1995:13) and Prasad (2015:138) state that no organisation in today's business world can afford to neglect or overlook the aspect of Human Resource Planning and Development if it tends to compete for survival in the global arena. The importance of these plans emanates from the fact that, in every corporate vision, mission and objectives of expansion of the organisation, new product development, searching for new markets, and introduction of new technology as well as improving quality of services there is a human resources component. So, planning for this component is vital for the public sector to achieve vision, mission as well as the goals of the state (Prasad, 2015:138-139).

2.3 THE IMPORTANCE OF HUMAN RESOURCE PLANNING AND DEVELOPMENT IN THE HEALTH SECTOR

In a more effective way, practitioners of Human Resource Planning and Development in the health sector are expected to exercise professionalism through performing their duties to serve health services to the public (MOHSW 2014:17). As the World Health Organisation, (2000) emphasises countries need to provide health services in time, produce results and be accountable for their actions.

In that manner, Harnmeijer and Dieleman (2006:1) insist that HRP and D enhance the health sector to fulfil those roles, functions and activities; ensures that dequate and capable health workers allocated equally, planned and maintained. Hence, through plans and development the health sector becomes more results oriented; get assurance of high performance as well as achievement of overall strategic objectives of the health sector (Verma, 2012:17).

Besides that, it is obvious that the role of HRP and D in health sector cannot be neglected. In the opinion of Dunn and Stephen, (1972:2) HRP and D act as a scanner to identify the workforce needed to perform certain activities to achieve the planned socioeconomic plan in the society. Koontz and Weihrich (1981) state that HRP and D in the health sector is a road map to provide future direction on the number and type of human resources required, to reduce unnecessary costs and risks (Meyer, 2002:219). According to Koontz and Weihrich (1981), no organisation can provide efficient and quality services without having these plans (Armstrong, 2012:211).

On the other side, proper HRP and D lead the health sector to acquire, develop, and retain health workers in the health sector (Chhabra, 2016:133). That means, motivated, well skilled, experienced, competent and knowledgeable health workers are important ingredients for health sector to perform well and deliver quality services (Dieleman and Harnmeijer, 2006:7). Kayani (2008:28), further pinpoints that succession and HRD planning ensures retention, increased efficiency, and effectiveness of health workers who are well equipped in knowledge, skills, attitudes, and performance.

In other words, whenever HRP and D are effective and linked with the strategic planning of the health sector, it ensures that the sector has the optimum number of resources as well as utilisation of workforces in terms of skills, competencies, experiences and knowledge (Ubeku, 1983:63). Similarly, Ubeku continue to illustrate that effective HRP and D provide assurance to the health sector to have right workforces throughout. Thus, from the argument above, we realise that HRP and D is an important element in ensuring accessible health sector services are accessible.

2.4 OVERVIEW OF TANZANIAN HEALTH SECTOR

This section provides an overview of the Tanzanian Health Sector and how HRP and D can facilitate to good service delivery. Furthermore, an overview of the health sector is provided

to help in the contextualisation of the problem currently under study. While efforts have been made by the Tanzanian government to improve the health sector, still there are a number of obstacles mainly emanating from the HRP and D, which affect service delivery in the system.

2.4.1 EVOLUTION OF HUMAN RESOURCE PLANNING AND DEVELOPMENT IN THE PUBLIC-SECTOR IN TANZANIAN CONTEXT

The evolution of Human Resource Planning and Development in the Tanzanian public sector has a long and distinguished history. At the time of independence, the emerging nation of Tanganyika inherited a public service designed to serve its colonial roots (TLTPP, 2013:7). Non-Africans dominated the upper end of the public service; there were few African doctors, managers and professionals. Reforms in the public service have been important for building of institutional HR systems and human resource capacity to respond to the needs of the new nation.

During this epoch (1960s-1980s) the government experienced (Yambesi, 2009) HR gaps in different areas of management mostly with shortage of skilled and competent staff in a number of public servants, Tanzanians were not occupying the middle and senior Management and Administrative level (The ratio was European (51.5%), Africans (29.5%) and Asians (19%). The government deliberately decided to pursue a policy of Africanisation to localise staff in the public sector realigning the administrative system to make it development-oriented, as opposed to the maintenance of law and order orientation of the system inherited at independence. Likewise, the government Instituted Manpower Planning and accommodated it as part of the Economic Development plan, development and implementation of HRD as well as considering equity (quantity and quality) in the allocation of workforces to overcome the shortage of workforces (Yambesi emphasis added). Moreover, in this period, the private health facilities were nationalised, the health service was government responsibility, and discharged free of charge and health workers were controlled centrally (Wangwe and Rweyemamu, 2001:4)

The period between 1980-1990s, which is viewed by (Yambesi, 2009) as “Unkind Period”. Tanzania experienced difficulties and challenging economic situation. The economy began to backslide, paving the way for hardships, and dismal performance in the public sector. The country’s economy stagnated hence could not sustain the capacity development gains of the

1970s. As a result, Tanzania shifted towards a free-market economy (where a private sector was to serve as an engine of growth) needed to be better reflected in the structure and size of the nation's public service (Faisal, 2010:4, PO-PSM, 2008:15). Hence, HRP and D was focusing on reducing and adjusting the number of workforces since the government was responsible for public services like education and health service, which resulted, to the increase number of staff. As a result, HRP and D function was regarded as a catalyst and system by increasing the size of the public service instead of controlling the number and quality of public servants (Yambesi, 2009).

In 1990s to date, the government focus on evolving the economy by attracting and improving investment environments, privatisation and liberalisation investments. During this time, the government continued to experience a critical shortage of staff in higher level, middle level as well as professional cadres but a high surplus of staff in lower level (Yambesi, 2009). Such situations made the government stop allocating graduates instead were required to compete for employment.

This shift was expressed through the Civil Service Reform Programme, which was launched in July 1991 with the major focus on cost containment and restructuring of government (PO-PSM, 2008:1, Faisal, 2010:5). It became apparent that the Civil Service Reform Programme had limitations in terms of scope and design and the impact it would have on improving the public service as well as health services. Because of this, in early 2000 the Government introduced the Public Service Programme (PSRP), which focused more intensively on service delivery improvements than cutting cost. During this programme, a number of key performance management systems and process that effectively enable the health sector to have adequate number and competent health workers all the times to provide health services were developed (P0-PSM, 2013:26-27).

Similarly, the government decentralised the management of HR, HRP and HRD, by the establishment of an HRP section within PO-PSM and MOHSW to deal with planning, development as well as conducting studies on HR needs in the health sector.

2.4.2 INSTITUTION ARRANGEMENT OF HUMAN RESOURCE PLANNING AND DEVELOPMENT IN TANZANIAN PUBLIC SERVICE

An integrated approach to Human Resource planning requires a good linkage and coordination of different stakeholders. The roles and responsibilities of key stakeholders are defined in the table 2.1.

Table 2.1: The role of key stakeholders in public service in Tanzania

Responsible	HRP and HRD
The Chief Secretary and Head of the Public Service	Provides leadership and direction in the development and implementation of matters regarding HR Planning and Development in the public service.
President's Office, Public service Management	• Provides Policy guidance on all HRM matters, including HRP and HRD • Provides support through research and consultancy services. • Sensitization and awareness creation. • Deals with the overall public service quantitative data, qualitative data and information compilation, distribution and dissemination. • Periodically monitors, evaluates and reviews the effectiveness of HRP reports. • Oversees the preparation of PE and Prioritised HR development activities in annual budgets.
Permanent Secretaries and Chief Executive Officer of MDAs	• Overall responsible for successful development and Implementation of HR plans in Ministries and other Public Service Institutions. • Ensure that Human Resource Planning and Development activities are incorporated by Heads of Departments/Sections in annual plans and budgets. • Monitors progress on HR Planning at Ministry/organisational level. • Submit a copy of approved HT Plan Report to PO-PSM.
Ministry of Labour and Youth Development	• Keeps useful information on labour movements and supply and demand issues. • Controls the flow of labour from the country and into the country • Keeps information on the kind of labour that is on demand externally and how it is spread nationally.
Other Ministries, Departments and Agencies (MDAs)	• Conduct research, collect and analyse all primary data on human resource trends and statistics with respect to resourcing, demographics, workforce profile, employment, skills and competencies, internal staff mobility, demand and supply data. • Reconcile demand gaps and come up with actual human resource and supply data; and identify requirements or projections for their organisational sectors. • Prioritise future human resource management or projection in terms of importance and MDAs strategic objectives. • Supply general HR Information and statistics to enable the PO-PSM gauge the level of Human Resource practices in the MDAs.
HR Planning Committee (in MDAs)	There shall be a HRP and HRD committee whose members shall be appointed by Permanent Secretary/Chief Executive Officer. The committee will be an adhoc one- owned to the HRP and HRD process-Its role will be to manage the overall process of developing and reviewing the HRP and HRD Report. **HRP Committee:** The Chairperson of the committee shall be the Director of Administration and Human Resource Management. The Secretary of the committee shall be a Principal/Senior Officer from the Administration and Human Resource Department. He/she shall also be the head the HR Management Section in

Responsible	HRP and HRD
	MDAs. Other members to this committee include Directors of Policy and Planning, Heads of Finance and Accounts, Information, education and Communication Units, Representative from Trade Union Office and any other 3 heads of technical departments. The committee shall have the following function: • Regularly monitor and evaluate the HR Planning activities; • Provide guidance and direction to the Ministry's HRM Section as well as to Heads of Departments, Units or Sections; • Provide a strategy to address HRP issues such as shortage or surpluses and provide directives to the HRM Section; • Discuss challenges arising from HRP activities that may impact on the successful implementation of the HR Action Plan; • Analyse and review research reports and agree on the next possible course of action; • Review and submit HR Action Plan to Management Meeting for Approval; • Ensures that each action is aligned to and integrated with the strategic plan and department's MTEF Budget cycle. **HRD Committee:** There shall be a HRD committee whose members shall be appointed by Permanent Secretary/Chief Executive Officer. The committee will own to the HRD process-Its role will be to manage the overall process of developing and reviewing the HRD Report. The Chairperson of the committee shall be the Director of Administration and Human Resource Management. The Secretary of the committee shall be a Principal/Senior Officer from the Administration and Human Resource Department. He/she shall also be the head of HR Management Section in MDAs. Other members to this committee shall be from each Department, Sections or Units. The committee shall have the following function: • Regularly monitor and evaluate the HRD Plan activities; • Provide guidance and direction to the Ministry's HRM Section as well as to Heads of Departments, Units or Sections; • Agreed on staff to be in development plans; • Discuss challenges arising from HRD activities that may impact on the successful implementation of the HRD Plan; • Review and submit HRD plan to Management Meeting for Approval;
Division/Department/Unit Heads	• Ensure that the vision, mission, strategic objectives and operational plans are communicated to all staff so that they understand their content. • Determine the quality and optimum staffing structure and establishment. • Provide necessary information for budget negotiations and support their MDAs in negotiations. • Collect data and information on Sectional/ Directorate's human resources. • Work with the HRM Section to prepare an annual HR Actions Plan covering priority issues. • Ensure compliance with relevant regulations and procedures. • Take interest in the well-being and satisfaction of staff.
Section Heads/Managers	• Assigning/scheduling staff to individual job description based on those of the department/Directorate. • Provide staff with on-going supervision including regular performance feed-back. • Conduct performance appraisal for their subordinates. • Identify training and Development needs. • Take interest in the well-being and satisfaction of staff. • Immediately report resignations, deaths, retirements etc as well as staff deficiency and/or surplus to update their systems.

Responsible	HRP and HRD
HRP or HRD Team	• Consists of different interdisciplinary experts, which are demanded by the HRM Section and shall be nominated by the relevant Departments/section heads. • Gives support and input to the HRM Section and work closely with them to collect and analyse HR data and prepare the HRP or HRD Report. • Acts as a multiplicator on HRP or HRD in the MDA and facilitates Departments/ Sections.
Individual Staff	Individual public servants have a duty to perform to the level of expectation and prepare for their own career development path and identify training needs
The Academia	• To promote HRP andHRD in academic institutions. • Research and disseminate findings about HRP and HRD in Public Service. • Organise forums which will offer further insights on current human resources trends and challenges. • Provide an opportunity to strengthen the network of HR practitioners and professionals within the public service and other players.

Source: (President's Office, Public Service Management, Human Resource Planning Manual, 2010:10)

Though there are many stakeholders involved in the process of HRP the primary responsibility rest with each Public Service Institution, according to the Public Service management Employment Policy paragraph 4:13 (i) and (ii). The figure below shows the interaction of the main institutions and stakeholders involved.

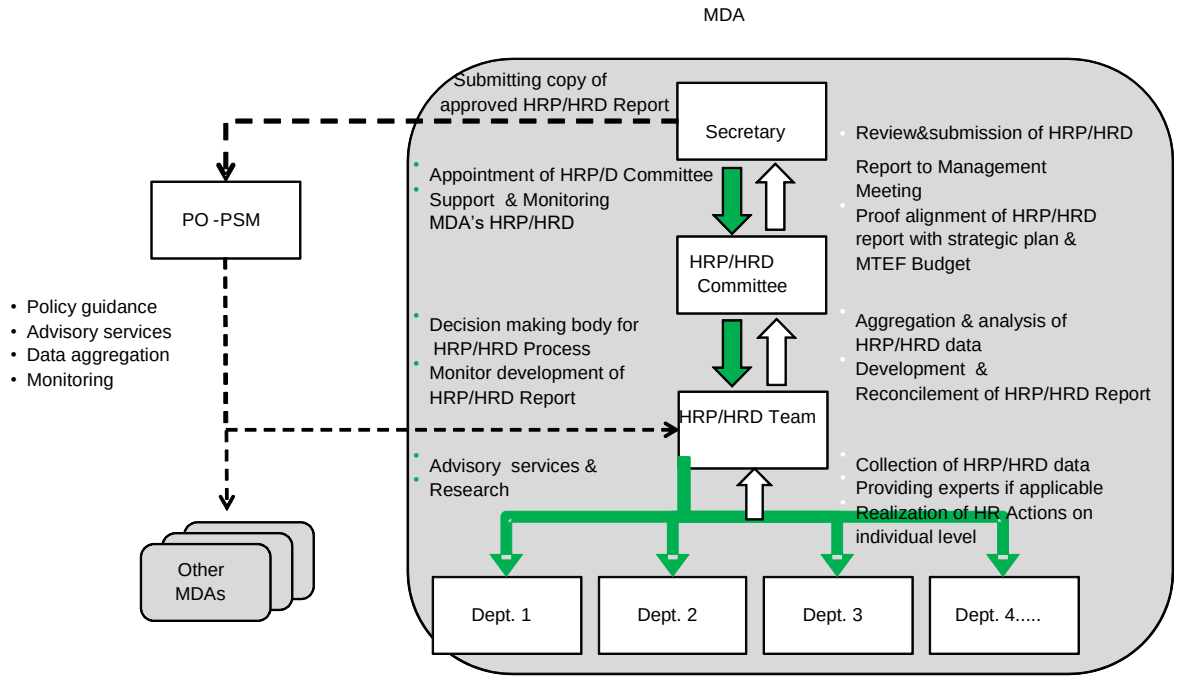


Figure 2.1: Tasks and responsibilities with the Institutional Framework
Source: President's Office, Public Service Management, Human Resource Planning Manual, 2010:10)

2.4.3 INSTITUTIONAL ARRANGEMENT OF THE TANZANIAN NATIONAL HEALTH SYSTEMS

The Tanzanian health system operates in a bottom up approach. It is arranged in pyramid ways and decentralizes its system of operation to make health services available and efficiently to the public (MOHSW, 2014:8). It operates on three levels as stipulate table 2.2:

Table 2.2: National Health Systems

National level	• The MOHSW is overseer and in charge of quality health services in the country. • MOHSW mandated the overall management of the health system and health workers in collaboration with PO-PSM,PMO-RALG, MoFE and MoEVT
Regional Level	• The Regional secretariat is the overseer of health services delivery in the region. • Regional Medical Officer (RMO) is the Assistant Administrative Secretary (AAS) of health and therefore reports directly to the Regional Secretariat (RS) • The HR issues such as acquisition and management addressed through Regional Hospital Plan. The plan developed by Regional Referral Hospital Team (RRHMT) and submitted to the regional secretariat of which RHTMT is apart, for scrutiny before it is forwarded to the relevant ministries. • Regional Health Management Team (RHMT) responsible for; (i) Management of HR issues, (ii) Scrutinising the health plans in the region to ensure that they correspond to the national priorities and provide oversight to local government, (iii) Provide technical support and oversight to the respective Regional Hospitals
District Level	• The Local government Authority have mandate for planning, implementation, monitoring and evaluation of health workers at this level. • Council Health Management Team (CHMT) responsible for health service delivery. • CHMT follows guideline for planning and management of district health issued jointly by MOHSW,PMORALG and MoFE • District Medical Officer (DMO) in charge of all District Health Services and head of CHMT. While is accountable to the Council Director on Administrative and managerial matters, and responsible to RMO on technical matters. • HR needs established in support of the CHMT by the management of the health facilities i.e.dispensaries, health centre and district hospital forwarded to the council to be incorporated into the *Comprehensive Council Health Plan*. Once plan is approved, it is the responsibility of CHMT to execute. • District Health Secretary (DHS) assist the DMO.

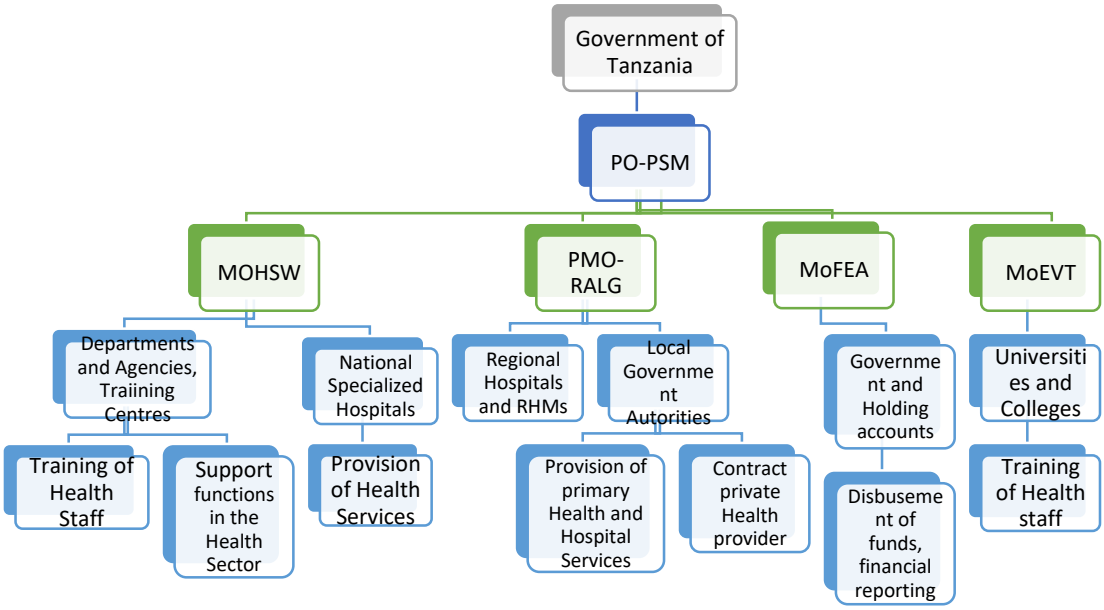


Figure 2.2: Government organogram Source: MOHSW Strategic Plan (2014-2019:8)

Currently, the Ministry of Health and Social Welfare is an overseer of the health system including Human Resource Planning and Development functions to ensure provision, accessible and require standards of health services to the public. The ministry manages the Human Resource Information System including analysing and generating the health workers needs to forecasting the future needs in all level of the health system. Similarly, it grants technical support and assistance to the local authorities and regions on Human Resource Planning and Development. The ministry also supervise independent departments, agencies and training centres to ensure the health system function well.

2.4.4 LEVELS OF HUMAN RESOURCE PLANNING AND DEVELOPMENT

Adequate, competent, and well-motivated workforce is a prerequisite requirement for the efficient delivery of public services. Without effective Human Resource Planning and Development at each level, the public will face a danger of being unable to meet its national objectives and goals because the required employees with relevant competences will not be available. For this reason,Agwu and Ogiriki (2014:137), Chhabra(2016: 134),and Prasad(2015:138) identify levels of HRP and D as follows:

2.4.4.1 Macro Level

Human Resource Planning and Development at Macro level refer to making the evaluation of skilled workforce available and required in specific time for the country to be more

developed and efficient in economic level. While Aimiuwu (2004:18); Allameh, Naftchali, Pool and Davood (2012:2) presents that economic development process is nothing but the process of expanding the competencies of people. The ultimate focus of economic development is human resource development. Thus, it is a three way process for the national economy to grow. Such process is expected to start by identifying the skills required, develop the required skills and the growth of the productive sector. In other words, having HRP, makes sure that supply of required skills is equally distributed to the identified needs (demand) and act as a framework for human resource development (education planning) and employment planning (Cherrington, 1995:136).

Horwitz (1991:113), support the idea and adds that for the country to be developed it needs workforces with specific skills, knowledge and training. This process of development needs to be a long-term plan. Hence, HRP is iintergrated in human resource development planning or educational planning which has to lead the economy of the country. Therefore, (Agwu and Ogiriki, 2014:134) posed the argument that training and development of people has to be planned in advance to ensure availability of skilled labour of the right types, in the right numbers and to use the scarce resources in educating more people to prevent shortage of manpower in the national development.

Hence, the challenge of shortage of workforces in a country can be avoided if HRP and Development are part of the economic planning (Aimiuwu, 2004:18). This need arises from the fact that changes in economic structure also necessitate changes in the structure of the workforce as well. In addition, it is known that the success of developmental planning depends on whether planning for human resource and educational development is consistent with workforce needs to achieve the national plans. In other words, these plans (HRP, HRD, and educational planning) should be harmonized with national economic plans (Kayani, 2000:3-4). The consistence between the above three plans depends on planning approach, procedures and strategies used for forecasting future human resource needs in specific time.

2.4.4.2 Micro Level

Human Resource Planning and Development at this level is confined to itself in organisation boundaries. Therefore, it is the systematic process of identifying the workforce needs in terms of skills, qualification, numbers, place, kind and time for doing the right kinds of jobs,

which results in long run maximum individual and organisational benefits (Swanson and Holton, 2009:3; Sheikh, 1999:17). Ibojo (2012:118) went further by not only acknowledging the availability of the workforce, but the focus to achieve the organisational goals and cope with the external challenges to make full utilisation of the available workforces. At this micro level, HRP involves forecasting present personnel functions into the future, which would be affected by the plans and organisation environment, both internal and external (Stredwick, 2006:46). In the views of (Aswathappa, 2013:269) development of capabilities focus on raising profit in business, especially in developing countries, with the aim of achieving personal and societal advancement.

Accordingly, HRD acts as a framework for developing and improving workforces in the organisation through learning, training and development. This is done for the purpose of the workforce and the organisation in totality so as be more efficient in service delivery as well as performance in general (Werner and DeSimone, 2012:11). Human resource development activities (Stone, 2008:365-66) lead to employee career development, coaching, succession planning, mentoring, employee training, performance development and management as well as organisational development.

The HRP and HRD plan carried out by regions and districts within the context of the Tanzanian health sector is expected to guide the health facilities under the micro level. Regions and districts management are expected to identify the required number of health workers required, and develop competencies that facilitate individuals in health facilities to execute current and future activities through designed and developed HRD framework. The intention is to ensure that, at micro level there is a match between the individual and health facilities requirements. In this way, health facilities performance is maximised. That a regional and district health facilities as sizeable number and competent health workers to deliver quality services. It is expected that, the created demands, acquisition and management on health workers in micro level are addressed and be a crucial part of macro level plan (MOHSW, 2014:7-8).

However, Prasad (2015:138) argued, that, HRP could be conducted in five levels; first, National level - generally, central government plans for HR for the respective country. It is expected that demand and supply for workforce goes along with competence development for people that need to be conducted at national level. Second is sectorial level – the

government plans for workforces in a sectorial level such as livestock, industrial and agriculture sector. Thirdly, industrial level-at this level, HRP is carried out to suit the workforce requirement of respective industry like textile industry, engineering, paper industry etc. Fourth, Departmental level of planning, HRP at this level is conducted in each department to identify workforce needs in operational level of the organisation. Lastly, HRP is done at Job level, this particular planning, is developed to identify needs of a particular job family within the department like number of procurement staff required in procurement department (Chhabra2016:134).

Besides, HRP can also be conducted in six levels with different purpose and methods. At national, sector and industry level, HRP development is controlled by the government of the respective country; company levels which are; organisational level itself, departmental and job level. It is important to note that each level has its own purpose to be developed and implemented in a particular organisation Chhabra, (2016:134). On the contrary, these levels have a specific purpose to be developed and are conducted in different range; short and long range plans. The long-range plans are incorporated in strategic planning which are five to ten years plans while short-range plans incorporate job plans and departmental plans are one-year plans (Prasad, 2015:149).

Based on these ideas, it can be concluded that, Human Resource Planning and Development has been seen as an important factor for an organisation as well as public sector to perform well. However, authors have a different approach to explaining the levels of HRP and D plans, but these plans can be developed, conducted and implemented in two levels; macro and micro level. Generally, national, sector and industriallevel can also be named as macro level of HRP and D while the remaining organisational levels (company, departmental and job level) can be considered as micro level of HRP of which two levels (macro and micro) can also be considered (Chhabra, (2016:134).

2.5 THE LINK BETWEEN HUMAN RESOURCE PLANNING AND DEVELOPMENT WITH STRATEGIC PLAN IN THE PUBLIC SERVICE

Rothwell and Kazanas (2013:42) describes the term *link* as “anything which is tying up two things or parts” similarly to them the word *linkage* refers to “an action of being linked” to two parts. In this milieu, the linkage involves interaction between strategic plan and HRP

and D plans while human resources being the unifying factor of these plans (Jackson and Schuler, 1990:236).

Under this linkage, workforce planning becomes a fundamental part of a strategic plan to be implemented (Armstrong 2012:210). To him, strategic plans receive inputs from HRP and HRD plans to facilitate the implementation of identified objectives and plan. In this bond, Armstrong adds that, the strategic process forecast the number and type of activities and services, which have to be performed or delivered by different institutions in the public service. Moreover, it provides a realistic foundation of competencies (skills, knowledge, behaviour and attitudes) required to execute those activities within the Public Service (Bernardin and Russell (2013:140). In a more elaborate way, Mondy and Noe, (2006) cited in Prashanthi (2013:63) refer strategic planning as a systematic process of determining how to pursue the organisation's long-term goals with the resources expected to be available. It is a systematic approach of analysing the opportunities and threats in the environment to enhance the efficiency and organisational productivity. It also refers to as activity, which includes the function of goal setting and strategy formulation (Davidson, 2001:5).

While on the other side, HRP and D put the plan into reality on the number and skills required for different occupational groups, utilisation and the way staff could be developed over a period in order to achieve the strategic plan (Jackson and Schuler, 1990: 223; Armstrong, 2012:210-211). Additionally, HRP and D aim to ensure that individuals are capable in terms of qualifications, skills, and attitudes (Prashanthi (2013:63) to implement identified strategic objectives. In other words, plans ensure the right people are available at right positions and at the right time to achieve organisational goals (Verma, 2012:17). The following figure illustrates the close connection between the MDA's strategic planning process and the HRP process:

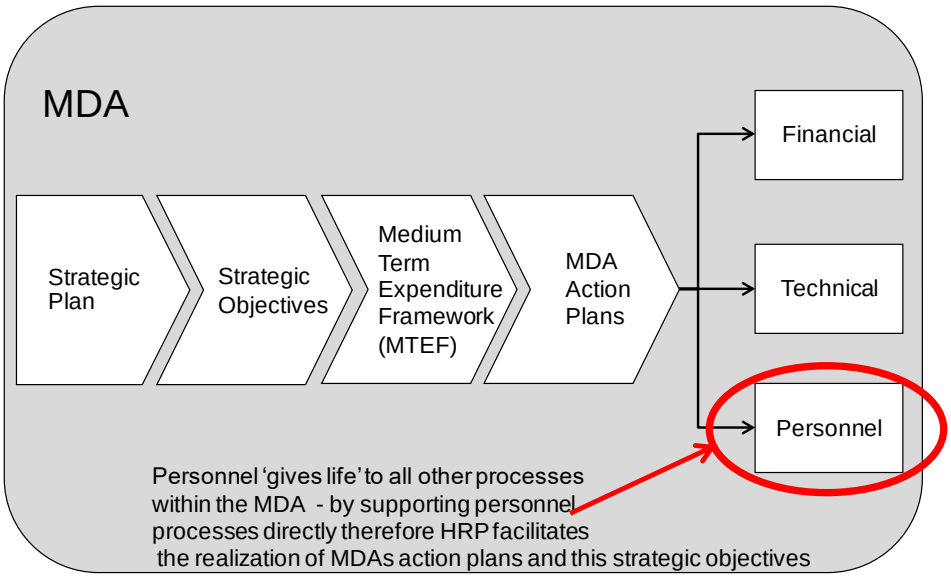


Figure 2.0.3 : Connection between MDAs Strategic Planning and HRP

Source: (Public Service, Human Resource Planning Manual, 2010:4)

In addition, Anyandike, (2013:65) went further to explaining the relationship of strategic plan with HRP and D, in aspects of partnership and followership relationship.

a) Partner relationship of HR plan

In this aspect of relationship, strategic plan, HRP and D considered are to be equal and collaborate in the relationship. In this partnership, HRP and D achieve the identified objective in the strategic plan while the human resource management exercise cement a partnership relation in the establishing of the strategic plan (Meyer, 2012:218; Prashashi, 2013:63)

b) Follower relationship of HR plan

Followership relationship view strategic plan as an organisational level plan, and within it, different plans are developed like succession planning, performance management plan while HRP and D plans being among of them. It is through HRP and D, the strategic plans are implemented. While on the other side, the HRP and D must be established and framed under strategic plan to reflect each other. In short, it is two-way traffic: Strategic Plan cannot be implemented without HRP and D, while the HRP and D cannot be developed without a strategic plan. Hence, this relationship is in hierarchical order (Anyandike, 2013:65).

2.6 THE LINK BETWEEN HUMAN RESOURCE PLANNING AND DEVELOPMENT WITH STRATEGIC PLAN IN HEALTH SECTOR

HRP and D do not exist as ends in themselves but exist to serve rest of the health systems in achieving the business goals of the health sector (MOHSW, 2014:2; Anyandike, 2013:65-66). Since Human Resource Planning and Development are means to achieve corporate ends, they need to be tied to, and driven by corporate roles, mission, vision and strategic goals, or else they simply end up as processes that add overheads (Mugo et al., 2014:81). However, this strong links of human resource and strategic management have impact on health sector on delivering quality services.

The requirement for delivering quality services to the public, O'Brien-Pallas (1993), argue that human resource planning needs to reference on the details of the overall strategic plan of the Health sector. O'Brien-Pallas, states that where there is a link between human resources planning and strategic planning the organisation will have adequate number of staffs. HR planning takes the information from the strategic planning process as input, and issues them to predict what will be needed in the future. So, the process of HRP and D consider the number of health workers required and HRP and D ensure the availability of competent health workers for efficacy delivering of quality health care services (MOHS,2014:3).

Hence, MOHSW (2014:2) reports that integration of these plans leads the health sector to be more efficient and effective in controlling the number of health workers and avoid unnecessary HR costs. Likewise, Dainty (2000) argue that competent and talented HR can surpass the organisation objective by saving a lot of resources. Therefore, the importance of HRP and D in the health sector (Farnham, 2006; Aswathappa, 2014:127) is neglected because of poor workforce information, inadequate resource and lack of leadership commitment. Besides, according to Aina (2005), these challenges lead to deficit or surplus of health sector, which can hinder efficiency of the sector. With this point of view, the link between HRP and D and strategic planning has direct impact to the performance of health sector. In addition, its' importance is an avoidable for the health sector to be efficacious in quality health care services to the public (Mosadegrad, 2014:78).

2.7 LINK BETWEEN HUMAN RESOURCE PLANNING AND DEVELOPMENT WITH OTHER PLANS IN THE PUBLIC SECTOR

Following the distinctive importance of human resource in the Public Sector, HR tend to act as an instrument which exploit other resources, making profit, generating capital as well as building economic, political and social benefits with the objective of attaining national development (Prasad, 2015:5-6). However, training and development of workforces for the development of the economy is a long-term process and plan. That means, HRD of the economy is also regarded as a long-term process and continuous in nature. Moreover, (Mavromaras, 2013:1) elucidate that HRD is rooted in Educational Planning (EP), which has to pave the way and match with economic development of a country.

Similarly, Kayani (2000:3) adds that training and education of the workforce has to be planned to make sure availability of educated workforce to avoid the use of scarce resources in educating more people than required or to prevent shortage. However, he also made it clear that both these problems can be tackled if HRP and EP are in place.

However, to (Kayani, 2000:3) HRP and D should also be treated as part of economic planning, due to the fact that changes in economic structure necessitate changes in the structure of manpower as well, which can be effected more efficiently through planned rather than external forces. It is therefore, recognisable that the success of developmental planning depends on whether planning for educational development is consistent with manpower requirement on one hand where manpower requirement and educational planning are in coordination with planning for economic development on the other hand.

The link between educational and economic planning is provided by human resource planning. While economic development is accomplished through the technical transformation of an economy production structure, it differs from one patterns of manpower associated with each stage of development to another (Healy, *et. al.*, 2013:1). To meet the requirements of such differing levels and types of human resources corresponding to a given stage of development, planning of education is needed in advance. It is through the appropriate educational process that the requisite types and levels of HR are prepared for reaching the targets of economic development.

When health sector operate and manage workforce under this relationship of HRP and D with EP and EP, it is expected to have adequate workforce. Notwithstanding, Tanzania

public service have these plans in place but health sector, still continue to have a challenge on imbalance of skills, competencies and knowledge. This is due to limiting contextual arena on operating these plans such as leadership style and political allegiance. Theoretically, these plans (HRP, HRD, EP and EP) seem should have linkages in operating the government but in reality, this does not take place. Thus, MOHSW (2014:34) reports that geographical distribution of workforce is inadequate for the population served and call for formal link between the central ministries, (President's Office Public Service Management, Ministry of Finance and Ministry of Education) to balance the situation in the sector.

2.8 ENHANCEMENT OF HUMAN RESOURCE PLANNING AND DEVELOPMENT IN THE HEALTH SECTOR

In the contemporary technological world in which organisations exists, new ideas, information, and technology continue to be treated as a priority for survival of the organisation. Information (Prasad, 2015:114) act as fresh blood in all systems of organisation for managing resources (financial, natural and human). The role of information is crucial for top management to execute management functions (Planning, budgeting, directing, coordinating as well as controlling) and decision making (Olum, 2004:3).

With the changing philosophy on HR since the early 1960 to present, Human Resource Information System (HRIS) has been undergoing changes to suit prevailing milieu of public sector because of technological development (Gupta, 2013:42). In other words, the required HRIS in the public sector cannot flourish if it is not complemented with management of HR as well as changes in technology. Grobler et al., *(*2005:15) contended that HRIS is a sub system in Management Information System (MIS) which contained information of finances, accountings, marketing, assets, production etc. It assists decision maker to store, view, analyse and forecast workforce's information on acquisition, utilisation, exit as well as training and development, rewards, compensation, staffing, succession and HR Planning in the public sector. Sheikhs (1999:24), further emphasises that HRIS act as a tool to facilitate and smoothen planning, policies, and decisions by the management. However, employees involved in using and running the system needs to be ethical.

According to Sheikh (1999:22), HRIS performs its activities in three processes: inputs, conversion and outputs. The whole process can be monitored and controlled through feedback. ***Input*** function involves storing all information of workforces required, organisation working systems like policies and procedures, these are known as raw data. The inputs are extremely important as they provide basic data in which are transformed to output. ***Conversion or transformation*** function is based on written instruction which instruct the system on when, how and what to do. Therefore, the user transforms input data to the required information. ***Outputs*** function- is processed data or transformed data ready to be used by user for making decision for example the employee's performance report, salary statement, and budget approximations.

Hence, planning for HR and development is determined by timely and perfect system of information. According to the Department of Health is South Africa (2006:50) supported HRIS system in the public sector facilitate availability of comprehensive and reliable HR information for top management or planners to make decisions on matters of workforces (like total number, competences and performance) to assure the sustainability of quality services provided by public sector. Through the system, management is able to trace the history and trends of workforces as well as analyse the workforce situation for developing different plans in all levels of the government, which HRP and HRD is among them. To achieve this, valid and genuine input data is required.

Furthermore, Aswathappa (2014:127), Rothwell and Kazanas (2013:21) states that sometimes there is a mismatch of information between HR information and other information used in strategy formulation. Mostly strategic planning of organisation are focused on market competition or financial implications and often neglect HRP and D and other information. HRP and D have financial implications of which should be considered in planning like HR audit, HR assets analysis.

The danger of inadequate HRIS is also experienced in Tanzanian health sector. According to MOHSW (2014:12), capacity for HR planning unit and policy- making is limited due to lack of updated skills and knowledge and shortage of support staff. In addition, the HRH information system is not adequate to support improved planning and management processes. The report of MOHSW, (2013:13) identifys some of HRIS issues like unsystematic medical records, weak supply chain management system and poor

coordination on data process. This study calls for health sector to invest in HRIS to enable effective management of health workers.

2.9 PLATFORMS WHERE HUMAN RESOURCE PLANNING AND DEVELOPMENT OPERATE

As long as Human Resource Planning and Development is futuristic in nature, the environment (internal and external) where organisation operates cannot be ignored. Taneja (2012:15) contends that no organisation can exist in isolation without being fragmented into the big system, which involves interaction of household, other organisation as well as the government. The dynamic demands of external environment affect internal environment of the organisation. Either, not all organisations survive in the dynamic environment. It is only flexible organisations can manage to survive (Kulkarni, 2013:136).

In great pressure of uncertain environment, organisation management obligation is to ensure internal environment (HR Systems, Policies, Rules, and Regulations) meet with external changes (Kulkarni, 2013:136). Hence, Human Resource Planning and Development systems among other systems can be used as tools and dynamic approach for organisation to survive and perform along the environmental requirement and situation (Meyer, 2002:58). For example, big companies use HRP and HRD as a strategy to overcome and reinvent the situation for them to survive in the external environment (Bassi and Van Buren, 1997:33).

However, Jackson and Schuler (1990:223) argued that currently, the external environment has become more uncertain, complex and unstable as compared to the past where HRP and D was even planned in short terms. This unforeseen and unpredictable situation has impact on the organisations HR plans and internal systems to manage workforces (White, 2004:164). The external environment is composed of competitive and general environment. In a competitive environment, organisations are competing with each other, Thus, general environment is segmented into; economic, political, social-cultural, legal and demographic factors in which HRP and D operates and hence needs to be considered in planning.

On the other hand, HRP and D operates in internal environment, which encompasses other HRM systems like policies, rules, regulations and other HR systems, that make an organisation operate smoothly (Prasad, 2015:68). The strong and flexible internal systems

(Iqbal, *et al*., 2012: 7939) give confidence for organisations to exist in competition for long time. However, external environment has all the external forces or factors and settings that have impact on the operation of the organisation in totality or subsystems.

2.9.1 Political Environment

HRP and D operate within different politics, power (Internal and External) which indirectly or directly have a negative or positive impact in planning, and development of workforces (Hatcher, 2003:4). This can be revealed in developed regulations, laws, policies and tax structure in a country. Hatcher elaborates more that, political ideology of the government determines the value of HRP and D to the existent government. In other words, politics of the government controls decision prioritisation and allocation of resources to sectors, organisations as well as to individuals in respect to what, how, and when to receive them. On the same note, Kreitner (1995:86), concluded that this situation force management to plan and develop workforces pending on the existence politics. For example, the political influence in health sector can force the management to recruit more workforce than what was planned, resulting to low wages, high turnover rate and low performance of workforce.

2.9.2 Economic Environment

According to Kreitner (1995:86), the economy of a country has direct influence to HRP and D plans implementation to the organisation and sector as well. Any planning is determined by the financial situation of the organisation or country (Prasad, 2015:73). The economic side of a country involves planning for scarce resources to priority sectors. While, HRP and D activities such as acquisition, utilisation, development of workforce involves availability of financial resources, so the higher gross domestic product (GDP), facilitate more employment, training and increase performance rewards and incentives of workforce (White, 2004:178). White further added that the economy determines all expenses and production inputs like financial and HR resource to produce services and products for public use. According to economist point of view, increased change of profit is a main factor for competition globally. In economic world, inputs (Financial and HR resources) processed with certain type of technology to produce products, services and profit (outputs) make an organisation compete.

Therefore, the Economic environment consists of all issues and activities that lead to the economic development; economic policies; conditions, systems; production and other activities, which influence workforce planning and development to occur (Prasad,2015:68). These are:

1. **HR marketing situation** provides information to employer on availability and quality of workforce to be employed, different pay rates, other competitor on the same resources and allocation of workforce which guide the planner.

2. **Human resource and population-** is considered as external supply of workforce to the organisation. It gives a clear picture on quantity in age, gender, as well as quality of workforce in terms of skills, knowledge, experience and culture. Others are inflation and national revenue.

2.9.3 Technological Environment

Technological environment comprises of skills, knowledge, experience, information and techniques on developing, designing as well as issuing products and services (Prasad, 2015:69). The technology contends the application of new knowledge, skills and thinking (Kreitner, 1995:93). This organised thinking and knowledge impact the development and implementation of HRP and D of an organisation or country. Hence, the developed competencies of country's workforce are distinguished and attract investment in the economic arena (De Silva, 1997:3). Yet, Prasad noted that, dynamic change in technology affect implementation of HRP and D and make an organisation design their jobs.

1. **Job design-**Technology is a basis for increase or decrease of performance, production as well as determines the job design or redesign, type of workforce and skills required to execute the activities in the organisation.

2. **Affecting HRP and D activities-**Besides, the level of technology, it has impact on the development and implementation of HRP and D activities like acquisition, training and development, employee's relation and well-being and communication (Prasad, 2016:10).

2.9.4 Legal Environment

From its essence, in any democratic country, the government formulates laws and rules to govern all HR activities and operations of organisations in the country. These laws Prasad (2015:69) stipulate the whole code of conduct and ethics that guide the development and implementation of HRP and D plans. This being the case, operation of HRP and D consider legal environment in all aspects of recruitment, rewards and incentives, utilisation of staff, working conditions, safety and equality among employees or groups in the organisation as well as the sector (Kreitner,1995:82-83; Prasad, 2015:69).

2.9.5 Demographic Environment

Human resource planning process depends on availability of labour, which is affected by demographic factors such as death, birth and migration. According to Kreitner (1995:73-74), the stability of an organisation depends on workforces, which use and make other resources move. Significantly, demographic environment keeps changing depending on many factors According to Kreitner, external population profile (allocation of workforces, total number and quality of workforces available as well as age and gender) are assets for HRP and D plans expert to take into consideration for adjustments. Changes in demographic profile in terms of number and quality of people affect the future of workforces (Jackson and Schuler, 1990:224). Hence, forecasting on HRP and D is based on existing people in the world, which inform the health sector to acquire, retain, develop as well as plan for succession. While the growth of the population affect the supply of workforces.

2.9.6 Social-Cultural Environment

Having in mind that a society is characterized with different people; attitudes and behaviour that make environment to be more complex for an organisation to operate (White, 2004:170) the aspect of HRP and D becomes inevitable. In HRP and D aspect, this type of environment means workforces in the society have different cultures, believes, values, languages, behaviour, attitudes and expectations from the organisation (Prasad, 2015:71). Therefore, HRP and D can be implemented well in the health sector if it incorporates social-cultural issues (Prasad, 2015:71). Hence, successful implementation of HRP and D depends on stable external environment as well as socio-political stability. The stability of these external

factors leads to a strong HRP and D plans in the health sector that leads to provision of quality health services, which contribute to economic growth.

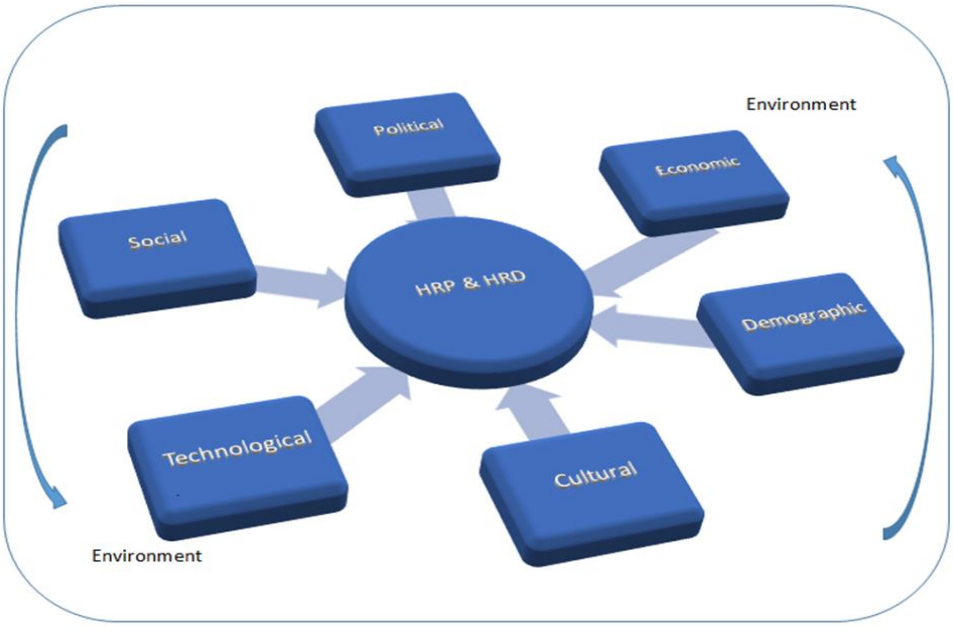


Figure 2.4: Platforms where Human Resource Planning and Development operate

Forecasting number and type of staff, usually consider the environment in which the organisation operate. The environment is normally political, economic, social- cultural and demographic.

2.10 THE CAPACITY TO IMPLEMENT HUMAN RESOURCE PLANNING AND DEVELOPMENT IN HEALTH SECTOR

As per objective two, capacity in implementation of Human Resource Planning and Development in the health sector tends to differentiate successful sector in the Public Service. The stability of health sector depends on many factors particularly on the capacity of workforces in terms of number and competences that it manages to acquire and retain. The quality of employees and their number rejuvenate the health sector to provide expected services. Planning for human resources informs management on the status of supply side and demand side of workforces, which rescues the health sector on experiencing workforce challenges (Ahmmed, 1988:9).

2.10.1 Under-or Over-Supply of Certain Skills

It is clear that internal and external health environment experience serious situation of skills mismatches between demanded skills versus the produced skills by the education system. This is also known as *skills imbalance*. Such mismatch (Mavromaras et al., 2013:7-9) rises in three perspectives: *first*, dynamic, and fixed mismatch, the situation can exist for short time or long period. *Second*, qualitative, and quantitative mismatch, which is known as "Skill shortage, this "means that skills is not available in the market and "*Skills gaps"* means the existing workforce is not having some of competences required. The qualitative mismatch involves a situation where the workforce skills are not correlated with the job while the quantitative mismatch, means there is high number of workforce looking for work than the availability of work. This mismatch resulted from demographic changes and growth (Berkhout,et al., 2012).The qualitative mismatch has no effect on number of workforces (overhead count) existing. Thirdly, economic, and non-economic mismatch occurs in situation when there is disparity on number of people required versus the supplies of the market. Hence, the mismatch developed can be under supply of skills (Shortage) or over supply of skills (Surplus).

In short, oversupply of certain skills entails identification of surplus staff to operational requirements while undersupply of certain skills is deficit of some skills of workforce, which are difficult to recruit and retain. In the view of Gimpelson et al, (2009:3) and Mavromaras et.al., (2013:10) these under- or-over supply of certain skills is caused by many factors such as internal or external environment which include poor information system on workforce in the market, poor payments of employers, high competition of certain critical and scarce skills, inflexibility of training institutions with the demand of the market, poor HR planning and development and rapid change of external environment like technology, economy, population growth as well as social-cultural behaviour and workforce attitudes. Besides that, under- or-over supply of certain skills can be resolved through updated information (human resource information system), good coordination between planners and training institutions, proper HRP and HRD plans.

Ahmmed (1988:4) argued that an organisation which is effective and efficient in management and planning on workforce, reduce risk of unforeseen circumstances and easier

to match the demand and supply of workforce skills in future because the organisation is already aware and can cope with the situation quickly than those ones which does not plan.

2.10.2 Under-or over-supply at different positions

In the health sector frameworks, workforce planners normally face various capacity challenges on acquisition and retention of workers, retaining, and succession planning for continuation of the health sector to supply the required health services (Chhabra, 2016:136). For instance, it is difficult to get eligible people fill management or administrative position, and difficult to get certain skills or cadre to fill management or leadership critical position, over or under supply at certain position in different locations. In this complicated state of free market, under-or-over supplies at different positions are inevitable. In short, it is the experienced imbalance between the demand and supply of staff in certain position.

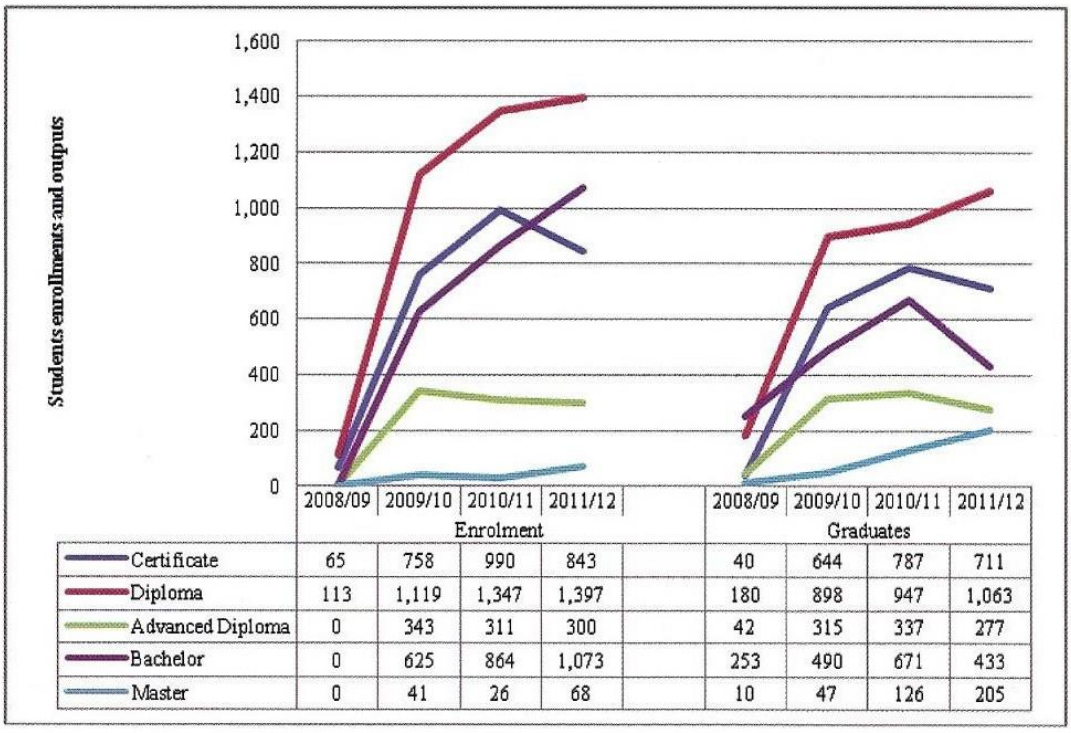
Scholars including Mangham (2007:3-4), argue that the health sector experience many challenges which lead to different positions being under-or over supplied than other. The report by MOHSW(2014:11) reports that the health sector lack staff in management and supervisory position which allow the primary health workers to work in certain months without being supervised; poor motivation which facilitate high turnover rate, absenteeism as well as health workers not complying with health professional ethics and standards. With these challenges, availability of HRP and D assist to plan and forecast on who and when to acquire people and develop them, where to get people for certain positions and incentives and rewards for each individual in their positions. Hence, Taneja, (2012:155) concluded that by having the HRD plan will ensure the sure health sector management and staff in different position have required skills, attitudes, ethics and knowledge to execute their jobs as well as efficient in their positions.

2.10.3 Under-or over-supply of different cadre

Health sector functions properly if all cadres of health professions like doctors, nurses, midwifery, pharmacists are in right places in all geographical allocation of health facilities are in the right time where and when they are needed. The concept cadre as explained in a Cadre Review of Group “A” Central Services Monograph of India (2010) means

"A cadre comprises persons who have been adjudged suitable and recruited to hold a group of positions required similar skills-technical, professional and/or administrative; within a Service there may be more than one grade arranged vertically according to the level of responsibility". In the views of Mavromaras, et *al.,* (2013:1) under supply or over supply in cadres occurs in situation where the demand for certain cadre of workforce are not equivalent with the supply of the market. Therefore, inflexibility of skills on demand and supply leads to overstaffing and understaffing of certain cadre.

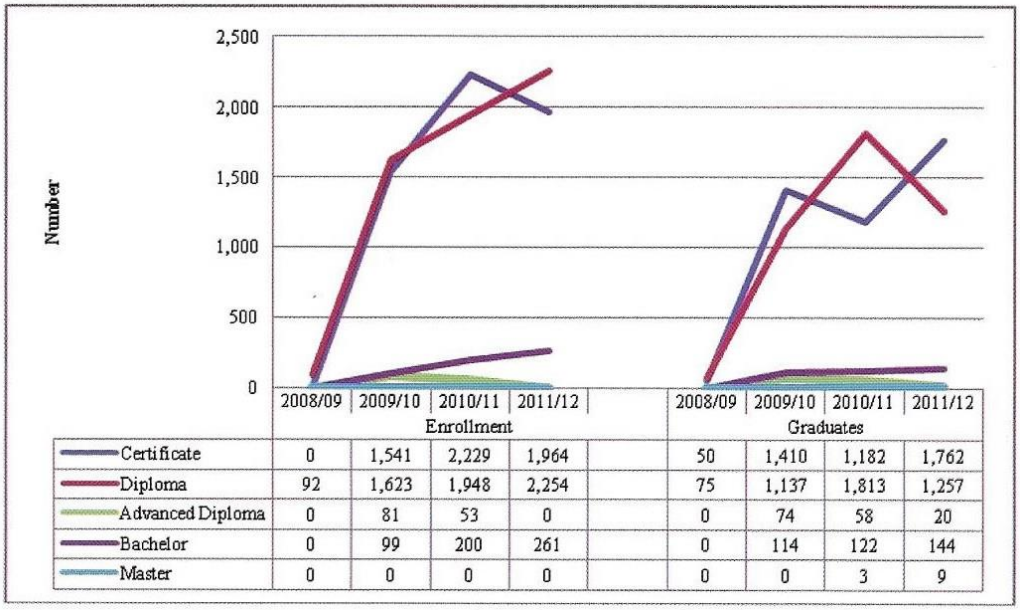
In the case of Tanzanian health sector, literatures reveal that, the sector experience shortage of health workers especially in rural areas as highly trained cadres do not like to work in those areas (MOHSW, 2014:1; Kwesigabo et al., 2012:4; MOHSW, 2011:9; Mangham,2007:3; WHO,2002:1). The report of MOHSW, (2014:12) points out that academic number of staff in health training institution is declining. In 2010/11 to 2012/13, the deficit of academic staff was 1,505 (34.79%). Either, some of available academic staff have no teaching skills and are not updated with new issues facing the health sector. Therefore, these institutions use part time trainers from other institutions or nearby hospitals. On the other side, the government has doubled student's enrolment, in 2005 to 2010 to reach 4914. The challenge that remains is the absorption of all graduates from colleges and universities. See the table below:



	Enrolment				Graduates			
	2008/09	2009/10	2010/11	2011/12	2008/09	2009/10	2010/11	2011/12
Certificate	65	758	990	843	40	644	787	711
Diploma	113	1,119	1,347	1,397	180	898	947	1,063
Advanced Diploma	0	343	311	300	42	315	337	277
Bachelor	0	625	864	1,073	253	490	671	433
Master	0	41	26	68	10	47	126	205

Figure 2.5 : Number enrolled and graduated in Allied sciences level by course level

Source: (Ministry of Health and Social Welfare, Strategic Plan, 2014:15)



	Enrollment				Graduates			
	2008/09	2009/10	2010/11	2011/12	2008/09	2009/10	2010/11	2011/12
Certificate	0	1,541	2,229	1,964	50	1,410	1,182	1,762
Diploma	92	1,623	1,948	2,254	75	1,137	1,813	1,257
Advanced Diploma	0	81	53	0	0	74	58	20
Bachelor	0	99	200	261	0	114	122	144
Master	0	0	0	0	0	0	3	9

Figure 2.6: Number enrolled and graduated in Nursing Courses level by course level

Source: (Ministry of Health and Social Welfare, Strategic Plan, 2014:15)

Despite of the recorded number of successes on increases of enrolment of students in health training institutions, still there is a challenge of quality of student produced. Such challenges identified by MOHSW, (2014:16) are; deficit of lecturers, poor infrastructure, graduates are

not equipped with new knowledge, limited practical exposure due to shortage of trainers, inadequate funds allocation, as well as students compared to teaching hospitals and (MOHSW,2014:16). As a result, graduates have qualitative mismatch with the job.

This imbalance of demand and supply of skills in certain cadres are made by misconnection between the educational systems and the demand of the economy Motlanthe, (2010:2). Tanzanian health sector experience the imbalance challenge in certain cadres Social workers for example, are only 13% (437) of the requirement (MOHSW, 2014:12). However, it is amazing that, even though the government experience the deficit of social workers, but there is high production of this cadre in the labour market (MOHSW,2014:15). The report reveals that, the problem lie on retention, deployment of workforce and poor recruitment process an example for this is that permissions are granted for cadres that were not requested with the institution.

In order to remedy such mismatches, application of HRP and D plans are needed to harmonize the situation and ensure different cadres required from low-level, mid-level to high-level of professional workers match with supply. With the support of HR information system, the health sector will manage to identify health workers in specific cadre with similar and different levels of skills in certain job are effectively distributed in all health facilities (MOHSW, 2014:30).

2.10.4 Diversity Gap

Change of external environment especially demographic, gender equality and special groups has been addressed by affirmative action. This has forced employers to progressively consider it in their organisation (Dessler and Varkkey, 2013:71). In Dessler and Varkkey view diversity as a set of demographic features, which are embedded within and characterized workforce such as culture, religion, colour, race, disability, national origin, age and sex.

Given the existing global forces, (Bernardin and Russell, 2013:147) require each organisation to consider diversity in all HRM actions such as recruitment, development, promotion, performances and transfer. In order for organisation to survive in the jungle of competition, consideration of diversity as a strategy to cope with forces must not be ignored.

However, gender diversity in health sector continues to be a challenge in providing equal opportunity and treatment of both gender and special group.

In order to overcome the diversity gap, the organisation and labour market should treat a diverse group like any other group of people. Women in organisations should be treated like men and do responsibilities like what men do because the difference is just a biological factor (Taneja, 2012:193-194). In addition, preparing policies to spell out commitment to diversity issues, identify targets, and time to achieve the balance or representativeness is important. Hence, diversity gap is existing in the Tanzanian health sector. Some of the works and cadres like nursing are regarded as for women as women do not want to learn complicated subjects like science. Science related subjects leading to skills that produce for example doctors are considered for men.

2.10.5 Capacity on competency of staff

Sustainability of health systems depends on the economic development of a country, which mostly relies on the relevant workforce skills to reach the country's, mission, vision, and plans. It is the relevancy of workforce skills; behavioural competences with the respective job; skills mismatch on demand of key sectors of economy with the supply of workforces that are needed for a country to allocate adequate resources to the health system (Ahmed, 1988:1).

2.10.6 Limited Qualifications

In an organisation, limited qualification occurs in a situation where individual's or group of people's qualifications and competences acquired are irrelevant with the job requirement. This means, the particular job might need to be executed with certain field skills, level of education, which a particular person has not acquired. It is known as "qualitative mismatch" or "limited qualification" (Sattinger et al., 2012:1). In their views, such qualitative mismatch resulted from market forces like advancement and change of technology, which require organisational change, high skilled workers, information system and advanced equipment, which brought divergence on human resource development system with job desires. Hence, gap in qualification lead to inefficiency in services and products, unemployment and backslide in the economy

In the opinion of Berkout et al., (2012:2), the mismatch happens in two scenarios; long run qualification mismatch and short run qualification mismatch. Long run qualification mismatch happens when change in external environment like economy, technology, globalization lead to modification of job content, wages, training and development of workforces. This kind of mismatch reveals that, there is no well-adjustment between the change of demand and supply in the labour market environment for long range of time (Sattinger et al., 2012:1-2). It might not come with the face of mismatching between the job attributes and workforce skills. Such situation can be resolved through increase of salary, incentives and rewards. On the other hand, short run qualification mismatch result with widening the range of work and workforce skills which make the employer and employee to meet in the labour market for employment.

Sattingers et al., (2012:1) adds that, this type of mismatch has an impact to employee such as earning low salary, or stay unemployed for long time on employer's side, this results into having continued shortage of staff or vacant post until he/she find required one, incurring cost, less production, loss of customer because of poor service or low products and increasing turnover rate of staff who look for other employment. However, these mismatches can be fixed. For instance in short run, there is need for flexibility of recruitment agencies and employers to replace workforce in particular work which is relevant to their skills than the post they advertise in the market. In long run, HRP and D plan should be implemented for forecasting the uncertainty mismatch between the demand and supply (Berkout et al., 2012:3).

Healy et al., (2013:2) further recognize two Limitation of qualification i.e *horizontal mismatch* means a person have high skills compare to the job requirement. This for example happens when graduates execute job, which can be even done by non-graduate. This is also known as over qualification. Other category of limitation of qualification is *vertical* mismatch. According to them, this type of mismatch happens in a circumstance where employee have high or low qualification as per job requirement. Hence, such circumstances result into wastage of skills and economy as well.

2.10.7 Limited skills to apply necessary tools

In additional to limited qualification, there are limited skills to apply necessary tools. Mavromaras et al., (2013:1) illustrate that this is a situation when a person does not have necessary skills to use certain tools to perform the job. This mostly occurs when there is advancement or change of technology. This forces the organisation to cope with the technological change like change of tools, applying new systems, as a result the organisation demands high skilled workforce. Such instances may result to paying workforce high salary to low pay jobs.

2.10.8 Limited behavioural competencies to perform higher standard

In any form of performing work, one or more competences are applied to execute the task. Armstrong (2012:90), views "Competency" as any qualification, skills and knowledge, or abilities and attitudes, demonstrated through behaviour that results in superior job performance. Competency can be known as "hard skills." Similarly, there are competence profile applied to groups of position such as occupational groups (leader, nurses, doctors, teacher) or that are function specific (e.g. finance, HR, IT). Competencies are of different functional areas such as, methodological, social and leadership demonstrated on different levels as required performing job/position related tasks and activities (Dessler and Varkkey, 2013:384).

Armstrong (2012:90) contends that competency is in three types: *first* type is Behavioural competencies, which refers to method or style used to handle the situation or execute the job. It is not about knowledge or skills of workforce, but how someone manages the work. To Armstrong these are known as "soft skills" which are under competencies (creativity, commitment, teamwork, customer care, quality and standard of work, communication, flexibility as well as problem solving). In using these competences, a workforce applies behavioural competencies to perform higher standard of work. For example, the competence of "quality of work" contained behavioural competences like developing standard and proper quantity of work required, able to keep time and identify urgency of job or assignment, able to execute different job or assignment at the same time and able to coordinate task and people to do it (Pg.91). *Second* type is technical competences - these are skills, qualification, capacity and knowledge of workforce to execute work. People with technical competences tend to avoid managerial decision and rather propose to top

management for decision (Dessler and Varkkey, 2013:384). *Third* is NVQ/SNVQ competences, this type of competency developed from UK standards for NVQ/SNVQ assesses tasks and provide certification. In these standards, competency means people are assessed on the level of competencies on specified type of work.

On the other hand, limited behavioural competencies to perform to the higher standard on agreed work brings inefficiency of organisation's standard performance in production or service delivery resulted to customers to look for other alternatives. Hence, each employees or group of workforce have specific demand regarding the type of competences to be developed which should be integrated on HR actions, such as training and development, succession planning, performance, retraining and redeployment plan (Pynes, 2009:39).

2.11 QUALITY OF SERVICE DELIVERY IN THE TANZANIAN PUBLIC SECTOR

The effectiveness and efficiencies of Public service is among the critical function of the government's accountability to its citizens. This embarked with the United Nations Declaration of Human Rights, Article 21(2) states that "*Everyone has the right to equal access to public service," It* means, every citizen has right to enjoy basic services provided by the government. Such services are like health, water, education and electricity. The question is, remains, as whether the public service provides quality and standard services as required?

A government provides necessary public service, it should ensure the provided services meet the require standards (Fourie, 2012:124). In other words, the government is there to meet public expectations and satisfaction by having proper systems that include HRP and D is among them. According to Gaster and Squires (2003:21), the notion of expectations, satisfaction, and perception of the public service consumed by public is founded on the quality system of public services. This argument is supported in Tanzania reform (PO-PSM, 2008:18) that the main strategy to enhance performance of public service in the effective delivery of public services commensurate with the people's expectations for value and satisfaction.

On the other hand, Public service delivery has a human element as most of such socio-economic services as education, public health, water, security, extension services in

agriculture, animal keeping and fishery, land management, waste disposal and alike, are delivered directly to the citizens and clients by public servants (Aswathappa, 2014:90).

One of the key components in rendering quality service is people. Meyer, (2002:5), argues that the qualities of employees in the organisation determine its position in the market environment and building the capacity of employees through quality training assure the organisation to deliver quality service to the people. Aswathappa (2014:90), argue that service excellence has five elements: employees competences, equipment and physical facilities, precise performance, care and timely assistance to deliver the services (Kayani, 2008:28).

The qualities of these services are largely determined by the proper development and implementation of HRP and D in the public sector. Mosadeghrad (2012:24) view quality of services in the public sector as something, which involves things like, how the Government is structured and how public servants are managed through which the goals of the nation can be realised. Thus, professionalism, ethics, performance enhancement, transparent and accountability in the public institution should be a priority to be addressed (UN, 2000:4; WHO, 2006:3). Hence, the public in Tanzania has been insisting on quality of service even though it experience some challenges.

2.11.1 Quality of Service Delivery in the Health Sector

The importance of quality health care has been increasing globally (WHO, 2006). On the other side quality of health care services has become a major focus in people's expectations (Mosadeghrad, 2014:77). People tend to incur any cost to look for health institution, which provides quality services. It is the quality of health services that differentiate those health centres with or with no high professionals' health workers.

Literature shows that "quality" elaborated can be in different elements and meaning like excellent, value, surpassing and/or attaining customers' expectations, suitable to use, provision of consistent services to according to specification to attain or surpassing customer satisfaction of needs (Crosby, 1992; Berry et al 1985:41-45; Juran, 1988; Peters and Waterman, 1982; Gilmore, 1974:9-16; Feigenbaum, 1951). The quality is more concern on the increasing amount of healthcare services derived to the person or population with consistent applicability of knowledge and professions (Lohr, 1991). There is no agreeable

meaning on the term quality and standard to measure it because countries have different priorities, cultures and views on the term quality. In spite of difference views on the quality concept, there is common understanding that quality means working according to identified standards (MOHSW, 2011:1).

Donabedian (1988: 1743-8) illustrate that "quality" contains three components; Interpersonal quality (this is considered the handling level to meet patient satisfaction in terms of preferences, expectations and needs). Other component is technical quality, which is more concerned with professionalism and competences in delivering efficient and effective health care to the patient. Lastly, facilities component - this involves conducive environment in providing services like facilities and accommodation. In other words, surrounding health environments make the patients to be comfortable in receiving services.

Therefore, quality of health care is constantly provision of efficient and effective health care services basing on the identified frameworks and policies to meet patient desires (Mosadeghrad, 2012:203). The quality of health services depends on service provider and receiver of that service (Mosadeghrad, 2014:78). In Tanzanian health sector, the meaning of the concept quality of health care framed in Tanzania Quality Improvement Framework (2004:vi) which views it as a degree of performance in relation to a defined standard of interventions known to be safe and that have the capacity to improve health within available resources. The quality of service embedded with the following key values – respecting professional ethics, caring for patients as well as ensuring access to health care by public.

Likewise, McLaughlin and Kaluzny (2006) explicates that quality Health care contained attributes such as consistence, timeliness as well as exactness or accuracy, which needs to be guided by principle. Even though is difficult to attain or measure, attributes like accuracy of service is more subjective and rely on customer's expectations. According to MOHSW (2011:2) they are six, which are consistently identified as important, such as system and processes focus, customer focus, provider focus, effective focus, use of data and team focus. These principles make health sector to be successfully, improved and perform high throughout in delivering health services.

Most important investment in health workers are required to update the quality of health sector so as it can be leading catalyst in achieving the national goals. As Lee Kuan Yew expounded it – the former Prime Minister of Singapore as quoted in Boon Siong NEO and

Geraldine Chen, (2007), highlights the importance of human resource factor of the Public Service:

"Can you have a good Government without good men in charge of the Government? American liberals believe you can. My experience in Asia has led me to a different conclusion. To get good Government you must have good men in charge of Government. I have observed in the last 40 years that even with poor system of Government, but with good men in charge, people get passable Government with dissent progress."

Likewise, Mangham (2007:3) support Lee Kuan Yew views that health sector must have good men (health workers) who are competent and professional to deliver quality health care services. Availability of those professional health workers are determined by clear implementation of HRP and D plan. Thus, effective plans to guide the health sector to have balancing demand of health workers to meet with supply of quality health services as planned by health sector. Therefore, the health sector will be prepared for the future and has a good set-up on quality of health services.

Acknowledging the importance of HRP and D in the quality of service, Meyer (2002:234) puts it clear that for organisation and sector to be in a position of efficiency and effectiveness depends on the connections and efficient combination of input and systems processes to deliver required services to the client. The process starts on HR planning, procurement (recruitment), development of human resources equivalent to the nature of the work. However, reliability of quality in the organisation based on recruited qualified and appropriate people (Meyer 1998:34). It is through these facts, the Tanzanian health sector reported to experience the challenge of poor services to patients especially to mental health services, poor access of health services, shortage of important diagnosis equipment and medicine, insufficient standards in services (MOHSW, 2013:14). The following figure illustrates the health service level in the government of Tanzania:

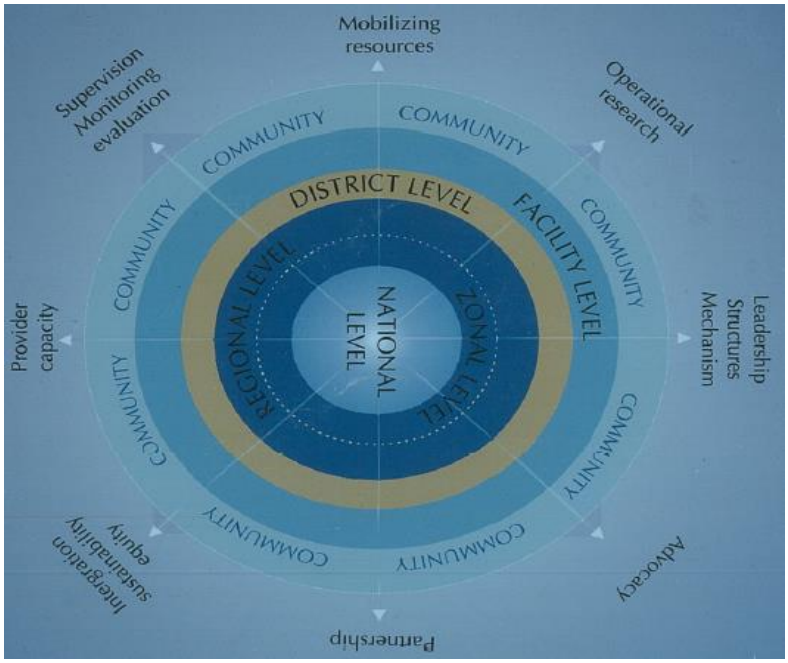


Figure 2.7: Health Service levels in the government context

Source, Ministry of Health and Social Welfare: Quality Improvement Framework, (2014:1)

Delivering quality health service in Tanzania community conducted in a sequential order from National level, zonal, regional to district level guided with policies. Sustainability of quality health involves different actions and strategies that effect that accessibility of standard health services such as mobilising resources, monitoring and evaluation, leadership structure mechanism, awareness, operational research, partnership with stakeholders to ensure all levels advocate quality of services to the community.

2.11.2 Evolution of Quality of Health Care Service in Tanzania

Knowing the importance of health sector, the government of United Republic of Tanzania has a long history on recognising the importance of delivering quality service in health sector (Wangwe and Rweyemamu, 2001:3). According to them, health care services can be explained in three phases

2.11.2.1 After Independence to the 1980's

During 1962 immediately after Independence, Tanzanian government focused on developing a country with new health policies on health care services developed and implemented based on the Arusha Declaration. The country adopted health policy that aimed at providing free health services to all Tanzanians.

The main idea was on building on small health facilities such as dispensaries and health centres, in the rural areas, and training a large numbers of auxiliary staff to run them (URT, 1994; Johnson, 1986). As a result, number of health workers increased, 90 per cent of the people who lived in rural areas got access to health facilities within a radius of 10 kilometres, while three-quarter of the people got access to health facilities within 5 kilometres in 1980 (Gish, 1983, URT, 1994). However, there is increasing demands over- stretched government resources, resulting in shortage of drugs, poor salaries, low staff morale and other logistical supplies (MOHSW, 2004:3).

In 1970s and early 1980s, the government experienced an economic crisis caused by high importation and low exportation of products, which resulted to government reducing its expenditure, which involved budget cuts on the health sector and other social sectors like education (Mogedal and Steen, 1995). The economic crisis (Lugalla, 1993) affected the quality of service provided by government, utilisation of health service and investment in health sector. In addition, this situation led to creating new central institution (ministries/departments) with a focus on controlling health workers centrally, capacity development, and corresponding institutions at the province, district, and ward and village level. Privatisation of health facilities and health service continued to be government responsibility (Wangwe and Rweyemamu, 2001:4). However, due to the economic crisis ability of the government to facilitate health services to entire public continue to decline.

1982/83 – 1984/85 the government started implementing Structural Adjustment Programme with the focus on recovering the economy. Such improvement went hand in hand with implementing different programs like Economic Recovery Programme (ERP) in 1985, Economic and Social Action Programme (1989/90 -1991/92) and also started to implement economic reform to make the health services more efficient and effective to the citizen (Semali, 2003:6-7).

2.11.2.2 The Reform Era in the 1990s-2000s

The 1990 saw health and education sectors adopting the crisis and stress of 1980s. During this period, health services delivery in all levels (referral level, primary health care, preventive and curative services) was inefficient due to budget allocation, inadequate number of health workers, limited facilities and low access of essential drugs (Wangwe and

Rweyemamu, 2001:6). On the other side, the non-government health care facilities continued to grow especially in health entrepreneurs. For instance, in 1995 – 1999 health facilities increased from 3,577 to 4,961 (MoH, 1999; Wangwe and Rweyemamu, 2001:11). However, these facilities were facing inadequate number of health workers who were poorly equipped or maintained.

During 1990-2000, the government focused on poverty reduction through implementation of different Policies, Strategies and Programs under Vision 2025. The Vision provides direction on socio-economic development on combating against poverty in the whole country. Concurrently, developed policy documents like Poverty Reduction Strategy Paper (PRSP), TAS and NPES were meant be a tool to concur existing social services, which was in poor quality and conditions (Wangwe and Rweyemamu, 2001:15). In addition, Wangwe and Rweyemamu add that, many reforms were implemented in this era, which was more focused on social sector and all economic aspect. In social sector, the focus was directing public funds on priority activities, encouraging private sector on providing social services, promoting quality services, promoting domestic investment in workforces, putting resources closer to domestic and facilities as well as delegate and decentralize authority to the local level.

The report of MoH (1994b) elaborate on areas of reforms in health sector which were- (i) Ideological reforms which focus on changing role of government of providing free health services and become a facilitator in the provision of health services. (ii) Organizational reforms included changes in administrative structures by decentralizing power from central level to district level, creating professional councils and district health boards to monitor and regulate quality of health care services and ensuring health workers adhere to professionalism ethics in provision of health services. (iii) Managerial reforms involved shifting of management functions from health service and district hospitals to local authorities. (iv) Financial reforms–developing health insurance, broaden sources of health care funds and creating more source of funds like earmarking taxes as a source of revenue. (v) Health research reforms to acquire information for improving health care practices. Lastly Public or private mix reforms involved supporting development of the private sector on provision of health services (Semali, 2003:9).In all these reforms, the main theme was decentralization in three areas; Administration, Political and Finance (Semali emphasis added).

These reforms, support WHO directives on promoting the quality of health services to be a priority in developed and developing countries. In implementing the directive of achieving high quality health and social welfare services (WHO, 2006:4-6) to the public including safety, good working environment, care, and management of quality services, the government developed vision 2025, which provides direction for long-term development, different frameworks, programmes, and strategies.

Despite the government initiatives of improving the health sector, still the sector faces challenges. According to McLaughlin and Kaluzny (2006:51-61) the quality of health care services involves relationship between the customer and service provider. Ladhari (2009: 172-98) acknowledges the difficulties in provision of quality health services. In his opinion, health workers who have different professions, competences, skills and experience (Heterogeneity) provide health service. In such circumstance, user of the service faces difficulties to judge the quality of health service.

The report of National Quality Board (2013) in England supports this argument that delivering high quality health care is a bit complicated process because it involves customer, professionals, standard facilities and supply, skills as well as health care (primary and secondary care).Thus, provision or improving the quality of health care services to the people or population is the collective responsibility which involve every one, each level of health systems and a clear health systems (NQB Report, 2013:4). Besides, Report of Centre for Health, Science and Social Research (CHESSORE) (2008:3) revealed that, health system in developing countries, while Tanzania being among of them, are not well built to allow provision of efficient, effective and quality health care services to the public (MOHSW,2013:14). In this fact, the proper implementation of HRP and D is required to allow proper inputs to be processed in health sector in order to achieve quality health service in the country.

2.11.3 Insight information from the existing evolution of health service delivery

From the literature review on the evolution of health service delivery in the Tanzanian health sector, it was revealed that due to advancement of technology, people are well informed and aware on issue of health especially on standard and quality health services. Thus, why, they tend to incur any cost to look for health institution, which provide quality services. In this note, as a mandate of the government to provide quality services people are expecting to

receive quality services even in government hospital. However, since independence, the government have been developing plans, strategies and framework to ensure people receive quality services.

Despite of many initiatives, the country continue to experience poor health services due to inadequate budget, shortage of health professions, poor facilities and poor working conditions especially in rural areas where more than 70% of Tanzania live (Kwesigabo et al. 2012:4, Msola 2008). This means that, people who have money can get quality services in private health centres where customer is priority to them. The report of United Republic of Tanzania, (2005:4) reveal that the level of poverty in rural areas is high, 87 percent of the people are poor. Also, the disparity or gap between the urban areas and rural areas is growing in a number of indicators especially on basic needs. Therefore, these people cannot manage to go for private hospitals. Yet, in certain rural areas, private hospitals are not present due to the business orientation.

Quality health services remain as theories on papers and documents of the government. In most instances governments invest into other priorities to sustain their power instead of health issues. This enables the government to be alive and stay in power. Therefore, it is important to note that such situation can be refrain through systematic HRP and D, adequate budget allocation as well as policies and frameworks to guide the sector.

2.12 PROFESSIONALISM IN HUMAN RESOURCE PLANNING AND DEVELOPMENT IN PUBLIC SECTOR

A competent and good performing public service is grounded on its professionalism, values and integrity (Elia, 2000). The issue is, to what extent do public servants adhere to professionalism? How are public servants capacitated and trained to facilitate public service to perform efficiently? Olaopa (2011:2) responds to these questions by arguing that, the structured systems, standard ethics and values as well as professionalism tie up the public service with its citizen in efficiency of services.

Professionalism in the framework of public service is valued asset. This is because it guides the public servants to perform public activities in agreed standards and systematic way, competence, commitment, objectivity, diligence and faithfulness, adhering to rules, laws, values, regulation, and ethics, concerned to provide innovative and standard services to the

respective society. (UN, 2000:3). In short, it is a commitment of public servant to adhere to standards as well as being impartial, competent, and neutral in performing work. According to Harmer, in this 21st century a professional is identified by these attributes. On the other hand, a professional is referred by Harmer (1996:32-52) as someone who is extremely competent in executing work. It is a person who has a character of helper or problem solver, visionary and goals oriented to acquire long terms plans. According to Harmer, in this 21st century a professional person is identified with these attributes:

- Is effective in identifying proper framework and technique to use in present and future as well.
- Keep learning wherever he/she is
- Engages in ongoing project and activities and understanding how to execute it and practice
- Concerned on getting things done
- Feels to be more concerned on clients issues like solving customer inquiries on time, add value which the customer needs
- Performs quality work does not just performs an activity (ies) in certain period.
- Has a good attitude, right skills and knowledge on what, how and why to do certain work.

In other words, professionalism emanates from the kind of management system, which embraces the achievement of high performance, and poor performance is discouraged at work because it cost a lot in the public service. In the observation of (UN,2000:26), instilling of professionalism in the public services needs to be applied in all functions of human resource management since acquisition, utilisation, disciplinary actions, training and development as well as promotions, rewarding and remuneration based on performance of workforces in the public service. That means, an effective public service mostly is devoted to maintain ethics and professionalism in its public servants.

However, in marketing competition economy the role and function of public service has changed to adopt the new rapid environment of advanced technology which demands new skills, proactive, knowledge, attitudes, ethics, quality service oriented and professionalism. In this sense, (UN, 2000:4) strong, talented management and high performance in the public service are required than ever to differentiate the economy in Sub Saharan countries and in

the whole world as well. In this context, proper planning and development of workforce to ensure availability of competent and ethical workforces who can contribute to the economic development of the country is necessary.

2.12.1 Professionalism in Human Resource Planning and Development in Health Sector

In today's changing world, the health care is faced with challenges on changing social-cultural attitudes, science, and technology, which lead to people being more open-minded and have more expectations from the health sector (Scottish Government, 2012:6). This situation demand health workers who are competent, professionals to behave ethically according to the professional standards and government policies (UN, 2000:3).

According to the Scottish Government report, the quality of health sector requires accountability, transparency, competent and professional health workers. This required committed leadership and health cares with sufficient resources to facilitate the provision of quality health care services. In the same vein, Dr. Rufaro Chatora, WHO Representative in his speech in Resource for Health Conference insisted that the health sector needs to have affordable number of health workers and good system to have certified health professions (WHO, 2006:3).

Additionally, Chairman of the Kenya Medical Association (cited in Tettey, 2003) points out that poor rewards, remuneration and working conditions are among factors leading into health professions not exhausting their professions due to job dissatisfactions. Furthermore, MOHSW (2011:15-16) agrees with Uneke *et al.,* (2007:3) by indicating other factors such as poor recruitment and retention plan, and exodus of staff soon after reporting to their work stations from rural areas to urban areas due to harsh conditions.

Since, professionalism has direct impact on the improvement of quality health care as well as involvement of skilled and competent physician in health sector. Nyoni *et al.,* (2006:1) insisted that government commitments and interventions are required to have policies, plans (HRP and D) which facilitate quality health services to the public through setting and complying with ethics and values to all health professions. This supported by Mahatma Gandhi as cited in Scottish Government Report (2012:8) that

"Patient In health care sector are important factor for the existence of it, caring them is not a favour but responsibility and purpose of health system to be there."

The idea of Mahatma Gandhi implies that, health professionalism in health sector is inevitable. His views are based on the fact that health professionals should behave in a professional way to provide standard services to patients and not think they are favouring them. Moreover, Scottish Government Reports (2012:12) reveals that professionalism in health care services is something expected and valued by patients. In other words, patients expect health workers to be competent and have professional features like empathy, understandings, tolerance, self-confidence, as well as good appearance and be anti-discriminatory.

Besides this, in some situation, there is a mismatch between the expected performances, attitudes of health workers against service provided to patient (Mangham, 2007:3). In addressing this situation, HRP and D need to ensure ethics and values on professional heath workers are adhered, to deliver high level of performance.

Despite the current challenging environment of globalisation, unprofessional behaviour is unavoidable and we still experience the quality of service delivery provided with health professions (Scottish Government, 2012:3). Thus, professionalism should be a priority factor to health professions and driving force to them to provide quality health services to the public. Generally, for the health sector to have commitment, process of recruitment should ensures only selecting health workers who are dedicated, committed and love their job (Hayes 2010:358).

In the observation of Stern (2006) professionalism in health sector can be developed in four principles as stipulated in the table 2.3.

Table 2.3: Principles of professionalism in public sector

No	Principle	Contextualised definition	Related Ideas
1.	Accountability	Demonstrating an ethos of being answerable for all actions and omissions, whether to serve users, peers, employers, standard-setting/regulatory bodies or oneself.	1. Professionalism: social and patient contract 2. Self –regulation including standard setting, managing conflicts of interest, duty, acceptance of service provision, responsibility

2.	Excellence	Demonstrating practice that is distinctive, meritorious and of high quality.	1. Commitment of competence 2. Commitment to exceeding standards (in education and practice). 3. Understanding of ethical principles and values 4. Knowledge of legal boundaries 5. Communication skills
3.	Altruism	Demonstrating regard for service – users and colleagues and ensuring that self-interest does not influence actions or omissions.	1. Opposite of self-interest 2. Acting in best interests of patients.
4.	Humanism	Proving humanity in everyday practice.	1. Respect and dignity 2. Compassion 3. Empathy 4. Honour 5. Integrity

Source: (Stem:2006)

These principles of Stem are constructed on the context of culture and individual clarification, which was supported by Health and Care professions Council report (2014:13-18) that professionalism has different meaning depends on context and people perceptions. Thus the professionalism meaning can be viewed or grouped in three scenario,

First, good care – this is based on how professionalism is applied on delivering health care services. Patients expect to see certain behaviours and attitudes embarked with competences and standards to do the job. Second – professionalism is based on how you do the job. This process starts from the time a health worker start to work, applicability of ethics, code of conducts and values at work. Third is appearance of personality. Thus professionalism framed on expression of good attitude and decent behaviour like caring, empathy, following ethical codes, on treating the other person. In addition, suitable appearance of worker in uniform, relevant cloth, neat hair and cleanliness at work, has an impact on perception of profession to the receiver of the service. Lastly, behaviour and attitude: it is a basement and foundation of professionalism. Good or bad attitudes as well as behaviour at work express the professionalism. Therefore, the health sector professionalism is expected to be framed under this scenario of Stem.

However, Amundsen, (2009) explains that in weak administration and political systems, professionalism become difficulty to practice. Hence, the role of Regulators and Employers

cannot be ignored in developing and providing good environment of professionalism to people (HCPC, 2014). It is through them that the professional or unprofessional behaviour is framed. Therefore, effectiveness and efficiency of the public service cannot ignore the issue of workforce professionalism. While the public service competences and technical skills required is more different from those required in private sector (CAPAM, 2005:5- 6 cited in Olapa, 2011:4).

2.13. CHALLENGES ON IMPLEMENTING HUMAN RESOURCE PLANNING AND DEVELOPMENT IN HEALTH SECTOR

HRP and D requires proper implementation ensure that there are adequate number and quality of health workers to deliver quality health care in health sector, (Verma 2012:17). The fact is that, existence of HRP and D makes (Prasad, 2015:151) the success for health system to provide expected quality services required by public. However, health sector experience some challenges, and if not addressed may led to the failure of health system as well as increase in complains to the respective government. The following challenges are encountered against the implementation of HRP and D in the health sector.

2.13.1 Country Economy Situation

Evidence from existing literature shows that countries' economic status determines the infrastructure and HR actions in health sector (Prasad, 2015:73, MOHSW, 2014:12 Kabene *et al.*, 2006; Maestad, 2006:2). It is noted that wealth of the country determines the contribution position or support to the health sector (Prasad, 2015:73). For example, retrenchment of employee is mostly conducted during economic crisis. The MOHSW, (2014:12) reports that the economic constrain in Tanzania have caused major impact to the health sector like management actions or HR actions extended a long period of time or failure to be implemented. For example, focus on service volume and institutional expansion rather than service quality, which has challenge of deficit of skilled workforce.

Based on this scenario, Rothewell and Kazanas (2013:20) acknowledge that the process of development and implementation of HRP and D plans need financial supports. He considers HRP and D and finance like chicken and eggs problem in which, one of the two should come first. This is emphasised by Kolehmainen-Aitken, (1993:10) that many countries spend 60% – 80% of their recurrent health budget on staff salaries and the remaining percentages

in other health activities like transport, purchasing of drugs, field visit and other operating activities. All these activities need a financial support for provision of expected health services to the public.

Further, Bankowski and Fulop (1986) expound that financial support in health sector is more than paying salaries, it is all cost associated in health systems like training and development programmes, health technology, buying drugs, employees' salaries. He continues to argue that, currently the health sector ignores the relationship of economics and HRP and D for health workers. Studies by Kolehmainen-Aitken (1993:11) shows that it is only some of HR plans have been economically analysed and assessed on the efficiency and effectiveness of its professions. Instead, these plans based on productivity, distribution of health workers as well as improving quality of services are viewed as a cost implication to be removed or not getting priority even though the health sector continue to be inefficiency and suffer with a lot of challenges (Akin *et al.,* 1986). While the MOHSW, (2014:18) reports that shortage of health professions in Tanzania requires government attention to address it immediately. The African countries budgets depend on donors or developed countries.

The literature shows that health workers in Tanzania health sector were abandoned and dispositional for a long time. Ironically, the country allocate more money on drugs, workforce continue to receive less attention especially on working conditions in such a way health professionals depart to look for greener pastures in other countries (MOHSW, 2014:18). In addition, the production plan of the MOHSW (2014:9) reports the same situation in education and development, that the government provides full scholarship for student in medical college while students in non-degree courses share the cost on accommodation and meals. This budget allocation to the health sector is still a challenge since the MOHSW (2014:5) reports that the population is projected to increase by 14 million (approximately to reach 59,709,483).

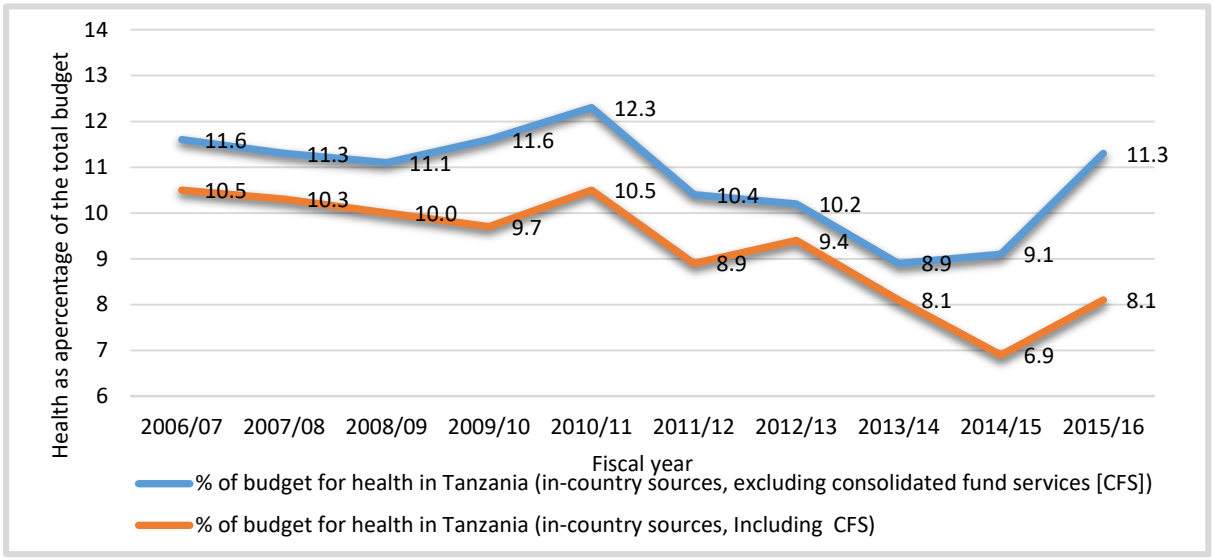


Figure 2.8: Percentage of Tanzania's National Budget Allocated to Health Source: (Lee et. *al.*, 2016:2)

From figure 2.8, in 2015/16 the government allocated 11.3% (Tsh.1, 821 billion) of the total budget to the health sector. However, that budget include development partners funds, allocated funds for Tanzania Commission for Aids (TACAIDS), the National Health Insurance Fund (NHIF) and Estimated funds to local government authorities (LGAs).

Although health sector is falling short of the Abuja Declaration target, in fiscal year (FY) 2015/16 the graph show an increase of the health sector budget compared to two years back (FY 2013/14 and 2014/15). Ten (10) years back from (2006-2015) the average budget allocated was around 10.8 percent. Moreover, the report of UNICEF (2014) analyse the budget allocated in priority sectors from 2011/12 to 2015/16.

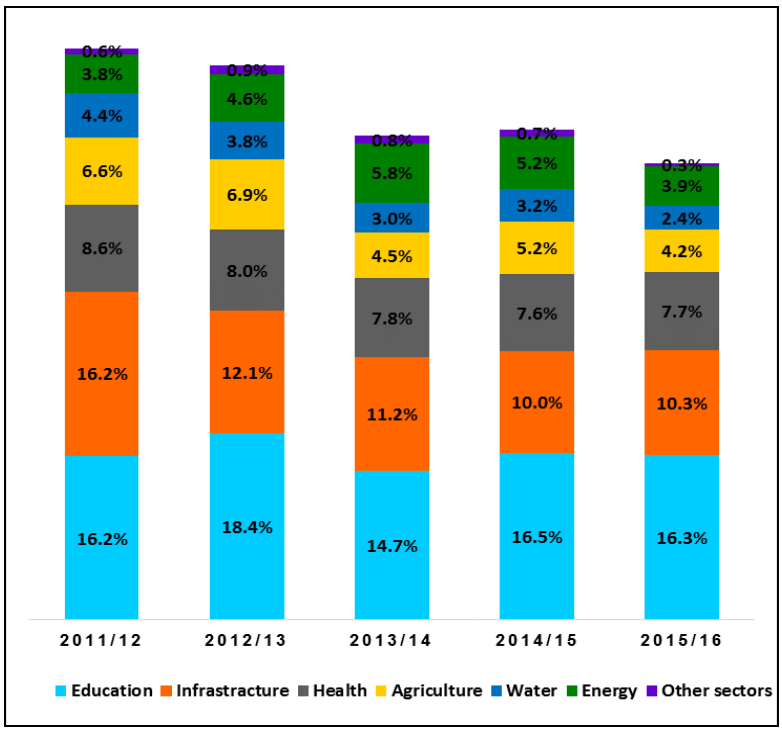


Figure 2.9: The share of the Health Sector in the total budget compared to other priority sectors

Source (United Nations Children's Fund, 2014)

Figure 2.9 shows the budget allocated in priority sectors for five years (FYs 2011/12 to 2015/16). The health sector lags behind education and infrastructure in receiving the share. The budget allocated to health sector in five years shows a declining trend.

2.13.2 Technological Factor

The widespread and rapid changes in technology have profound effects on the contents and context of jobs. These changes create problems concerning HR actions on recruitment, redundancies, retraining and redeployment of Human resource. According to Taneja (2012:186), technological environment is very dynamic and speedy. These technological innovations pronounced effects in changes of health sector especially in facilities, skills, and knowledge. It create more demand and competition of some skills in the market which in turn affect the HRP and D plan because it becomes difficult to recruit and acquire certain skills hence the sector continue to experience vacant post always. WHO, (2006:4) reported that advancement of technology and medical discipline create floundered in health delivery system to supply constantly required quality to the public.

2.13.3 Environmental Uncertainties

Another challenge is environmental uncertainties. It is clear that the organisation cannot exist in vacuum but in a certain environment, which cannot be ignored. The environments have direct or indirect impact on organisation performance of its strategic plans as well as HRP and D (Anyim et al., 2012). As it is considered of its importance, the environment tends to be dynamic, complex and uncertain where by accurate behaviour may not be predicted (Verma, 2012:21-22). In this uncertainty environment management formulate different programs and policies of HRM functions (recruitment, selection, incentives, capacity development, and ethics). According to Prasad, (2015:152) since HRP and D is part of planning which involves prediction of future in that uncertain environment, the results of prediction can be unrealistic.

In addition, changes in environment act as a driver for the organisations to plan efficiently and effectively on their workforces (Stoney 1995). While, the organisation experience more challenges to plan in accuracy in this situation, such difficulties are revealed much when conducting quantitative approach to forecast the requirement and supply of workforces in accurate manner (Armstrong, 2012:211). In overcoming environmental uncertainty organisations think on or use a short-term method to overcome HR surplus or deficit. The ministry must take into account the environmental dynamics; acquire the adequate HRIS systems that enable them to forecast the future of the health sector in accurate manner.

According to Rothwell (1995), rapid changes in the environment force the health sector to align the HRP and D with corporate plan and consider HRP and D as a tool to rescue the situation even though not always given the priority. In that manner Armstrong,(2012:211) concluded that HRP is "*extra than art and science"*, so it might not be important on the accuracy of number and skills requirements in future than the workforce required in the organisation which can be done through systematic methodology. Hence, Stredwick (2006:46) concluded that, in a rapid dynamic global environment, it becomes difficult to centrally plan for some of HR activities like succession, training and development and career development for large numbers of management. Therefore, to overcome this challenge, the Tanzania health sector needs to enhance the implementation of HRP and D in micro level (Regional and District level) and sustain the operation of HRIS system.

2.13.4 Management Capability and Inadequate Planning

According to Hall (1991) planning for health workers requires a team of experts on HRP and D with different area of specialization like Education planning, Economics, human resource planning, statistics, policy, Health, public health administration, hospital and facility planning as well as some specialization in health disciplines. Moreover, these skills are of expertise and scarce as explained by Hornby *et al.*, (1980) even though planning for health services start from local level, regional up to national level

Kolehmainen-Aitken (1993:14 -15) argues that, planning for HR in health sector needs a special unit, which in many developing countries does not exist. Even in those countries where HR unit exist still have limited functions and skills of HR. Hall and Mejia (1978) asserts that planning unit is being important function of the organisation due to its mandate to conduct and coordinate the whole process of planning. It should be integrated to suitable part of the organisation structure to function properly. This situation unfortunately characterize the Tanzania health sector operations, where Human Resource for Health Planning Unit lack of updated competencies to plan for its workforces (MOHSW, 2014:12). Therefore, there is no doubt that inefficiency on implementation of HRP and D exist since this potential unit have limited skills and knowledge.

2.13.5 Inadequate information

The efficacy of HRP and D is based on timely availability of relevant required HR data in conducting the plans. In the view of Prasad, (2015:152) if the importance of HR information is ignored in the health sector the forecast of HRP will be not accurate either, and might be minuses or pluses which can cost or frustrate the management of workforces in the sector. Concurring with this, Stone (2008:75) argued that, these plans (HRP and D) are functioning well if there are parts of existing HR information system.

While some studies assert that quality health care systems depends on proper implementation of HRP and D, which is conducted in different levels of Health sector such as policymaking and planning level, management level and operation level. In every level, it needs different types of data to support development, implementation and decisions (Chhabra, 2016:134; Prasad, 2015:138). These levels, according to WHO (1990) requires relevant data related to health and epidemiological. The WHO experience shows that most of countries' have

inadequate, incomplete, scattered, and inaccurate health activities data. Kolehmainen-Aitken (1990:19) claims that even the collected statistical data are rarely analysed to give a clear picture of health situation and allow decisions and planning on health problems and requirements health workers. On the other side, even some of the research, data produced by academic institutions are not presently in such a way that are accessible or user friendly to apply for management decision. Thus, why, Kolehmainen-Aitken advice that information being a potential requirement for the health sector decisions must gather it without considering the cost involved.

There is no denying though, that since the Tanzanian health sector conducting HRP and D the environment are dynamic and technology advanced very fast which need certain HR skills to perform health works. This situation brings a challenge to the health sector to have a HRIS system to manage and control the movement of health professions. As it was revealed in the Health Sector Performance Profile Report (2009) of Tanzania that there have been inconsistencies in the HRH data at the central and district government level. In addition, little information on professional cadres of graduates, curricula, diversities, gender distribution, employment and unemployment situation and the impact of universities programmes is provided on the health workers professions. MOHSW, (2014:12) the HRH information system is not adequate to support improved planning and management processes. Therefore, the management need to improve and sustain the HRIS system for proper management of health staff.

2.13.6 Human Resources Practitioners not Business Expert

HR practitioners have the responsibility to ensure the organisation operate effectively and efficiently in business environment. It is believed that HRP and D practitioners are not expert in managing business instead they deal with development of HR plans as well as personnel matters like recruitment and selection, promotions, transfers, succession planning, career development, performance management (Aswathappa, 2014:127). In that case, HR practitioners cannot be reliable on formulating the business plan in which HRP and HRD plan relies on. This raised the problem of not having the realistic HR plans because the business or strategic plan is not capturing the conducive environment of the organisation as well as the vision, mission and goals which organisation want to achieve.

In addition, Rothwell and Kazanas elaborate that due to the external forces in the health sector to provide quality health services, involvement of business experts and competent people in formulation of business plan is inevitable in order to be effective in implementations of HRP and D to cope with environment forces. Hence, this problem can be solved if HRP and D experts involved or given executive status in formulation of strategic plan of the health sector.

2.13.7 Skills Migration and Management

Human resources have become a competitive factor in health sector among developed and industrialised countries (Onodugo, 2012:1). Due to highly skills competition, Tettey (2003) points out that African countries lost their potential professions who cross borders to developed countries. The experience of loss of professions differs among countries. For example Soludo (2007:19) reports that out of 17 million of Nigerians who live in America, 26,000 are medical doctors. Similarly, Tettey (2003) reports the same situation nn South Africa that estimated more than 300 specialist nurses leave the country monthly while in Egypt – 600 rare specialisations and 45, 0000 scientist in different field reported having migrated out of country over the last 50 years. In addition, the migration challenge seems to continue in near future as reported by Southern African Migration Project Survey that within five years, half of 1,700 health professions surveyed in future would migrate.

Similarly, this happens in Tanzanian health sector in recruitment process. Not all posted employees report to their duty stations. Other employees report to their stations and quit. For example out of 11,912 posted staff, 5,159 employees were tracked and confirmed that they have reported to their duty stations while 57% of did not report. Either, 13% of the reported staff resigned for several reasons such as delays in being entered in the payroll and get pay on time MOHSW. It took an average period of three months for staff to be included in the payroll and receive salary payment (MOHSW, 2014:16;MOHSW 2011:6-7).

In spite of efforts of the MOHSW to ensure access of health facilities in a wide coverage still there are challenges on migration of skilled health workers, geographical imbalance, understaffing of health facilities as well as mal-distribution of competencies especially in rural areas (MOHSW, 2014:10). However, the data show that the population will increase by 30.5%, which estimated to be 59,709,483 million. With this population development will

require more health services while the sector is experiences migration of staff. Such challenges continue to exist because of (Kwesigbo et. *al.,2012)*, low motivation to staff which increases absenteeism that estimated to reach 40 percent (including training absences).

Shevel and Boyle (2008:16) add that migration of health professions is contributed by as many factors HRM being among them (poor salaries, no promotion, motivation, working environment etc. On the other side, Choykowski (2002:83) admit that migration of professional skills makes it difficult in HRM as well as HRP and D. For example, Tanzanian health sector experiences a high shortage of skilled health workers compared to other developing countries in African continent. According to the report of MOHSW, (2014;8), the standard requirements for good health system in low income countries the ratio for physician is 2.20 per 10,000 people and people and 4.7 nursing and midwifery per 10,000 people while standards for the WHO African region is 2.20 physician per 10,000 people and 5.3 nursing and midwifery per 10,000 as shown in the figure 2.10 below.

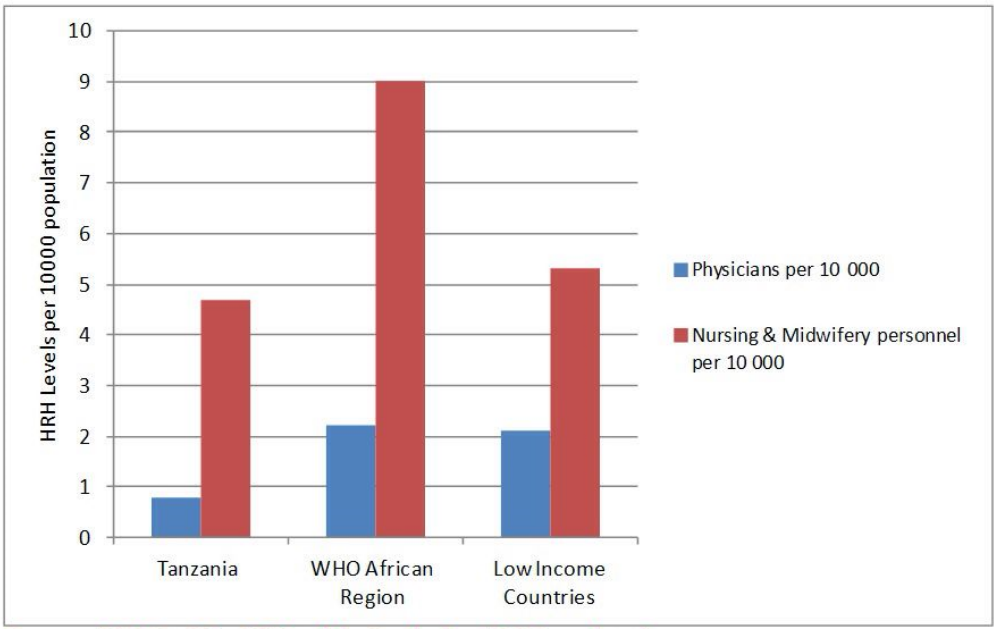


Figure 2.10: Human resource levels per 10,000 population in Tanzania compared to low income countries and the WHO African region (2014)

Source: (Ministry of Health and Social Welfare, 2014:8)

Therefore, with the situation of deficit of staff shown in figure 2.10, Onodugo, (2012:123) proposes that the government should invest in health sector and encouraging training in all

kind of health professional personnel. Hence, they need to write clear types of measures to be taken such as attraction and retention of skilled health workers. This is an unavoidable strategy, since migration of skilled workforce, cost a lot of money and destruct economic development of a country in health sector. Hence, Mejia and Fulop (1978) concluded that the mismatching between demand and supply of HR in the health sector is brought by poor planning of HRP and D where each side (demand and supply) work separately, thus making health systems workforce management suffer unnecessary.

2.13.8 Rigidity in Employees Attitude

Another challenge for inefficient of HRP and D is rigidity in employee's attitudes of top management and workforces. For example, some of the organisations tend to change their HR department names from so-called personnel department to HR department while they continue with old culture of treating workforces as a commodity and subordinate. In such situation, HRP and HRD plan is viewed as a luxury to be implemented in the organisation (Prasad, 2015:152).

On other hand, workforce attitudes affect the implementation of HRP and D with negativity on certain policies, programs and systems (Anyim *et al.,* 2012:73). However, in the view of Thornhill (1994:4) change of workforce attitudes is unavoidable because is human nature but HRP assist to avoid recruiting problematic workers and deal with employee's attitudes and behaviour. Either, some of leaders in Tanzanian health sector reveal rigidity on implementation of Open Performance Review and Appraisal system (OPRAS) to measure their performance. As supervisor in health facilities, they are reluctant to enforce the use of OPRAS to their subordinates (MOHSW, 2014:18; Faisal, 2012:12).

2.13.9 Conflict between Short-Term and Long-Term HR Needs

Inefficiencies in HRP and D reveal the conflict between short and long term planning. According to Prasad, (2015:152) in long term planning, there is a flexibility of matching workforces with work while in a short term is not. Works have to be matched with available workforce and pressure on some arrangement in the organisation is required. For instance, capacity building of Health workers is not a mere activity to be done in short term plan but need a long-term preparation and involve resources to invest on it. As Aswathappa

(2014:127) said, most of organisation management tend to give less priority in HR requirements because managers considered that all skills are existing in the market and organisation can get at any time as long as the organisation is good financially to pay good salaries. The above view was criticised by Peter and Hull, (1969) one's successful performance in one job level it is not an indicator to prove competences to another level.

In addition, Rothwell and Kazanas (2013:22) provided an example of short and long-term confliction on the case of good accountant who was experienced, very loyal and prove competences to his superior. Through these grounds, he was promoted to the position of a chief accountant, the position that later on he turned out to be disappointed about. He did believe on his subordinates so he do all the work himself and no succession plan was done to his subordinates. Soon he had to exit early to give a chance for other ones with leadership skills to take the position. According to them, the short-term and long-term HR needs can conflict with each other in ensuring workforce continuity (long-term plan) and get work done on time (short- term plan). Hence, the role of HR planners in health sector in HRP and D plans are set in long term with a short-term plan within; and their management consider and differentiate short term as well as long-term workforce needs.

2.13.10 Lack of Priority on Human Resource Problems

Problems that involve HR do not abruptly exist and in long run become difficult to solve. Mejia and Fulop (1978) declare that inefficiency of health services is something that developed in long process, which involves poor HRP and D, poor coordination, and mismatch between health training institutions and health care services providers on developing type of health workers required for the market. Prasad, (2015:127) argued that people tend to consider HR activities as not future oriented that need to be planned for. For example, workforces can be procured anytime when needed, they are not something to be planned for, is a matter of offering nice package to attract them and retrench them when finding surplus.

However, WHO (1986) reports that improved personnel management in developing countries is a new idea. Meanwhile, ideas of goals setting, cost-efficiency, and organisation performance were put in practice in their health sector. As discussed before, it is in this context, Kwesigabo *et al.,* (2012:34) points out that inefficiency of Tanzanian health sectors

is a global agenda in terms of poor planning of HRP and D. Despite these developing countries facing many challenges, concerning HRP and D, they still give little attention and priority to HR plan.

2.13.11 Lack of Appropriate, On-going Processing for Planning

Taneja (2012:134) illustrates that, for an organisation to have optimal number of staff and ensure skills and knowledge are available throughout, HRP and D activity should not be neglected but considered as a continuous process in the organisation. This emanates from the fact that HR enters into the organisation and exit through different factors like death, resignation, transfer and promotion and retirement. Kolehmainen-Aitken (1993:13) adds that many organisations considered HRP and D as a process, which starts somewhere and end, instead of cyclical process where each level of planning is catalyst of next level. In other words they put more efforts on developing plans and when done, no concentration of its implementation. He continue to argue that because planning process has financial implication and large number of people involved, managements tends to give priority and less attention on monitoring and evaluation of the plans to make some review is needed. HRP and D needs to be supported by mechanisms for monitoring and evaluation for managing the health instructions performance and managing health workers across the country (MOHSW, 2014:35).

2.13.12 Effective Policies and Systems

Human resource Management of health workers involve different policies and systems to ensure that health workers are available, developed, motivated and retained to deliver health services. Mangham, (2007:9) argue that lack of effective HR systems and policies in the Malawi health sector lead to poor management of health workers; transfer and promotion, motivation, in career development and dissatisfaction of health workers. Taneja (2012) adds that, wherever there is no Human Resource Planning and Development, the organisation can face challenges of overstaffed or understaffed. When the organisation is understaffed, it will not be able to perform to its fullest capacity because the staff is overstressed. It ends up losing customers, which in-turn the organisation becomes unable to attain its goals.

Moreover, when the organisation is overstaffed, the skills of employees remain underutilised and the organisation incurs more expenses of paying unnecessary salaries (Sekhri, 2010).

The Tanzanian public hospital experiences a challenge of understaffing. In 2014, the total number of staff was 68,348 compared to the population of 45 million and beds. The standards ratio for low-income countries is 11 beds per 10,000 people while in Tanzania public hospitals are estimated to be 21. Therefore, occupancy rate for beds is very high which pose the challenge of stress and pressure to health workers and inefficient in quality services (MOHSW, 2014:6). This calls for appropriate policies, strategies and HR systems to meet the demand of health workforce from top to low level of health system (Maestad, 2006:11).

2.14 PERFORMANCE MANAGEMENT IN PUBLIC SECTOR

Globally, public sector faces challenges of globalization and dynamic changes of environment which develop diversification of their needs, new customer requirements and expectations on services (Fourie:2012:124). This requires the public sector to be more innovative and coordinate HR systems well to overcome dynamic forces and changes of environment. Efficiency and quality public servants facilitate public sector performance well (Andrews,2014:2). The nature of performance management within public sector impact the services provided to the citizens. Isaac-Henry, Painter and Barnes (1993:59) state that performance management is a specific chain of procedure, techniques, and ways applied in managing workforces to attain success and targeted goals. It is how the public sector has capacity to the extent of delivering efficient and effective services (Faisal, 2010:5). Generally, performance management is considered as the level of accomplishment of specific activity or assignment by the workforce. Normally, certain sector or institution in the public service can be remarkable as high performer when it has designed performance assessment instrument to provide feedback to management to improve and maintain its status (Mealiea and Latham, 1996:541)

Thus, Performance is an important indicator of the quality of public servants in the public sector (Fourie, 2012:131).The capacity of performing its duties (Faisal, 2010:5) framed in quality policies, frameworks, and relevant environment, which allow implementation of those policies and frameworks. Then, Faisal adds that the Tanzanian Public Service develop HR policies and systems like Open Performance Appraisal System, client service charter

and monitoring and evaluation system to evaluate the quality of work-forces versus service delivery. It is through the strength and weaknesses that public servants are known (DeCenzo and Robin, 2007:256). However, Lee, *et al.*, 2015) describe that employees performance depends on leadership style and behaviour. In the Tanzanian public service, there are two types of leaders –administrative and political leaders. All these leaders have effect to the staff performance.

Boden, Cox and Nedava, (2006:129) expounds that public sectors claimed to be inefficient and ineffective due to outdated and sometimes incomplete frameworks, competence gaps of employees, unethical behavior and political interference. In order to be efficient Hood (1991:4-5) illustrate that incentives and rewards should be linked to performance of public servants works as well as politics must not impede administrative works and vise versa (Mafunisa,2010).

2.15 PERFORMANCE MANAGEMENT IN HEALTH SECTOR

As far as quality of health sector is among the public requirements, health sector should react immediately to dynamic environment of external forces such as technology, social, economic, political, demographic and globalisation. Continuity of quality health service, calls for an effective performance management systems, which are well planned and integrated in the HRP and D of health sector. It means, performance is directly interconnected to the overall performance of the public institution and the capacity of manpower available to deliver quality services. Performance management is a mirror through which health management see themselves in terms of what happening throughout within the health sector.

Buchan (2006) cited in Tikare (2009:51), expounded that uniqueness of health sector mostly relied on its measures or indicators of performance basing on outputs (like number of patients treated), workload (like patient insight measures, health worker per occupied bed) as well as outcomes (like, fertility rates, rates of post-surgery complications, mortality rates). In other words, Fourie (2012:124) advises that health sector to set up what they want to attain and develop indicators as a means to attain identified goals and success. The performance of the health workers must be planned, monitored, reviewed as well as assessed in identified period.

Health sector performance management is required to meet standards, and to ensure efficient and effective delivery of its service and in a sustainable manner (Mosadeghrad, 2012:203). However, health system performance differs country wide depending to economy, revenue, expenditure as well as how the system is designed, implemented, coordinated and budgeted (Semali,2003:1-2). The Ministry is an overseer of quality services. It cascade the performance goals to local government authorities (Regional and district level) to ensure the health workers perform well as directed.

Tikare (2009:24) adds that better performance in health sector depends on commitment of management on implementing HRP and D to acquire quality workforces, proper coordination, motivation to staff and well defined goals (Mosadeghrad, 2012:20). Currently, the Tanzanian Health sector uses OPRAS as an instrument to improve performance of health workers. However, its implementation still face challenges like less utilisation of OPRAS; staff promotions rewarded by considering working experience instead of both performance and experience; poor commitment of management on use of OPRAS due to poor knowledge on application of OPRAS (MOHSW, 2014:18). Thus, Martinez and Martineau, (2001) claim that there is no effective comprehensive performance management system existing in African countries.

Generally, the good performance of the respective health institution is the function of every individual or employee within it (Armstrong, 2012:328). It is important therefore for every person to accomplish the assigned duties to achieve the required goals of the public institution. Gheorghe and Hack (2007:19) concluded that managing performance properly is like running a business. It is a continuing process which start on planning, implementing and at the end needs to be evaluated for planning again to ensure right things are done at a right time. Hence, training and development needs to be viewed as an important factor for improving poor performance instead of viewing it as a cost incurred in the sector.

2.16 DETERMINANT FACTOR RELATING TO PERFORMANCE OF HEALTH WORKERS

According to the WHO, (2006) health workers performance is more than competences the person have but is how facilities, HR systems, frameworks, infrastructures and equipment are in place to facilitate employees to full utilise their competencies. Fourie (2012:1) further

argue that committed management enhance information system, transparent and accountable system ensures performance and quality system in place (Gaster and Squires, 2003:21). In the same vein, Dieleman and Harnmeijer (2006:5) identify four factors for successful implementation of performance management in health sector: Improved competences, improved responsiveness, increased productivity and increased availability in the sector. The figure below elaborates the determinant factors of performance.

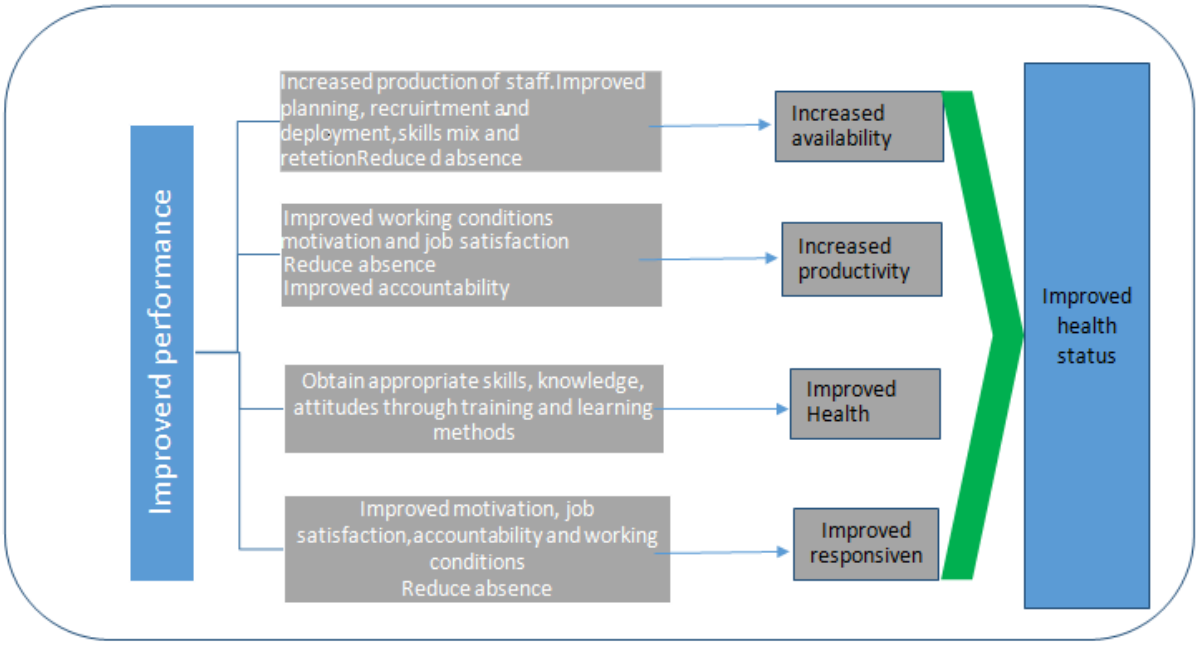


Figure 2.11: Determinant factors of performance in Health Sector Source: Dieleman and Harnmeijer, (2006:6)

Improved performance resulted from systematic process of integrating intervention (inputs) such as policies, frameworks and HR systems and processed to give out the desired outcomes like improved workforce recruitment, retention, motivation, career development and conducive working environment. Moreover, outputs can be measured through increasing organisation production, improvement of workers competences, transparency and accountability. These, in turn positively improve performance which resulted to efficient of health sector in service delivered to the public.

2.17 EQUITABLE DISTRIBUTION, RETENTION AND ATTRACTION OF STAFF IN HEALTH SECTOR

One of core functions of the Government is to ensure provision of quality service to the public. In order to achieve this role, there is a need of having equitable distribution of staff, attraction and retention plan in the public service.

Equitable distribution of public service refers to a state of affairs in which all people within a society have a same status in receiving public services such as health, education, water and electricity. In most cases, provision of these services, mostly depends on the availability of public servants. For example, provision of health public servants should be distributed equally to all service delivery facilities (Kurowski *et al.,* 2004; Maestad, 2006:3). However, there is unequal distribution of health workers in Tanzania with most health practitioners not liking to work in rural areas where more than 70% of Tanzanians live. Instead they concentrate and remain in urban areas where many hospitals are located. In Dar-es-salaam, doctors-patient- ration is 25 doctors to 100,000 patients other regions like Kigoma, Rukwa, Tabora and Shinyanga the situation is more worse at a ratio of below 4 doctor per 100,000 patients (MOHSW, 2014:12; Kwesigabo *et al.,* 2012:40; Msola 2008). This skewed representation of health workers especially doctors and nurses' cadres result into people in rural areas not enjoying equal health facilities compared to those people in urban areas (Ojakaa *et al.,* 2014:2; Maestad, 2006:3).

Therefore, Ojakaa *et al.,* (2014:2) contended that unequal distribution of health profession is made by problem of attraction and retention in the health sector. The report of MOHSW, (2014:17) reveal that 53 percent health professionals in districts intend to quit their jobs. This problem attributed to several factors such as lack of special poor working conditions, incentives, supplementary income opportunities, suitable quality housing and adequate access to health, education and social facilities. Others problems include inadequate access to telephone and internet services; and utilities such as water and electricity (Franco *et al.,* 2002:1255-66; Ojakaa *et al.,* 2014:2). Further, MOHSW, (2014:17) adds that challenges lies on issue of compensation and working conditions. There is no national framework or instrument to guide on retention of staff. However, PO-PSM developed pay and incentive policy in 2010, which is not yet operationalized. This situation fosters the brain drain to look for greener pasture in other countries particularly to developed ones. Therefore, health sector continues to suffer with shortage and imbalance of health profession in health facilities.

It is for this reason Dieleman and Harmeijer, (2006:18) propose that for organisation to perform its objectives diligently, it must have the best recruitment plan to attract highly qualified and experience candidates and also retain them to cater the organisation activities. The main objective for retention (Armstrong, 2012:241) is to avoid the loss of professional and talented workforce, which can resulted to recruitment cost, training cost and poor service delivery. However, national level retention strategy ensures competent, skilled and talented professionals remain in the country and does not leave to search for greener pasture in other countries. They remain and use their skills to support the national plans.

However, there are some non-voluntary retention strategies, which invent to neutralize the environment that forces the competent workforce to migrate like scholarships and bursaries. Thus, Kinnear and Sutherland (2001:17) substantiate that money is a means for attracting, retaining and motivating competent and qualifies workforce in different institutions. Further, Kinnear and Sutherland observe that in South Africa, competent workforces are oriented where they expect their performance to be rewarded by money as compensation. Mutale *et al.*, (2013) concluded that motivation have interconnection and act as a catalyst of job satisfaction and retention of health worker in Tanzania, at a regional level.

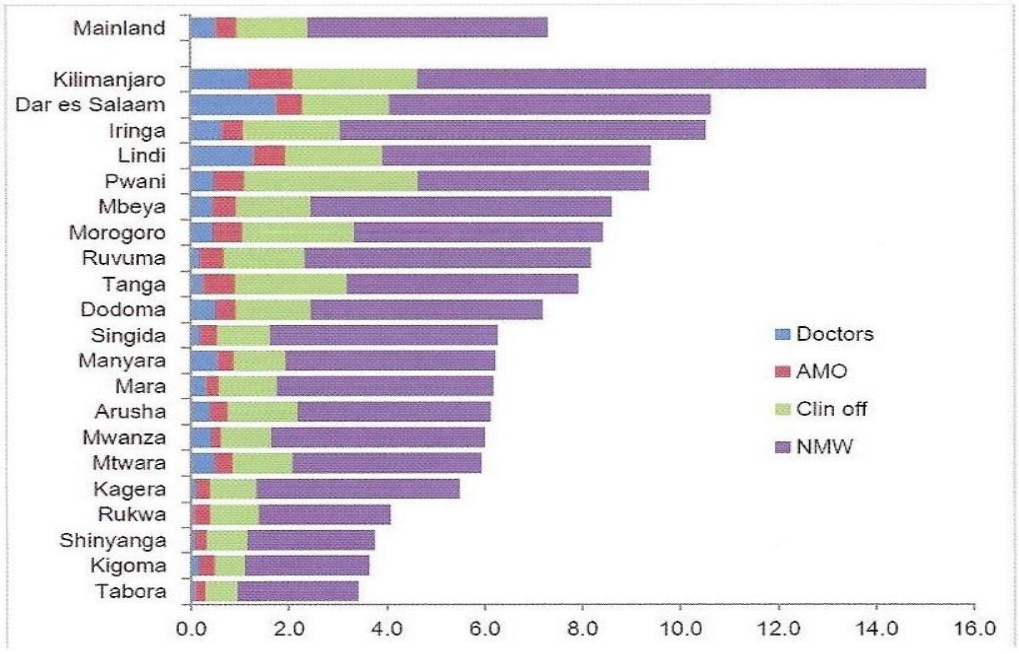


Figure 2.12: Health Workers Distribution in Regions Source: Ministry of Health and Social Welfare (2014:13)

The report of MOHSW,(2014:13) shows that the distribution of health workers in Tanzania region is not balanced especially at the level of dispensaries. There is a huge gap of

availability of staff between regions. For Kigoma, Shinyanga, Tabora, Rukwa, kagera the situation is critical compared to Dar-es-salaam, Lindi, Pwani, Kilimanjaro and Iringa. This is due to the poor working environment in rural areas. Staff prefers to work in urban areas. Hence, those regions, which have inadequate number of health workers, cannot manage to provide quality services.

2.18 CULTURE, DEVELOPMENT AND MANAGEMENT IN THE HEALTH SECTOR

In any sector; such as health, agriculture and industry, culture is among the factor that shapes development and implementation of HRP and D. Culture is perceived as all aspects of lives of people that distinguish them from other people (Prasad, 2014:624). The concept covers all facets of human society: knowledge, behaviour, beliefs, art, morals, laws and customs. Culture should not be seen only as material possess like health workers dresses, health facilities, medicines but consisting of institutions, health workers behaviours, feelings, attitudes and beliefs.

It is a learned behaviour, which identify people in a certain society. Hofstede (1991) and Iguisi (1994), advocates that since societies exhibit distinct and persistent cultures, organisations in different social context are likely to experience such variations. Moreover, Aluko (2001) insisted that organisation members from different cultures differ in their needs for affiliation, security, self-actualisation, achievement and these have a close relationship of behaviour within an organisation. This because the individual try to fit in the culture of that society. Hence, Societies differ in norms and attitudes of people towards authority. Consequently, subordinates from different societies react differently to superiors and will experience different organisational rules considering rights and duties (Hofstede, 1991; Aluko, 2001).

Organisation culture has impact on performance and success of the organisation when managed well (Abdul *et al,* 2003:708). In a more elaborative manner Lynch (1997) illustrate that culture is a feature of the entire organization, not just for some of the individuals within that organization. Therefore, if someone –even the chief executive leaves the organization, the culture of that organization should not change significantly. Culture is on-going it is not a one –time event (Olanipekun *et al.,* 2013:207).

Aswathappa (2014:500-501) insisted that development and planned change cannot be understood or be effective without considering how culture may be a source of resistance-since it is shaped by the past experiences, culture commonly acts as an impediments to change. This took place in the Tanzanian health sector being resist to implement OPRAS system as a mechanism for performance evaluation. Some of management were rigid to enforce this system to their subordinates due to inadequate knowledge on use of OPRAS mechanism and not want to be accountable. It is through employees performance the HRH planners can forecast the number and competencies needed in health sector (Faisal, 2012:12). Therefore, there still a need for heath sector institutions to change and implement performance management tools, to influence health sector culture of transparency, accountability, quality service and ensure that health staff adjust to new performance culture on accountability.

Prasad, (2015:73), advanced the argument that, culture has effect to health workers performance, satisfaction, retention and attention in doing work. Also emphasised that ethics and efficiency are highly correlated in such a way that an Organisations with high levels of integrity are also proven to be highly efficient and effective in performance and in provision of quality services. This relationship also can be subjected to management culture. Management Culture as attitudes and behaviour that characterise the functioning of a group or organisation in a management setting (Krumbholz and Maiden, 2000). In building and sustaining health culture, HRP and D need to reinforce continually through planning and training in order to maintain health workers character through practices and become good one to deliver quality services.

2.19 PHYSICAL INFRASTRUCTURE,

In the health sector, and policy directives govern Human Resource Planning and Development, which are known as internal infrastructure. At the same time, management of health workers needs involvement of external infrastructure affects motivation, satisfaction, retention, and health in a sustainable manner. These infrastructures support the study because human resources are exception resource in the health sector and needs proper management and strategies to maintain quality of health services.

2.19.1 Internal Physical Infrastructure in Health Sector

The report by (WHO, 2005) revealed that, globally, more than 18 million of people lost their life due to nutritional deficiencies, maternal and perinatal situation and communicable diseases. However, majority of these deaths happen in Africa. This being the case, health based Millennium Development Goals were approved by United Nation in 2000 to improve the health sector in developing countries and ensure availability and access of quality health service. Being the framework in the global community, MDGs identify common priority to developed and developing government in attaining development success.

Moreover, in the MDGs, health is recognised as the most important element in its objectives as it is revealed in three (In objective number four, five and six of MDGs) out of eight objectives and makes its importance on achieving other objectives. These objectives aimed at reducing child mortality by two-thirds, maternal rate by three- quarters and combat HIV/AIDS, Malaria, and other diseases (UN, 2000). In addition, MDGs view the importance of global partnership for country's growth. It recognised this in objective eight that some of the activities and objectives for developments in developing countries needs support from developed ones.

However, the challenge in implementation of MDGs is to ensure unbiased and efficiency health system, priority of health sector in country's economy, development of health policies and strategies, improvement of workforce information system and health data as well as mobilization of all type of resources in developing countries (WHO,2005:1-2).

In Tanzanian context, epidemiological profiles show high burden of disease and this remains a major challenge facing the health sector (MOHSW, 2014). In spite of a decline in infant and under five mortality, overall Maternal Mortality Ratio (MMR) and prevalence of other major diseases like HIV/AIDS (11.4%), malaria (2.4%), pneumonia (3.2%). and tuberculosis (5%) the workforce requirements of most of the interventions Programs are not provided for in the current staffing levels. A country also faces high incidence of non-communicable conditions such as cancers, diabetes, malnutrition, and cardio-vascular diseases, which hinder the attainability of MDGs.

Therefore, MDGs objectives achieved if and only if there is proper implementation of HRP and D, which facilitate the availability of competent workforce, talented and committed

leaders. Similarly, all those capacity of workforce and leaders needs to be developed through human resource development to meet the challenges of poor workforce capacity. It mean, availability of Human Resource Planning and Human Resource Development plans in health sector ensure availability of capable human capital to provide quality health service.

2.19.3 THE TANZANIA DEVELOPMENT VISION 2015

In recognising 21st Century, which is dominated with technological advancement, highly developed and efficient infrastructure, high competition and productivity as well as highly skilled workforce, the Tanzania government in 2000 launched development vision 2025 to strengthen its self in order to cope with global developments.

The Development Vision 2025 is a government framework and roadmap, which guide a country in achieving social and economic development of the nation up to 2025. Similarly, the vision aims at managing and co-ordinating resources (workforce, finance, and natural resources) available in priority sectors in which health sector is among them.

Furthermore, one of the objectives of Development Vision 2025 meant to keep up human development through attaining efficiency and quality livelihood for all Tanzanian. According to Sirilli (2014:1), achieving quality livelihood requires well-organized health system with efficient HRP and D systems to ensure existence of quality people. Also under that goal, the vision aims to ensure that the creation of wealth and its distribution are inclusive forms of wealth-creation and sharing processes. The investments that have been made and continue to be made in education and learning should have created a critical mass of highly qualified and educated people.

The vision meant to build a strong and competitive economy. As a technological and market conditions change, the country must be able to adapt them efficiently and effectively. By 2025, Tanzania should have created a strong, diversified and resilient competitive economy. Finally, the vision is also aimed to achieve good governance and rule of law to embrace a culture of accountability, rewarding performance and doing away with all vices in the course of creating, and sharing wealth. The high level of workforce will have to become an important source of growth and will be able:

a) To propel Tanzania to self-reliance

b) To generate a positive mind-set and a culture of hard working, entrepreneurship, creativity, innovativeness and ingenuity; and

c) Finally, peace, stability and unity are the important ingredients in the endeavour

2.20 THE TANZANIA NATIONAL STRATEGY FOR GROWTH AND REDUCTION OF POVERTY

The Vision 2025 was launched in 1999 with overall objective to steer a country to become the "competitive" and "middle income economy." Although there was no formal instrument to operationalize the Vision, it is imperative to suggest that the three successive Strategies for Growth and Reduction of Poverty (NSGRP or MKUKUTA in Swahili acronomy) which were adopted in 1999 and2005 were assumed largely, to bride this gap. In other words, NSGRP interprets Vision 2025 and MDGs into organised outcomes.

All three phases of Tanzania National Strategy for Growth and Reduction of Poverty focused on increasing speed of economic growth, reducing poverty, developing and improving the standard of life and social welfare of the citizen as well as accountability and good governance of leadership. As revealed in the Primary Health Services Development Program (MMAM) of 2007-2017 that most of Tanzanian people who leave in rural areas are poor (pp: 5). Such situation of people being poor can be removed by the government which practice good governance and design frameworks to enhance the well-being of the public.

The strategy primarily meant to cope with the changes of world economic environment such as dynamic changes of prices in oil and food impact in the Tanzania's economy. Such crisis enforces Tanzania to develop strategy to speed up economic development and fight against poverty. The strategy also advocates and encourages quality of life and well-being for entire Tanzanians. MOHSW (2014:6) develop different interventions, which recognize this objective (quality of life and well-being) like controlling diseases and maintaining immune for children to build strong skilled workforce, which can participate in development of the country's economy. In addition, it aimed to increase relationship among stakeholders and all sectors to tackle crosscutting issues such as gender, disability, employment, environment, HIV/AIDS, and settlement.

2.21 TANZANIA NATIONAL HEALTH POLICY OF 2007

Quality of health service has been the government priority in ensuring that it is available and accessible to all citizens in rural and urban areas. The government recognise the importance of quality of health to the people as it is an important component in economic growth of the nation. In order to ensure this, the government developed different National health Policies since and after independence. In 2007, the government developed National Health Policy to guide and provide a direction to the MOHSW towards managing, improving and accessing health services by all Tanzanians. These policies target especially special groups like children under age of five years, children under age of starting school and those who are in already in school, disabled, women under reproductive age and elders. This is to ensure the rates of mortality; morbidity and disability reduced as well as improving health situation and increase life expectancy of citizens.

The Policy focus on ensuring that, primary health services are available and provided through good system in a participatory way of involving the society with recognition of existing policies, laws and guidelines. Also the Policy aimed to ensure that it reduce the burden of disease, maternal and infant mortality and increase life expectancy through provision of adequate, equitable maternal and child health services; facilitate the promotion of environmental, health and sanitation, promotion of adequate nutrition, control of communicable diseases and treatment of common diseases.

Moreover, the Policy recognise importance of stakeholders by insisting the sustainability of partnership in health sector between public –private sector, religious institutions, NGO's and society as well in provision of quality health services. The Policy emphasises on sensitisation and awareness to the society on common preventable diseases, in order to identify and assess diseases, to develop appropriate strategies to overcome through society involvement as a whole. In addition, the Policy encourage health sector to sensitise on family health as a responsibility of the individual, society and nation while ones' health rests in the person responsibility.

Finally, the Policy meant to guide the training, development and ensuring availability of competent and optimal number of health workers to manage and provide standard health services with gender outlook at all positions in the health sector. This will ensure the health services are accessible to the citizens in all areas. Finally, intention of the Policy is to monitor

and evaluate Policies, laws and standards of health services to the public to ensure people access to quality health services as intended by the government.

2.22 TANZANIA STANDING ORDER FOR THE PUBLIC SERVICE OF 2009

Tanzanian Standing Order for the Public Service of 2009 considered as a useful framework, which guides the public service in making rational judgment on HR issues such as appointment, transfer, promotion, leave and training. According to the Tanzanian Standing Order of the Tanzania Public service third edition of 2009, there is existing a framework which guides the Public Service conduct (2009; G1) in order to provide an overview about the importance of training and development in the Public Service sub-section. G1 (1) states that:

> *"It is Government Policy that Tanzania should be self-sufficient in trained and skilled human resources in order to manage its economy."*

Given such section G1 of training reveal that, skills, knowledge and competences, which are well planned, are so important for the social-economic development of the country. In other words, this section G1 informs the HR planners on all issues of training like forms of training, conditions governing training and types of leave, needed to be taken into account in developing HRP and D of health workers. Armstrong (2012:210), point out that HR planning as a process that incorporates projection of health workers workload, turnover, quality and number of health workers required.

In addition, Part D.2 of the Standing Order informed employers on group of appointments to be integrated in developing HRP and HRD plans on issues of acquisition, utilisation and development of health workers. For example, in a short term plan of HRP, due to shortage of health workers, the HR planner can opt to include temporally or part time appointment workers to fill the gaps. As the responsibility of management to ensure, sufficient number of workforce is available in a right time and at a right place (Verma, 2012:17).

2.23 TANZANIAN PUBLIC SERVICE MANAGEMENT AND EMPLOYMENT POLICY OF 2008

Public Service Management and Employment Policy of 1998 reviewed in 2008 with the view to transform the image of the public service system. This exist in order to meet the

expectations of public in this century following the changes that are taking place within a country. The policy aimed to set out the ethics and core values, principles of management and procedures that will transform the public service into a better one, based on merit and development approach. In addition, the Policy aimed at having adequate number of staff in the public service depending on government capacity on implementing its mandates.

Moreover, the Policy aimed at insisting on well-trained, experienced, ethical, professional, creative and motivated workforces in the delivery of quality services. Thus, the policy recognises the importance of human resource development and motivation of public servants as a tool for public service to flourish in uncertain environments. In this case, the Policy continue to insist on the public institutions in recognising, encouraging, rewarding and maintaining performance standards of employees and institutions on doing works. However, for those who have poor performance should be punished. According to Martinez (2001), top management must recognize, reward employees, and create good environment for them to perform according to the standards.

Moreover, the Public Service Management and Employment Policy of 2008 meant to direct the availability of exchange program between the public servants and employees in private sector to exchange knowledge and skills. In addition, the policy insists on availability of contract employment in specific period for employees who have required professional, experience, skills and knowledge. As a result, the public servants will gain the new skills, knowledge, behaviour and competences on doing works, which facilitate changes on performing jobs.

2.24 TANZANIAN PUBLIC SERVICE TRAINING POLICY OF 2013

For public service to continue to execute its mandates, it needs competent people with capabilities to manage allocated duties efficiently and effectively. However, due to dynamic environment, public servants need continuous sharpening, improving and developing skills, abilities and competences through training. Therefore, the government of Tanzania critically assessed this and decided to develop Public Service Training Policy of 2013 to guide the government institutions on coordinating and managing training of public servants. Morrow et al (2011:22) view training as an investment with long-term pay-off, and can be a most effective way to bridge performance gap if it appropriately designed and implemented.

In that view, development of Training Policy focus on putting in place rational systems, clear procedures, cost-effective measures, accountability, transparent, organised and fair

administration of training in all public institutions. The uniformity in training will enable to create affordable and continuous learning environment. Often, training programmes prescribed as immediate solution to performance problems although there is a consensus that, if training needs are not identified properly and analysed training programs may not be useful and effective. Effective training has to be preceded by training needs assessment which refers to analysing and evaluating the available skills, knowledge and attitudes at organisational and individual level against the requirements necessary for effective performance (Prasad, 2015:247).

The need for well-targeted and appropriate training and development met by using this policy, which is a framework to guide Public service Institutions to develop and implement human resource development. The Policy is also standardising HR management processes within the public service. Its use can foster equal opportunities among public servants in terms of career development and retention.

Further, the policy meant to harmonise the existent of various policies, systems, as well as procedures applied in the supervising and management of employees' training. Moreover, the policy seeks to improve efficiency of government in service delivery by having competent public servants. It look on the other side of cost effectiveness and demand driven which means training policy emphasises on skills development through training that responds to service delivery requirements and seeks to facilitate career growth. However, training function in the Public Service is the responsibility of the employers to prepare and implement the training plan to their institution.

2.25 TANZANIAN PUBLIC SERVICE SUCCESSION PLANNING GUIDELINE OF 2011

Undoubtedly, efficiency of Public Service depends on many factors among other things, succession planning. The Succession plan conducted to ensure there is equitable number of staff available, which is the jewel need for proper management, planning, and development. Rothwell (2005) argued that if importance of succession planning not recognised in the institution, no changes will take place for transition. Due to importance of human resource in the public service, the government of Tanzania through Public Service Reform Programme II (PSRP II) needs to improve service delivery in the public service. In this context, succession-planning guideline of 2011 developed to identify, develop, and retain talents for key positions and areas in line with organisation strategic objectives.

Succession Planning guideline, facilitates uniformity and systematic way towards management of public servants to ensure that the government institutions have prepared, developed public servants with required skills, knowledge, competences, attitudes and culture in order to execute their current and future position activities or jobs. Through the guideline, all vacant posts made by retirees, transfer, promotion especially in top management posts replaced on time without distorting the institution to attain its objective and provide required services to the public.

With establishment of succession planning guideline, government institutions have adequate, competent, committed and efficient leaders, transferring invaluable organizational knowledge, continuation of culture and proper procedure in the public service. The intention of the guideline is to prepare the public servants to acquire required skills for higher posts, so that they can replace posts, which fall vacant. Moreover, by doing replacement of those vacant post from within it create job satisfaction, career development and retention of public servants to continue working with public service. Chhabra, (2005:150) observe that succession planning promote more replacement from internal supply which encourage employees career development, not simply jobs.

Additionally, having the succession planning guideline it improve the performance of public service because of having a talent pool of successors who have capabilities, experience and competences required to fill top positions. Stinchcomb *et al.,* (2010) admits that succession planning is more than making available competent, motivated employees for promotion to top position but capacitate the employees to perform and execute job effectively in management positions. Similarly, the guideline assists to make monitoring on public servants performance and develop competency gaps for capacity development.

2.26 EDUCATION AND VOCATION TRAINING POLICY OF 2014

The Education and Vocation Training Policy of 2014 resulted after improvement and cancellation of other three legislations: Education and Vocation Training of 1996, Higher Education Policy of 1999 and Information and Communication Technology (ICT) Policy due to changes of government, which came with different organisation structure. The new policy was established to meet global changes in political, economic, social-cultural as well as science and technology which inquire new way of managing education sector. However, the plan of the Tanzanian government is to become the "Middle Income Country" by 2025

while the education sector has the responsibility to develop and prepare enough workforces to complement those changes.

The policy meant to ensure a country has educated, skilled, knowledgeable, experienced and competent people who can compete in the global market and support economic development of the country, due to dynamic changes in technology, social, economy, market and politics dimensions which demand high skills, capacity and knowledge to deal with such situation happens in many countries globally which recall for restructuring policy and investment especially more in HRD systems to meet the environment forces and threats. Gerber et al cited in van der Walt, (1999:176) admit that workforce capacity is the key factor to overcome social and economic challenges. Thus why South Africa invest in development of its workforce to overcome the situation of economic risk Also, policy advocates for education and vocation training system which takes into account cross cutting issues to manage production of workforces who meet market demands.

Similarly, the Policy focuses on having systems, frameworks, strategies and procedures, which encourage and facilitate Tanzanians to develop themselves in different ways in attaining their professions and career. In addition, the policy meant to produce standard and quality training and education, which recognised internationally, regionally and nationally.

Furthermore, under this policy, efficiency in operation and managing of training and education in the country is emphasised. The policy meant to encourage training institution and employers to invest in education and training with adherence to stipulated education and training standards. The Policy is also focusing on increasing number of workforce similarly to national priorities. Therefore, it continues to insist on government responsibilities on paying education cost in the country as a right for Tanzanians to acquire education as stipulated in Section 11 of the Constitution.

2.27 TANZANIAN OCCUPATIONAL HEALTH AND SAFETY ACT OF 2003

The formal and informal sectors, in most African countries calls for special attention to enhance, prevention and control occupation hazards; which resulted into disability and burden of disease to the people. Development and enforcement of policies, rules, and regulation on occupation health services require strengthening to respond to situation (WHO-ILO, 2000:2). However, health and safety policy gets little attention by most of

managements in organisations (Armstrong, 2012:440). In overcoming this situation in Tanzania, the government developed Occupational Health and Safety Act of 2003, which insist on every employer to ensure safety and healthy working environment for employees. For instance, emergency exit, availability of clean water, sewage disposal, fire protection, welfare facilities, accommodation, first aid facilities, adequate sanitary and facility for resting.

Similarly, the Act informs employers to conduct regular occupational medical testing for employment and fitness of workforces in order to carry out their activities with the required standards; ensure working equipments and machines are well secured and safe for use as well as conducting training, supervision and research on using those equipment and machines . Also, the Act, require employers to ensure work places and factories are maintained and suitable for working. That means workers should conduct regular inspections of their facilities and machines like steam boilers and fittings, lifting machines, cranes and conducted by authorised inspectors.

Furthermore, the Act inform employers to conduct annual or when required risk assessment on activities which involves use of hazardous chemical substances or hazards equipment or processes which lead to damage of properties or environments and effects to peoples' health. Health and Safety audit (Armstrong, 2012:441) reveals risk involved in certain work. Thus, employers should overcome that risk by protecting employees from injurious and accident environment by ensuring safety and health environment and giving employees protective equipment. It is the responsibility of the employer to ensure conducive working environment, which consider Occupational Health and Safety for the employees to perform their activities in a required standard. In the views of Chhabra, (2016:482) Health and Safety are also responsibility of everyone associated with the work place, but to achieve and keep standard of health and safety working environment is a management duty.

Aswathappa, (2014:518) disclosed that if an employee get injury or occupation diseases in a work place, it is a responsibility of employer to compensate him or her. Hence, maintaining health and safety in work place is a cost saving for management to rescue the organisation from paying medical expenses, compensation, as well as management risk. This is insisted in the Public Service Regulation of 2003, (110.1) that, it is the government responsibility when an employee gets injury or death that is made by occupation disease or an accident course or during his or her employment. However, health and Safety as among management

activities which receives minimum attention or not valued at all in Human Resource Planning and Development, publications, literatures and in work place especially in global big industries (Lakshika *et al.*, (2010:67).

2.28 TANZANIAN PUBLIC SERVICE PAY AND INCENTIVE POLICY OF 2010

Public Service Pay and Incentives Policy of 2010 developed primarily to harmonise and remove disparities among public service institutions especially in managerial, technical and professional cadres in entire public. Moreover, the Policy meant to ensure attraction, retention of competent, skilled, knowledgeable workforce as well as motivating and managing employees to perform efficiently in order to avoid unnecessary cost of recruitment and training.

Similarly, the policy aimed to remove staffing perceptions and problems in LGA's by making sure that there is equal pay for equal value of task, in order to attract public servants to work at any location and remove unequal distribution number of employees in the public service. In addition, the policy encourages the workforce to increase level of performance and standard of working and productivity in the public institutions. Further to the purpose of Pay and Incentive Policy 2010, the policy meant to guide a compensation structure to organisations. In addition, the Policy seeks to get effective accountability and transparent workforces to the management across the public service.

3.16 TANZANIAN EMPLOYMENT AND LABOUR RELATION ACT OF 2004 (ACT 6 OF 2004)

The Employment and Labour Relation Act of 2004 enacted to stipulate the essential labour rights, employment standards and provide framework for employers and employees to conduct collective bargaining and settlement of disputes in the public service. The Act stipulates fundamental rights of employees in work place, which include employment age, free from discrimination and harassment and freedom of association.

The Act aimed at guiding the employers on the working environments and employment standards such as standard working hours, remuneration, and

unmerited termination of employment, which can affect employees to execute their work in the required standards. Furthermore, the Act guides trade unions, employers, and federations overall process of formulation, organising and coordinating the associations. In Section 20 (1) of the URT Constitution, it gives employee rights to associate and cooperate with others. Gerber *et al*., (1998:95) expounds that professional associations of health workers like doctors, nurses, pharmacist create an easy environment or opportunities for the members to meet with employers.

Moreover, the Act aimed to inform employers to recognise trade union activities in HR functions like paid leave to participate in trade unions activities, and allow trade unions activities to be conducted in the organisation premises. It means that registered associations should have the representation and office in the organisation. Similarly, the Act meant to encourage employer or employees through associations or trade unions to use collective bargaining tool as a means to settle disputes with employees or employers. The Act stipulates the completely bargaining process between the employer and employee in order to find the consensus.

Under part VII of the Act, it stipulates the right to strike and lockout. The Act is allowing the employer to lockout and employees to strike in a systematic identified procedures, discipline, and peaceful manner. In addition, the Act provided the way to settle disputes between the employer and employees to find solution in order to continue to build the national development.

2.29 EXTERNAL INTERNAL PHYSICAL INFRASTRUCTURE IN HEALTH SECTOR

2.29.1 Working Environment

Success of health sector on procurement and retention of health workers is beyond employment contract or conditions and incentives, but also good working conditions and social facilities. In the current organisation management (Chhbra, 2016:479) conducive working environment, become factor of winning and attracting workforce to join in the organisation. Such attention rose due to open-minded of top management on recognising importance of working environment in workforce performance and the development of trade

unions on fighting of workers' rights. Moreover, Chhbra emphasises that, workforce's need good health working facilities since they spend about 8 hours at work place. So, good working environment is needed for workforce to execute their activities without physical or mental problem.

It is believed that, organisation environments are good identity of health workers attitudes, culture and behaviour (Adams, 2000:24). Thus, why, most of health workers especially from Africa tend to be more satisfied and prefer to work in developed countries because of attraction working environment, motives of job satisfaction as well as high salaries and career development (Mangham, 2007:4).

According to Dieleman and Harmeijer (2006:18), working environment infrastructure viewed as a motivation factors for good performance. Such motivation factors go beyond adequate equipment, drugs, materials as well as supplies. It involves infrastructure, quantity, and workload of job, capacity of workforce as well as management communication and decisions of the health facilities affect efficiency of health services (Mangham, 2007:1). However, if the working environment is poor, employees will abstain, lack concentration at work, fail dedicate themselves in doing activities and finally quit the job as a result high turnover rate or absenteeism, which will result to low quality and efficiency of services.

In Tanzania, health facilities standards and condition differ from one another, and some of them change status from health centres to district hospital or from district hospital to regional hospital, but continue operating with the same working environment like buildings, workforces, management, and materials to meet the actual demand of the population. This situation, lead to health facilities to work beyond their capacity and workforce stress, patient complains increase, long patient queue, and poor health services.

Similarly, working environment conditions can enabled via a good and commitment of management on viewing importance of health facilities to the public (Mangham, 2007:8). In other words, poor management, misallocation of resources, unfair distribution of activities or responsibilities lead to job dissatisfaction of health workers and view themselves as redundant or neglected resources. Moreover, another challenge occurs in availability of materials, supplies, drugs, adequate equipment in provision of health services. On the other hand, inadequate availability or supplies affect the health services, health workers job satisfaction, and working environment.

In Tanzania medical supplies and administration of materials, drugs and equipment are centrally procured and distributed by Medical Store Department (MSD) in health facilities. However, health fallibilities managements have been complaining on inefficiencies services and poor administration and even condemned with unethical behaviour. Thus, Dieleman and Harnmeijer, (2006:18) concluded that poor working conditions have blood relation with poor performance. Hence, knowing the working environment facilitate proper development of HRP and D to ensure implementation of those plans, which motivate health workers to achieve the planned objectives of the health sector.

2.29.2 Budget

Budget is yet another internal infrastructure of HRP and D. Implementation of HRP and D is typically tied and enclosed to annual budget of the health institution (Gabrielsson *et al.*, 2002:48). Like any other function in health sector, a HRP and D cannot be implemented without any budgetary provision. Therefore, HR planner during the time of planning needs to generate HRP and D cost for each activities in HR Action plan which is developed to fill or eliminate the identified gaps like recruitment, promotions, transfers, training and development, termination or retrenchment, performance rewards etc; and even the all cost of running of HR such as salaries, wages, bonuses and other employees' benefits to be align with annual plans and budget (PO-PSM, 2010:27).

2.29.3 Human Resource

As far as organisations exist, human resource factor cannot be over emphasised. Human Resource makes financial and physical resources to progress. Thus, why, it is viewed as a capital asset to invest (Sheikh, 1999:17; Bakke, 1958:1; Kayani 2008:15; Iqbal, 2012:1). Such important resources in the organisation need planning for it to facilitate competitive advantage, attaining planned goals, which render to economic development of a country. In other words, it is an investment component, which facilitates management to link HR goals with organisational goals and plans. Iqbal, (2012:1) insist that human resources require proper integration of policies, rules, regulations, assets, strategies, HR systems as well as Human Resource capabilities.

In addition to the above, quantity and quality of human resources act as a differential factor, which can make the health sector to succeed or fail, grow and develop (Sheikh, 1999:17). Hence Human Resource Planning and Development facilitate this process from mechanism

of searching, acquiring, develop HR to ensure cooperate strategic plan are attained and implemented. However, these planning should be conducted in a proper manner otherwise; too many supply of HR to an organisation may be costly and pull back it in delivering quality services and attaining performance standards.

2.29.4 Salaries

Salary is an important external physical infrastructure, which is part of compensation need to be budgeted and planned to enable smooth operation of organisation and workforce retention. Chhabra views it, (2016:331) as a compensation to an employee to service provided annually, monthly or weekly. In addition, salary known as permanent monthly payment and sometimes articulated as an annual sum (PO-PSM, 2010; viii). That means salary infrastructure is a motivation factor for retention and employment of workforces. There must be salary survey to achieve external alignment with other organisation (Chhabra, 2016:351). Otherwise, the employers will not manage to attract or retain skilled, experienced, capable, and competent workforce. Meudell and Rodham (1998:128) advocate that money can be a means, which people use to value the organisation with others.

In the views of Mangham(2007:4) sometimes this infrastructure tend to be a difficult motivator to health workers satisfaction because of the market competition where there is also a private sector which compete for skilled, health professions and customers. So, this requires government attention in researching, planning and implementation. Hence, for HR to manage employees, salary survey for conducting HRP is unavoidable to maintain organisation performance.

2.29.5 Compensation

Compensation as an external physical infrastructure needs to be recognised in HRP planning as long as Workforce exists in the organisation. Due to competitive environment, organisation which offer good package of compensation are in good position to attract, retain competent and skilled workforce. According to Chhabra (2016:327), compensation is a reward entitled to workforce who provides services to the customer. Compensation can be either financial or non-financial in the form of leave, retirement benefits, insurance, free travel facility to mention, but a few. Therefore, compensation infrastructure should be integrated in HRP to ensure retention of existing workforce, motivation, and attraction of skilled workforces as well as reduce turnover rate of workforce in organisation.

2.29.6 Houses

Efficiency and effectiveness of provision of health services connected to availability of the infrastructure, which ensure availability of health workers. As healthy services being a factor for people's well-being, progress and development have to be available for people in rural and urban environment. It means that infrastructure such as health workers' houses should be near to health facilities to facilitate availability of health service. Therefore, planning for this infrastructure in HRP is required to ensure availability of health services and satisfaction of health workers. However, according to the MOHSW (2011:15), such internal infrastructure (houses) seems to be among the challenges in most Tanzanian health centres, which affect the retention strategy of health workers. For example, in 2008/2009 out of 11,912 recruited staff, 13% of the reported staff left due to many factors like poor working environment, poor infrastructure especially unavailability of houses was considered as a reason.

2.29.7 Motives

As it is known that, the word motive is a Latin word "Movere" means "Need." According to Prasad (2014:218), these needs or motives are internal state or condition, which cannot be seen but drives person attitudes, behaviour, or action. Therefore, these personal behaviour and attitudes are connected and stimulate to motivation and performance (Sheikh, 1999:63). Such motives differ from each person in the workplace and are keeping changing overtime. Hence, HR planners should take into consideration these motives in HRP and D because motivation is a heart of job performance.

2.29.8 Security

As far as this infrastructure (security) is concerned, it is essential for health workers as a motivation factor. The management should assure safe working environment in terms of safety, health, and social security. Verma (2012: 341), view social security as a protection of employees from social and economic hazards like unemployment, injury, maternity, death, sickness, old age to mention but a few. Therefore, the employers designate to support employees on these grounds through social security funds and well organised HR plans.

2.29.10 Safeties

Literature reveal that, safeties in work place is a management responsibility (Aswathappa, 2014:518; Armstrong, 2012:440-441; Verma, 2012:301; Chhbra, 2016; 282). Therefore, this external infrastructure needs to be assured in working environment to prevent workers from suffering and loss to dependants and relatives. On the management side, absence of workforce from injuries and accident improves its operations and productivity. Verma (2012:301), reports that, globally, in every 20 seconds industrial managements experience death of workers as results of accident. That means, employers should maintain safety in work place through rules, regulations and HR planning and development plans to emphasis safety environment.

2.29.11 Offices

This is yet another internal infrastructure in the health sector, which is important to be planned for HR to be efficient in service delivery. In the view of Chhabra (2016:479) health workers' capacity in delivering health services will be low if top management does not facilitate physical comforts like offices. As health profession, ethics and conduct require health workers to keep secret of their patient. Therefore, allocation of offices should be well organised and planned to fit health sector requirement like one room allocated to one doctor with proper light, ventilation, right level of temperature and humidity and layout of equipment. Yet, HRP and D plans should project and recognise the number of offices needed to facilitate workforces.

2.30 STAKEHOLDERS IN HEALTH SECTOR

Health sector operate under unstable economy, political, technology, social as well as demographic and epidemiological environments. Due to this complex environment, health sector need support from stakeholders such as institutions, groups and individuals to influence, health management decision on its operation. Griffiths *et al.,* (2007:9), give out a clear content of stakeholders against partner. Stakeholders mean single person or group of people with enthusiasm in investing or involved in something. In other words, they are not involved in executing work but they have influence in the project or ready to bear the consequences of the project. On the other side, partnership mean union or association of

individuals or group of group of individuals with collective responsibilities in achieving identified objectives.

Engagement of stakeholders in health sector is an important element in monitoring and evaluation of health sector operation. It develop accountability and transparency environment where communication of information, criticism, discussion and opinions are encouraged and allowed (Stoker, 2006). In a more workable way, targets of achieving health sector goals, plans, vision, and mission need consideration and participation of stakeholders. Feldman and Khademian, (2007) cited in Vernesi and Keasey (2009:3), recognise the importance of stakeholders by saying that, bigger size of stakeholders encourage different ideas on development and implementation of health frameworks and programmes.

However, involvement of stakeholders in health sector needs to ask these questions; do these stakeholders view their support as an investment to receive return? Alternatively, they are supporting because of competition environment. Or do they support because of believing is a right way to do that? or they do because is pressure of certain situation or environment? In the Tanzanian Health sector context, (MOHSW, 2007:12) stakeholders involved in health workers management and facilitation of health sector to perform its mandate are;-

(i) Presidents' Office, Public service Management (PO-PSM) has a mandate on controlling, monitoring of entire employment, determine, control and approve all remuneration, pay, incentives and compensation based on Policies in the public service.

(ii) Presidents' Office, Public Service Recruitment Secretariat (PO-PSRC) facilitate recruitment process in the public service;

(iii) Prime Minister's Office Regional Administration and Local Government (PMO-RALG) recruit, administer, control and monitor health activities in regional and district as well primary and secondary education

(iv) Ministry of Finance and Economic Affairs facilitating availability and controlling financial resources;

(v) Ministry of Health and Social Welfare responsible to control manage, administer standards of health services delivered in the nation.

(vi) Ministry of Education and Vocational Training, controlling and facilitate availability and standards of education to Tanzanians

(vii) Local and International Institution as well as NGOs monitor control and support the health sector.

(viii) Consumer of Health facilities provides opinions, critics and advice of developed frameworks and standard of services provided.

These stakeholders are important factor for the success and implementation of HRP and HRD plan. Therefore, importance of stakeholders should be recognised in the development of HRP and D. According to Stoker (2006), involvement of stakeholders in health sector moulds functions, management, and implementation of activities, workforce, and projects in health sector to deliver quality services. This reveals even in health sector reforms era in developing countries (Mogedal and Steen, 1995). Donors and developed countries initiated and founded the reforms where by HRP and D systems being among the reform to influence quality of services to the public. Besides, HRP and D plans existence, different Health Institutions are crucial for a successful implementation of plans. Communication involves stakeholders within the MDAs, NGOs, and Local or International Organisations to get a 'buy- in' and support from them are important (PO-PSM, 2010:30).

Even though stakeholders are important, the challenge is how many stakeholders should be involved, to what extent stakeholders are supposed to be involved? Who are supposed to be involved and in which function of health sector? What are the effects of stakeholders' involvement in development and implementation of HRP and D plans? The report by WHO, (2006:4) reveal that too many health partnership brought some challenges in management, organising and coordination of HRP and D in health sector. Hence, MOHSW (2007:12) reveal that too many stakeholders in management of health workers somehow contribute to inefficiency function of health sector.

2.31 GRASPING INFORMATION FROM THE HUMAN RESOURCE PLANNING AND DEVELOPMENT INFRASTRUCTURE

Implementable Human Resource Planning and Development plans in health sector require proper process on development and implementation. The processes framed on physical infrastructure especially internal physical infrastructure such as Policies, Acts, and Regulations. The process needs involvement of stakeholders and other sectors that have effect on workforce management. It is policies, which can hinder or facilitate proper

development and implementation of Human Resource Planning and Development plans. However, quality of these Policies depend on how the government involves the local and, or international Stakeholders in its development (Dussault, 1999:2).

However, absence of proper infrastructure enforces health workers to look for greener pasture abroad. As it was discussed in Regional WHO, meeting that despite developing countries has been trying to recognise the importance of health workers but there have been inconsistence and sluggishness in developing and implementation of frameworks and strategies to guide these resources (WHO, 2002:1). Moreover, sustainability, efficiency, and effective health sector infrastructure requires government dedications and stakeholder's participation to build both internal and external physical infrastructures of health sector.

2.32 IMPLEMENTATION OF HUMAN RESOURCE PLANNING AND DEVELOPMENT

Currently, inadequate capacity and quality of health workers in all level of MOHSW is a crisis to be solved in special attention. The sector has challenges on mismatches between the required number and quality of health workers and available staff in terms of skill, knowledge, competences and diversity (MOHSW, 2014:2). Yet, even those available health workers some of them have limited skills, knowledge and behavioural competences to perform to the required standard of performance (Pynes, 2009:42). This situation has been a challenge on implementing health initiatives and attainment of planned objectives and goals.

Moreover, number of plans, strategies and reform programs conducted in central government (Public Service Reform Program) and in Local Government (Local Government Reform Program), they provide priority on key issues to be addressed in relation to workforce planning, acquisition, utilisation, development as well as management and monitoring health workers within the sector. Hence, with those initiatives, it is expected that the sector will have right number of health workers, competent and professional who are equally distributed in rural and urban areas, managed well and developed to ensure the health sector plans, objectives and goals are achieved.

2.33 INSIGHTS FROM LITERATURE CONCERNING THE HUMAN RESOURCE PLANNING AND DEVELOPMENT IN PUBLIC SECTOR

Human Resource Planning and Development takes cognizance of the need to acquire, develop competent, resourceful and responsible human resources in the Public Service to steer the governmental tasks of nation building (Allameh, Naftchali, Pool and Davood, 2012:2; Luzinga 2012:3) African countries including Tanzania have recognize the need and importance of HRP and D.

It is argued that the public sector needs to conduct Human Resource Planning in order to ensure that the best possible use of public servants available is made, recognise the requirement for different occupational groups and forecast of public servants availability over a period. This, informs the decision-makers on the current supply and demand for human resources, as well as HR actions to be taken for the purposes of development, utilization and retention of staff (Chhabra, 2016:133; Meyer, 2002:219). In the same vein, Cherrington (1995:136) expounds that having HRP and D plans in place, it ensure supply of required skills in the public sector are equally distributed to the identified needs (demand), and act as a framework for human resource development (education planning) and employment planning in the country. Aimiuwu (2004:18) concludes that existence of skilled workforce in specific time make the country to be more developed and efficient in economic level (Allameh *et al.*, 2012:2).

Moreover, for the public sector to be efficient and effective in service delivery needs workforces with specific skills, knowledge and training which attained through human resource development (Horwitz,1991:113). Therefore, Agwu and Ogiriki, (2014:134) pinpoint that training and development of public servants has to be planned in short and long term to ensure availability of skilled labour of the right types and in the right numbers to prevent shortage of manpower in the public sector.

It means strategic plans receive inputs from HRP and HRD plans to facilitate the implementation of identified objectives and plan (Armstrong, 2012:210). HRP and D put the plan into reality on number and skills required for different occupation groups, utilisation and the way staff developed over a period of time (Jackson and Schuler, 1990:223; Armstrong, 2012:210-211). Hence, a proper coordination with Ministries, independent departments and executive agencies is required to generate the staff requirements. Similarly,

for HRP and D plan to function well needs commitment of leaders, allocation of resources, suitable planning techniques and validity of data as well as on time reviews of human resource plans. However, the problems have been the adoption and practice (Luzinga, 2012:3). Due to the improper practice of HRP and D, globalization and environmental changes the public sector continue to faces challenges of shortage of workforces, imbalance of staff, migration of professions as well as under or over supply in different cadres, skills and positions which can be avoided if HRP and Development are conducted in a systematic manner (Aimiuwu, 2004:18).

2.34 INSIGHTS FROM LITERATURE CONCERNING THE HUMAN RESOURCE PLANNING AND DEVELOPMENT IN HEALTH SECTOR

Efficiency and standards of health services set internationally which each country has to follow to ensure quality services delivery to the people. World Health Organisation (WHO) is among the international organization to ensure that health care systems are delivering as per its standards (WHO, 2000). The provision of such services facilitated by Human Resource Planning and Development, which should be in place. Unfortunately, such provisions are normally hampered by the lack of resources, skills, as well as relevant data (Awases *et al.,* 2014:1; Mavromaras *et.al.,* (2013:10); Rothwell and Kazanas, 2012:3).

It was noted that, Tanzanian health sector, Human Resource Planning and Development has been a Government priority in its efforts to respond to the needs of the Public (TLTPP, 2013:11). Initiatives made to develop skills, build capacity, and make available inappropriate HR systems and tools that effectively enable MDAs to have adequate numbers and competent staff continuously in order to provide service to the public. However, the sectors continue to experience challenges of quality services, shortage of profession and unethical attitudes of staff.

Similarly, the literature reveals that the health sector works under a dynamic environment, which requires effective performance management systems, frameworks and culture to guide the health workers to perform their duties in required standards. In the opinion of Elia (2000), a competent and good performing health sector grounded on professionalism, value, integrity and culture. It means, functionality of health sector requires accountability, transparency, competent and professional health workers. Currently, the health services is faced with challenges on changing social- cultural attitudes, science and technology which

lead to people being more open-minded and have more expectations from the health sector (Scottish Government, 2012:6).

This situation demands health workers who are competent, professionals to behave ethically according to the professional standards and government policies (UN, 2000:3). However, in many African countries there is a skewed and imbalance number of health workers between rural and urban areas (Kurowski *et al.,* 2004). This facilitated by factors like motivation, houses, poor infrastructure as well as inadequate access to utilities, telephone, internet services, health and education facilities (Mutale *et at.*, 2013; Franco *et al.*, 2002:1255-66).

Hence, this call for proper implementation of human resource planning to be in place. However it cannot be comprehensive if Development of human resources is not taken into consideration (Public Service Management and Employment Policy, 2008; Taneja, 2012:134). This is because Development transcend beyond the current job requirement and concentrate more on long-term perspectives (PSMEP, 2008). It means quality health services provided to the public also rely on the availability of quality workers who are well furnished through human resources planning and development (Mugo *et al.,* 2014:2).

Human needs based on priority in order to master them. This also happen in less developed countries, which have different priority like building strong economy, enhance infrastructure and education to be attainable by people. Nevertheless, these priorities have more collection to personnel like to have a good life, prestige, houses but do not have priority to health issues. People tend not to make health as a priority regardless its importance. To the government it seems health is extra thing or redundant one. It is a political setup of leaders to sustain their position in the power by banking on security issues while factually health becomes a second hand priority. However, when those leaders retired from the public service, a health issue becomes first priority for them to survive. This undervalue the recognition of health development (Goma, 2008:3) hence challenging health sector with mismatch of supply and demand of workforce, unequal distribution of workforce and financial resources leading queuing and patients complaints. While it is the Government has Constitutional responsibility of ensuring health services are provided equitably to all her people by employing skilled workers, motivating them, and applying retention strategies to keep them.

2.35 THE CONCEPTUAL FRAMEWORK

The study argued that, the health sector supposed to develop and implement human resource planning and development plans. The government focus to ensure the health sector has adequate number and competencies required for the sector to be efficient. On the other side, the environment that involves technology, political, economic, social-cultural and demographic keep changing.

The conceptualization reveal that currently the health sector services is not efficient, effective and accessible to the entire public even though the government have the mandates to ensure the health services is available and accessible. The question dawdles is that how the ministry recognise the role of human resource planning and human resource development plans? How does the infrastructure influence the implementation of human resource planning and development? What are the capacity situation of the ministry in implementing human resource planning and development? What are the challenges encounter by the ministry in implementing human resource planning and development? How do the ministry resolve those challenges? Moreover, it is viewed by scholars that, the ministry can perform well in provision of quality health services, if health workers are properly managed.

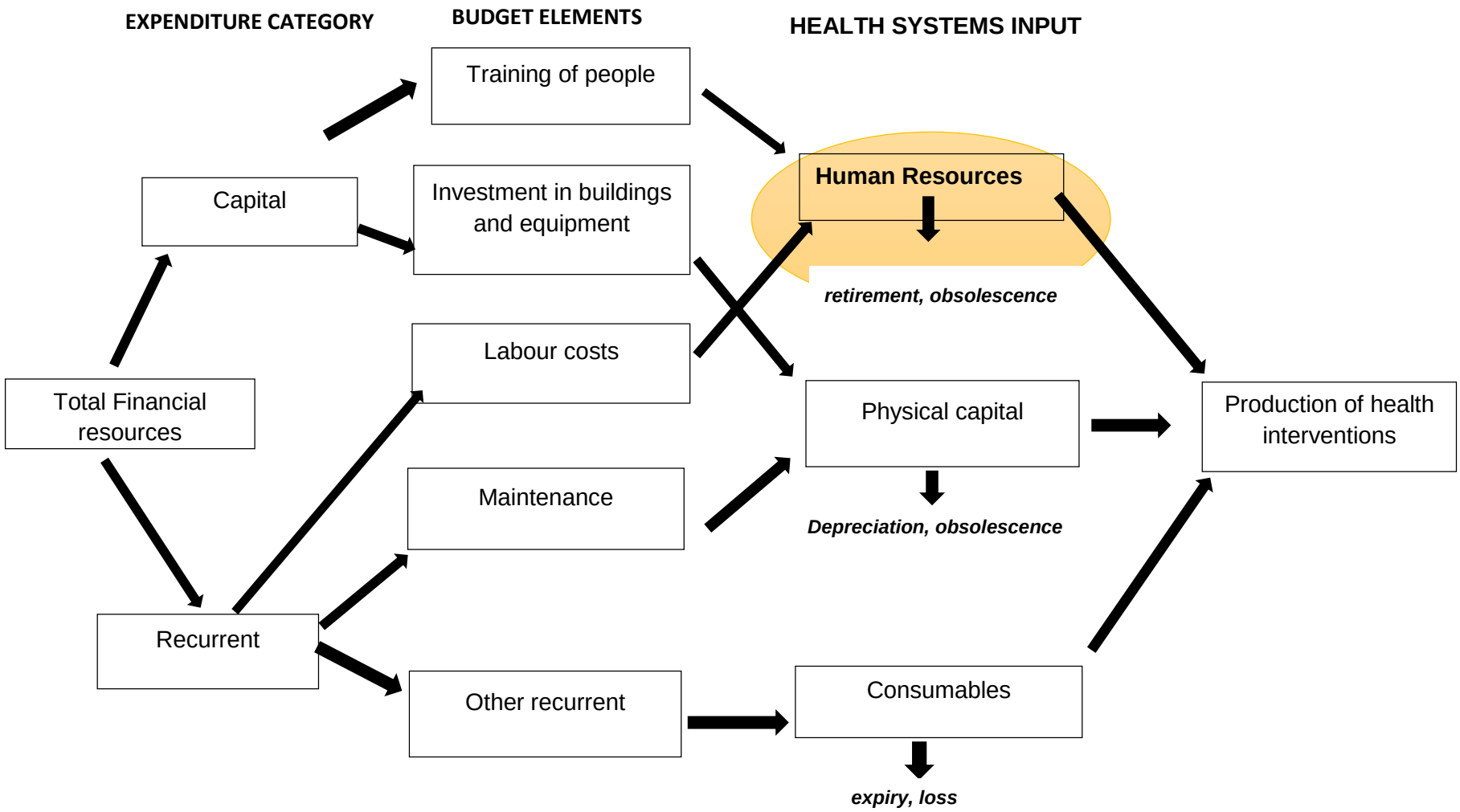


Figure 5.0.13 Relationship between the health systems inputs

Source: World Health Report (2000)

Figure 2.12 illustrates a three principal health system inputs namely: human resources, physical capital, and consumables. It shows the linkages between financial resources inputs and capital investment. The system provides a glimpse into the health system, and where does human resources fit in. In this study, the researcher frame the study based on a health system like in figure 2.12

Our main emphasis is on human resources as highlight by the circle in the figure. The study note that two of budget elements linked to human resources are labour costs and training of people. Therefore, the study framed these inputs into the Tanzanian health system and other inputs as well.

2.36 KNOWLEDGE GAP

Tikare (2009:24) focuses on HRM Practices in hospitals and its impact on employee satisfaction in Mumbai. The afore-mentioned study came up with findings that better performance, for any hospital, is as a result of various factors, HRP and D being an important factor whereby incentives for workers are a big motivational factor. Similarly, Koltnerova, Chilpekova and Samakova (2012) state that human resource planning as a system of human resource management realises optimal number of staff in a firm by identifying the current and future HR issues calling for improvement to ensure quality service delivery which differentiate the firm in the market. They further stated that the demand of workforce in the firm should base on the strategic plan. If not, the firm cannot sustain in the market arena.

On the other hand, Mwemezi (2011) explore problems encountered in the HR succession planning in the Tanzania public and private organizations. The study results show that the role of succession planning rest with the management while most of employees do not understand the meaning of concept and how it operate in their organizations. Even though the management understands the role of succession planning, they are not conducting it in systematic manner. Therefore, increasing budget, effective management, as well as, attracting and recruiting suitable people required for implementation of succession planning.

In the same vein, Erasmus (2009) also made a study on succession planning but look on it is effectiveness in SARS enforcement in Port Elizabeth, South Africa. The study reveals that when succession planning is not conducted in a systematic manner, some of the alarming

indicators can be seen such as the lack of communication of HR actions to the employees, no training needs assessment, no pool of potential successors and no link between successions planning with other HR systems. This results to loss of institutional memory of the organization and inefficient of services provided.

Therefore, Fourie (2012) argue that performance management is a tool in controlling efficiency, accountability, and transparency within an umbrella of governance in public administration. It focus is to measure its actual performance with the planned potential performance to attain in future. The study shows that highly performance management can be attained when the performance tools are used to measure performance. Therefore, the study suggests that performance management and governance can be successful in the public administration if competencies, resources, HR systems and mechanisms are in place to support.

Similarly, Amina (2013) also conducted a study in the public service by analyzing implementation of training programmes in President's Office, Public Service Management. The study reveals that there is no agreement on training needs and priorities, lack of leadership commitment and shortage of funds. Thus, limiting the sustainability of programs. Conclusively, the research suggests that training programmes should be restructured to bring social and economic benefit and enhance organizational performance.

In addition, findings of the study conducted by Awares (2006:v) concerning setbacks that pulling the efficacy of Professional Nurses in Namibia reveals that poor working environments and lack of proper HRP and D are among of those barriers.

Anyandike (2013:56) made on the study on contribution of human resource planning in workforce productivity in the public service. The findings show that, Productivity of public organisation keep declining downgraded argued shows that proper human resource planning must be in place for well management of resources to stimulate the productivity. However, the findings also state that, general dissatisfaction ground has affect the HRP to be regarded a solution to raise employees productivity. Therefore, the researcher recommend the public organisation to embrace HRP if they want to survive and increase employee's productivity. Therefore, HRP must be part and parcel of strategic plan to enable employee productivity.

Prashanti, (2013) conducted analytical study of human resource planning and observed that human resource planning constructed on the notion of human resource being the most and expensive resource in the organisation. The plan act as a connector to link the strategic plan with resources. It put into reality on the number and competencies required for organisation to exist. HRP also deals with development of employee's capacity to ensure the quality HR available all the time for the effectiveness of the organisation.

On the other hand, findings documented by Jackson and Schular (1990) on human resource planning reveal that unpredictable environment, change of demography and technology as well as poor short term planning for HRP and D threatens the health sector survival. Hence, concluded by calling the ratification of the situation by suggesting several measures, including deploying proper short term and long term solutions. Anyim *et al.,* (2012) suggest systematic recruitment and selection of workforce pave a way for gaining the suitable candidate to fill vacant jobs in the right time and identified place to achieve organizational goals.

Therefore, Mosadeghrad, (2014) identified factors that influence quality health care. Health sector can increase quality of its services if it has good cooperation with customers, improve health care systems and environment, adequate resources allocation. Moreover, the quality can be improve through proper planning, effective resource management, leadership commitment, education and training as well as strong cooperation among the service providers.

Addition, Nkechi (2013) suggested developing an integrated HRP and D to organisations' strategic objectives and goals will ensure acquisition, utilization, development and retention of workforce since the organization want to exist in dynamic environment. It is not a plans to be done once in a while but a continuous process to match the demand and supply for effective way of attaining the organisation's plans. Yet, without forgetting to develop HR systems to facilitate optimality of workforce in the organization.

Despite the fact that there are many studies concerning Human Resource Planning and Development, little with similar settings has been done on assessing the impact of Human Resource Planning and Development in Tanzania. This gap necessitated the need to conduct this study since it will enable the ministry, stakeholders and other policy makers to

concentrate on how to have proper Human Resource Planning and Development for the efficiency and delivering of health services to the public.

2.37 SUMMARY

This chapter reviewed literature on importance and evolution of human resource planning and human resource development. The chapter gave details about workability of Human Resource Planning and Development in health sector as well as public service in totality. The chapter also presented challenges and success factors for effective implementation of these two plans (HRP and HRD plans) in the health sector. Capacity of the Ministry of Health in implementing Human Resource Planning and Development was reviewed. Furthermore, quality of service delivery, professionalism, and performance management in health sector was also expounded.

The next chapter present a detailed internal and external physical infrastructure and strategies for the implementation of Human Resource Planning and Development. The chapter also expounds about frameworks that guide the implementation of Human Resource Planning and Development in health sector as well as entire public service.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The purpose of this chapter is to present the research design that underpins the study and provide a full explanation of how the research was conducted. The research was grounded in a mixed research design employing both quantitative and qualitative approaches. The chapter provides the research design, research paradigm, sample and population size, methods of collecting data and data analysis. The study was directed by the following research objectives:

1) To assess the importance of Human Resource Planning and Development in the ministry;

2) To assess the capacity of the ministry in implementing Human Resource Planning and Development;

3) To identify the Human Resource Planning and Development infrastructure and its delivery capacity;

4) To recommend strategies for enhancing the application of Human Resource Planning and Development in the ministry.

3.2 RESEARCH DESIGN

Cooper and Schindler (2003:663) and Creswell (2014) define research design as procedures of inquiry and the specific research methods of data collection, analysis and interpretation. The study adopts the above stated definition, this involved the researcher systematically collecting, and analysing the data to answer the research questions (Bertram and Christiansen, 2015:40; Durrheim, 2014; Wild and Diggines, 2013). Durrheim (2014) views research as a process consisting of five stages namely:

Stage 1: Defining the research question
Stage 2: Designing the research
Stage 3: Data collection
Stage 4: Data analysis
Stage 5: Writing a research report.

According to Creswell (2014), the research plans involves several decisions and choosing which plan should be used to study a topic. The decision taken should be based on philosophical assumptions that the researcher brings to the study namely, procedures of inquiry (called research designs), and the specific research methods of data collection, analysis and interpretation (Creswell, 2014). Yet, Bertram and Christiansen (2015) state that a research design is a structured plan that proceeds in linear way. As noted by Okafor (2013) the research design is a separated research methodology because a proper conceptualization of the research design leads to an understanding of the application of the methodology. In this study, the research followed the processes of Bless, Higson-Smith, and Sithole (2014), to come up with the ten-step research process as shown in Table 3.1.

Table 3.1 Research steps

The 10-step research process
Step 1: Selection and formulation of the research problem
Step 2: Reviewing literature
Step 3: Developing a research method
Step 4: Developing a data collection instrument
Step 5: Sampling
Step 6: Data collection
Step 7: Data analysis
Step 8: Interpretation of results
Step 9: Conclusions and recommendations
Step 10: Dissemination of results

Sources: Bless *et al*. (2014)

The researcher as a guide in conducting the study closely followed the steps shown in table 3.1.

3.3 RESEARCH PARADIGM

Bryman and Bell (2015:17) states that a research paradigm is a cluster of beliefs of scientists in a particular discipline, and it influences how the research is conducted. A paradigm provides ontological, epistemology and methodological positions of the study. A methodology provides the procedures and the process that are undertaken in the research (Bryman and Bell, 2015:10-17). Yet, epistemology is a throaty of knowledge that looks into

the relationship between the researcher and the respondents, whilst ontology refers to the nature of reality. As claimed by Bryman and Bell (2015:17), the paradigm, which is selected by the research, then guides the philosophical assumptions of research and leads to the instruments used and method of the research. Therefore, this study was guided by a positivist paradigm, which according to Henderson (2011:341) it leads to the truth as a whole, and describes the phenomena that is experienced. Henderson (2011:340) further states that it is deductive in nature and assumes that scientific research is objective. In this study, it can therefore be said that with positivist research, the researcher and the respondents are independent from one another (Henderson, 2011:341; Mittwede, 2012:25, Bryman and Bell, 2015:10. In addition, the researcher without bias can study the respondents and the topic.

The main paradigm that was chosen by the researcher was mainly grounded on positivist approaches. This involved a manipulation of variables, a norm in positivism (Bryman and Bell, 2015:10; Maree, 2016:33). Importantly, the researcher administered questionnaires and used interviews in cases were a deeper insight needed. Therefore, the study has traces of post positivism as well due to the nature of the instruments used to gather data. Trochim (2006:1) points that this paradigm recognises the way in which researchers think and that all observation is not perfect and could include errors. Post- positivism views the reality as objective and imperfect. Manion and Morrison (2006) state that post positivism has a pluralist approach to research, drawing most from positivism and interpretive epistemologies. Willis (2007) thus claims that the objective of post positivism is to find the truth about something. Thus, post positivists do not believe in finding the truth by one study.

Ryan (2006) extends by stating that the post positivist research assumes a learning role as opposed to testing a phenomenon. As such, it was justified for the researcher to draw inspiration from the post positivist approach. The approach motivated by the topic at hand; as a result, the study was exploratory in a way. The researcher noted that the topic at hand needed a deeper grasp to other issues, which suited by an interview. As a result, the researcher saw it fit to explore both approaches (qualitative and quantitative) simultaneous. The next section provides a description of the design that followed for this study.

3.3. 1 Research design

A research design can be defined as a procedural plan which assists researchers to answer the research questions validly, objectively, precisely and economically (Bless, Higson-Smith and Sithole, 2013:130; Davis, 2014:93). Yet, Bertram and Christiansen, 2014:40) hold that a research design is a plan which looks at how the researcher collets and analyses data in order to answer the study objective. Briefly, it can be said that a research design is a roadmap on how the researcher intends to achieve his goals or objectives. Three types of research designs come at the forefront; these are descriptive, causal, and exploratory. Davis (2014:75) describes a descriptive research design as a relation between variables and aims to describe situations. Yet, causal research design looks at the cause and effect relationship between events (Zikmund and Babin, 2010:44). Exploratory research design is about obtaining news ideas to explore a problem. For this study, an exploratory descriptive design was deemed appropriate to answer the research question because of the quantitative nature of the information that was sort. However, the complexity of healthcare, contributes to methodologically difficulties in exploring healthcare quality or policies. Consequently, necessitating some form of qualitative design as well.

3.3.2 Research approach

Creswell and Clark, (2016:307) points that there a three types of research approaches namely qualitative, mixed methods and quantitative. A qualitative approach is based on subjectivity and involves observation, listening, and interpretation (Bless *et al.*, 2013:16). Qualitative research provides information in the form of words, images and sounds instead of numbers (Veal, 2011:231; Bless *et al*., 2013:16). A qualitative approach is appropriate in improving the understanding of issues under study. It is often inductive, propositions emerging at the end of the study rather than hypothesis driven.

While, quantitative approaches are based on numerical reasoning (Veal, 2011:34). Numerous authors agree that quantitative approach measures concepts with scales that provide numerical values based on statistics (Bryman and Bell, 2015:99; Quinlan, Bain, Carr, Griffin and Zikmund, 2015:126). On the hand, a mixed method combines both the quantitative and qualitative approaches. A mixed method was used in this study, where interviews were conducted in order to get a deeper insight to the problem at hand. As well as, questionnaire administration was done.

Leech and Onwuegbuzie (2005) state that mixed methods research involves collection, and interpretation of both quantitative and qualitative data. While Dencombe (2008) posit that, this method increases the accuracy of data and provides an in-depth picture of the phenomenon under study. Thus, overcoming weakness of single approaches. To this end, this approach assisted the researcher to get a deeper insight into other matters, which would have been hard when using single approach. Thus, survey, interviews, and desktop analysis were used to answer the research questions.

3.4 UNIT OF ANALYSIS

Neuman (2013) hypothesized a reality that researchers' theoretical concepts are applicable to one or more unit of analysis. The unit of analysis is defined as an object or person whom the researcher intends to collect data (Bless *et al.*, 2014). Similarly, Monette *et al.,* (2008) view units of analysis as specific elements or objects whose characteristics we wish to explain or describe. A unit of analysis can be micro (individual, group, family) or macro (national, regional) level. Leedy and Ormond (2014), and Welman *et al.,* (2005) point that individuals are the most common units of analysis. The researcher, therefore, investigates the actions, attitude, and conditions of an individual. On the hand, a group of people are sometimes studied in form of focus groups or teams (Monette et al., 2008). Alternatively, more than one person is regarded as a group. Sometimes researchers study organisations, in this case these are formal structures that are composed of certain people (Bless et al., 2014). On the other hand, social artefacts are studies, in such cases; it can be anything like poems, letters, art, and anything that is for cultural remembrance (Bless *et al,* 2014). **I**n this study, the unit of analysis were public sector employees from various institutions and departments in Tanzania. The employees were chosen based on their relevance to the study objectives.

3.5 POPULATION AND SAMPLE

Babbie (2013) defines a study population as an aggregation of elements from which as sample is drawn. This then completes the population under study to be of individuals, objects, or events that are specific to a certain criteria (Welman *et al.*, 2005). However, Burns and Grove (1997:51) concede that researchers hardly have access of the full population. The population for this study included all government employees in Tanzania.

3.5.1 Selecting the sample

Care should be taken when selecting a sample size. Kumar (2000:219) defines a sample as a chosen subset of elements from the population. The sample is drawn from a population with differing characteristics; a sample is drawn from sample frame (Zikmund and Babin, 2010:417).Churchill *et al.* (2010:39) states that a sample frame is the list of the population elements from which the sample would be drawn. In addition, the researcher needs to define the sampling plan to be used and the size of sample. There are two types of sampling plans (probability and non-probability). Table 3.2 illustrates the differences between the two sampling methods.

Table 3.2: Sampling types

Probability sample	
Simple random sample	Every member of the population has an equal chance of selection.
Stratified random sample	The population is divided into mutually exclusive groups, if the distribution of population elements believed to be skew in one or more areas, such as age groups or race.
Systematic sample	Using a sample frame that list members of the population, each member has equal chance of being selected, more effective than simple random sampling.
Cluster (area) sample	The population is divided into mutually exclusive groups and the researcher draws a sample of the groups to interview.
Non-probability sample	
Convenience sample	The researcher selects the most accessible population members.
Referral (snowball) sample	Respondents are asked for names or identities of others like themselves who might qualify to participate in the study.
Purposive/ Judgment sample	The researcher selects population members who are good prospects for providing accurate information.
Quota sample	The researcher finds and interviews a prescribed number of people in each of several categories.

Source: Adapted from Kotler and Keller (2006:110), Burns and Bush(2010:369,383)

3.5.2 Probability sampling

Babbies (1990:71); Seaman (1987:233) defines probability sampling method, as a technique were a known positive probability is associated with each element of the population that will be selected as a part of the sample. Kothari (2004:15) state that probability-sampling methods include simple random sampling, systematic sampling, stratified sampling and cluster sampling. For instance, random sampling is whereby every unit has an equal chance of being selected in a sample. Therefore, it can be said that chance determines whether a unit

is included in the sample or not. Thus, it is possible to estimate measurement errors or significant of results. On the other hand, stratified sampling involves dividing the population into homogeneous non-overlapping groups and selecting a sample from each group (Cochran, 1963). Cluster sampling involves dividing a number of units of the population into clusters, then randomly selecting sample clusters. The main challenge with probability sampling techniques is that when sampling a population that is distributed across a wide geographic area, the researcher needs to cover a lot of ground geographically in order to get to each unit that will be sampled (Sukhatme, 1954), which is expensive to do (Trochim, 2006).

3.5.3 Non-probability sampling

A non-probability sampling technique is whereby units within a sample do not have an equal chance of being selected. This is a sampling technique in which people are chosen for a particular purpose (Brink *et al.,* 2014; Neuman, 2014; Welman *et al.,* 2005), or who are especially knowledgeable about the question at hand (Brink *et al.,* 2014; Denscombe, 2014). Therefore, no probability can be assigned to non-probability sampling techniques (Hill *et al.,* 1999:26). Table 4.3 shows the types of non-probability sampling techniques. Examples of non-probability sampling includes, purposive sampling, quota sampling, referral sampling, snow balling, and convenience samples (Zikmund and Babin, 2010:426).

In this study, a purposive sampling technique was used. The main reason for using such an approach was motivated by the study aims and objectives of eliciting information from specific people in certain jobs. Using a probability sampling technique would not have yielded the required results on the basis that the study intention was based on assessing a government policy. This, therefore, meant that the researcher needed to interview the relevant policy drafters as well as implementers. Therefore, only the targeted sample was reached in this study. The researcher approached the Ministry of Health and other state institutions where respondents were positioned, and managed to conduct surveys and interviews at the respondents' work place.

3.5.4 Sample Size

Scholars are divided on what constitutes to an adequate sample size, especially in qualitative research (Leedy and Ormrod, 2005). There are no fixed rules on determining the sample size (Bertram and Christiansen, 2015; Brink *et al.,* 2014). Nevertheless, some scholars have tried to put a guideline on the targeted sample. Table 3.4 illustrates a guideline from different scholars and the likely sample sizes.

Table 3.3 Sample sizes

Population	Percentage suggested	Sample (No of respondents)
20	100	20
30	80	24
50	64	32
100	45	45
200	32	64
500	20	100
1000	14	140
10 000	4.5	450
100 000	2	2000
200 000	1	2000

Source: Stocker 1985 (cited in Brynard *et al.,* 2014)

The following is a breakdown of the sample numbers in this study. Table 3.4 illustrates the breakdown of respondents by region.

Table 3.4 Sample distribution

Region	Ministry	Hospitals	Beneficiaries
	Frequency	*Frequency*	*Frequency*
Arusha		2	48
Dar es Salaam	7	7	150
Kilimanjaro		3	76
Mwanza		3	77

Table 3.4 illustrates that the majority of the respondents were from the beneficiary sample (351), Ministry (7) and Hospitals (15). The disproportionate samples were determine by their purpose in this study. For instance, the sample in Ministry was composed of Directors who were in the policy administration in the government, yet in the Hospital only 15

respondents were interviewed based on their direct link with policy implementation. Lastly, the beneficiaries were the one direct involved with the public. Moreover, to get more oversight on the implementation of the plans, three training institutions and two health professional association leaders were interviewed.

Table 3.5: Respondents distribution

	Participants	***Organisation***	***Position***	***Qualification***	***experience***	***Age***
	Dar-es-Salaam Region					
1	P1	Ministry of Health and Social Welfare	Ag. Assistant Director	Master degree level	Sixteen (16) years	Between 41-50
2	P2	Ministry of Health and Social Welfare	Assistant Director	Master degree level	Thirty (30)years	Between 51-60
3	P3	Ministry of Health and Social Welfare	Assistant Director	Doctoral degree level	Twenty seven (27) years	Between 51-60
4	P4	Ministry of Health and Social Welfare	Assistant Director	Bachelor degree level	Twenty Eight (28) years	Between 51-61
5	P5	Ministry of Health and Social Welfare	Assistant Director	Master degree level	Twenty Eight (28) years	Between 51-62
6	P6	President's Office Public Service Management	Assistant Director	Master degree level	TwentyTwo (22) years	Between 41-50
7	P7	President's Office Public Service Management	Assistant Director	Master degree level	Twenty seven (27) years	Between 51-61
8	P8	Muhimbili National Hospital	Director	Master degree level	Twenty Five (25) years	Between 51-61
9	P9	Mwananyamala Regional Hospital	Health Secretary	Master degree level	Thirteen (13) years	Between 41-50
10	P10	Amana Regional Hospital	Health Secretary	Bachelor degree level	Three (3) years	Between 31-40
11	P11	Temeke Regional Hospital	Health Secretary	Bachelor degree level	Seven (7) years	Between 31-40
12	P12	Sinza District Hospital	Health Secretary	Bachelor degree level	Three (3) years	Between 31-40
13	P13	Mnazi Mmoja District Hospital	Health Secretary	Master degree level	Ten (10) years	Between 31-40
14	P14	Mbagala District Hospital	Health Secretary	Master degree level	Twenty Eight (28) years	Between 51-61
	Mwanza Region					
1	P15	Bugando Medical Cetre (Zonal Hospital)	Director	Doctoral degree level	Twelve (12) years	Between 51-61

2	P16	Sekou Toure regional Hospital	Health Secretary	Master degree level	Twenty One (21) years	Between 41-50
3	P17	Nyamagana District Hospital	Health Secretary	Bachelor degree level	Four (4) years	Between 31-40
	Arusha Region					
1	P18	Mount Meru Rigional Hospital	Health Secretary	Master degree level	Fourteen (14)years	Between 41-50
2	P19	Meru/Tengeru District Hospital	Health Secretary	Master degree level	Eleven(11) years	Between 41-50
	Kilimanjaro Region					
1	P20	KCMC Hospital (Zonal Hospital)	Director	Master degree level	Twenty (20)	Between 41-50
2	P21	Mawenzi Regional Hospital	Health Secretary	Master degree level	Twelve (12) years	Between 31-40
3	P22	Hai District Hospital	Health Secretary	Master degree level	Three (3) years	Between 31-40

3.5.5. Inclusion criteria

When doing research it is crucial that one come up with criteria of selecting the respondents. As noted by Brink *et al,* (2014) it is very important that the researcher defines and describes the population and its inclusion criteria. Polit and Beck, (2008) refer to the criteria as the 'eligibility criteria' or 'inclusion criteria'. The following inclusion criteria were used:

- Participants were public sector employees
- Participants were directly involved in the policy planning, strategy and implementation

Following Babbie and Mouton (2014), the researcher made sure that the respondents chosen were able to functions as informants by providing rich descriptions of the problem under investigation (Valle and Halling, 1989). Furthermore, there had experience of the problem under study and were in a capacity to provide sensitive information. More so, the respondents were able to express themselves with ease in terms of language.

3.6 TYPES OF ITEMS IN QUESTIONNAIRES

According to Wild and Diggines (2013:161), questionnaire design is not an isolated activity in the research process. Factors such as the length of the questionnaire, the length of the

individual questions, the number of alternative responses and the use of different question wording, formats and answers are determined by the research problem, the aim of the research, the nature of the population, the size of the sample, the choice of data-collection methods and the analysis of the data (Wild and Diggines, 2013:161). With the above in mind, seeing that there are no hard and fast rules in designing questionnaires (Wild and Diggines, 2013:161),this study's questionnaire design was modified from different authors as seen in the 11-step model of questionnaire design in Table 4.6 below.

Table 3.6: 11 Step model in questionnaire design

Step	Action
Step 1: Determining aims of the questionnaire	From step 1 of Pallant (2012:12)
Step 2: Specifying the information needed	From step 1 of Wild and Diggines (2013:162) and Step 2 of Cant *et al.* (2012:148)
Step 3: Determining the type of questionnaire	From step 3 of Wild and Diggines (2013:162)
Step 4: Determining the content of individual questions/question format	From step 3 of Wild and Diggines (2013:162) and step 2 of Cant *et al.* (2012:148)
Step 5: Determining the structure of the questions	From step 3 of Wild and Diggines (2013:162)
Step 6: Determining the wording of questions	From step 5 of Wild and Diggines (2013:162) and step 6 of Cant *et al*. (2012:155)
Step 7: Determining the sequences of questions	From step 6 of Wild and Diggines (2013:162) and step 5 of Cant *et al.* (2012:156)
Step 8: Determining the layout of the questionnaire	From step 6 of Cant *et al.* (2012:156), Step 3 of Johnson and Christensen (2014:219) and step 8 of Wild and Diggines(2013:162)
Step 9: Pilot-testing the questionnaire	From step 9 of Cant *et al.* (2012:156-7), step 4 of Johnson and Christensen (2014:219), step 4 of Pallant (2011:12) and step 7 of Wild and Diggines (2013:162)
Step 10: Revising questions	From step 5 of Pallant (2011:12) and step 8 of Wild and Diggines (2013:162)
Step 11: Administering questionnaire	From step 5 of Johnson and Christensen (2014:219) and step 6 of Pallant (2011:12)

Sources: Johnson, Christensen (2014), Wild, Diggines (2013:162), Pallant (2011:12), and Cant *et al.* (2012:148)

As seen in Table 4.6 above, the researcher used the seven steps of questionnaire design by Cant *et al.* (2012:148), the five steps of questionnaire design by Johnson and Christensen (2014:218-222), the eight steps of questionnaire design by Pallant (2011:12) and the nine steps of questionnaire design by Wild and Diggines (2013:162) as a guide of a reasonably successful questionnaire and came up with 13 modified steps in designing this study's questionnaire.

The 13-step model in designing a questionnaire

The 13 steps on designing a questionnaire are as follows:

Step 1: Determining aims of the questionnaire: In determining the aim of the questionnaire during stage 1, the main purpose of the study was written down, the research questions and the type of information required by the researcher were identified. The researcher then considered how the information was going to be used and an overall questionnaire plan was prepared.

Step 2: Specifying the information needed: It was decided to include a short demographic section to allow sample representatives to be assessed and to demonstrate a measure of the internal validity of the questionnaire by showing that respondents with different demographic profiles used the questionnaire.

Out of the different categories of questions, this study used semi-structured questionnaires where questions consisted of both closed-ended and open-ended questions. This was then followed by using the scale questions. In the design of the questionnaire, the researcher ensured that all respondents could easily understand the sentences and the words, which were used in the statements and questions in the questionnaires. This was achieved by drafting the statements and questions in the questionnaires in shorter sentences to ensure that the statements contained only a single meaning, which could easily be understood and interpreted by respondents.

Step 3: Determining the type of questionnaire: The researcher used both closed-ended questionnaire with a five-point Likert scale and open-ended. The Likert scale is very convenient when the researcher wants to measure and construct (Maree and Pietersen, 2014:167). A series of Likert scale questions were asked, calculated and a total score for each respondent, that is, assigning the values 1 to 5 (if five categories are used) was added to the categories and then each respondent's five values were added, based on their responses (Maree and Pietersen, 2014:167).

Step 4: Determining the content of individual questions/question format: According to Wild and Diggines (2014:163), question content refers to the general nature of the question and the information it will provide, not to its phrasing and format. In this study, individual questions were formulated after deciding on the type of information needed and the collection method (Wild and Diggines, 2014:163). When determining the content of each

question, the researcher answered the following questions: (i) Is the question necessary? (ii) Are the several questions needed instead of only one? (iii) Do the respondents have the information that is needed? (iv) Does the question fall within the respondents' field of experience? (v) Will the respondents find it difficult to answer the question? (vi) Will the respondents be prepared to provide the required information?

Step 5: Determining the structure of the questions: There are many ways in which a question or statement can be worded and several ways in which the response can be made. The type of items in the questionnaire of this study was based on the advantages, uses and limitations of the options (McMillan and Schumacher, 2006:197).

For this reason, the first consideration for the types of items and format in questionnaires in this study was to decide whether the items would be open-ended or closed-ended. Closed-ended items were chosen for the questionnaire. According to Neuman (2014:331), closed-ended question refer to a type of survey research inquiry in which respondents choose from a fixed set of answers. The next step was to determine which scale to use because scales are useful ways in questionnaire research for measuring how respondents feel or think about something (Maree and Pietersen, 2014:167). Out of the different scaling procedures, this study used questionnaires with Likert scale and summated ratings Likert scales that respondents completed in less than 20 minutes, based on anonymity. Since a Likert scale is convenient when a researcher wants to measure a construct (Maree, 2007), a Likert scale becomes an example of a summated rating scale, which is frequently used to test attitudes or feelings describes (Brink *et al.*, 2014:159). It is summative in that item scores are added to obtain the final result, consisting of a number of declarative statements about the topic, and five or seven responses for each statement, ranging from 'strongly agree' to 'strongly disagree' (Brink *et al.*, 2014:159; Zikmund *et al.*, 2013:316).

A proposition by Brink *et al*. (2014:160), which was followed in the design of this study's questionnaire, is that an approximately equal number of positively and negatively worded items should be included in a Likert instrument. To score a Likert scale, the score responses of all items are added to obtain a total score. The values obtained are treated as interval data. If five responses are used, scores on each item generally range from 1 to 5. A score of 1 is usually given to 'strongly disagree' and a score of 5 to 'strongly agree'. Negatively worded items are often reverse scored, in which case 'strongly disagree' is given a score of 5, and 'strongly agree' a score of 1. The measurement was achieved by asking a series of 5-point

Likert-scale type questions in which respondents could tick, darken the circle or put an 'X' on the appropriate answer on the Likert scale and on the summated Likert scales.

In this study's questionnaire, all items with the same format were grouped together and key dimensions were defined. Indicators and scales were identified and then formulated, and the scales selected allowed respondents to choose from a list of possible options (See Appendix B for questionnaire).

3.6.1 Question designs

It is important to write the questions in such a way that the meaning of each will be the same for all respondents. A question that is not carefully worded may result in answers, and therefore data, that are meaningless (Maree, 2014).

Two semi structured interview guides were used for the Ministry Directors and Hospital Secretaries samples. Firstly, the interview guide for the Ministry Directors was composed of questions which focus on HRP and D in the Ministry; the capacity of the ministry in implementing human resource planning and development; Human resource planning and development infrastructure and its delivery capacity; and strategies needed for enhancing the application of human resource planning and development in the ministry. The selection of these questions was mainly determined by the study objective of finding out from the main strategy drafters in HRP and D in the Ministry. Therefore, it was necessary to understand the challenges facing the health sector in Tanzanian from a national point of view.

Secondly, the interview guide of the Hospital Secretariat included the same questions, which were asked to the Ministry Directors to identify inconsistencies in terms of the HRP and D challenges because they are the implementers of that strategy.

Yet, the semi structured questionnaire for the beneficiaries of the HRP and D in the health sector was composed of questions focusing on HRP and D in the Ministry; the capacity of the ministry in implementing human resource planning and development; Human resource planning and development infrastructure and its delivery capacity; and strategies needed for enhancing the application of human resource planning and development in the ministry. The questionnaire design was greatly influenced by the pilot study that was conducted before the

main interviews. In other words, the questionnaire focused on similar questions posed in the interview guides to make it easy to test the impact of the HRP and D in the health sector.

3.6.2 Pilot testing the questionnaire

A pilot study is a specific pre-testing of research instruments, which is done in preparation for their full-scale use to see if the envisaged methods are valid in the practical research environment (Van Teijlingen and Hundley, 2002:1).

A pilot study was done was done to test the questionnaire. Firstly, it was tested on a few randomly picked individuals and then sent to experts in the same field to get a thorough understanding if whether it measured what it intended to measure. Fortunately, the steps followed in drafting the questions improved the questionnaire content and design. As a result, only a few grammatical areas were identified and fixed.

The questionnaire was structured to facilitate a cross sectional survey. The questionnaire started with an explanatory paragraph to put on board the respondents to understand the posed questions. Following up with the instructions on whether the boxes can be circled or ticked, whether the question with more than one box can be circled or ticked at a time, or the question which need explanation is it compulsory or not.

The questionnaire was systematic in order by number. Starting with general to specific questions, and grouping questions in line with the identified objectives of the study. For example, how human resource planning and development is important to the organisation.

3.6.3 Administration of the questionnaire

Questionnaire were administered at work place to the beneficiaries (health workers) from different hospitals and health training institution in different departments/section or units based to get a clear on implementation of HRP and D. It took 15 minutes to 25 minutes based on the participant understandings on the implementations of these plans.

Region	Hospital/Training Institution	Number of Questionnaire Distributed (*per each)*
Arusha	Mount Meru Regional Hospital	24
	Meru District Hospital	24
Dar es Salaam	Muhimbili National Hospital	11
	Temeke Regional Hospital	24
	Amana Hospital	24
	Mwananyamala Hosp	24
	Mbagala District Hospital	24
	Manazi Mmoja District Hospital	24
	Palestina District Hospital	24
Kilimanjaro	KCMC Zonal Hospital	28
	Mawenzi Regional Hospital	24
	Hai District Hospital	24
Mwanza	Bugando Medical Centre-Zonal	28
	Sekou Toure Regional Hospital	24
	Nyamagana District Hospital	24
Total		**355**

3.6.3 Interview Approach

Patton (1990) points that a critical assumption in an interview is the perspectives of other are knowable, meaningful and made explicit. Yet, Rubin and Rubin (2005) visualises interviews as conversations where a researcher guides an extended discussion. Thus, interviews are used to extract information about a phenomenon under study. The researcher used semi- structured interviews to elicit information. A semi-structured interview is define as having pre-determined questions (Robson, 2002). Furthermore, this type of interview gives guides to interviewees when answering questions. This approach was favoured on the basis that it allows participants to think, speak, and be heard, and it is very suited of in depth discussion (Reid *et al.*, 2005). The researcher then conducted a face-to-face interview with the respondents. A face-to-face interview is a two-way conservation between the interviewer and participant, and it helps in extracting precise information (Zikmund, 2003). This type of interview gives a researcher a number of options and chances of judging the quality of information received on an ongoing basis, or using visual signs to communicate (Folwer, 2002). Therefore, based on the stated advantages, the researcher relied on face-to-face interviews to sample the Directors and Secretaries. As stated before, the interview were conducted at work places of the participants and lasted at most 40 minutes to 60 minutes based on how the participants were responding to questions.

3.7 DATA COLLECTION PROCEDURES

Since the study was a mixed method in design, data was gathered simultaneous from different respondents. Semi structured questionnaires were administered to the respondents at their work places. This approach was meant to make sure that the data collection process does not disturb their work activities. First, questionnaires were administered to the beneficiaries after receiving permission from the superiors. The survey took on average 20 minutes, and the data collection process took 2-3 weeks to be completed. While the researcher was collecting data from beneficiaries, permission now was also sort from the relevant department to conduct interviews with the Directors and Secretaries. Permission was granted and the interviews were conducted at the respondents' workplace as well. The following section describes how the qualitative data was collected and handled.

3.8 TRANSCRIPTION, NOTE TAKING AND RECORDING

While the researcher was conducting face-to-face interviews with the Directors and Secretaries, she was taking notes and recording with a tape recorder. Arksey and Knight (1999) favour tape recording because of its ability to keep the researcher concentrating on what is said. Furthermore, tape recording increases accuracy since the researcher can replay the message many times to get a meaning. Recording does not eliminate the need to take notes; as a result, the researcher was taking notes at the same time. This was done through writing and observation of the respondents. Observing how respondents answer questions can give a clue of what may be very sensitive in the interview. This then helps in further interrogating of the respondents to get a deeper insight to what is being asked. In the process, providing a rich description of the phenomena under study. To reduce chances of possible bias, the researcher made effort to report questions and provide clarity where there is a need. Furthermore, building on incomplete questions and offering the interviewee suggestion of what to think about. Easterby- Smith *et al.,* (2002) note that 'probes' can be used as a technique to sharpen responses. Probes should not lead the interviewee, but leave the questions unbiased and open. The techniques mentioned were used effective during the interviewing process, and this reduced cases of missing information. Immediately the interviews were concluded, the researcher transcribed the voice recordings for easiness in writing.

Table 3.7: Fieldwork schedule

	Participants	*Date*	*Place*	*Organisation*	*Length*	*Notes/Voice*
	Mwanza Region-Tanzania					
1	P15	18/04/2016	Work	Bugando Medical Cetre (Zonal Hospital)	130	Notes/Voice
2	P16	19/04/2016	Work	Sekou Toure regional Hospital	120	Notes/Voice
3	P17	20/04/2016	Work	Nyamagana District Hospital	90	Notes
	Arusha Region-Tanznaia					
4	P18	25/04/2016	Work	Mount Meru Rigional Hospital	130	Notes
5	P19	26/04/2016	Work	Meru/Tengeru District Hospital	130	Notes/Voice
	Kilimanjaro Region- Tanzania					
6	P20	2/5/2014	Work	KCMC Hospital (Zonal Hospital)	130	Notes/Voice
7	P21	27/04/2014	Work	Mawenzi Regional Hospital	130	Notes/Voice
8	P22	27/05/2016	Work	Hai District Hospital	130	Notes/Voice
	Dar-es-Salaam Region- Tanzania					
9	P1	10/5/2016	Work	Ministry of Health and Social Welfare	130	Notes/Voice
10	P2	11/5/2016	Work	Ministry of Health and Social Welfare	130	Notes/Voice
11	P3	12/5/2016	Work	Ministry of Health and Social Welfare	130	Notes/Voice
12	P4	17/05/2010	Work	Ministry of Health and Social Welfare	130	Notes/Voice
13	P5	18/05/2010	Work	Social Welfare	130	Notes/Voice
14	P6	25/05/2016	Work	President's Office Public Service Management	120	Notes
15	P7	25/05/2016	Work	President's Office Public Service Management	120	Notes
16	P9	30/05/2016	Work	Mwananyamala Regional Hospital	120	Notes/Voice
17	P12	30/05/2016	Work	Sinza District Hospital	120	Notes
18	P8	30/05/2016	Work	Muhimbili National Hospital	120	Notes/Voice
19	P10	5/6/2016	Work	Amana Regional Hospital	90	Notes
20	P11	6/6/2016	Work	Temeke Regional Hospital	90	Notes/Voice
21	P13	7/6/2016	Work	Mnazi Mmoja District Hospital	120	Notes/Voice
22	P14	7/6/2016	Work	Mbagala District Hospital	130	Notes/Voice

3.9 DATA ANALYSIS

The study used a mixed method whereby both the qualitative and quantitative methods were used simultaneous. To begin, immediately the questionnaires were filled, there were coded in an Excel Spreadsheet. Coding refers to the process of grouping and assigning numeric codes to the various responses to a particular question (McDaniel and Gates, 2010:486). Upon finishing coding, the data was cleaning of any errors. McDaniel and Gates (2010:491) points that this is a necessary step before proceeding to statistical analysis. All the coded data were from closed ended questions, where respondents were choosing from a number of options given. The Excel Spreadsheet was then transferred to the SPSS statistic package for data analysis were descriptive statistics were conducted. McDaniel and Gates (2010:505) claim that descriptive statistics are the most efficient was of summarizing the characteristics of large data sets. In this statistical analysis, the researcher used frequency, mean, percentages as way of describing the variables under study.

The data gathered from interviews were transcribed and recorded on Excel Spreadsheet in form of themes for easy analysis. Transcribing was done by seeking the services of a transcriber who converted the audio file into readable text. After preparing the data, a thematic analysis process was used to get meaning of the data.

3.9.2 Thematic analysis process

An inductive thematic approach was utilised in this study. Thomas (2006) describes an inductive approach as a method used to condense extensive raw data into a brief format, create a link between the research objectives and the outcomes, then develop a framework of casual structure of the process that arise from raw data. The inductive process unfolded in six stages as follows:

1. Familiarisation of the data, which includes transcription, reading, and re-reading material. The researcher re-read the transcripts more than two to be familiar with the data as suggested by Braun and Clarke (2006) in order to get a deeper insight and search for meanings as well as, patterns in the data set. A thorough literature review was done in this step by the researcher to sensitive potential themes and embedded the data that may not have been identified without having to do so (Braun and Clarke,

2006).

2. Then codes and systems coding were generate based on their relevance to the researcher questions across the whole data set and paraphrasing of emerging ideas from the data set and looking for connections. Boyatzis (1998) points are labels are codes using few words. This step began when the researcher finished familiarising herself with the data. Braun and Clarke (2006) posit that the data is organised into meaningful groups. Concisely, coding depends if whether the theme are driven are theory or data. It is always advisable that this process is thoroughly detailed and attention is given to each line. Following Brauna and Clarke (2006) advice, different text and segments were highlighted using different colours.
3. The step involved searching for collating codes into themes and gathering all codes relevant to text.
4. Then reviewing themes to check for suitability of the documents extracts and creating athematic map;
5. Lastly, defining and naming themes by generating and refining definitions was performed. This entails looking for names within themes to ensure closeness to data.

The report was then produced by selecting relevant extracts to illustrate themes and then relating them back to the research questions as well as, literature. Braun and Clarke (2006) suggest that researchers relate themes based in research questions as opposed to their importance to quantifiable measures. Therefore, characterization and identification of themes began early in the study and continued through the data collection period. A number of potential themes were created through reading transcripts and evolved throughout the coding process.

3.10 RELIABILITY

Reliability means dependability or consistency and that the same thing is repeated or occurs under identical or very similar conditions (Bertram and Christiansen, 2015:186; Blanchard and Thacker, 2013:160; Bless *et al.,* 2014:222; Creswell, 2014:247; De Vos *et al.,* 2013:177). Therefore, carrying out research using an instrument requires that the instrument used to collect data is reliable and valid.

The questionnaire for this study was administered using the test-retest reliability but to a limited sample due to the influence of factors such as cost and time. Test-retest reliability is assured when the researcher administers the research instrument to the same participants on two or more occasions and afterwards makes comparisons to determine whether the instrument is reliable or not (Babbie and Mouton, 2014:120-122; Du Plooy-Cilliers *et al.*, 2014:255).

Although it is rare to have perfect reliability, the researcher considered the following procedures to increase the reliability measures, as proposed by Neuman and Kreuger (2003:179-180) as well as Salkind (2006:108). The researcher: (i) Eliminated items that were unclear since an item that is unclear is unreliable; people may respond to it differently (ii) Moderated the degree of difficulty of the instrument (iii) Standardised instructions (iv) Maintained consistent scoring procedures and (v) Develop a draft of a questionnaire and tested it before applying the final version.

3.11 VALIDITY

Validity suggests truthfulness (Neuman, 2014:212). Validity is defined as a two-fold concept: that the instrument actually measures the concept in question and that the concept is measured accurately (Delport, 2005:160; Zikmund, 2003:301). For this study, validity was enhanced through face validity. Face validity refers to the extent to which the instrument used to collect data appears to be valid after it has been scrutinised by experts in the field where research is conducted and after comments, assistance and advice from experts have been used by the researcher to make adjustments on the instrument so that it is valid (Babbie and mouton, 2014:122-123; Du Plooy-Cilliers *et al*., 2014:256; Neuman, 2014:216-217). Accordingly, the researcher availed the instrument to two different expert opinions: professors in the department, the researcher's supervisor and to a statistician. The comments and advice of the supervisor and the statistician helped the researcher to shape the items in the questionnaire to collect data that increased its relevance, reliability and validity to answer the research questions for this study. Through this assistance, content validity for the questionnaire was enhanced.

3.12 ETHICAL ISSUES

Ethics need to be taken into consideration when selecting data. Following Bertram and Christiansen (2015:65) ethic guidance, these were principles guiding this study:

- ✓ The principle of respect to person was observed. This implies that individuals had a right to participate or not in the study without any risk of penalty (Babbie and Mouton, 2014, 521). At the same time, individuals had a right to refuse to divulge information deemed sensitive to themselves.
- ✓ Secondly, the principle of beneficence means that the researcher needs to secure the wellbeing of the respondents, who has a right to protection from any discomfort and harm (Babbie and Mouton, 2014: 522; Bless *et al.,* 2014:29; Brink *et al.,* 2014:35; Creswell, 2014:94). This is similar to the principle of justice were the respondents has a right to fair selection and treatment. All these principles were observed throughout the study.
- ✓ Furthermore, the researcher sort permission before the data collection period, as a result, respondents were given a consent form (See Appendix C). The letter was very explicit in terms of the objectives of the study and anonymousity in the collection of information (Babbie, 2013:36; Babbie and Mouton, 2014: 523; Creswell, 2014:99). Respondents were made aware that there will be no falsification of information to favour a certain outcome from the researcher, and the possible benefits of this study ij addressing some of the challenges affecting Tanzania;
- ✓ Before the study commence, an Ethical Clearance was obtained from the University of Fort Hare Ethics Committee (See Appendix D) giving a go ahead for the study.

3.13 SUMMARY

In this chapter, the methodology and procedural process followed in conducting this study were presented. A thematic analysis approach was identified as the suitable research strategy based on reasons, which were afore-mentioned. The chapter further described the methods that were used for data collection and data analysis as well as the justification for choosing those methods. The methods were deemed suitable for a thematic analysis study. Furthermore, research ethical issues guiding the study were stated. The next chapter presents the findings of the study.

CHAPTER FOUR: FINDINGS AND DISCUSSION OF RESULTS

4.1 INTRODUCTION

The previous chapter provided the research design and methodology that was used in the study. This chapter presents the data analysis, and provide discussions. Three different sets of questionnaires were utilized to gather the required data from three different samples namely; Hospital, Directors, and Beneficiaries. This chapter begins by providing the demographic characteristics, which include age, sex, marital status, and education level of all the respondents. Since the study approach was hinged on mixed methods, the results are triangulated to provide a deeper in-depth analysis to the research problems as stated in chapter one. The concurrent triangulation method involves backing up certain results with other sample findings. This approach is meant to help dismantle the current problem under study into small components that are easy to follow, even for policy makers, since the idea is to strengthen a policy in Tanzania. The following were the questions that guided the study.

1. How Human Resource Planning and Development is important in the ministry?
2. Does the Ministry of Health and Social Welfare have the capacity to implement its strategic plan for Human Resource Planning and Development?
3. How can human resource infrastructure assist to focus on Human Resource Planning and Development?
4. What should be done to improve the implementation of Human Resource Planning and Development in the ministry?

4.2 DEMOGRAPHIC DETAILS

This section provides a summary of the demographic characteristics, which were considered in the study. The questionnaire retention rate was over 81 percent; as a result, it was deemed enough to provide the study with the needed insights pertaining the research problem at hand.

4.2.1 Distribution of Age

Table 4.1 illustrates the demographic distribution in terms of age groups. Of the three samples, the age group of 51-60 years contributed 70 percent of the Ministry sample, and the 31-40 years age group contributed 48 percent of the Hospital sample, and 38 percent of the beneficiaries sample was aged between 31-40 years. Overall, the beneficiaries sample was composed of mainly people who were 50 years and below. Yet, on the other hand, Hospitals and the Ministry samples did not have any respondent who was 30 years and below. The distribution of the samples were a reflection of the composition of the workforce within the Ministry of Health, were the youth are employed in basic jobs, and the older hold high positions.

Table 4.1 Demographic characteristics of respondents

	Ministry		**Hospital**		**Beneficiaries**	
Age Groups	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
20-30					108	30.8
31-40			7	46.7	132	37.6
41-50	2	28.6	5	33.3	79	22.5
51-60	5	71.4	3	20	31	8.8
60+					1	0.3
Total	**7**	**100.0**	**15**	**100.0**	**351**	**100.0**

4.2.2 Distribution of sample gender

In addition, Table 4.2 shows the distribution of male and female respondents. It was found that males dominated the Ministry (85%) and Hospital (53%) samples. Yet, females (53%) were the majority in the Beneficiaries sample. The gender distribution was balanced for both the Hospital and Beneficiaries samples, pointing that there have been improvements in gender distribution in the government. However, it was not surprising to find that males (85%) in the Ministry were in Managerial positions. It as norm in the Tanzania government that females are not equally represented at management level in the government.

Table 4.2 Distribution of samples by gender

	Ministry		**Hospital**		**Beneficiaries**	
	Frequency	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**

Male	6	85.8	8	53.3	164	46.7
Female	1	14.3	7	46.7	187	53.3
Total	**7**	**100.0**	**15**	**100.0**	**351**	**100.0**

This shows that the Tanzania government has a long way to go in improving female representation in high government positions.

4.2.3 Distribution according to marital status

In terms of marital status, the majority of respondents (Ministry (100%); Hospital (87%); Beneficiaries (70%)) were married as shown in Table 4.3. While the remainder 3 percent was divorced and 2 percent widowed in the Beneficiaries sample. The results are in support of a number of government reports in Tanzania, which point that most households are married.

Table 4.3 Distribution of samples by marital status

	Ministry		**Hospital**		**Beneficiaries**	
	Frequency	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Single			2	13.3	89	25.4
Married	7	100	13	86.7	246	70.0
Divorced					9	2.6
Widow/widower					7	2.0
Total		**100.0**	**15**	**100.0**	**351**	**100.0**

4.2.4 Distribution according to education

The study examined the level of education for the respondents. The result in table 4.4 shows that the majority of respondents (beneficiaries) hold a diploma qualification, 38 percent holds a Bachelor/ Honours degree, 9 percent have a Master degree, and 2 percent a PhD degree. While in the Hospital sample, 67 percent hold a Master degree, 7 percent a PhD, and 27 percent a Bachelor/Honours degree. In the Ministry sample; the minimum qualification held was a Bachelor/Honours degree, and the majority (72 %) had a Master degree.

Table 4.4 Distribution by education level

	Ministry		**Hospital**		**Beneficiaries**	
	Frequency	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Certificate					20	5.7
Diploma					160	45.6
Bachelor/Honours	1	14.3	4	26.6	132	37.6
Masters	5	71.4	10	66.7	33	9.4
PhD	1	14.3	1	6.7	6	1.7
Total	**7**	**100.0**	**15**	**100.0**	**351**	**100.0**

Source: Fieldwork survey, 2016

This means that the sampled respondents were literate; as a result, no challenges were encountered during the data collection period in terms of language difficulties. The education level is a demonstration of the current situation in Tanzania were the literature rate is over 71 percent, highlighting that most people can read or write (World Bank, 2016). In addition, it was expected that most people employed by the government were educated in one way or the other because of the jobs, whichthey do, demand a literate person.

4.2.5 Experience in working in the Public Sector

In terms of experience working in the public sector, it was expected that respondents from the Ministry sample had a lot of years of experience based on the requirement of managerial jobs in running a public entity. As shown in table 4.5, all the respondents from Ministry had over 14 years of experience working in the public sector. While in the beneficiaries sample 15 percent of the respondents had above 14 years' of experience working in public sector, 11 percent had 11-14 years' experience, 23 percent had 5-10 years' of experience, and 50 percent had less than 4 years' of experience. On the other hand, 33 percent of respondents in the Hospital sample had less than 4 years of experience in the public sector, 20 percent had 5-10 years, likewise 20 percent again had 11-14 years of experience, and the remainder (27%) possessed over 14 years of experience.

Table 4.5 Experience working in the public sector

Response	Ministry		Hospital		Beneficiaries	
	Frequency	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Less than 4 years			5	33.3	177	50.4
5 - 10 years			3	20	80	22.8
11-14 years			3	20	40	11.4
Above 14 years	7	100	4	26.7	54	15.4
Total	**7**	**100.0**	**15**	**100.0**	**351**	**100.0**

In summary, a number of respondents included in the sample were very much aware of a number of issues that were being studied by the researcher. Therefore, years of experience working in the public sector was expected to be a major factor in getting rich descriptions of information or deeper insights into the problem being studied.

4.3 THE IMPORTANCE OF HRD IN THE ORGANIZATION/MINISTRY

In this section, we focus on the importance of the HRP and D in the Ministry of Health as seen by the respondents. The discussion is as follows: a mixed analysis is given using inferential statistics in conjunction with a thematic analysis. The approach is expected to provide a rich picture on how the HRP and D is visualised in the Tanzanian health sector. Efforts were made to extract some quotes from the respondents to further the analysis.

4.3.1 Human resource planning

HRP is an important aspect for every organisation to achieve its goals and objectives. As a result, it is always advisable to have a well-done strategic plan in terms of HRP objectives. We posed a question to all the sampled respondents pertaining their view on the importance of HRP in the health sector. Figure 4.1 illustrates the results that came out of the question. As shown, 61 percent stated that HRP is important, 12 percent said No, and the remainder (27%) did not know. This

indicates that the majority of respondents are aware of practices in human resource planning in their organization. However, the researcher observed that most of beneficiaries' were not familiar with the concept of HRP as compared to the HRD concept due to their professions.

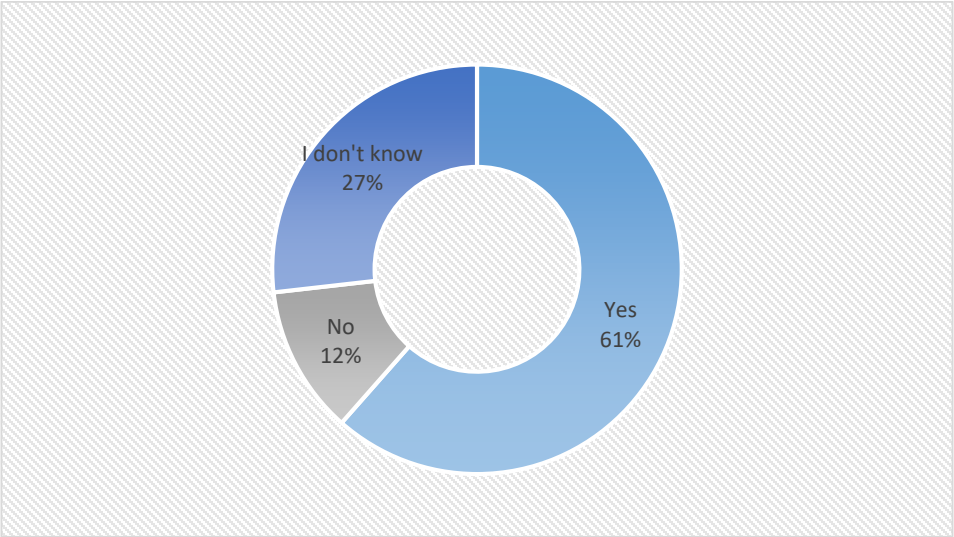


Figure 4.1 Organisation practise of HRP Source: Fieldwork survey, 2016

Then the researcher proceeded to interrogate the respondents by follow up questions to their answers. Four themes were extracted from the thematic analysis. The emergent themes based on responses were as follows:

1. Theme 1: Importance of HRP and Development
    a. Subtheme HRD complexity
2. Theme 2: Capacity in HRP in the public sector
3. Theme 3: HRP and Development, and delivery capacity
4. Theme 4: Effective HRP and Development
5. Theme 5 Strategies to enhance HRP and Development

By providing respondent views on the five major themes, it was possible to provide a deeper insight into the interactions with the respondents through listening to their voices. Through the concurrent triangulation, it is possible to provide estimates in terms of figures of certain views or opinions, at the same time supporting with qualitative data.

Table 5.6 illustrates some extracts that were collected from the respondents pertaining to the importance of the HRP. In the beneficiaries' sample, a majority of respondents noted the importance of the HRP in the organization, and its impact in contributing to the effectiveness of the organisation. Although, some stated that economy changes do have an impact on how the HRP works. Yet, in the hospital sample, it was agreed as well that HRP is a very important aspect of an organisation functionality. However, the effectiveness of the HRP rests on political pressures such as the change of government. Others claimed, '*Big Results now, was introduced while hospitals were not having staff to execute those activities'*. The view was that since the 'Big Results programme' was introduced, it has not been successful as a supporting measure because of problems in the HRP. *'Big Results Now'* is a government programmes were all public servants are expected to deliver quality services to the public. As a result, staff deficit is now on the rise because of non-alignment between the government policies and programmes. Aswathappa (2013:101) stresses that a failure to implement plans leads to a shortage of skilled and high turnover rate of workers. This is exact what the Hospital respondents were experiencing due to a lack of staff or personnel.

Yet, the Ministry sample composed of the Directors who plan the government policies pointed that, change of government comes up with different policy structure which overall affects how policies are delivered and implemented. They give an example of how naming of government ministries affects policies. In 1995-2005, the MOHWS was known as Ministry of Health. In the fourth government (2005-2015), it was the Ministry of Health and Social Welfare, while in fifth government it was changed to Ministry of Health, Community Development, Gender, Elders and Children. While the broader scope of the Ministry of Health has not be done with a supportive financial backing. For instance, the Ministry of Health has consumed other ministries such the Community Development, Gender, Elders and Children. The broaden of the ministry of health without considering the impact on HRP and HRD policies seems to be a blinded approach based on the following reasoning.

To begin with, the Ministry of Health operates under different modalities compared to lets say Ministry of Community Development. On the simple basis that the Ministry of Health deals direct

with peoples' wellbeing in terms of physical space. Yet, the Ministry of Community Development would be dealing with improving the community and harnessing its potential in terms of socio-demographics. Therefore, the clustering of unrelated ministries has undoubted made the HRP and D policy very ineffective, largely by over burden the ministry on how to combine different goals at the same time maintain a functioning HRP and HRD. A proper HRP and D lead the health sector to acquire, develop, and retain health workers in health sector (Chhabra, 2016:133). That means, motivated, well skilled, experienced, competent and knowledgeable health workers are an important ingredient for the health sector to perform well and deliver quality services (Dieleman and Harnmeijer, 2006:7).

The researcher observed that most people were aware of the importance of the HRP and HRD, although it was evident that the MOHSW was not following guideline in terms of HRP and HRD implementation. Therefore, it was affecting its operations. A shocking finding was that a number of people were not aware of the HRP and HRD guides, for instance, of the interviewed Hospital respondents only one was aware of the guide because she was among the HRP team of the Arusha Regional Administrative Secretariat who were supported by the PO-PSM to develop its HRP in 2010/2011. According to views from respondents from the PO-PSM.

P7: 'PO-PSM developed a Human Resource Planning Guideline (2010) was used in 2009/2010 and 2010/2011 to facilitate all the ministries and regional secretariats to develop their own HRP by using the Public Service Reform Program (PSRP II) funds. However, due to line of decentralization of power they train a HRP team from Prime Minister's Office, Regional Administrative Local government Authority (PMO-RALG) to assist the remaining institutions in the district level to develop their own HRP'

Further, P1 stated that even though the ministry did not use the PO-PSM guideline to develop the HRP and HRD plan but the ministry have human resources for health and social welfare production plan that used for acquisition, development, growth. He further state that the ministry develop staffing levels guideline for health facilities and institutions to use on identifying the number of skills required and distribution of staffs.

The researcher observe that, those regional hospitals which are under supervision of RAS which had an outdated HRP at least, have tried to improve the quality of health services compared to the district hospitals which does not have the plans in place. However, the trained staff on HRP most of them were transferred or promoted to other institutions and the remaining ones are new even not aware if they had that plan before. Therefore, It was noted that, there was no coordination of responsible between ministries (i.e. PO-PSM, PMO-RALG and MOHSW) between the three levels of hospitals; hospitals manned with the ministry, regional hospitals and district hospital to develop the HRP and HRD plans. This might have been caused by the lack of coordination between the Ministry of Health and Social Welfare and Prime Ministers' Office, Regional Administration and Local Government Authority, or budget constraints or resistance to change.

Moreover, P3 and P5 stated that, '*the challenge is, MOHSW and PMO-RALG has the same mandate on supervision of these health hospitals'.* Similarly, P1 stated that *the health sector vested to many authorities which hinder the implementation of HRP and D.* Even the respondents from hospital claims that there many stakeholders in the health sector which sometimes challenging the implementation of HRP and D.

This extract reveals that these ministries refrain their responsibilities knowingly that any between them can do it. The operation and responsibilities of these ministries are elaborated (see. Section 2.8) in the Tanzanian health system operation, which are pyramid in shape (MOHSW, 2014:8). As a results district hospitals did not develop their HRP even those RAS, a huge setback in service delivery to the masses.

Table 5.7 shows that HRD has its complexities that emerged pertaining the complexity of HRD in general. The directors in the Ministry highlighted three areas affect the HRD planning in Tanzania health sector. Firstly, technology advances should not neglect the HRD planning. Secondly, people shun working in rural areas; therefore, there is a shortage of skilled people in the rural hospitals and clinics. Thirdly, there is a lack of experience, especially with the current youth. Yet, some respondents at the Hospital claimed that politicians interfere with the running of the heath sector. Respondents in the beneficiaries' sample supported this. Therefore, both samples (Hospital and Beneficiaries) do agree that technology has undoubted led to improvements in terms of health delivery to the public, although some areas are still lagging behind, notable, in the rural areas.

Technology is viewed as an enabler of a progressive HRD planning process, and influencing positively.

Table 4.6 Theme 1: Importance of HRP

Ministry	Hospitals	Beneficiaries	Field Notes/ Observation
P1;P2;P3;P4;P5; The ministry has Human Resource Plan, which is an important tool developed through strategic plan. The tool assist for development, growth and direction of health workers in the ministry. However, implementation of HRP has positive effect and many challenges, which based on political, social, economic, technology, demographic and Policies. **Economic:** Any plan need money to implement. The decrease in economic growth affect the implementation of HRP and the sector depend much on Development Partners. **Political:** Change of the government comes with different government structure which affect existent Polices, laws and regulation example in the third government (1995-2005 the MOHWS was known as Ministry of Health, In the fourth government (2005-2015) was Ministry of Health and Social Welfare while in fifth government was changed to Ministry of Health, Community Development, Gender, Elders and Children. These changes require some changes to the existence policies while the government financial constrain to review them	**All interviewed** in regional, zonal and district hospitals recognise the importance of HRP on generating the staff requirements. The hospitals use staff level guideline from Ministry of Health and Social Welfare to develop staff needs. There are some external and internal challenges on implementation of HRP: **Economic: All interviewed -**contended that the economic factor affect the number of the health workers to be recruited, reduce the motivation and attraction elements to staff in their hospitals. **Political: (a)** Change of government comes with new vision, priorities and policies which affect implementation of HRP in a positive or negative way like change of government structure, introduction of new programme without infrastructure like Big Results Now was introduced while hospital not having staffs to execute those activities. So it increase deficit of staff (**P9; P10; P12; P18;P22)**	Most interviewed recognise the importance of HRP. 216 out of 351 accept their organisation practice it and 131 agreed is well done implemented in their organisation however, 85 claims that is fairly done. 216 agreed organisation consider HRP as an important component of HRM and effective implementation of it contribute to organisation performance as expounded by 327. **Economy:** 292 out of 352 agreed economy as an effect to the implementation of HRP and D like Change of economy affect the number of staff to be recruited and trained as well as motivation	**Ministry** **(a)** HRP of the MOHSW not following the PO-PSM guideline to develop their plan. **(b)**Every government in power have its own priority, policies and government structure. This affect the operations of the health sectors and require some review on some of frameworks while there is financial constrain **Health Secretaries** **(a)** All of them recognise the importance of Human Resource planning. **(b)** Most of them not aware on the existence of Human resource planning Manual which guide them to develop HRP. They just use MOHSW staff guideline to develop their need in budget session. Out of 15interviewed only one knows there existence of that manual and because she participated on development of HRP of the Regional Secretariat in 2010 which is now outdated.

As an observer, I noticed a disharmonised HRD system that is being influenced by different policies from different actors in the government. For instance, the Ministry of Health does its recruitment plans not in line with President's Office, Public Service Management, which deals directly with staffing. Secondly, there is no consistent reviewing of the impact of the policies in HRD to make corrective action. Thus, there is a huge gap in terms of HRD delivery in regional hospitals and districts.

Based on the information received from the respondents, it can be concluded that there is little communication between major players in the government concerning policy alignment. This lack of communication is another major contributor to the ineffectiveness of both the HRP and D. We then pose a question for respondents to estimate the level of the HRP implementation in the government ministries.

Table 4.7 Subtheme HRD complexity

Ministry	Hospitals	Beneficiaries	Field Notes/ Observation
Technology: Technology functionalities through Human Resource Information System (HRIS) assisting the plans in health sector by capturing the data up to District level Importance of HRP cannot be neglected. **Social: (a)** negative perception on health workers and health centres due to the change of health systems like people prefer to go to Regional hospitals and not in District hospitals because there are clinical offices instead of specialist and professionals. **(b)** Cadres which have high skilled workers does not want to work in remote areas where there is no good working environment and motivation instead they want to work in National, Zonal and Regional hospital **Demographic:** The new generation which enter into the health sector have no experience compared to the exit one and the number of exist staff is high then recruited ones as reported in MOSW,2014 that the ministry recruited 15% while the exist employees is 27% this affect the quality of services while the staff are overloaded with work.	**(b)** Politicians interfere some management decisions of hospitals like announcing some of health services for free such as pregnant delivery services, malaria treatment while in reality is not for free (**P14; P15;P16; P21)** **Technology: (a)** change in technology assist the government to work efficiently like develop Human Capital Management System (HCIMS), which facilitate health workers data to be accessed on time. This is a motivation for staff. (**P9; P18; P22)** **(b)** Most of hospitals are using computerised system to attend patients to fasten the services and increase government funds. However, some hospitals are behind the technology and some of staff is rigid to change. (**P9;P12 ;P15 P21; P22;)** **Social:(a)** pandemic diseases affect the number of health workers (**P8;P9;P22)** Also staff to follow their spouse affect the number of staff (**P11;P19)** **(b)** High development in urban areas so health workers prefer to work there than rural areas which lead to deficit number of staff in rural hospitals (**P16)**	**Political:** 271 out of 351 agreed political factor effect the implementation of HRP and D such as Politicians interfere hospital management decisions and health workers activities. **Technology:** 278 out of 351 support that it affect positively or negatively implementation of HRP and D like make job to be performed easily however training is needed for new technology. **Social:** 276 out of 351 recognise that it affect positively or negatively implementation of HRP and D like government is investing much to tackle the diseases without training much health workers. **Demographic:** 245 out of 351 recognise that it affect positively or negatively implementation of HRP and D. **Policies:** Change of government policies affects the number and quality of staff.	**(c)** No HRP at National, Zonal, and District hospital as directives of the President's Office, Public Service management (PO-PSM) .They generate health workers needs based on Staffing Level Guideline from the Ministry, which shows number and skills require in each level of the hospital. **(d)** Due to National health system and government policy of decentralization by devolution PO-PSM was mandated to facilitate Ministries, Regional Secretariats, Independent Departments, and Executive Agencies to develop their HRP then the Ministries facilitate the District levels to develop that plan. However, PO-PSM through Public Service Reform Program (2008-2012) in financial year 2009/2010 managed to facilitate all the ministries and regional secretariats (which incorporate Regional Hospitals in plan) but they did not even review them after being expired in 2013. While, it seems the Regional hospital, which had HRP before, are providing good health services.

Figure 4.2 shows that in terms of implementation of the HRP, this emerges in response to the questions about the importance of HRP in the Ministry. Respondents from hospitals were dissimilar in views with regard on how the health facilities function. At least 50 percent of the respondents agreed that it is well done and satisfactory, 39 percent believe that it is fairly done but unsatisfactory. There were only 11 percent respondents who stated that it is strongly well done and satisfactory.

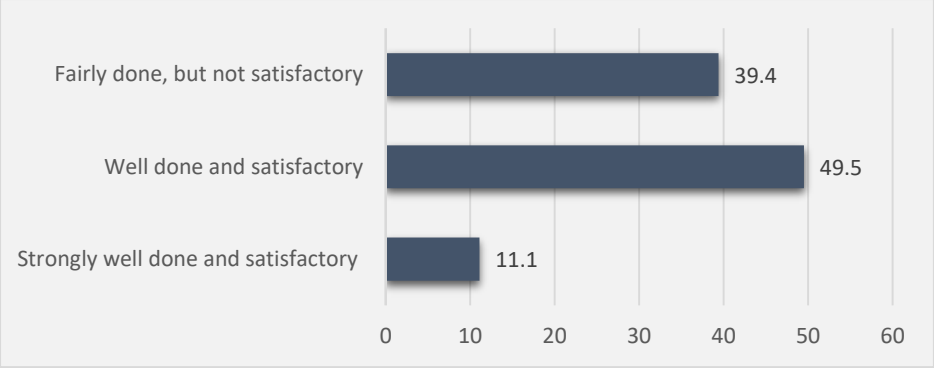


Figure 4.2 Implementation of the HRP Source: Fieldwork survey, 2016

This indicates that most of health workers in the public health facilities were satisfied with the implementation of human resource planning. The researcher then proceed to dig further by asking the respondents to rank their satisfaction in terms if HRP implementation. Figure 5.4 illustrates the opinions of the respondents pertain the HRP implementation.

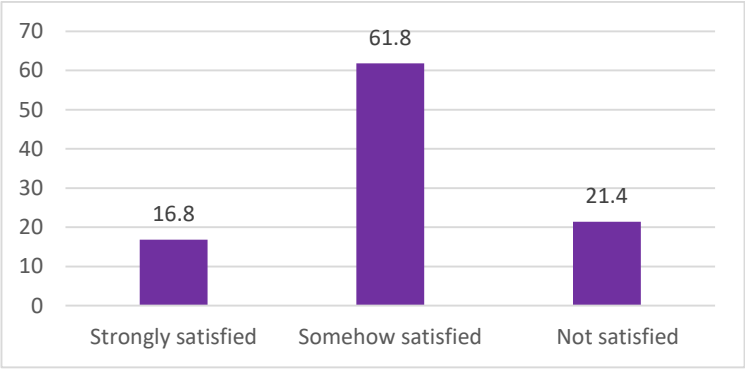


Figure 4.3 Implementation of HRP choices Source: Fieldwork survey, 2016

The results from figure 4.4 show that 62 percent of the respondents were somehow satisfied with the implementation of HRP in their organisation, while 17 percent were strongly satisfied, with the remaining 21 percent not satisfied at all. This findings point that HRP implementation is not as bad as some would like to think, and there is some effort in fixing the shortfalls.

On the other hand, Figure 4.4 shows implementation of human resource development in the organization. The majority(47.4%) of respondents declared that human resource development planning in the organisation is well done and satisfactory followed by 42.2% who revealed that it is fairly done and but not satisfactory. In addition, 10.0 per cent of the staff stated that human resource development planning in organisation is strongly well done and satisfactory while only 0.4 per cent of staff revealed that human resource development planning in organisation is never done. This reveals that the human resource development in public health facilities was implemented satisfactorily.

The responses were similar to what was contended by Chhabra, (2016:133) that proper HRD lead the health sector to acquire, develop and retain health workers. Yet, when HRD is properly conducted in the organization, it generates motivated, well skilled, experienced, competent and knowledgeable health workers to perform well and deliver quality services (Dieleman and Harnmeijer, 2006:7). Therefore, Koontz *et al*., (1981), Armstrong, (2012:211) concluded that efficient and quality services depends on implementation on the availability of HRD plan in the organization. The figure below illustrates the responses received.

Figure 4.4: Implementation of HRD choices Source: Fieldwork survey, 2016

4.4 CAPACITY OF THE MINISTRY IN IMPLEMENTING HRP

Study responses indicated that HRP implementation is satisfactory; our attention was on the capacity in implementing HRP. We then posed a question asking if the organisation where respondents were working has the capacity to implement HRP. We elicited the responses by asking if the organisation was properly staffed. Figure 4.5 shows the percentage of the adequate number of skilled staff. The results show that only 22 percent of the respondents agreed that they have adequate number and skilled staff in the organization. The lack of adequate staffing is confirmed by 67 percent of the respondents.

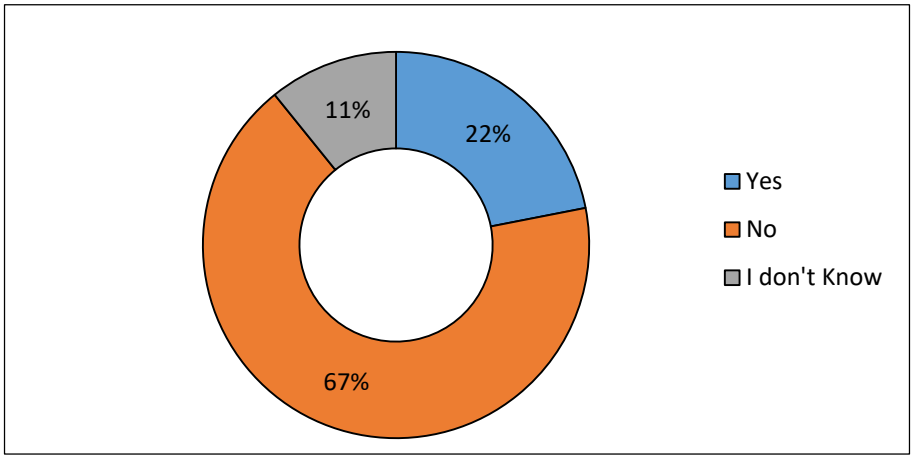


Figure 4.5: Organisation skilled staff Source: Fieldwork survey, 2016

In short, staffing has been a huge problem, especially in the health sector. Table 4.8 shows respondents' list of capacity challenges facing their organisations. Results from the study indicated that 20 percent of respondents said that deficit in the number of staff is strongly available in the organization. While 40 percent stated that, there is a deficit in the number of staff. This indicates that the majority of respondents agree that the deficit of staff for implementing the Human Resource Planning and Development is available in health sector organizations. On the other hand, 7 percent of respondents said that there was a huge deficit in terms of skills, knowledge, and experience of staff, and 51 percent of respondents agreed that there is a deficit. This indicates that majority of respondents agree that there is deficit in terms of skills, knowledge and experience of staff for implementing HRP in their workplaces.

Furthermore, the results from table 4.9 shows that 4-6 percent of respondents were undersupply of skills, knowledge and experience in different positions respectively in public health organizations. This show that majority of respondents in public health organizations agreed that there was an undersupply of skills, knowledge, and experience in different positions. In addition, respondents (55%) from the public health organization stated that there was no oversupply of skills, knowledge, and experience in different positions. Yet, inequality in allocation of staff in public health hospitals was low to moderate. This implies that majority of respondents were satisfied with allocation of staff in public health hospitals.

Table 4.8 Ranking of capacity challenges in implementing HRP

Items	**Strongly available (%)**	**Available %)**	**Somehow available (%)**	**Not Available (%)**
Deficit number of staff	46(19.5)	94(39.8)	85(36.0)	11(4.7)
Deficit in terms of skills, knowledge and experience of staff	16(6.8)	120(50.8)	87(36.9)	13(5.5)
Undersupply of skills, knowledge and experience in position	10(4.2)	92(39.0)	109(46.2)	25(10.6)
Oversupply of skills, knowledge and experience at different position	6(2.5)	39(16.5)	54(22.9)	137(58.1)
Inequality allocation of staff	32(13.6)	54(22.9)	94(39.8)	56(23.7)

Source: Fieldwork survey, 2016

The study assessed the quality of health service provided to the respondents who indicated that they have adequate number of staff. Table 5.10 presents the percentage of respondents view on the quality of health services provided by public organization with adequate staff. The findings indicate that 30 percent of respondents agreed that the quality of health service provided is strongly well done and satisfactory in public health hospitals. In addition, the results show that 47 percent

of respondents said the health service provided are well done and satisfied. This shows that majority of respondents were satisfied with the quality of health service provided to the people.

Table 4.9 Organisation with adequate staff (N=77)

Quality of health services	**Number**	**Percentage**
Strongly well done and satisfactory	23	29.9
Well done and satisfactory	36	46.8
Fairly done, but not satisfactory	18	23.4

Source: Fieldwork survey, 2016

To understand issues of capacity, we triangulate the three sample responses by providing some extracts as shown in table 4.11. According to the Ministry respondents, the discrepancy in the number of health staff is blamed on the freezing of recruitment in the 1990s, under production of graduates by universities in Tanzania, poor succession planning, poor management and leadership. The report by MOHSW (2014:11) concedes that the health sector lack staff in management and supervisory position. High turnover rate and absenteeism are some of the contributing factors to a low staffing. Similarly, Dominick and Kurowski (2004:14) argue that the deficit of number of health workers developed between the demand and supply, while poor HRP is pointed as another cause.

Further, the director form the ministry (P7) highlighted deficit in health sector by stating that, staff are not prepared to do multiple work and be flexible they just mentored for specific work. Moreover, the researcher wants to know if these few people who are in health facilities are they adhered to the health professions and ethics. Respondent from Hospitals, P8, P14, P15, P16, P18, P20, and P2 stated that based on the professional policies, guidelines and HR systems. Professional standards and quality services are maintained. P5 disputes that even though there policies, guidelines and rules for public servants still it is a challenge for staff to be ethical. The researcher observes that there is a decline in professional ethics and values due to globalisation, working environment and person development and attitudes.

Table 4.10 Theme 2: Capacity in HRP in the public sector

Ministry	Hospitals	Beneficiaries	Field Notes/ Observation
P2; P3;P4;P5;P6:P7 There is inadequate number of health workers in health centres due to freezing of recruitment in 1990's; economic factor the recruitment process is low; and undersupply of staff in certain health position and cadre as well as in all health skills such as mental health, lack of skills in **speciality**: oncology, dental, anaestazia, neural, kidney, lenal ,nurses, lab technology, neural surgeon, pathology, ENT, lack of skills professionals on non-**communicable diseases** like diabetic, cancer, high pretension **P1; P3: the** deficit of staff made by underproduction of health universities and colleges and lack of motivation and good working environment so professional look for greener pasture. **P4:** There is deficit on staff because before the activities was conducted centrally but due do decentralization of power to PMO-RALG, some cadres like social welfare have a huge deficit on social workers. **P1:** Poor succession planning. There is no correlation between the employed and exit employees example; employee entered in health sector are 15% and 27% are living. **P1; P3; P5**: Hospital lack managerial and leadership knowledge on health speciality and lack of knowledge on existing new technology in hospital like cashless system, equipment.	**All interviewed** hospitals experienced a shortage number of staff in all skills, cadres and certain positions. Such skills shortage are like gynaecologist, physician, cardiology, paediatrician, neural surgeon, biomedical engineering, radiology, psychiatric, anaesthesia, clinical, medicine, optometric like there is a shortage of 1100 staff in Bugando zonal hospital, 337 in Mawenzi regional hospital and 125 in Arusha regional hospital. However, there is a huge deficit in nurses and clinical cadre. **P15:** there deficit on position of "super specialist" in zone hospital. The deficit made by low recruitment process by the government, poor working environment, lack of working facilities, and motivation. **P22:** there some oversupply of staff in certain cadre like medical attendants who are supposed to be 170 but they are 210 in Mawenzi Regional hospital. This is due to low commitment of leaders and miscommunication of top leaders with supervisors. **P21; P22;** Missing of certain knowledge on research, management planning, hospital does not have a person knows to keep dead people.	140 Interviewed health workers agreed there is deficit of number of staff. 136 Deficit in terms of skills, knowledge, and experience of staffs. And 110 agreed there is undersupply of skills. However, 45 agreed there is Oversupply of skills, knowledge, and experience in different cadre. 59 interview agreed hospitals provide quality services to the public	**General comments** Inadequate number of staff especially in speciality skills and lack of leadership knowledge on that speciality. Management have been trying to motivate and retain staff by different motivators. Example those hospitals out of Dar-es-Salaam Region like in Arusha, Moshi and Mwanza Regions have been trying to retain staff by giving new employees their allowances on time, looking for accommodation and houses. However, I observe that the regional and zonal hospital are not much in trouble of attracting and retaining staff because of their status, geographical allocation so most of health profession like to work there. Mostly the deficit is due to limitation of recruitment permit due to certain reasons of the government. In addition, health-training institutions not producing enough health professions to meet the demand.

Table 4.11: Theme 2: Capacity in HRP in the public sector

Ministry	Hospitals	Beneficiaries	Field Notes/ Observation
P7; Job plans- staff not doing multiple work prefer to work on identified specific work, no flexibility **P1;P2;P3;P5;P4;** professionalism are enhanced through frameworks, guidelines, professional board, councils, associations **P1;P2;P3;P4;P5;** The quality of service are guided with policies, guidelines, reports, HR systems like Open Performance Appraisal system (OPRAS) **P1;P2;P3;P4;P5;(a)In staff allocation,** the Ministry have been looking for the government priority, needs of specific areas like the District enter into contract with students to pay for their training and employ them when they finish studies. **(b)**Government have been trying to attract and retain staff by different motivation through different policies, programme, and strategies like increasing number of training institutions, ensuring availability of employment when health student finish school, building houses for health workers, increase package of salary. **P1;P2;P3;P4;P5;** Health sector have different culture like value client, save life, love to patient, equal treatment, love to patient, patient, humble, listening, cleanness, wearing specific uniform, but the some of these culture are not adhered by some of health workers due to environment forces, personal attitudes. **P7;** health workers feel as expert group in the society rather than servant group	**P8;P15;P16;P19;P20;P22;P2**:Proffesionalism enhanced through policies, guideline, trainings and meeting to remind health workers. **P8;P14; P15; P16; P18;P20;P2:**Hospital keep insisting on following professional standards, maintained Performance and quality of service through policies, guideline exist interview with patient, advisory board committee or quality assurance officer or team, Monitoring and evaluations well as HR systems like Open Performance Appraisal system (OPRAS), and **P8:** quality of services are mainted through department of quality assurance, standard operation procedures, patient charter and customer care training. **P5;P8; P10;11; 13; 14; P16;P17;P20; P22** (a)Allocation of staff to different departments are considering the needs of specific department and workload. **P22;** Hospital provide motivation to the area or department which staff doesn't like to be allocated like in Mawenzi hospital share with staff 10% of cost sharing (b) Hospitals attract and retain staff by giving them allowances, houses, training if budget allow, permission to go for training, **P8; P10; P13; P14; P16;P18; P21;P22** Hospitals have culture of team work, tolerance, polite, language, listening, humble, value of situation and work without considering money, wearing uniform, hard worker, quiet and calm		There is a decline in professional ethics and values. Health workers behaviors, languages and appearance are not relevant to their professional standards. Low leadership commitment and poor coordination while some hospitals have overstaff of some cadres while other hospitals have the deficit of the same cadre. This could be solved by transferring those staff. Management at least are good in conduct training because is a motivation factor to staff and staff will demand it than Human resource planning

Health workers behaviours, languages and appearance are not relevant to their professional standards. For example, one laboratory staff putting earphone when attending customers. The hospital respondents concurred that there was a deficit in staffing, but due to a low recruitment drive by the government. They further provide a rare case of oversupply of staff in Mawenzi Regional Hospital. Furthermore, lack of advanced medical skills pointed because of lack in specialists' staff. Yet, the beneficiaries sample agreed as well that there is a deficit of staff in certain places, although in other areas there is an oversupply. As an observer, l agree that there is a huge deficit of staff in the public sector due to lack of specialists. For example supply of clinical officers for per year is 600 students while the demand only in primary health care is 3404 (MOHSW,2014:36). In other areas, hospitals have been trying to retain staff by motivating them by allowances. However, bigger regional hospitals hardly face challenges faced by non-urban hospitals because a number of people are willing to relocate to peri-urban and urban areas. On a different point, the view that the universities are not producing much graduates contradicts the information that was collected from the health science universities/colleges as shown in table 4.12.

Table 4.12: Enrolment in health institutions

University	**Studies**	**2013/14**		**2014/15**		**2015/16**	
Muhimbili University of Health and Allied Sciences (MUHAS)		Male	Female	Male	Female	Male	Female
	Masters	123	97	143	118	220	134
	Bachelor Degree	1161	561	1331	581	1467	640
Total		**1942**		**2173**		**2461**	
Catholic University of Health and Allied Sciences (CUHAS)	Masters	42	22	51	22	72	41
	Bachelor Degree	657	397	760	502	917	657
	Diploma	277	145	296	214	399	214
Total		**1540**		**1845**		**2300**	
Kilimanjaro Christian Medical University College (KCMUC)	Masters	123	53	123	55	112	79
	Bachelor Degree	664	450	558	354	900	590
	Diploma	54	33	21	24	33	72
Total		**377**		**1135**		**1753**	

Table 4.12 reveals that in terms of enrolment all the three universities have been experiencing growth from 2013 to 2016. For instance, Kilimanjaro Christian Medical University College (KCMUC) enrolment rose from 377 in 2013/14 to 1135 in 2014/15, this is over 300 percent increase. It further increased to 1753 in 2015/16, which is an over 110 percent increase. Therefore, the claims that there are less qualified people are not backed up by statistics from the government side. At this stage, we notice that the medical universities/colleges have been producing graduates. The only major concern is that most graduates do not have experience, as a result, there are recruited in internship positions. If that were the case, then with time there would be an oversupply of medical qualified graduates, since most of them seem to be not absorbed in the health ministry as pointed by the Directors interviewed. There seem to be a mismatch of jobs and qualifications as well. As opined by Berkout et al. (2012:2), mismatch happens when there is no well adjustment between the supply of labour and the change of demand in the market. This then contributes to the GAP, which needs to eliminate by the HRM actions (Pynes, 2009:42; Prasad, 2015:148).

4.5 HRP AND DEVELOPMENT INFRASTRUCTURE AND ITS DELIVERY CAPACITY

The researcher then went further to interrogate respondents on the HRP and Development infrastructure as well as its delivery. This was done in order to identify areas that need to be strengthened by the government in order to improve health delivery. In terms of external physical infrastructure, the results in table 4.13 show that 51 percent of the respondents stated that the good working environment is somewhat available, with 26 percent stating that it is available. However, the researcher observed that at Catholic University of Health and Allied Sciences (CUHAS) that, a professional doctor in plastic surgeon, which is a rare skill, went to work abroad simply because the university did not have relevant facilities for executing that such skill. Similarly, 57 percent stated that offices and budget were somewhat available. Yet, in terms of salaries over 40 percent of the respondents said it was available to strongly available. Perhaps demonstrating that salaries are hardly an issue in most cases. On the other hand, 6 percent of respondents said that compensation was strongly available for health workers. This indicates that the majority (41 % plus) of respondents were dissatisfied with the state of compensation in the public health sector since it is centrally allocated.

Table 4 13: Status if HRP and Development and delivery capacity

Items	Strongest Available (%)	Available (%)	Somehow available (%)	Not available (%)
Good working environment	36(10.3)	92(26.2)	178(50.7)	45(12.8)
Offices, Budget	16(4.6)	86(24.5)	199(56.7)	50(14.2)
Salaries	75(21.4)	141(40.2)	115(32.8)	20(5.7)
Safeties	32(9.1)	124(35.3)	151(43.0)	44(12.5)
Compensation	20(5.7)	62(17.7)	142(40.5)	127(36.2)
Security	31(8.8)	106(30.2)	153(43.6)	61(17.4)
Houses	5(1.4)	30(8.5)	76(21.7)	240(68.4)

Source: Fieldwork survey, 2016

The results in table 4.13 also show the status of security and houses in public health organization. On security, only 9 percent of respondents agreed that security was strongly available in public health hospitals while 30 percent said available. This indicates that the majority of respondents are not satisfied with the security in their working environment in public health organization. Additionally, hospital respondents(P22) support the issue of security and give example that, *'There some department like psychiatric which has challenging activities need people who are strong like male nurses so there should be a well plan in security and type of people'.*

Furthermore, 1 percent of respondents agreed that houses for health workers in the public health organization were strongly available. This indicates that most of health workers in the public health organization were not satisfied with the availability of houses for health workers. Such shortfalls in the working conditions of health sector workers may be a cause of concern considering that already there are shortfalls in terms of staffing.

On the internal physical infrastructure, the results in table 4.14 shows that both PO-PSM and MOHSW ministries have developed good policies, laws, and regulations to guide the HRP and D plans in health sector but some of the health institutions are not aware on some of the important policies issued. They agreed that the issue is coordination and dissemination of those policies to

reach to the entire public service that would improve the implementation HRP and D plans. The directors 'point to a shortage in terms of budgeting, for instance the two respondents state that:

P1; P4; '*The ministry conducted M and E quarterly through national supportive supervision and Regional health management team which conduct M and E monthly even though not efficiently due to budget constrain. Also through reports, health management information system (HMIS) are generate monthly report'.*

This extract points to lack of funding in terms of monitoring and evaluation on these infrastructures, and an admittance to lack of efficiency in the process. What we get from this extract is that there is little evaluation in terms of implementation of HRP in the health sector. Similarly, two hospital respondents (P15 and P20) support the issue of lack of funding and claim that, 'these are road map to implement HRP and D, but the issue is funding'. Likewise, l observed that some of employees in health facilities are not aware on some of the important policies that guide their activities and implementation of Human Resource Planning and Development. Yet, the issue of funding was a serious concern in the implementation of the HRP in the health sector.

It was noted that implementation of HRP and HRD plans involves many stakeholders from ministries, development partners, international organizations, religious institutions, civil societies, professional councils and associations to assist for capacity building, technical and finance. However, the director from the ministry responds that: *the stakeholders assist for capacity building, technical and finance however, there is a challenge of interfering our decisions and priorities*.

Similarly, the Hospital respondent P5 states that:

Lack of coordination of stakeholders in supervising and regulating the HRD and health workers as a whole like PO-PSM, PMO-RALG, and MOHSW every one provides directives to the health institution but sometimes does not link.

As an observer, l also agree stakeholders assist the health sector in different areas but they provide support on their interested areas not government priorities and interest. Yet, with stakeholders

Table 4.14: Theme 3: HRP and Development infrastructure

Ministry	Hospitals	Beneficiaries	Field Notes/ Observation
P1;P2;P3;P4;The ministry developed and disseminate guideline to entire public service although not all the entire health sector access, aware and understand those policies, laws, regulations and guidelines which guide the implementations of plans. **P6:** Ministry facilitate, remind, and create awareness on the policies, laws and regulation. **P5:** Ministry provide salary for health teachers and some facilities for student in health training institutions. Also it provide grants to private institutions in order to increase number of health students **P1; P4;**The ministry conducted MandE quarterly through national supportive supervision and Regional health management team which conduct MandE monthly even though not efficiently due to budget constrain. Also through reports, health management information system (HMIS) are generate monthly report. **P3:** It is a continuous process to conduct MandE by join review between ministry, development partners and NGO to check the implementation of Policies by using discussion, observation and meetings. **P2;** MandE conducted with specific department of policy and planning to check implementation of internal infrastructures	**P15; P16; P20; P22: The** internal infrastructure like Policies, standing order, regulation, schemes are important infrastructure assist to provide guidance in planning and decision making. **P15;P21:**these are road map to implement HRP and D but the issue is fund **P16:** Internal infrastructure are machinery for planning	Majority of health workers agreed that internal infrastructure are somehow available.	**Ministry** The ministries have developed good policies to guide the health sector but the issue is coordination and dissemination of those policies to reach to the entire public service. The ministry have a good system for monitoring and evaluation but the problem is funds for staff to conduct the monitoring and evaluation. The government have been trying to develop external infrastructure, the challenge is there is no adequate infrastructure to motivate and facilitate health workers to deliver quality services **Hospital** The hospitals are not aware on some of the some of the important policies to guide their activities and implementation of Human Resource Planning and Development. **Beneficiaries.** Most of health workers were not happy with internal infrastructure thus why majority of them said, infrastructure are somehow available. It means there not much satisfied

assistance, the government has been trying to revive a number of facilitates to improve the implementation of the HRP, unfortunately the efforts have been very slow. As a result, respondents are justified in stating that the infrastructure and capacity for implementing the HRP is very low.

4.6 STRATEGIES FOR ENHANCING THE APPLICATION OF HRP

Respondents were asked to rate the internal factors which affect the implementation of Human Resource Planning and Development in public health organization. The results are as indicated in Table 4.15.

Table 4.15 Internal factors affecting the implementation of HRP

Internal Factor	***Strongly agree (%)***	***Agree (%)***	***Neutral (%)***	***Disagree (%)***	***Strongly disagree***
Organization structure	61(17.4)	176(50.1)	85(24.2)	13(3.7)	16(4.6)
Internal work regulations and management system	48(13.7)	179(51.0)	90(25.6)	2597.1)	9(2.6)
Human Resource Information System	50(14.2)	178(50.7)	90(25.6)	22(6.3)	11(3.1)
Sectorial Policies	48(13.7)	160(45.6)	98(27.9)	32(9.1)	13(3.7)
Staff welfare issues	63(17.9)	135(38.5)	109(31.1)	32(9.1)	12(3.4)
Ethics and values	67(19.1)	145(41.3)	100(28.5)	30(8.5)	9(2.6)
Health and wellness	74(21.1)	142(40.5)	100(28.5)	25(7.1)	10(2.8)

Source: Fieldwork survey, 2016

Table 4.15 shows that 17 percent of respondents strongly agree that organization structure affect the implementation of Human Resource Planning and Development in the public health sector. In addition, results show that 51 percent agree that internal work regulations and management system affect the implementation of Human Resource Planning and Development in public health organization. On the other hand, 14 percent of respondents strongly agree that the sectorial policies affect the implementation of the Human Resource Planning and Development. This was strongly agreed also on the staff welfare issues (18%), ethical and values (19%) and health and wellness (21%). The highlighted factors can affect the organisation both positively and negatively.

We then asked respondents to rate how political and social factors affect the implementation of the HRP and HRD. The results in table 4.16 show that 33 percent of the respondents strongly agree that political factors influence the implementation of the HRP and HRD. Respondents from hospitals claim that politicians' promises free services to pregnant women, which cannot be attainable due to the running cost of health facility. This creates hatred between health staff and the public.

Economic factors also affect the implementation of the HRP and HRD, 39 percent of respondents strongly agree. Respondents from the Ministries state that the economy of the country determines their training budget; they further argue that, due to the current economic situation the training budget is not enough. Respondent P1 had the same view that the economy affects the production of health workers. Similarly, respondents from the hospital argue that due to budget constrain, staff are allowed to attend evening training on their own cost. This concur with the South Africa Department of Labour (2005) reveal that skilled workforce are the catalyst of living standards of people. In the same vein, Tshilongamulenzhe and Cotzee, (2013:18) contended that human resource development act as an important components on country's economic development. Therefore, people should be given access to acquire skills through education and training. Briefly, both political and economic factors have a huge impact on the implementation of the HRD and HRP on the basis that when a new government is in power a number of this are changed. As a result, it becomes harder to implement HRP and HRD on consistent basis.

Table 4.16 The implementation of HRP and HRD

Item	**Number**	**Percentage**
Implementation of HRP and HRD negatively affected by political factors		
Strongly agree	114	32.5
Agree	157	44.7
Neutral	44	12.5
Disagree	23	6.6
Strongly Disagree	13	3.7
Implementation of HRP and HRD negatively affected by Economic factors		
Strongly agree	137	39.0
Agree	155	44.2

Neutral	31	8.8
Disagree	23	6.6
Strongly Disagree	5	1.4

Source: Fieldwork survey, 2016

Evidence from existing literature shows that the countries' economic status determines the facilities, acquisition, development, succession, promotion, transfer, retention well as performance rewards of health workers in health sector (Prasad, 2015:73, MOHSW, 2014:12; Maestad, 2006:2). It is also argued that the wealth of the country determines the contribution of the health sector to its people. Consequently, to have a flourishing HRP and D negative political and economic factor should be minimised at all costs.

Table 4.17 shows the result pertaining the implementation of Human Resource Planning and Development affected by social and technological factors.

Table 4.17 Implementation of HRP and HRD affected by social and technological factors

Item	**Number**	**Percentage**
Implementation of HRP and HRD negatively affected by Social factors		
Strongly agree	104	29.6
Agree	172	49.0
Neutral	42	12.0
Disagree	14	4.0
Strongly Disagree	19	5.4
Implementation of HRP and HRD negatively affected by technological factors		
Strongly agree	109	31.1
Agree	169	48.1
Neutral	50	14.2
Disagree	18	5.1
Strongly Disagree	5	1.4

Source: Fieldwork survey, 2016

The results in Table 4.17 show that 30 percent of the respondents strongly agree that social factors influence the implementation of the Human Resource Planning and Development in public health sector. On technological factors, 31 percent of respondents strongly agreed that these factors also affect the implementation of the Human Resource Planning and Development. Overall, respondents agree that social and technological factors have a huge impact on the implementation of the HRP and HRD. Similarly, table 5.18 illustrates that 50 percent of respondents agreed that

the implementation of Human Resource Planning and Development affected by the demographic factors in the public health sector.

Table 4.18 Implementation of HRP and HRD by demographic factors

Item	**Number**	**Percentage**
Implementation of HRP and HRD negative affected by Demographic factors		
Strongly agree	70	19.9
Agree	175	49.9
Neutral	77	21.9
Disagree	18	5.1
Strongly Disagree	11	3.1

Source: Fieldwork survey, 2016

The Scottish Government (2012:6) pointed that today's world is filled with many challenges emanating from technology progress, social cultures and more. As a result, this situation demands health workers who are competent, professionals and ethically according to the professional standards and government policies (UN, 2000:3).WHO, (2006:4) stated that advancement of technology and medical discipline affect the implementation of HRP and D in health sector. This is dependent on the type of technology being offered to the market.

Table 4.19 reveals that the following: human resource policies (31%), committed management (35%), alignment of HRP and P (23%), adequate resource allocation (33%), suitable planning techniques (31%) and reviews of HR plans (29%) were strongly pointed as key determinants of effective implementation of the HRP and D.

Table 4.19 Key determinants of effective implementation of HRP and Development

Determinants	***Strongly agree (%)***	***Agree (%)***	***Neutral (%)***	***Disagree (%)***	***Strongly disagree (%)***
Human resource policies	107(30.5)	148(42.2)	67(19.1)	18(5.1)	11(3.1)
Committed management	121(34.5)	133(37.9)	66(18.8)	19(5.4)	12(3.4)
Alignment Human Resource Planning and Development	82(23.4)	150(42.7)	88(25.1)	21(6.0)	10(2.8)
Adequate resources allocation	117(33.3)	109(31.1)	66(18.8)	39(11.1)	20(5.7)
Suitable planning techniques and validity of data	107(30.5)	120(34.2)	84(23.9)	26(7.4)	14(4.0)
Reviews of HR plans	103(29.3)	126(35.9)	83(23.6)	26(7.4)	13(3.7)

Source: Fieldwork survey, 2016

Theme 3 on table 5.20 has some extracts from the respondents pertaining the determinants of HRP and Development. Extracts from the ministry paint a dark picture to the current status quo about the HRP. For example, the statement *'Policies are there but not adhered with public servants',* reveals that the directors are aware that the policies are not followed , but, there is no corrective action to deal with that problem. This is in contrast to the results in table 4.19 were over 42 percent agree/strongly agree that HR policies determine effective implementation of HRP and D. This leads to the next view put forward by the directors in the ministry when they state that, *'There is a slit problems in issuing documents between the central government and local government like issuing policies which are not correlated'.* Perhaps this may be the major contributor of unaligned policies and poor implementation of HRP.

Similarly, the following is an extract from the hospital respondents:

'Policies: Regulate the activities in hospitals however change of policies without creating clear infrastructure for implementation affect the management of health workers like change of hospital status require some cadres like clinical officers to be in district level instead of regional while the district hospitals are no developed enough so people tends to go to regional hospital' (P18;P20;P22).

This means there is view that policies within the ministry are not congruent; as a result, their delivery is weak. Likewise, both respondents from the ministry and hospital raise the issue of demographic by stating the following:

Ministry, *'Increase of population affect the number and quality of skills because it require similar identified proportions to carter the needs of health workers'*

Hospitals, *'increase number of population affect the number of health workers and health facilities while there is no budget'* (P9; P10; P11; P12; P22)

Although, the view is that population increase affects how the HRP is delivered, the outcomes differ on the basis that the ministry sees the skills mismatching the available needs. Yet, the hospital respondents see the increase in population affecting health workers as well as constraining the budget. Consequently, leading to the ineffectiveness of the HRP. The research observed that policies, programmes directive should be facilitated with the required infrastructure otherwise, it creates HR gaps. For instance, change of status of some hospitals while they are still getting the same budget, using same workforce and facilities create poor health services. Is just an impossible task to achieve a viable HRP. In addition, culture in certain places where hospital exists affect the service delivery; like Masai tribe are very harsh to some staff in Moshi Hospital, as a result some people do not want to work there. This means, HRP cannot achieve its goals in such a culture intolerant environment. Likewise, the Chagga tribe in Moshi like to speak their language while not all staff is from there. This means there are currently many challenges faced by the HRP. The challenges faced in the implementation require efforts that are meant to address the current short falls. Therefore, in table 4.21 we provide the proposed strategies to enhance the HRP and Development in the public sector.

Table 4.20: Theme 4: Effective HRP and Development

Ministry	Hospitals	Beneficiaries	Field Notes/ Observation
The Ministry has Human Resource Plan but its development does not following the Human Resource Planning Manual developed by the President's Office, Public Service Management. The Implementation of HRP face positively or negatively internal or external forces like policies, technology, and social. **Policies: (a)** Policies are there but not adhered with public servants. **(b)** There is a slit problems in issuing documents between the central government and local government like issuing policies which are not correlate **Economic:** The decrease of economy affect the wage bill of the public service which hinder the ability to recruit many health workers, good working environment and motivation **Technology:** Advancement of technology requires competent health workers, if not responding well it lead to poor services, immigration of staff unutilised of health workers. **Social:** culture or social behaviour of staff affect the HRP, tends to resistance or not following the ethics, values, and conduct of their professions and public sector as well which sometimes lead to increase of pandemic diseases. **Demographic:** Increase of population affects the number and quality of skills because it require similar identified proportions to carter the needs of health workers.	**Demographic: (a)** increase number of population affect the number of health workers and health facilities while there is no budget (**P9;P10;P11; P12;P22)** **(b)** Change of population characteristics affect the experience of health workers while there is a huge gap between staff who are going to retire and the successors (**P215;P16; P20**) **Policies:** Regulate the activities in hospitals however change of policies without creating clear infrastructure for implementation affect the management of health workers like change of hospital status require some cadres like clinical officers to be in district level instead of regional while the district hospitals are no developed enough so people tends to go to regional hospital **(P18;P20;P22)**		**e)** Policies, programmes directive should be facilitated with required infrastructure otherwise it create HR gaps. Example change of status of some hospitals while in reality, they are still getting the same budget, using same workforce and facilities create poor health services. **(f)** Culture of a certain place where hospital exist affect the service delivery like Masai tribe are very harsh so some staff in Moshi hospital does not want to work there. Moreover, chagga tribe in Moshi like to speak their language while not all staff are from there. Also financial status or the population affect the service while in Nyamagana district hospital the people are poor they seek for service without money where sometimes the staff forced by situation to pay for them because of their professions are different, the issue was to agree so that they can not be condemned on the results of research.

Table 4.21 Strategies to enhance the application of HRP and Development

Items	**Strongly used (%)**	**Used (%)**	**Sometimes used (%)**	**Not used (%)**	**Not used at all (%) (%)**
Attracting and recruiting the potential employees	60(17.1)	117(33.3)	113(32.2)	37(10.5)	24(6.8)
Promoting staff on time	39(11.1)	87(24.8)	126(35.9)	63(17.9)	36(10.3)
Rewarding and recognizing hard working employees	44(12.5)	86(24.5)	127(36.2)	54(15.4)	40(11.4)
Talent Management	30(8.5)	83(23.6)	125(35.6)	73(20.8)	40(11.4)
Performance Management (eg. OPRAS, client Service charter, Customer care etc.)	66(18.8)	147(41.9)	98(27.9)	24(6.8)	16(4.6)
Organizational learning and development	37(10.5)	140(39.9)	122(34.8)	40(11.4)	12(3.4)
Equity in allocation of staff	28(8.0)	141(40.2)	120(34.2)	42(12.0)	20(5.7)
The return option strategy	25(7.1)	76(21.7)	136(38.7)	83(23.6)	31(8.8)
The Diaspora strategy	12(3.4)	51(14.5)	119(33.9)	115(32.8)	54(15.4)
Improvement of infrastructure capabilities	34(9.7)	82(23.4)	145(41.3)	67(19.1)	23(6.6)
Setting enough budget for human resource development	27(7.7)	60(17.1)	138(39.3)	86(24.5)	40(11.4)
Monitoring and Evaluation	43(12.3)	108(30.8)	122(34.8)	63(17.9)	15(4.3)

Source: Fieldwork survey, 2016

Table 4.21 presents the responses on strategies to enhance the application of Human Resource Planning and Development in public health organization. The result shows that performance management (19%), attracting and recruiting (17%), monitoring and evaluation (12%), and promoting staff (11%) were the mostly used strategies. Yet, the frequently used were organizational learning and development (40%), equity in allocation of staff (40%), monitoring and evaluation (31%), and attracting of employees (33%).Monitoring and evaluation is an integral part of the HRP process which leads to the correction of problems in the HRP (Aswathappa, 2014:125). The HRP process should assess the impact of the HRP and D, its relevance, effectiveness, and efficiency.

In terms of qualitative information elicited from respondents, table 4.22 provides some extracts on the strategies used to enhance HRP. According the respondents in the ministry expansion of infrastructure to enhance the learning environment was suggested.

This budget can be allocated to training and other supportive infrastructure for the HRP. Other suggestions involve the government seeking extra funding to pursue its HRP objectives. Russell (2013:279) points that training needs to be accessed, and competencies identified were there are lacking, and type of training needed. The PO-PSM, (2010:18) state that assessment must be conducted on consistency basis.

Lack of strategies in dealing with HRP and Development poses a huge challenge to health care delivery. Taneja (2012:135) found that, wherever there is no Human Resource Planning and Development, organisations are often faced with issues of understaffing or overstaffing. This was the norm in a number of health care places in Tanzania. Sekhri (2010) points that overstaffing leads to the underutilisation of certain skills of employees and unnecessary expenditure incurred by the organisation in form of salaries. Considering that some health places were overstaffed as claimed previously by respondents, there are unnecessary expenditures.

Another, suggested strategy was to equip personnel with leadership skills, motivate them, and provide support were it is needed. It is a general norm that a well-motivated staff has the ability to deliver goals of the HRP and Development.

Table 4.22 Theme 5: Strategies to enhance HRP and Development

Ministry	Hospital	Beneficiaries	Field Notes/ Observation
P1: Renovation and expansion of training institutions and using technology to simplify the training learning**.** **P2:** Participation and involvement of stakeholders of HRP and D to address the policies and circulars and financial resources. **P3:** Increase budget in health sector, coordination of central government between ministries involved in health sector such as Presidents' Office, Public Service Management, Ministry of Finance and Economic Affair, Ministry of Education and Vocation training as well as reviewing policies, laws and regulation to cope with time and situation. **P4:** Increase provision of training budget and development of HRP and HRD plan**.** **P5:** Government should base on its priority even though is seeking funds. Also implementation of Abuja Declaration and other assigned health declarations and goals **P6:** To solicit other opportunities from Private sectors and development Partners to support the health sectors.	**P1;P5;P6;P7;P8;P10;P19;P14;P15** Government to allocate enough budget for the Human Resource Planning and Development. **P2; P9;** Human resource development strategy to equip well the health workers. **P2; P5; P9; P10: Motivation** to staff like provision of good working environment and facilities to health workers to work. **P4:** the hospital should have succession plan and other source of funds. **P5, P10:** Awareness and equip the management with leadership skills and knowledge. environment for retain ship of staff **P6:** President's Office should provide permit on recruitment of time and as requested in order the hospital to fill the HR gaps. **P8:** Review HRPandHRD plans on time. **P7:** Promotion strategy- promotion should be conducted on time. **P8;P13;P15:**Training on HRP and HRD to the hospital		Most are complaining about budget constrain on implementing strategies, they argued that if budget are increased in health sector activities most of policies, programme and strategies will be implemented and the health sector will produce quality services.

Table 5.22: Theme 5: Strategies to enhance HRP and Development

5.7 SUMMARY

The chapter presents results and discussed the assessment of the implementation of human resource and development in the Ministry of Health and Social Welfare in Tanzania. The study assessed the effect of Human Resource Planning and Development for the best practice in the health sector in Tanzania. It started by assessing the importance of Human Resource Planning and Development in the public health organization. The results showed that the Human Resource Planning and Development is important in public health sector. The majority of respondents revealed that, the Human Resource Planning and Development is very important for organizational performance. The next chapter presents the conclusion and recommendations from the study findings.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1: INTRODUCTION

The previous chapter presented the study results and findings. A thematic analysis in conjunction with inferential statistics was used to provide a rich description to the matter that was at hand. Themes were used to provide detailed information pertaining the study objectives. This chapter, therefore, concludes the study by providing conclusions and recommendations based on the results and findings. Conclusions and recommendations are embedded in form of study objectives to provide a direct contribution on ways of improving the HRP and Development policy. Furthermore, the chapter provides future areas of research pertaining the study topic.

5.2 SUMMARY OF THE MAIN FINDINGS

The main purpose of this section is to present the conclusions and provide recommendations based on the various areas covered under the study. This part brings a deeper understanding on the objectives, at the same time demonstrating how these findings contribute to the body of knowledge regarding of the topic.

5.2.1 Objective 1: To assess the importance of Human Resource Planning and Development in the ministry

The Tanzania Public Service Training Policy (2013), Human Resource Planning Guideline (2010), Public Service Management (PO-PSM), guides the implementation of human resource planning and human resource development in the health sector. These frameworks need to be intensified by other government efforts. Most health institutions are aware and recognise the importance of HRP and D, although, most of health institutions did not have those plans as directed by PO-PSM. The situation was caused by different factors. Firstly, there is a low budget for the entire health sector. The fact is PO-PSM under Public Service Reform Programme (PSRP) managed to facilitate all ministries and regional secretariat, which was in their line of authority and neglected the district hospitals to be facilitated by the PMO-RALG. However, PMO-RALG had also a specific reform programme known as Local Government Reform Programme (LGRP), which based on transferring some resources and power from central government to local government. With these reforms, it might be expected there will be proper management and

coordination on developing the human resource plan and human resource development plan in health sector, which was not conducted. Besides, the health institutions develop workforce needs in budget session through the Ministry of Health and Social Welfare staff guideline, which specify the number of health workers required in each level of health centres.

Moreover, there is confusion on managing and coordinating of health institutions between PO-PSM, PMO-RALG and MOHSW in the three levels of hospitals; Hospital manned with ministry, regional hospital and district hospital to develop the HRP and HRD plans of their hospital. This situation tends to make these authorities to abstain from responsibilities on development and implementation of HRP and HRD plans even conducting monitoring and evaluation of these plans for those, which already has these plans.

Failure to effectively implement of Human Resource Planning and Development, among other factors, is caused by low budget allocation. Budget as a source of facilitating activities in the health sector to be executed, is viewed as a means to attain the end. But due to the economic situation, the government have been allocating inadequate budget for the sector to manage, recruit, and train the required number of health workers in different skills, to renovate and expand training institutions, and improving the working conditions as planned.

Resistance to change was also another factor observed because even those regional secretariats who had the plans in place they did not review them. Similarly, the MOHSW did not see that importance of developing the systematic HRP and D as directed because of having staffing guideline and HR information system which used to generate their needs but in reality the developed guideline did not use the PO-PSM guideline. This contributes to the inefficiency of the health sector in delivering health service to the public.

5.2.2 Objective 2: To assess the capacity of the ministry in implementing Human Resource Planning and Development

The capacity of the health sector in terms of number and skills of health workers is weak. The sector has a deficit in all areas of health speciality and management. As evident by participants, that it is hard to have optimal number of health workers because of different factors. The ministry receives a low budget to facilitate the availability of health workers in the sector. Thus, recruitment, development, and capacity building of health workers have not been enhanced sufficiently due to the budget constrain. The respondents claim that, health sector experiences a high deficit due to many factors like the government poor retention plan, freezing employment

in 1990's, coordination between stakeholders of health sector, training institution do not have enough lecturers , Poor Human Resource Information System (HRIS), low budget allocated to training institution do not produce enough students.

Further, not managed to absorb all the graduates from training institutions because the government is not efficiency on recruitment process and interference of politicians to management decisions. Even though, some of the health institutions are over staffed. The fact is some of health institutions management does not have proper management of health workers because they do not follow the available HRP and training programme, poor Human transferring staff without getting status of staff from the health centre.

Similarly, the respondents claim that mostly the new government came with new organisation structure, policies, directives and programmes which has an impact on the implementation of HRP and D plans. In principle, Human Resource Planning and Development have a short and long-term plan, which is supposed to be forecasted and consistent in its implementation in order to be efficient in delivering quality services. For instance, the directives of government of having hospitals in each district, dispensary in villages and health centres in every wards, and change in status of some hospitals to be regional or district hospitals. In reality, the regional hospitals receive high populations because regional hospitals are supposed to have specialist health workers, while they have a huge deficit of specialist in other areas. Yet, these hospitals continue to receive the same budget as allocated before, their current status cannot manage to train many employees and expand the facilities to accommodate those changes. Therefore, with the same facilities and workforce how can you expect the health institutions to achieve excellent service delivery. This is a huge setback in the health sector.

5.2.3 Objective 3: To identify the Human Resource Planning and Development infrastructure and its delivery capacity

In practice, the Tanzanian public service has, good internal infrastructure like policies, laws and regulations to guide the HRP and D plans in health sector but some of the health institutions are not aware of some of the important policies issued. The problem is the development and implementation of HRP and D plans should be framed on these guidelines. Findings reveal that, the issue relied on coordination and dissemination of those policies to reach the entire public service to enable the management of health workers and implementation of HRP and D plans.

However, even the existing internal infrastructure is outdated, and it needs to be reviewed to meet some of government and health environment changes.

On the side of external infrastructure, the respondents recognise the government commitment on improving that infrastructure, but there are some challenges in many health centres on motivation and good working conditions for health workers to deliver quality services. It is the working conditions, financial and non-financial motivations that enables the health workers to perform their activities smoothly in required standards. Instead, with poor infrastructure health workers are dissatisfaction, migrate and have poor performance. It was also noted that monitoring and evaluation of infrastructure is a challenge due to the budget constrain.

5.2.4 Objective 4: To recommend strategies for enhancing the application of Human Resource Planning and Development in the ministry

The findings reveal that the health sector has a deficit of health workers in different cadres, skills and positions especially leadership positions. This meant that the health sector could not manage to provide a quality health services as expected from the Tanzanian people. Most of the challenges identified by respondents were budget constraints, limited incentives, especially to work in remote areas, multiple authorities, poor succession planning, irrelevance of some of policies and frameworks with the government structure and health environments, as well as, inadequate working and living environment like housing facilities. Therefore, in order to overcome these challenges the respondents proposed different strategies such as increase of health sector budget, improve motivations, increase budget for training institutions, review policies, laws and regulations to cope with time and situations, training on developing HRP and HRD plans.

5.3 RECOMMENDATIONS

Health workers in Tanzania health sector are regarded as assets, who run and operate the health sector (Aswathappa 2014:37). In order to get things done, Armstrong (2012:34) points out that there must be people who provide advice and services to reach the targeted goals of the organisation. Human resource plays pivotal roles in the creation and enabling people to utilize their capacities and capabilities in realization of their potential for the benefit of themselves and the respective organisation (Meyer, 2002:5). This can only be achievable if health workers are well planned and managed to ensure the best possible use of available health workers.

Poor planning of health workers contributes to the loss of professionals, specialist and experienced health workers, who leave in large number to private sectors or out of the country. In the view of Mangham (2007:3-4) the health sector experiences deficit of staff especially in leadership positions because the health workers are looking for well paid positions and good working environment. In short, the sector experienced imbalance between the demand and supply of staff in certain cadres, positions and skills.

As indicate in literature and in section 6.2, the following recommendations are suggested to the implementation of Human Resource Planning and Development in the Ministry of Health and Social Welfare in Tanzania. These recommendations will assist the ministry and other stakeholders in health sector to review or formulate policies, strategies and programmes that will facilitate proper implementation of Human Resource Planning and Development to ensure the required health workers are available in a right time, in the health sector.

The majority of the participants interviewed noted the importance of the HRP in the organization functionality. Although, majority of health institutions did not follow the guideline, they usually use the MOHSW staffing manual to develop their HR needs. In order for the health institutions to develop and implement the HRP and HRD plans in systematic orders, there should be a budget for all health institutions to be trained by PO-PSM on how to develop their HRP and HRD plans. Moreover, PO-PSM should include the element of HRP and HRD plans in the Human Capital Management Information System (HRMIS), which is the central government information system, in order to enforce the respective institutions to develop their HR needs on time before the preparation of an appropriate Personal Emolument (PE) budget. This will have a better buy-in from the government institutions, and the government will be well informed on the situation so it can plan HR strategies like recruitment, promotion, training and development on time, especially to those areas, which have scarcity of staff.

Secondly, some participants claimed insufficient budget to training and development as a limitation in recruitment permit, poor motivation as a challenge for implementation of HRP and D plans. Adequate funding should support implementation of HRP and HRD plans. It is important that the government allocate adequate budget for recruitment to ensure that the responsible ministries allow health institutions to recruit adequate personnel. On other hand, training and development of health workers competencies should not be seen as a cost to be minimized in the budget or being implemented when the budget allow. Instead, government should allocate enough budget for capacity building to facilitate the health institutions to train health workers on areas

where they have competence gaps and motivate them to deliver quality services. Moreover, enough budget should also be allocated to health training institutions for renovation and expansion of training institutions, to help them cope with new technology and processes. Therefore, training and development strategy in all levels needs to be regarded as a continuous and endless strategy to ensure quality health workers are available at right time in the sector.

Similarly, some participants claimed that external forces like political, economic, social, demographic, and technological changes do have an impact on how the HRP works. Therefore, politicians should refrain from interfering with the implementation of the HRD plans if they are to make any meaningful contribution to the health sector. So, the plans of health institutions cannot be genuine if the policies and strategic plans are not relevant with the current organisation structure. It is further recommended that, politicians should be aware of government policies, strategies, and programmes as well as communicating with management before they provide promises and directives.

It was also raised that some of hospitals' management do not follow the training program, transfer of staff without communicating with respective hospitals, this has contributed to an oversupply of staff in certain cadre and positions. Therefore, it is important for leaders to be committed to implementing HRP and HRD plans. They should coordinate and commit to manage HR issues.

In order for health sector to be good in implementing HRP and HRD they should have a good coordination and cooperation with other central and ministries (stakeholders) in supervising and regulating the implementation of HRP and HRD plans. It was noted that the health sector relied on many authorities like PO-PSM and MOHSW to develop policies, allocate human resources, and facilitate training and development. These authorities provide directives to the health institutions, which sometimes do not link with the challenges facing hospitals. Therefore, coordination and line of demarcation between central government and local government is essential to remove the controversial of multiple authorities.

Similarly, in order to have optimal number and quality of workforce it will be worth to have a strong link and coordination between the MOHSW with the Ministry of Education and vocation training institutions. This link is essential to generate the health professionals from low to high level of training institutions. This will reduce the mismatch between the demand of health institutions and supply of training institutions.

Besides, the MOHSW has been engaging with development partners for capacity building, technical and finance support, but they provide support on their interested areas not government priorities and interest. Yet, with stakeholders assistance, the government has been trying to revive a number of facilitates to improve the implementation of the HRP, unfortunately the efforts have been very slow because of the infrastructure and capacity for implementing the HRP is very low. Therefore, the MOHSW should engage stakeholders basing on the national priority, interest and plans. Funds should have no strings attached. Moreover, the government should support the effort of stakeholders by improving the infrastructure for implementation of HRP and HRD plans, for example, those who are trained to work in hard to reach areas should be recruited to reduce the deficit of health workers.

Moreover, due to inadequate number of staff, equitable distribution of Staff Strategy is recommended. Efficiency in quality of health services depends on the availability of health workers. Even though there is deficit of health professions, responsible authorities should ensure that available staff are evenly distributed in rural and urban health facilities. The government should support and collaborate with those stakeholders like Benjamini Mkapa Foundation who sponsor some of people to acquire some of scarce skills with the contract to work in remote areas after schooling in order to reduce deficit in those remote areas. Hence, this will ensure that there is no oversupply or concentration of professional health workers in some health centre than others.

On the issue of internal physical infrastructure, it was discovered that the PO-PSM and MOHSW ministries have developed good policies, laws, and regulations to guide the HRP and D plans in health sector but some of the health institutions are not aware of them. Yet, even the existing policies some needs to be reviewed to incorporate changes of the new government and external environment of health sector. This also contributed to the inefficient of implementation of HRP and HRD plans in health institutions. It is suggested that adequate budget should be allocated for the responsible ministries to develop, review, disseminate, and monitor these policies. The other issue is that, even Public Service Commission, which is a watchdog on the implementation of policies and frameworks, does not have enough budget to conduct monitoring and evaluation on the adherence of policies and frameworks to the entire public service. So in order to solve this issue, the government should provide adequate budget allocation to the ministries and the commission to work on policies issues.

Most of health workers in the public health organization were not satisfied with the internal infrastructures like working environment, availability of offices, houses for health workers. As a result, this poses a challenge in retention of professional health workers especially non-urban hospitals and health facilities because a number of people are willing to relocate to peri-urban and urban. Therefore, the government should improve some of the motivation policies, working environment, like putting access of internet so that staff can even access local or international training and other important issues, this can retain talented and scarce professionals. Therefore, when working conditions are dynamic, meaningful, attractive, and productive, retention strategy can succeed.

Performance management strategy as an important function for recruitment and retention need to be considered in the implementation of HRP and D in health management. However, a talented workforce likes much to work with organisation that influences high performance environments. It was noted that, the health institutions use Open Performance Review and Appraisal System (OPRAS), used as a tool to measure and monitor employee's performance. Similarly, it would be worth for the government to incorporated performance management with motivation strategies to provide health sector with marvellous retention strategy of highly skilled and competent employees.

There is inadequate number of health workers in different position, cadres and skills in health centres especially in remote and rural areas. The study recommends that, the government should improve and maintain motivations system and incentive in these areas. The developed Public Service Pay or Incentive Policy of 2010 should be operationalize. Further, make as a principle for all new recruited graduates to be allocated in local government especially in district level at a certain period as a way to gain experience but also to reduce the deficit gaps.

Due to the deficit number of health workers, there should be a means, initiatives and strategies to put diaspora workers closer to the country like improving information system to assist them to make decisions that would improve the health care system in Tanzania. These internal initiatives will assist to tap highly qualified and competent health people to fill the gaps. Second, use also return option strategy to convince and attract competent and skilled professionals who left the health sector or country to come back to work in the country. Such return option strategy will be possible through motivation to push the urgent needed professionals to come back and work for their national economic development. However, some of the problems that may occur are that some of the reasons that pushed the skilled workforce to go abroad may still not be resolved.

It is also recommended to use talent management strategy. Due to deficit of professional staff needs management with talent and leadership skills to manage resources. Talented health workers should be managed well with talented management to ensure the health sector acquires, utilise and develop talented workforce in order to achieve planned goals. In other words, through this strategy will retain the talented and brain drain health workers who have capabilities to influence the achievements of the organisation's plans. However talented management functions well when talent management information systems exist; integrated with talented management systems like learning, succession planning, recruitment, training and development, rewards and incentives as well as career management to use and connect their competences, training knowledge, development, performance, observation to improve career wise.

The respondents from the ministry claimed that there are experience gaps in professional areas between the health professionals and the health sector requirements. The health sector should have a succession strategy to develop potential employees who are available and qualified to take over senior positions in the event of a vacant post due to retirement, death, transfer, appointment, resignation, or dismissal. The succession strategy should be a guide master for the health sector management to ensure that those who are leaving the sector; nurture and groom the remaining employees.

Moreover, the management should encourage and facilitate potential candidates to undertake relevant training, capacity building, or engagement in developmental interventions. This strategy will create experienced and capable employees and facilitate the long-term health of an institution through balancing the demand and supply by ensuring there is an adequate number of staff maintained in the organisation.

Hence, monitoring and evaluation should be conducted by responsible ministries on implementation of HRP and HRD plans. For example, PO-PSM should conduct M&E to ensure the plans are implemented; both MOHSW and PMO-RALG should ensure health facilities have plans in place and identified gaps are solved on time. This will inform the respective ministry on HR issues in order to take action to ensure the health sector has optimal and suitable qualified number of staff who brings the performance impact against the strategic plans set. Monitoring of the HRP and D plan should be conducted on continuous basis. It keeps on track the management and provides a useful base for evaluation strategy.

5.4 CONCLUSION

Human resources are a key element in delivering quality health care to all people wherever they are. Therefore, planning for human resources in the public sector is essential for the effectiveness and efficiency of the health services, because the health sector needs to have competent human resources, at the right time in the right place in order to achieve the planned goals.

This study aim was to assess the implementation of Human Resource Planning and Development and its effect on service delivery in the Ministry of Health and Social Welfare in Tanzania. The findings showed that the HRP and D were not implemented well. The management of health institution does not have a systematic HRP and D plans, instead they develop the workforce needs annually basing on the MOHSW staff guideline which identifies the required number of health workers in all hospital levels. While, the health facilities environments keep changing and affect quality and quantity of health worker and health services. It was noted that the implementation of HRP and D in health sector face challenges in terms of understanding the concept itself of Human resource planning to the implementer of the plans (health secretaries). Similarly, another challenges was coordination of these plans among the health sector stakeholders, budget constraints and lack of leadership commitment. These challenges in the health contribute to the failure of the health sector in achieving its objectives.

Therefore, it was indicated that in order to have proper implementation of HRP and D, maintaining the existence of HRP and D in health sector needs to be supported with human resource strategies and systems to ensure the health sector is equipped with capable individuals in terms of competencies and attitudes in order to provide quality health services. The top management, therefore, needs to bridge the gaps and create an environment where it easy for employees to execute their jobs without difficulties.

5.5 LIMITATIONS OF THE STUDY

Every study has limitations, which are encounter throughout especially during the data collection period. These were the limitations faced:

- ✓ In choosing a sample, a purposive sampling technique was used to select the respondents. This technique is a non-probability; as a result, there is always biasness in choosing the respondents. This might have minimised data collection, simple because a certain criteria

was used to select the respondents. Nonetheless, based on the objectives of the study it was necessary to select certain type of people who had the relevant information, which was sought. This approach did provide rich information and enhanced the study contribution.

- ✓ The study focused on the Ministry of Health and Social Welfare in Tanzania, this might have disadvantaged some ministries that really needed a similar study. However, the health sector is one of the most crucial one in every country due to its linkage withthe wellbeing of people. As a result, it was seen fit that a study of this nature starts in the health sector, and other ministries can follow suit thereafter.

- ✓ It was a challenge to access all the candidates that were targeted for interviews, especially, the Directors due to their challenging schedule of activities.

5.6 SUGGESTIONS FOR FUTURE RESEARCH

This study was conducted in Tanzania, therefore, the results and findings can only be generalizable to the areas were data was collected. Though when generalising, it should be noted that the sample, which was used, could not wholly provide a clear picture on the issues, which were being studied, or represent various government ministries. Therefore, based on the study findings, it is suggested that future research be focuses on other ministries in Tanzania. The findings of the study demonstrated that there is a huge gap between the government targets and the reality. This was demonstrated by government directors having a different viewpoint compared to hospital and beneficiaries respondents on the impact of HRP and Development. In addition, another angle that can be taken is to assess the skills gap between the governments' targeted skills and universities. In the study, it was noted that specialist skills were lacking, therefore, it is suggested that future studies focusing on identifying skills gap be initiated

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APPENDIX A: HOSPITAL QUESTIONNAIRE

University of Fort Hare

Together in Excellence

INTERVIEW GUIDE FOR HOSPITAL HEALTH SECRETARIES

Dear respondent,

I Edith Rwiza, am doing a research on "An assessment of the implementation of Human Resource Planning and Development and their effect on service delivery in the Ministry of Health and Social Welfare of Tanzania". This is in fulfilment of the requirement for an award of a Doctor of Philosophy Degree (PhD) in Public Administration at University of Fort Hare in South Africa under the supervision of Prof. D.R. Thakhathi.

You have been selected to participate in this research. Kindly answer a number of questions accurately and honestly as possible. The questions are about importance of Human Resource Planning and Development, the capacity of the health sector in implementing Human Resource Planning and Development, infrastructure of Human Resource Planning and Development as well as what can be done to enhance the implementation of Human Resource Planning and Development. The interview will take about 45 minutes of your time.

Your responses and comments will be treated with a high sense of confidentiality and anonymity. It is only the researcher who will have an access to the information that you will give in this research and during publication no names will be mentioned or any comment that would reveal your identity.

Your participation in this research is highly appreciated in advance and will assist the health sector to have good plans for human resource in the sector which will enhance health services. There is no monetary or any other material benefit associated with completing this questionnaire. In case of any questions please do not hesitate to contact me via this phone number.

Please tick the relevant answer on the following questions:

Organisation.....

Position.....

Section A

Age

18-29	30-39	40-49	50 plus

Gender

Male	Female

Qualification

Certificate	
Diploma	
Graduate	
Master's Degree	
Doctoral Degree	
Others (Please specify	

Experience at work……years

Section B

Importance of Human Resource Planning and Development in Ministry.

1. How Human Resource Planning is important to your Organisation?

A. Human Resource Planning

1. Do you have Human Resource Plan in your organisation?

   Yes……...

   No……

   If Yes: How is it effectively used in your organization?

   ……
   ……
   ……

   If No: How do you plan for Human Resource in your organisation?

   ……
   ……
   ……

2. How often do you review the HRP?

   …….....

3. What are the benefits of HRP in your organisation?
   ……
   ……

4. Which aspects do you focus on during implementation of HRP?

   ……
   ……
   ……

5. How many levels of HRP do you know? which one do you implement? How successful is it or are they?

   ……
   ……

6. Is there any strategic plan in place?

   Yes…….
   No……

   If No: Please explain the reasons for not having a strategic plan.

   ……
   ……

   If yes: How do you operationalize the Strategic Plan?

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   ……

7. How do you link Strategic Plan with HRP?

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8. In what ways does the existing policies, laws, regulations affect the implementation of HRP.

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9. How economic factor such as inflation rate, tax policies and national revenue negatively or positively affect the implementation of HRP?

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10. In what ways do political factors like change of government, government policies and abuse of power affect negatively the implementation of HRP in health sector?

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11. What are the positively or negatively effect of technology in implementation of HRP in health sector?

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12. How do Social factors like culture, mortality rates, pandemic diseases and poverty negatively or positively affect the implementation of HRP in health sector?

……
……
……

13. In what ways demographic factor such as gender issues and ageing population (young against old people) negatively the implementation of HRP in health sector?

Human Resource Development

1. Do you have Human Resource Development Plan in your organisation?

   Yes……..

   No……

   If Yes: How effective is it used in your organisation?
   ……
   ……
   ……
   If No: How do you conduct Human Resource Development planning in your organisation?
   ……
   ……
   ……
2. How often do you review the HRD plan?

   …….
3. What are the benefits of HRD in your organisation?

   ……
   ……
   ……
4. What type of HRD do you use in developing human resource competencies?

……
……
…….....
.....

5. How many levels of HRD do you know? Which one do you implement? How successful is it/are they?

……
……
……
……

6. Is the strategic plan in place?

Yes…….

No……...

If No: Why?

……..…
…….....
.....

If yes: How do you use it?

……
……
……

7. How do you link Strategic Plan with HRD?

……
……
……

8. In what ways does the existing policies, laws, regulations affect the implementation of HRD in health sector?

……
……
……

9. How economic factor such as inflation rate, tax policies and national revenue negatively or positively affect the implementation of HRD in health sector?

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10. In what ways do political factors like change of government, government policies and abuse of power affect negatively the implementation of HRD in health sector?

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11. What are the positively or negatively effect of technology in implementation of HRD in health sector?

……
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12. How do Social factors like culture, mortality rates, pandemic diseases and poverty negatively or positively affect the implementation of HRD in health sector?

……
……
……

13. In what ways demographic factor such as gender issues and ageing population (young against old people), social preferences, negatively the implementation of HRD in health sector?

……
……
……

The capacity of the Ministry in implementing Human Resource Planning and Development

2. Does your organisation have the capacity to implement its strategic plan for Human Resource Planning and Development?

A. Human Resource Development

1. Do you have adequate number of staff in your organisation?

Yes……..

No……..

If yes: How many?
……
……
……

If No: Why?
……
……
…….....

2. Do you have any deficit in terms of Skills, knowledge and experience?

a) Skills

Yes…….

No……..

If yes: In which particulars areas do you have gaps?

……
……
…….....
.....

If No: Why?

……
……
…….....

b) Knowledge

Yes……
No……

If yes: Specify the areas?

……
……
…….....

If No: Why?

……
……
…….....

c) Experience

Yes……
No……

If yes: How?

……
……
…….....
.....

If No: Why?

……
……
…….....
.....

3. What measures have you been taken to address such deficit and what has been the outcome?

……
……
……
……..

4. Is there any oversupply of staff at different positions?

Yes……..

No…….

If yes: How?

……
……
…….....
.....

If ***Yes***: "Please explain why there is oversupply of staff at different positions"

……
……
…….....

5. Is there any oversupply of staff at different cadre?

Yes……
No……

If yes: How?

……
……
……
……..

If ***Yes:*** "Please explain why there is oversupply of staff at different cadre"

……
……
……

6. Is there any oversupply of certain skills?

Yes.....

No.....

If yes: How?

.....
.....
.....

If ***Yes***: "Please explain why there is oversupply of certain skills"

.....
.....
.....

7. Is there any undersupply of staff at different positions?

Yes.....

No.....

If yes: How?

.....
.....
.....

If ***Yes***: "Please explain why there is undersupply of staff at different position"

.....
.....
.....

8. Is there any undersupply of staff at different cadre?

Yes.....

No.....

If yes: How?

.....
.....
.....

If ***Yes***: "Please explain why there is undersupply of staff at different cadre"

.....
.....
.....

9. Is there any undersupply of certain skills

Yes.....

No.....

If yes: How?

.....
.....
.....

If ***Yes***: "Please explain why there is undersupply of certain skills"

.....
.....
.....

10. Are there any chance of under supply of skills, knowledge and experience in different cadre?

……
……
…….....

11. Do you experience over supply of any competence level (knowledge, skills and experience) in your organisation?

    Yes……

    No…….

    If yes: How?
    ……
    ……
    ……

    If ***Yes***: "Please explain why there is oversupply of competencies"
    ……
    ……
    …….....

12. Apart from skills, knowledge and experience, are there any gaps in your organisation?

    a. If Yes: which ones?

       .....
       .....
       .....

    b. What efforts have you taken to mitigate the problem?

       ……
       ……
       ……

    c. How successful are they?

       ……
       …….....
       .....

13. How capable are you in implementing HRD in your organisation?

……
……
…….....

14. Which processes do you normally use in the implementation of HRD?

……
……

……
……

15. How do you enhance professionalism in your organisation?

.....
.....
.....
.....

16. Do you consider quality in delivering health services? If yes, how do you consider such qualities?

……
……
…….....
.....
.....

17. How do you handle performance management in your organisation?

……
……
……
…….....

18. Do you consider equity in allocation of health staff?

Yes.....

No.....

a. If Yes: How?

……
……
……
…….

b. How effective are you in implementing such equity?

……
……
……..….....
.....

c. How do you retain staff in your organisation? How effective are you in retaining staff?

.....
.....
.....
.....

d. How do you attract staff in your organisation? How effective are you in attracting staff?

……
……
……
……

19. What are the things that identify staff in you institution as health sector personnel?

……
……
……
……

a. What is the culture of Health Sector? Is it there in your organisation or not?

……
……
……
……

b. How does the culture influence the development of the health sector?

……
……
……
…….....

c. How does it affect the development of the health sector?

……
……
……
…….....

d. If it is non-existent, what measures have you taken to rectify the situation?

……
……
……
…….....

e. How effective are these measures?

……
……
……

B. Human Resource Planning

1. How capable are you in implementing HRP in your organisation?

……
……
……
…….....

2. What are the process do you normally use in the implementation of HRP?

……
……
……
……

Human Resource Planning and Development infrastructure and its delivery capacity

3. How can infrastructure assist to focus on Human Resource Planning and Development in the organisation?

    1. Do these internal infrastructures assist you in focusing on Human Resource Planning and Development in the organisation?

        a. Policies
        Yes……
        No…….
        If yes: How?
        ……
        ……
        ……

        b. Standing Order
        Yes……
        No…….
        If yes: How?
        ……
        ……
        ……

        c. Regulations
        Yes……
        No…….
        If yes: How?
        ……
        ……
        ……

        d. Schemes

        Yes……

        No…….

        If yes: How?

……
……
……

NOTE:

i. The Constitution of the United Republic of Tanzania.
ii. National Health policy/ Act
iii. Standing Order of 2009
iv. Public Service Act No.8 of 2002
v. Public Service Regulation of 2003
vi. Labour Relation Act of 2004
vii. Occupational Health and Safety Act of 2003
viii. Public Service Training Policy of 2013
ix. Succession Planning of 2011
x. Education and Training Vocation Policy of 2014
xi. Public Service Management and Employment Policy of 2008
xii. Public Service Schemes, 2003

2. Do these external infrastructures assist you in focusing on Human Resource Planning and Development in the organisation?

a. Working environment
Yes……
No…….

If yes: How?
……
……
……

b. Offices

Yes……
No…….
If yes: How?
……
……
……

c. Budget
Yes……
No…….
If yes: How?

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d. Human Resources
Yes……
No…….

If yes: How?
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e. Salaries
Yes……
No…….
If yes: How?
……
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f. Compensation
Yes……
No…….
If yes: How?
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g. Security
Yes……
No…….
If yes: How?
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h. Houses
Yes……
No…….
If yes: How?
……
……
……

i. Motives
Yes……
No…….
If yes: How?
……
……
……

3. As you implement HRPandHRD what are the stakeholders?

……
……

(a) Do the stakeholders in health sector facilitate the implementation of Human Resource Planning and Development?

Yes……
No……

If yes: How?
……
……
……
If No: why?
……
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……

(b) Are there any challenge experienced from the stockholders? If yes: which ones?
……
……
……
…….....

Strategies needed for enhancing the application of Human Resource Planning and Development in the ministry.

4. What should be done to improve the implementation of Human Resource Planning and Development in the organisation?

1. Outline the main challenges in implementing HRPandHRD in your organisation.

……
……
……
……

2. What should be done to improve the implementation of Human Resource Planning and Development in the organisation?

…….
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……

End of interview: Thank you!

APPENDIX B: INTERVIEW GUIDE MINISTRY

University of Fort Hare

Together in Excellence

INTERVIEW GUIDE FOR MINISTRY DIRECTORS

Dear respondent,

I would like to bring your attention that, Human Resource are the "most valuable" resource in the health sector, they need to be empowered, motivated, developed and nurtured rather than being treated as a variable cost to be minimized. It is for this reason that Edith Rwiza, doing a research on "An assessment of the implementation of Human Resource Planning and Development and their effect on service delivery in the Ministry of Health and Social Welfare of Tanzania". She is doing a Doctor of Philosophy Degree (PhD) in Public Administration at University of Fort Hare in South Africa under supervision of Prof. D.R. Thakhathi.

You have been selected to participate in this research. Kindly answer a number of questions accurately and honestly as possible. The questions are about importance of Human Resource Planning and Development, the capacity of the health sector in implementing Human Resource Planning and Development, infrastructure of Human Resource Planning and Development as well as what can be done to enhance the implementation of Human Resource Planning and Development. The interview will take about 45 minutes of your time.

Your participation in this research is completely voluntary, and you have the right to withdraw from it any time when you feel you don't want to continue with the interview. Your responses and comments will be treated with a high sense of confidentiality and anonymity. It is only the researcher who will have an access to the information that you will give in this research and during publication no names will be mentioned or any comment that would reveal your identity.

Your participation in this research is highly appreciated in advance and will assist the health sector to have a good plans for human resource in the sector which will enhance health services. There is no monetary or any other material benefit is associated with completing this questionnaire. In case of any questions please do not hesitate to contact me via this phone number: **0754295554**.

Please tick the relevant answer on the following questions:

Ministry.....

Position.....

Section A

Age

18-29	30-39	40-49	50 plus

Gender

Male	Female

Qualification

Certificate	
Diploma	
Graduate	
Master's Degree	
Doctoral Degree	
Others (Please specify	

Experience at work……years

Section B

Importance of Human Resource Planning and Development in Ministry.

14. How is Human Resource Planning important to your Organisation?

B. Human Resource Planning

14. Do you have Human Resource Plan for entire health sector?

Yes……

No……

If Yes: How is it effectively used in your ministry?

……
……
……
……

If No: How do you plan for Human Resource in entire health sector?

……
……
……

15. How often do you review the HRP?

……

16. What are the benefits of HRP in the health sector?

……
……
……

17. Which aspects do you focus on during implementation HRP?

……
……
……
……

18. How many levels of HRP do you know? Which one do you implement? How successful is it?

……
……
……

19. Is the strategic plan in place?

Yes……
No……

If No: Please explain the reasons for not having a strategic plan.

……
……
……

If yes: How do you operationalize the strategic plan?

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20. How do you link Strategic Plan with HRP?

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21. In what ways does the existing policies, laws, regulations affect the implementation of HRP in health sector?

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22. How do economic factor such as inflation rate, tax policies and national revenue negatively or positively affect the implementation of HRP in health sector?

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23. In what ways do political factors like change of government, government policies and abuse of power affect negatively the implementation of HRP in health sector?

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24. What are the positively or negatively effect of technology in implementation of HRP in health sector?

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25. How do Social factors like culture, mortality rates, pandemic diseases and poverty negatively or positively affect the implementation of HRP in health sector?

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26. In what ways demographic factor such as gender issues and ageing population (young against old people) negatively the implementation of HRP in health sector?

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……
…….....

C. Human Resource Development

1. Do you have Human Resource Development Plan in entire health sector?

   Yes……..
   No……

   If Yes: How effective is it used in your ministry?
   ……
   ……
   ……
   If No: How do you conduct Human Resource Development planning in health sector?
   ……
   ……
   ……

15. How often do you review the HRD plan?

    ……

16. What are the benefits of HRD in the health sector?

    ……
    ……
    ……

a. What type of HRD do you use in developing human resource competencies?

   ……
   ……
   ……

17. How many levels of HRD do you know? Which one do you implement? How successful is?

    ……
    ……
    ……

18. Is the strategic plan in place?

    Yes……

    No…….

    If No: Why?
    ……
    ……
    ……
    If yes: How do you use it?
    ……
    ……
    ……

7. How do you link Strategic Plan with HRD?

   ……
   ……
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8. In what ways does existing policies, laws, regulations affect the implementation of HRD.

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9. How economic factor such as inflation rate, tax policies and national revenue negatively or positively affect the implementation of HRD?

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10. In what ways do political factors like change of government, government policies and abuse of power affect negatively the implementation of HRD in health sector?
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11. What are the positively or negatively effect of technology in implementation of HRD in health sector?
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    ……
    ……

12. How Social factors like culture, mortality rates, pandemic diseases and poverty negatively or positively affect the implementation of HRD in health sector?
    ……
    ……
    ……
    ……

13. In what ways demographic factor such as gender issues and ageing population (young against old people) negatively the implementation of HRD in health sector?

    ……
    ……
    ……
    …….....
    .....

The capacity of the ministry in implementing Human Resource Planning and Development

2. Does your organisation have the capacity to implement its strategic plan for Human Resource Planning and Development?

C. Human Resource Development

20. Is there optimal number of staff in health sector?

Yes……

No……

If yes: How many?
……
……
……..
If No: Why?
……
……
……..

21. Do you have any deficit in terms of Skills, knowledge and experience?

a) Skills

Yes…….

No……

If yes: In which particular area do you have gaps?
……
……
……..
If No: Why?
……
……
……..

b) Knowledge
Yes……..

No……

If yes: specify the areas?
……
……
…….
If No: Why?
……
……
……

c) Experience

Yes…….

No……..

If yes: How?

……
……
……..
If No: Why?
……
……
……..

22. What measures have you been taken to address such deficit and what has been the outcome?
……
……
……..

23. Is there any oversupply of staff at different positions?

Yes……

No……..

If yes: How
……
……
……
If ***Yes***: "Please explain why there is oversupply of staff at different positions""
……
……
…….

24. Is there any oversupply of staff at different cadre?

Yes……
No……

If yes: How?
……
……
…….

If ***Yes***: "Please explain why there is oversupply of staff at different cadre"
……
……
…….

25. Is there any oversupply of certain skills?

Yes……..

No……

If yes: How
……
……
……

If ***Yes***: "Please explain why there is oversupply of certain skills"
……

……
……

26. Is there any undersupply of staff at different positions?

Yes.....

No.....

If yes: How

.....
.....
.....

If Yes: "Please explain why there is undersupply of staff at different position"

.....
.....
.....

27. Is there any undersupply of staff at different cadre?

Yes.....
No.....

If yes: How

.....
.....
.....

If ***Yes***: ""Please explain why there is undersupply of staff at different cadre"

.....
.....
.....

28. Is there any undersupply of certain skills

Yes.....

No.....

If yes: How

.....
.....
.....

If ***Yes***: "Please explain why there is undersupply of certain skills"

.....
.....
.....

29. Are there any chance of under supply of skills, knowledge and experience in different cadre?

……
……
…….....

30. Do you experience over supply of any competence level (knowledge, skills and experience) in health sector?

Yes…….

No…….....

If yes: How?

……
……
……

If ***Yes***: "Please explain why there is oversupply of competencies"

……
……..……
……..

31. Apart from skills, knowledge and experience, are there any gaps in health sector?

d. If Yes: which ones?

……
…….

e. What efforts have you taken to mitigate the problem?

……
……
…….....

f. How successful are they?

……
……
…….

32. How capable are you in implementing HRD in your ministry?

……
……
……..

33. Which processes do you normally use in the implementation of HRD?

……
……
……

34. How do you enhance professionalism in health sector?

……
……
…….....
.....

35. Do you consider quality in delivering health services? If yes, how do you consider such qualities?

……
……
……
……

36. How do you handle performance management in the health sector?

……
……
……
……

37. Do you consider equity in allocation of health staff?

Yes……

No……..

e. If Yes: How

……
……
……

f. How effective are you in implementing such equity?

……
……
……
…….

g. How do you retain staff in health sector? How effective are you in retaining staff?

……
……
……
…….

h. How do you attract staff in health sector? How effective are you in atracting staff?

……
……
……

38. What are the things that identify staff in you institutions as health sector personnel?

……
……
……

f. What is the culture of Health Sector? Is it there in the ministry or not?

……
……
……
…….

g. How does the culture influence the development of the health sector?

……
……
……

h. How does it affect the development of the health sector?

……
……
……

i. If it is non-existent, what measures have you taken to rectify the situation?

……
……
……

j. How effective are these measures?

……
……
……

D. Human Resource Planning

1. How capable are you in implementing HRP in your ministry?

……
……
…….

2. What are the process do you normally use in the implementation of HRP?

……
……
……
……

Human Resource Planning and Development infrastructure and its delivery capacity

3. How can infrastructure assist to focus on Human Resource Planning and Development in the organisation?

1. How do these internal infrastructures assist you in focusing on Human Resource Planning and Development in the organisation?

a. Policies

Yes……
No…….
If yes How?

……
……
……..

b. Standing Order

Yes……
No…….

If yes How?

……
……
…….

c. Regulations

Yes……

No…….

If yes How?

……
……
……..

d. Schemes

Yes……

No…….

If yes How?

……
……
……

NOTE:

xiii. The Constitution of the United Republic of Tanzania.

xiv. National Health policy/ Act

xv. Standing Order of 2009

xvi. Public Service Act No.8 of 2002

xvii. Public Service Regulation of 2003

xviii. Labour Relation Act of 2004

xix. Occupational Health and Safety Act of 2003

xx. Public Service Training Policy of 2013

xxi. Succession Planning of 2011

xxii. Education and Training Vocation Policy of 2014

xxiii. Public Service Management and Employment Policy of 2008

xxiv. Public Service Schemes, 2003

3. To what extent the Ministry assist and support the Health Sector Institutions to implement Policies, Regulations and Schemes?

……
……
……

4. To what extent the Ministry monitor and evaluate the implementation of health policies, regulations and schemes in health sector institutions?

……
……
……
…….....

5. Do the Ministry committed to facilitate the provision of the following external infrastructure in Health Institutions

a. good working environment
Yes……
No…….
If yes: How?
……
……
……

b. Offices
Yes……
No…….
If yes: How?
……
……
……

c. Budget
Yes……
No…….
If yes: How?
……
……
……

d. Human resources
Yes……
No…….
If yes: How?
……
……
……

e. Salaries
Yes……
No…….
If yes: How?

……
……
……

f. Safeties
Yes……
No…….
If yes: How?

……
……
……

g. Compensation
Yes……
No…….
If yes: How?

……
……
……

h. Security

Yes……
No…….
If yes: How?

……
……
……

i. Houses a

Yes……
No…….
If yes: How?

……
……
……

j. Motivation in working?
Yes……
No…….
If yes: How?
……
……
……
……

6. As you implement HRPandHRD what are the stakeholders?

……
……..

(c) Do the stakeholders in health sector facilitate the implementation of Human Resource Planning and Development?

Yes……
No…….

If yes: How?
……
……
……

……
……
If No: why?
……
……
……
……
……

(d) Are there any challenge experienced from the stockholders? If yes: which ones?
……
……
……
……
……

Strategies needed for enhancing the application of Human Resource Planning and Development in the ministry.

4. What should be done to improve the implementation of Human Resource Planning and Development in the health sector?

1. Outline the main challenges in implementing HRPandHRD in the health sector.

……
……
……
……..……

2. What should be done to improve the implementation of Human Resource Planning and Development in the health sector?

……
…….....
.....
.....

End of interview: Thank you!

APPENDIX C: QUESTIONNAIRE BENEFICIARIES

Questionnaire for Beneficiaries of Human Resource Planning and Development

Dear respondent

I Edith Rwiza, am doing a research on "An assessment of the implementation of Human Resource Planning and Development and their effect on service delivery in the Ministry of Health and Social Welfare of Tanzania". This is in fulfilment of the requirement for an award of a Doctor of Philosophy Degree (PhD) in Public Administration at University of Fort Hare in South Africa under the supervision of Prof. D.R. Thakhathi.

You have been selected to participate in this research. Kindly answer a number of questions accurately and honestly as possible. The questions are about importance of Human Resource Planning and Development, the capacity of the health sector in implementing Human Resource Planning and Development, infrastructure of Human Resource Planning and Development as well as what can be done to enhance the implementation of Human Resource Planning and Development. The questionnaire will take about 15 minutes of your time.

Your responses and comments will be treated with a high sense of confidentiality and anonymity. It is only the researcher who will have an access to the information that you will give in this research and during publication no names will be mentioned or any comment that would reveal your identity.

Your participation in this research is highly appreciated in advance and will assist the health sector to have good plans for human resource in the sector which will enhance health services. There is no monetary or any other material benefit associated with completing this questionnaire. In case of any questions please do not hesitate to contact me via this phone number: **0754295554**.

Part One: Personal information *(Please tick the relevant answer)*

1. Region.....
2. Name of the Organisation ----------
3. Your age

   a. 20-30 years ( ) b. 31-40 years ( ), c. 41-50 years ( ),

   d.51-60 years ( ) e. 60 + ( )
4. Gender

   a. Male ( ) b. Female ( )
5. Marital Status

   a. Single ( ) b. Married ( ) c. Divorced ( ) d. Widow/ widower ( )
6. Academic qualifications

a. Certificate ( ) b. Diploma ( ) c. Graduate ( ) d. Master's degree ( ) e. Doctoral Degree ( ) f. Any other (specify)……

7. How long have you been working at this organisation?

   a. Less than 4 years ( ) b. 5-10 years ( ) c. 11- 14 years ( )

   d. Above 14 years ( )

8. Directorate/ Department working with ------- ----------

Part Two: Importance of Human Resource Planning (***circle the relevant answer)***

A: Human Resource Planning

9. Does your organisation practice human resource planning?

   a. Yes b. No c. I don't know

10. If yes, choose the most right statement on state of human resource planning in your organisation.

    a. Strongly well done and satisfactory by the organisation

    b. Well done and satisfactory by the organisation

    c. Fairly done but not satisfactory by the organisation

    d. Not done all by the organisation

    e. Never done in the organization

11. To what extent does your organization consider human resource planning as an important HRM component?

    a. Very important b. Important c. Neutral d. important at all

12. To what extent are you satisfied with the way your organization conducts HRP?

    A. Strongly satisfied b. Somehow satisfied. C. Not satisfied at all

B. Human Resource Development

13. Does your organisation practice human resource development planning?

    a. Yes b. No c. I don't know

14. If yes, choose the most right statement on the state of human resource development planning in your organisation.

    a. Strongly well done and satisfactory by the organisation

    b. Well done and satisfactory by the organisation

    c. Fairly done but not satisfactory by the management

d. Not done all by the organisation

d. Never done in the organization

15. How important is Human Resource Development in your working environment?

a. Very important b. Important c. Neutral d.Not important at all

Part Three: **The capacity of the ministry in implementing Human Resource Planning and Development**

16. Does your organisation have the adequate number and skilled staff? (**Please circle the correct answer**).

a. Yes b. No c. I don't know

17. If ***No,*** Rank these capacity challenges in implementing Human Resource Planning and Development in your organisation***.(circle the most correct one)***

1= strongly available. 2= available, 3=Somehow Available, 4=Not available

S/N	***Items***	***Ranking***
1	Deficit number of staff	1 2 3 4
2	Deficit in terms of skills, knowledge and experience of staff	1 2 3 4
3	Undersupply of skills, knowledge and experience in different cadre	1 2 3 4
4	Undersupply of skills, knowledge and experience in position	1 2 3 4
5	Oversupply of skills, knowledge and experience at different cadre	1 2 3 4
6	Oversupply of skills, knowledge and experience at different position	1 2 3 4
7	Inequality allocation of staff	1 2 3 4

18. If ***YES***, Does your organisation provide quality health services to the Public? ***(circle the most correct one).***

a. Strongly well done and satisfactory to the public

b. Well done and satisfactory to the public

c. Fairly done but not satisfactory to the public

d. Not good and not satisfactory to the public.

Part Four: Human Resource Planning and Development infrastructure and its delivery capacity

19. Comment on the status of the following items by **circling the most correct response**)

1= Strong available 2=Available, 3=Somehow Available, 4=Not Available

S/N	***Items***	***Ranking***
1.	Good working environment	1 2 3 4
2.	Offices, Budget	1 2 3 4
3.	Salaries	1 2 3 4
4.	Safeties	1 2 3 4
5.	Compensation	1 2 3 4
6.	Security	1 2 3 4
7.	Houses	1 2 3 4

Part Five: Strategies for Enhancing the Application of Human Resource Planning and Development.

20. Please indicate your reaction to the statement that the following internal factors positively or negatively affect to the implementation of Human Resource Planning and Development in your organisation" ***(Circle the most appropriate responses).***

1=Strongly agree, 2= Agree, 3= Neutral, 4=Disagree, 5= Strongly disagree

S/N	***Items***	***Ranking***
A	***Internal Factor***	
1.	Organisation structure	1 2 3 4 5
2.	Internal work regulations and management system	1 2 3 4 5
4.	Human Resource Information System	1 2 3 4 5
5.	Sectorial Policies	1 2 3 4 5
6.	Staff welfare issues	1 2 3 4 5
7.	Ethics and values	1 2 3 4 5
8.	Health and wellness	1 2 3 4 5

i. What are the negative or positive effects of these factors?

……
……
……

21. Please tick the most correct answer to the following statement. “Implementation of Human Resource Planning and Development is negatively affected by Political factors like Change of Government, Government Policies and abuse of power”.

    a) Strongly agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( )

    e. Strongly disagree ( )

    i. What are the negative or positive effects of these factors?

    ……
    ……
    ……
    ..

22. Comment on the statement that “economic factors such as inflation rate, tax policies and national revenue negatively or positively affect the implementation of Human Resource Planning and Development”

    a) Strongly agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( )

    e. Strongly disagree ( )

    i. What are the negative or positive effects of these factors?

    ……
    ……
    ……..

23. “To what extent do you agree with a statement that technological factors positively or negatively affect the implementation of Human Resource Planning and Development in your organisation?

    a) Strongly agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( )

    e. Strongly disagree ( )

    i. What are the negative or positive effects of these factors?

    ……
    ……
    ……

24. To what extent do you agree a statement that “Social factors like culture, mortality rates, pandemic diseases and poverty positively or negatively have effect to the implementation of Human Resource Planning and Development”

    a) Strongly agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( )

    e. Strongly disagree ( )

i. What are the negative or positive effects of these factors?

……
……
……

25. To what extent do you agree with a statement that demographic factor such as gender issues, and ageing population (young against old people),social preferences positively or negatively affect the implementation of Human Resource Planning and Development?

a. Strongly agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( )

e. Strongly disagree ( )

i. What are the negative or positive effects of these factors?

……
……
……

26. To what extent do you agree with content that the following are key determinants of effective implementation of Human Resource Planning and Development in your organisation? ***(Circle the most appropriate responses).***

1=Strongly agree, 2= Agree, 3= Neutral, 4=Disagree, 5= Strongly disagree

S/N	**Determinants**	**Ranking**
1	Human resource policies	1 2 3 4 5
2	Committed management	1 2 3 4 5
3	Alignment Human Resource Planning and Development	1 2 3 4 5
4	Adequate resources allocation	1 2 3 4 5
5	Suitable planning techniques and validity of data	1 2 3 4 5
6.	Reviews of HR plans	1 2 3 4 5

27. To what extent does your organisation use the following strategies to enhance the application of Human Resource Planning and Development?***(circle the most correct one)***

1= strongly used, 2=used 3=Sometimes Used, 4=Not used 5=Not used at All

S/N	***Items***	***Ranking***
1	Attracting and recruiting the potential employees	1 2 3 4 5
2	Promoting staff on time	1 2 3 4 5

3	Rewarding and recognizing hard working employees	1	2	3	4	5
4	Talent Management	1	2	3	4	5
5	Performance Management (eg. OPRAS, client Service charter, Customer care ect)	1	2	3	4	5
6	Organizational learning and development	1	2	3	4	5
7	Equity in allocation of staff	1	2	3	4	5
8	The return option strategy	1	2	3	4	5
9	The Diaspora strategy	1	2	3	4	5
10.	Improvement of infrastructure capabilities	1	2	3	4	5
11.	Setting enough budget for human resource development	1	2	3	4	5
12.	Monitoring and Evaluation	1	2	3	4	5

28. Please tick the most appropriate option from this statement "Effective Implementation Human Resource Planning and Development contributes to organisation performance and quality of health services".

Strongly agree ( ) b. Agree ( ) c. Neutral d. Disagree ( )

Strongly disagree ( )

Thanks for your cooperation

APPENDIX D: ETHICAL CLEARANCE CERTIFICATE

University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA Level 01

Certificate Reference Number:	THA201SRWI01
Project title:	**An assessment of the implementation of Human Resource Planning and Development and their effect on service delivery in the ministry of Health and Social Welfare of Tanzania.**
Nature of Project:	PhD
Principal Researcher:	Edith Rwiza
Sub-Investigator:	N/A
Supervisor:	Prof D.R Thakhathi
Co-supervisor:	N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

Special conditions: Research that includes children as per the official regulations of the act must take the following into account:

Note: The UREC is aware of the provisions of s71 of the National Health Act 61 of 2003 and that matters pertaining to obtaining the Minister's consent are under discussion and remain unresolved. Nonetheless, as was decided at a meeting between the National Health Research Ethics Committee and stakeholders on 6 June 2013, university ethics committees may continue to grant ethical clearance for research involving children without the Minister's consent, provided that the prescripts of the previous rules have been met. This certificate is granted in terms of this agreement.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
  - Any unethical principal or practices are revealed or suspected
  - Relevant information has been withheld or misrepresented
  - Regulatory changes of whatsoever nature so require
  - The conditions contained in the Certificate have not been adhered to
- Request access to any information or data at any time during the course or after completion of the project.
- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office

The Ethics Committee wished you well in your research.

Yours sincerely

Professor Gideon de Wet
Dean of Research

25 May 2016

APPENDIX E: PERMISSION LETTER

THE UNITED REPUBLIC OF TANZANIA
PRESIDENT'S OFFICE

Telegrams "UTUMISHI", DSM.
Telephone: 2118531/4
Fax: 2125299
Email: permsec@estabs.go.tz

Public Service Management,
Utumishi House,
8 Kivukoni Road
P.O. Box 2483,
11404 DAR ES SALAAM.

In reply please quote:

Ref. No. AB.252/287/01/25

26 May , 2016

Permanent Secretary,
President's Office,
Regional Administration and Local Government,
P.O. Box 1923,
DODOMA.

RE: INTRODUCTION LETTER

Ms. Edith Rwiza is an employee of President's Office, Public Service Management as Senior Human Resource Officer.

2. Ms. Rwiza has been enrolled at the University of Fort Hare to pursue her PhD studies, and currently she is in the process of collecting data on the research tittle called "An Assessment of the Implementation of Human Resource Planning and Development and their Effect on Service Delivery in the Ministry of Health and Social Welfare of Tanzania.

3. Kindly assist her with relevant information she needs in her research.

Thank you for your cooperation.

S. C. Kessy
for: **Permanent Secretary**
(PUBLIC SERVICE MANAGEMENT)