Job Motivation and Associated Factors among Health Workers in Urban Public Hospitals in Tanzania,
March – June 2007

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Submission Date: 15/12/2012
Abstract

Background: This study focused on the motivation of human resource for health in urban public health facilities in Tanzania. Motivation is defined in this study as an individual's degree of willingness to exert and maintain an effort towards organizational goals. Motivation of health workers was studied based on Herzberg’s two-factor theory.

Purpose: The overall purpose of this study was to study job motivation and associated factors among urban health workers in public hospitals in Dar es salaam, Tanzania.

Methods: The study employed predominantly qualitative research methods. Data was collected from three municipal hospitals and one referral hospital, the Muhimbili National Hospital. Some information was also collected from key informants in the Municipality Administration, the Non–Governmental Organisations and the Ministry of Health and Social Welfare. A combination of direct observation, key informants interviews, Focus Group Discussions and a desk review of key documents was done. Sampling of participants was done using purposive methods with representative, intensity and sometimes snow-ball sampling done in different stages and at different environments. Data analysis was done following the principles of grounded theory.

Results: This study established that a number of extrinsic or ‘hygiene’ factors (dissatisfiers) which match with those proposed by Herzberg et al, are important and necessary for maintaining human resource for health in urban health facilities. The study also found that intrinsic factors (satisfiers) when available would increase job motivation among the healthcare workers in government-owned health facilities in Dar es salaam and that when are not available would not cause any dissatisfaction.

Conclusion: Although the theory did not provide a fit in all circumstances, it formed a firm foundation on which to study job motivation and associated factors among urban health workers in public hospitals in Tanzania.

Keywords: Job motivation, motivation theory, Frederick Herzberg, satisfiers, hygiene factors, dissatisfiers, job satisfaction, Tanzania
Acknowledgements

I would like to use this opportunity to extend my sincere gratitude to all the people who contributed much in my quest for learning and for making studying at Blekinge Institute of Technology (BTH) possible and successful. First and foremost, GOD the almighty for granting me good health to date, and then my dear parents and grandparents who showed me the importance of education, respect for work, perseverance and discipline, and my teachers who saw some potential in me. As much as I could have wished to thank everybody who assisted me in any way, it is never possible to mention all. For those whose names are not mentioned here, please consider yourself highly appreciated for your assistance.

The successful execution of this work would not be possible without the guidance and mentorship of Dr. Thomas Danborg; to him I send my utmost gratitude. Other people whom at one point or the other contributed to my finishing this work successfully are Dr. Klaus Solberg Søilen, Dr. Anders Hederstierna and Dr. Katrin Anderson. Without these people, my student life at BTH wouldn’t have been any fruitful.

My sincere and very particular gratitude goes to all the people who spared their time out of their busy schedule to respond to my questions. It’s the insight of these people which forms a strong base to the conclusions drawn from this study. Without you, my dear colleagues, my work could never be possible.

I also, in a very special way, would like to thank Dr. Deogratias Michael Pisa, my good friend, who accepted to assist me with data collection at no any pay. Thank you so much. And also to Drs. Beatus K. Leon and Aziza Mwisongo of the National Institute for Medical Research (NIMR), for their valuable advice and guidance and for sharing some important policy and guideline documents and for referring us to key people at the Ministry of Health who in turn provided us with some documents and also granted us their valuable time for our interviews.
At some point in the course of my studies, it was impossible for me to secure books in Tanzania or buy them online. Some friends volunteered to send me books from abroad or get me some ebooks, and on this front, I am highly indebted to Drs. Mgaywa GMD and Julie Riise Kolstad.

It would be unfair if I would forget my fellow students at BTH from whom I learnt quite a great deal. Thank you so much for your cooperation and assistance you rendered when needed. Without you, my life would never have been the same.

Lastly, but not in importance, I specially grant my most sincere and heartfelt gratitude to my beloved wife, Dr. Bayoum A. Kigwangalla and my daughters, Sheila Kahabi Kigwangalla and Hawa Siasa Kigwangalla for allowing me time to concentrate on my studies as well as my thesis. I know you missed me a lot, and I have nothing to say to you but to thank you.
List of abbreviations

HRH = Human Resources for Health
WHO = World Health Organisation
URT = The United Republic of Tanzania
MOHSW = Ministry of Health and Social Welfare
CSD = Civil Service Department
HIV = Human Immunodeficiency Virus
AIDS = Acquired Immunodeficiency Syndrome
NGO = Non-Government Organization
PMS = Performance-based Management System
MKUKUTA = Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
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1.0 Introduction

Motivation is a complex concept and over the years several efforts by scientists have been made to define, understand the details and measure a number of factors underlying motivation. Often times it is visualized as the most important factor for increased commitment, productivity and involvement of employees on their job. Motivation can be defined as an individual's degree of willingness to exert and maintain high levels of effort towards certain goals. It is not a debatable fact that employees are the single most important factor of production in any given workplace, as they form the core of the system, so making them motivated means fueling the performance of the whole system.

The focus of motivation research in the early times was on the manufacturing industries, which was natural then, as the demand for increased productivity and efficiency in the workplaces was high and very crucial given the rapid technological advancements as well as the economic growth of the time. There are few efforts directed at studying motivation of workers in the service professions, especially the health as well as the educational service industries. In Tanzania the research gap on motivation and on human resource for health is big, with only few studies conducted.

This study focused on studying the factors leading to motivation of human resource for health in urban public health facilities; and on the other hand, also the factors that may lead to de-motivation or dissatisfaction of the human workforce among workers in the urban health facilities. The motivation-hygiene theory as proposed by Frederick Herzberg (1966) guided the design of the study, from conception to analysis, with the data collection tools, data handling and analysis techniques as well as the empirical discussion sticking to the core factors he proposed. The idea being to look at the possibilities of using it to redesign health policies in Tanzania with a focus on motivation, and design incentive packages with theoretical basis from his theories.
Understanding the factors leading to motivation or to dissatisfaction of the human workforce is very crucial since it will enable leaders and decision makers to design employee packages that would attract and retain them in their jobs.

### 1.1 Background

This study looked at the relevance of the motivation theory proposed by Frederick Herzberg in 1966 with intent to see if the motivators/hygiene factors for employees would fit our local circumstances (Herzberg (1966) and Herzberg et al (1959)). The basic assumption in this (two factors) theory is to redesign and improve employee positions so as to increase motivation, involvement and performance (Herzberg, 1966).

The two factors are the *satisfiers* (motivating factors), which are the primary causes of job satisfaction and the *dissatisfiers of the hygiene motivators*, which are the primary causes of job dissatisfaction.

A number of ‘extrinsic’ conditions when are not available will result in dissatisfaction among employees. These are the necessary conditions which are expected by employees and include things such as pay, working conditions, good personnel policies and procedures, and supervision. However, even if these conditions are present, it doesn’t mean that they will necessarily motivate employees. These factors are therefore called the dissatisfiers or hygiene factors, since they are expected by employees to be available and are required to maintain at least a level of ‘no dissatisfaction’.

The second set of conditions is ‘intrinsic’ and these are called ‘satisfiers’. Satisfiers create influential levels of motivation which is needed for good job performance of workers. They include things like sense of challenge, achievement, recognition, responsibility, advancement and personal growth. Satisfiers are not expected hence when are not present they do not result in dissatisfaction.

The relevance of Herzberg’s theory in this study is to find out whether the problem in question involves factors that are either satisfiers or dissatisfiers and hence suggest
appropriate practical strategies for improving performance, commitment and retention of health workers in urban hospitals in Tanzania.

1.2 Problem Discussion

Health workers working in urban health facilities in Tanzania face many difficulties. In general, salaries of health personnel are very low, working conditions are poor, and furthermore, there are poor personnel management practices and procedures and there are no explicit policies for incentives (Munga and Mæstad, 2009). Although allowances are provided for various kinds of tasks or for the implementation of projects, it remains difficult to survive just on this income. Therefore most health professionals engage in other income generating activities such as private practice, agriculture, small enterprise development, and by large divide their attention. For medical doctors it is for instance, more attractive to remain in the urban areas, where there is a potential market for private practice.

Recently we have seen health workers avoiding lowly paying public service jobs and move into relatively better paying and less demanding and frustrating jobs in local research institutions or international service non-government organizations. Some have decided to migrate into nearby countries where they would earn four to five times their local benefits, within the continent, and others have drained to even greener pastures in Europe or the United States where they would earn more than ten times the salary they could fetch back home.

Having insufficient manpower, equipment and supplies including medicines has seen to decrease morale of healthcare workers. With the health budget being low, below the agreed 15% of the total budget, as per the Abuja declaration, it has been difficult for Tanzania to meet up to the challenges of ensuring adequate supply of equipments and supplies, medicines, and recruiting enough health workers despite efforts to increase training opportunities and enrolment. The insufficient manpower in urban health facilities increase the burden to the few available ones as their workload increases consequentially
and this in turn has a negative bearing to the quality of healthcare services rendered to clients.

Private health facilities offer more attractive salary perks, better working conditions and good HRH personnel policies and procedures than public ones rendering them more attractive than the public ones. However; one wonders, what are the existing factors at play that retain the workforce in the public health facilities in urban areas despite all these hurdles? There could be some motivators that remain to be understood. This motivated the interest to conduct this study on motivation with a strong theoretical basis from Herzberg (1966), hoping to understand the distribution of the factors and thus inform policy making.

Having a motivated workforce that would provide high quality healthcare with a high degree of efficiency and commitment is a goal of the Tanzanian government through its National Health Policy (1990). Its furthermore a commitment to a humanitarian call to provide high quality healthcare in a just manner to all in need, and thus improving quality of the public health system is a necessary requirement for justice since many people in Tanzania cannot afford private healthcare costs and therefore would only resort and rely on the overburdened, understaffed and underfunded public healthcare system.

Although there are policies and procedures providing the direction regarding the treatment of the health workforce in Tanzania, still the health sector faces serious financial difficulties, and probably this could explain the rural – urban dichotomy that exists in the health workforce distribution, where it is believed they would earn an extra income from extramural activities or from intramural private practice, or else engage in enterprising activities. This poses a serious question whether there is implementation of the motivation policies as proposed by various theorists. And even if there are policies, and these policies are implemented, have they managed to increase productivity, commitment and efficiency of health workers in Tanzania?
Clients in urban health facilities have been complaining of receiving low quality of care from health providers. Is this linked to the lack of job motivation among health workers in urban health facilities? Or is there anything else?

### 1.3 Problem Formulation

In Tanzania there is a serious shortage of the health workforce, both in terms of quantity as well as quality. The shortage has reached crisis levels with the quality of health services provided in the country becoming very low and alarming. This has risked the realization of the various goals and implementation of plans, such as the millennium development goals (MDGs), the primary health care development plan (MMAM) and the National Strategy for Growth and Reduction of Poverty (MKUKUTA).

The reasons being, among other things mentioned below, inequitable distribution of the human resource for health, with urban areas being densely populated as opposed to rural areas (Munga and Maestad, 2009). Moreover, the contracted health manpower is not motivated and is highly overburdened, adding further to high levels of de-motivation. This has led to decreased productivity, efficiency, commitment and involvement. The environment where the health workforce is working is not very conducive with most important equipment and supplies missing or working in sub-standard levels. Due to a low health budget, well below the Abuja Declaration (15% of total country budget), and the health workers’ management system (as a result of devolution of powers) it has become difficult to employ health workers, despite the successful efforts attained in increasing numbers of student intakes to about fivefold since 1997 (O’shea et al, 2009), and to design incentive packages geared at increasing productivity, efficiency, commitment and involvement of health workers in their job, and thus improve quality of health for clients. Health workers have also lost a sense of ownership on their job.

With the existing situation it is expected that, to make use of the small sized workforce, Tanzania could benefit by harnessing the best out of the health workforce through the design of robust policies, plans and packages for motivation of healthcare workers.
So many theories of motivation have been put in place but do they work in practice? This remains a matter to be determined.

1.4 Purpose of the study

1.4.1 Broad objective

To study health workers’ motivation with their current jobs and associated motivating factors in the urban public hospitals in Tanzania

1.4.2 Specific objectives

The specific objectives of this study were: -

1. To determine the main motivators/de-motivators among health workers in urban hospitals

2. To determine the level of commitment of health workers to their profession/clients

3. To assess whether the presence of motivators/de-motivators affects job commitment

4. To assess the availability of policies/plans/regulations for motivation of urban health workers in public hospitals at the facility and ministerial levels

1.5 Research questions

This thesis is focused on answering the following questions:

1. What are the perceived motivating/de-motivating factors for health workers working in urban public hospitals?
2. What are the available policies, regulations and procedures for motivating health workers in Tanzania

1.6 Justification of the Study

This study is significant now since it highlights the importance that the issue of health care workers shall be accorded in all facets of the health systems cycle as it forms the core piece. The trend that governments in Sub Saharan Africa have put much emphasis on building health infrastructures and on improving the supply chain of medical inputs is of little meaning if the health manpower is not motivated. Thus studying how motivational theories could be used to redesign health personnel policies and procedures is of paramount importance. Since few studies on human resources for health have been done in Tanzania, this particular study will inform policy and decision makers on the state of affairs and would contribute in the furtherance of academic interest on the subject among future scholars.

In order to inform policies and decisions related to human resource for health, and to avoid unforeseen barriers to staffing efforts of facilities, it is imperative to study the factors that have led to the migration of workers to urban areas as opposed to those that have pushed workers away from rural areas.

The study is further justified because it contributes to the increase of knowledge base on the area of motivation, especially among health workers in Sub-saharan Africa; and also because it forms a partial requirement for the fulfillment of the requirements for the award of a degree of Master of Business Administration of the Blekinge Institute of Technology.

1.7 De-limitations

The study would have been more impactful if it had considered studying employee motivation by comparing the factors for the mobility of health workers between urban public hospitals vis-à-vis private ones, because by doing so, it would have elucidated the
factors that have pushed some employees who have chosen to stay in rural areas and those that have pulled those who have chosen to work in urban areas, those who have chosen to stay working in the public health system as well as those who have moved into the private sector; and also if it would have looked for factors that have forced some workers to have stayed in-country and those who have chosen to drain to others, and furthermore, the factors which have pushed healthcare workers to drain to other employment opportunities, in the research institutions, the international and local non-government organizations and self employment. And of interest would have been to study the factors that, on the contrary, have blocked others to move to all those potential job markets given the advent of globalization and the free market policies that our country is implementing at the moment.

Further studies could look in detailed into these areas as well as the effect of the background of the health professional onto choosing a particular geographical locale or even the effect of the reasons for joining the health profession onto the future job location.
2.0 Theory

2.0.1 Introduction to Chapter Two

This section forms a review of important relevant literature and it offers an overview of the current theory and research related to motivation. The various literature reviewed provides a firm foundation to understanding the investigated problem. The main texts studied are the books and peer-reviewed scientific papers on the original theories, various other scholarly articles on motivation and national guidelines, policy and strategy documents. The reading of these publications had given me a strong opening up for a better analysis and understanding of the problem.

2.0.2 Review of Literature and Theory

Tanzania is currently implementing its third Health Sector Strategic Plan (HSSP III, 2009–2015). The plan was developed in line with the goals of the National Strategy for Growth and Reduction of Poverty (MKUKUTA), the National Health Policy of 2007, and the Millennium Development Goals (MDG), 2000 - 2015. In all of these important documents and roadmaps, the improvement of quality of life of the people is at the centre. And certainly they recognize the fact that quality of people’s life is paramount to their ability and capability to engage and fully participate in Tanzania’s economic and social development, thus underscoring the importance of general improvement of the health sector. The improvement of the quality of health services could never happen without health workers. The health workforce must be motivated in order to be effective, efficient, productive and highly committed to their work. This forms a strong basis as to why it is important to study employee motivation and lay foundation to inform policy and decision makers so as to re-design policies that are employee-friendly.

Munga and Mæstad (2009) report that although Tanzania has a high burden of disease it is one of the countries in the world with a serious human resource for health crisis. They further assert that the problem is aggravated by the serious uneven distribution of the
human resource for health between rural and urban areas, with many preferring to work in urban over rural areas.

Dambisya (2007) reports that Tanzania may not have a huge problem of emigration of health workers, but has low numbers due to low output from the training institutions.

Kolehmainen-Aitken (2004) suggests that an adequate and equitable remuneration, timely payment of salary and other benefits, and satisfactory working conditions are very important for the performance, productivity and motivation of staff.

Dieleman et al (2003) in a study of motivation among rural health workers reports that health workers perceive supervision as control or audit by superiors. And they further found in their study that the selection of workers for training is unclear leading to demotivation.

Oshvandi K (2008) suggests that there are several main themes that have emerged to describe the factors that hindered nursing job motivation in Iran. Nurses in this study identified job difficulty, powerlessness and lack of authority, low income, harassment and violence to them, lack of support for nurses, centralized management, physician-centred culture in hospitals, lack of facilities and lack of a clear nursing job description. These factors are responsible for a decreased job motivation among nurses in Iran, some of which have been explained by Herzberg, and it would be interesting to see if the same would be the case with Tanzania.

Fort and Voltero (2004) found non-monetary incentives as one of the most important predictors of performance. Providers were reported to receive incentives from their employers or the community they work with, in the form of recognition, in-kind contributions, community respect and assistance with services. These incentives were reported to significantly enhance performance in Armenia. Similar factors were reported in a review by Rigoli and Dussault (2003).
Kolehmainen-Aitken (2004) examined decentralization in four countries and its impact on human resources for health, especially on motivation of health workers. He observed that health worker motivation and performance were issues that required urgent action because there has been evidence associated with reduced morale of health workers as a result of decentralization. He suggests that those factors that under decentralization most critically impact health worker motivation and performance must be identified and most cost effective way to deal with them must be documented and widely shared. For instance, he says most health workers put a high value on job security; therefore this must be looked at carefully when decentralization is implemented.

In the study done in Tanzania by Manongi et al (2006), supportive supervision, appreciation by supervisors, the community and seniors on the job, salary, opportunities for training, promotion and working environment were found to be important factors for motivation of health staff. Participants of the Focus group discussions conducted were found to feel proud that they were able to work despite the un-conducive environment, they claimed to be happy to do so because they felt they were doing the ‘work of God’, although they were unhappy that their willingness to serve their clients under difficult environment was not being recognized by seniors and neither by the community members.

Munga and Mbilinyi (2008) and Manongi et al (2006) further found that the human resource for health was de-motivated by workload and shortage of staff. Also the physical infrastructure and equipment further worsened the de-motivation status of health care staff. Although the authors generally reports to have found that HRH wanted just to be valued and appreciated to become motivated. This however, in the same study, does not rule out the need for the presence of hygiene factors.

The challenge for researchers and policy analysts in the health sector is to bridge the current knowledge gap – between what we know from the general evidence base on human resource management inputs and performance, and what we know from the
health-specific evidence base focusing on sector-specific outcome measures (Buchan, 2004).

Byrne (2006) reports that, one of the most important goals in the Irish Health Sector Reform is to improve the experiences of Irish Health Sector employees on their job satisfaction. This goal recognizes that employees are the Irish Health Sector’s most valuable asset since they create what the organization sells and that their support and enthusiasm is critical if the Irish Health Sector is to adapt to change. This conversion of the mindset and behavior of these employees (to embrace change) will happen only if they remain motivated. However, this required organizational cultural change will be difficult given staff shortages and high turnover rates (Munga and Mbilinyi, 2008).

“Within the quality initiative there is a clear recognition that only so much can be achieved by appealing to individual practitioners, and that more effort needs to be expended on understanding how the organisation and management of care affects outcomes. Many of the goals of the new NHS—including clearer lines of accountability and responsibility, better communication, and improved conditions for staff—require interventions at the level of the organization” (West, 2001).

The MoHSW in Tanzania has developed career development structures for each category of health workers, including criteria for upgrading. Other incentives for health workers include housing and appreciation of good performance as well as improvement of communication between different levels of the health system (The URT, 1994).

The key task of the HRH department is to make sure that employees are highly motivated. Many people concerned with keeping the HRH motivated are interested to find the best way of motivating them. Over the years, various people, most important ones are found below, have studied the subject of motivation and came up with various theories that can be applied in the workplace in order to improve job performance.

Two of the best-known theories of motivation were proposed independently by Abraham Maslow and Frederick Herzberg in the midst of the 20th century. These theories have had
a considerable theoretical as well as practical influence in management practice for years now.

Abraham Maslow’s theory of motivation (1943) is based on a hierarchy of needs model. He believed that individuals are motivated by certain needs. Abraham Maslow defined ‘Motivation’ as the willingness to exert high levels of effort to reach certain goals, and ‘needs’ as internal states which make certain outcomes appear attractive. And he further asserts that when certain needs have been attained they cease to be motivators but a higher level of other needs would emerge to motivate new behaviour. The needs were then arranged from the lower level physiological needs to the higher level needs for self-actualization, as follows: biological and psychological needs, such as food and shelter; safety needs, such as stability and security; belonging and love needs, such as work and family relationships; esteem needs, such as achievement, status and responsibility and self-actualization needs, such as personal growth and self-fulfillment. (Maslow, 1943)

Herzberg (1966) on the other hand, believed people only had two sets of needs known as hygiene factors and motivators. He defined certain basic needs (hygiene factors), as things like acceptable working conditions, good relationships with colleagues and a reasonable salary. He thought people strive to achieve these basic needs, but once the satisfaction wears off, they require other motivating factors such as achievement, responsibility, advancement and personal growth to keep them motivated and happy.

According to Herzberg, individuals are not content with the satisfaction of lower - order needs at work, for example, those associated with minimum wage or secure and good working conditions. He asserts that, individuals look for rather higher – order things such as recognition by colleagues/clients/seniors at work, a sense of achievement, a sense of ownership and belonging, a sense of responsibility and job advancement and the nature of work itself. This is by far in alignment with the premises of Maslow’s theory of hierarchy of needs. Based on the premise that satisfaction and dissatisfaction are not on a continuum, that they do not depend on one another, that when one increases the other must decrease, Herzberg went further by proposing a new element in his two-factor theory that both extrinsic and intrinsic factors are important and must be addressed.
independent of others in order to improve employee attitudes; thus administrators must recognize and address both sets of factors (extrinsic and extrinsic) in order to unleash commitment and productivity of workers on their jobs.

There are many efforts to study the linkage between employee benefits to Herzberg’s and Maslow’s theories. Traditional benefits like pay, work conditions, cars, housing and healthcare are in essence more of Herzberg’s hygiene factors. Most employees are expected to expect these things when they consider any position in competition with another.

Many argue that for employees to reach the higher elements of the hierarchy, as asserted by Abraham Maslow, such as self-actualisation, organisations need to look at benefits that may not be regarded as traditional benefits but in some occasions others have argued that pay is also significant for some individuals who would relate a higher pay to their self-worthiness and recognition. Organizations need to look at non-traditional benefits such as flexible working schedules to offer staff a greater work-life balance, or training and development opportunities.

As part of an overall benefits package, pay is of very little importance according to Maslow and Herzberg. Herzberg’s theory affirms that pay is a hygiene factor which will lose its relevance once employees are earning enough. On the other hand, Abraham Maslow asserts that, pay allows basic biological needs, such as nutrition and shelter, to be met. However; it could also be of great significance in the higher levels (self esteem) as some individuals would relate the volume of their earning to their self-worth and recognition.

Timmreck (2001) in a study of the motivation-hygiene theory among 99 health service mid-managers found the following factors at play. Hygiene factors that (adapted in the health sector) are organizational policies, administrative structures and protocol, governmental regulations, supervision by departmental heads and top administrative staff, a working relationship with the department head or healthcare work environment, salary, incentives and rewards, relationship with subordinates and coworkers in the
immediate work environment, personal life, professional respect and positional status, and job security. Similar factors were also observed by (Byrne, 2006; Munga and Mbilinyi, 2008).

The motivational factors are achievement, recognition, work itself, responsibility, advancement, and growth (personal, professional, social and psychological).

Another theory was proposed by David McClelland (1961), claiming that people have three needs they have to attain; achievement, power and affiliation. Employees who are most driven by power are more likely to value rewards such as company cars, prestigious job titles and executive share options. Those most driven by a sense of achievement, however, might feel more rewarded by performance-related pay schemes or incentive-led programmes.

Later theorists, like Victor Vroom in 1964 when putting forward his expectancy theory linked job motivation with employee benefits. Vroom (1964) asserts that for a person to be motivated the rewards must have been deserved and expected (hence expectancy theory). If organizations observe this, then they can expect improved performance. The individual make choices depending on how best the expected results of a given behavior match up with or eventually leads to the desired outcome. Vroom holds that motivation is a product of the individuals expectancy that a certain effort will lead to the intended performance (E > P), and that there is a reward (outcome) upon realizing a certain performance (P > O); this reward comes in the form of pay increase, promotion, recognition or sense of achievement. The variable explaining this was termed by Vroom (1964) as Instrumentality, and it is low when a reward is given for all performances rendered. Formalized written policies have a positive impact on instrumentality as individuals when they know what the rewards are feel they have control over. And the third variable is Valence (R), which is the value an individual places on the reward. It is dependent on the individual preferences, needs, values, goals and sources of motivation.
3.0 Methods

This chapter answers the ‘how to’ question, here the different data collection and analysis techniques used are unveiled; and also the reasons that motivated the choice of this design, methods and techniques as well as the merits and demerits.

3.1 Study design

This study employed predominantly qualitative research methods. The data collection as well as the analysis techniques adhered to the principles and techniques of grounded theory approach (Glaser and Strauss, 1967). The choice of methods and techniques fits the topic and phenomenon studied as it provided an avenue for the investigator to study a complex concept that is difficult to measure quantitatively but needed a wider and detailed understanding of the themes and concepts in order to assist the development of theories. It further provided an opportunity to ethnographically choose and use many types of data available that would add value to the findings in the quest to link the concepts and derive the emergent theories.

3.2 Study area

The study was done in Dar es Salaam city. The city has three districts namely Ilala, Temeke and Kinondoni. Each of these districts has one public hospital. The hospital setting and administrative structure of the three district hospitals is similar. The fourth hospital included in the study is the Muhimbili National Hospital, which is the biggest referral government hospital in the country, and is found in Ilala district. This hospital has a different setting and administrative structure and it is included in the study to represent referral hospitals in the country. All these facilities are owned and operated 100% by the government, the three municipal hospitals are managed by the Local municipal governments while the referral hospital by the central government through a board appointed by the Minister for Health and Social Welfare.
3.3 Study population

The study was done among nurses, doctors, laboratory technicians, pharmacists and other allied health professionals, with all the groups represented. Sixty nine health providers were interviewed in the total of eight focused group discussions. Approximately, 10 providers represented each cadre. The selection was initially done conveniently based on their availability but special efforts were made, as much as possible, to make sure that all professions are equally represented. The different cadres were interviewed separately. Selection followed convenient sampling techniques that allowed all the groups represented purposefully. Managers and or leaders of these facilities were purposefully included. Ministry officials responsible for policy/planning/regulation making were, for similar reasons to above, included. These were interviewed individually in the category of ‘key informant interviews.’ Clients exiting facilities were also included.

3.4 Sampling methods

Representative sampling was done to select participants to participate in the study. This was complimented with intensity sampling and snow-ball sampling. Intensity sampling means that, participants were selected based on their authority, knowledge, position, availability and expertise in the area while snow-ball sampling was done to select participants based on interviewees’ recommendation about their knowledge and experience on the topic. Intensity sampling was used to select such individuals as the Municipal Executive Director, the Director of Training and Personnel at the Ministry of Health and Social Welfare, the Municipal Medical Officer, The Director of Personnel at the Muhimbili National Hospital, the Director of Finance and Administration at the Ministry of Health and Social Welfare, the Unit Head of the HRH Unit of the National Institute for Medical Research and few other Departmental heads.

However, sampling continued (text-based sampling) for some aspects of the study until a ‘theoretical saturation’ of the text was reached. It was thought that this type of sampling would solve both the scientific as well as the convenience purpose given a small budget and time of the data collection process; scientifically, since it provided for a fit in terms
of the methodology adopted i.e. the grounded theory methodology and the cyclical process of data collection and analysis.

3.5 **Data collection methods**

3.5.1 Phase One: Initial Documentary Review, Assessment and Interviews

The first step of data collection consisted of desk research, which entailed reading various relevant literatures and key policy, review and guideline documents, study papers and technical working group papers. These helped shape the direction of the data collection tools, procedures, and analysis techniques. The exercise was made simple by making use of the internet search and recommended documents by contacts at the Human Resource for Health Unit (of the National Institute for Medical Research) and some key informants who were later interviewed in detail. The list of references is made available at the end of this thesis report, but it included documents such as:

- The National health policy, strategy and guideline documents, operational plans and technical working papers issued normally by the Ministry of Health and Social Welfare of the United Republic of Tanzania and some other stakeholders
- Various assessments and scientific studies done by the Ministry of Health and Social Welfare or other interested stakeholders such as the WHO, the USAID and others
- Quantitative data from the NBS (the National Bureau of Statistics) and other sources

It was important to read these documents to acquaint myself with the situation at hand before going out for on-site data collection. This enabled me to understand the extent of the issues under investigation and informed properly the design of the study as well as the data collection tools.
3.5.2 Data Collection On-Site

On site data collection from participants in the facilities was conducted from March 1 to April 30\textsuperscript{th} 2007. This methodology aimed at collecting raw data from participants themselves face to face and sense their extent of knowledge and experience, with intent to fill the gaps and expand on the initial findings from the desk research, and also to validate the information collected by the desk review, also to collate the information to see the gaps arising between policies and actual practices on the ground. This was the most important stage where the perceptions of the participants were tested against the propositions of Frederick Herzberg’s theory of motivation. The process was carried out systematically in cycles with initial data collection done using a pre-structured guide, with each interview recorded, and collected data translated and transcribed, and later subjected to a quick initial analysis and if need arises at a later time further interviews would come. Efforts were made to perform this exercise on the day of the data collection so as to maintain fresh memories.

Data was collected from four groups of people, from health providers of all cadres – properly represented, facility leaders/managers, clients exiting facilities and ministry of health officials in charge of human resource policies and plans. Health workers from the four main public hospitals in Dar were interviewed. 8 focused group interviews were done, 2 from each center with a range of between 6 – 12 participants. Each of these was recorded to compliment notes taken during the group discussions. Two facilitators were responsible for monitoring and facilitating the discussions; one of the facilitators was the principal investigator and the other a well experienced competent qualitative researcher, who was oriented on how to collect data specifically for this particular research.

Two in-depth exit interviews were done with clients of health providers in each of the four facilities. The inclusion of clients was important so as to see what perceptions do they have of their providers’ levels of motivation/demotivation, which in turn has a bearing on commitment on the job and the quality of care received and experienced by clients. Two in-depth interviews were done for each hospital management and four for
ministry officials responsible for human resource for health policies and management in the country. Further interviews were conducted with various stakeholders such as with one representative of an international organization (i.e. Intrahealth International), and two people from the Medical Association of Tanzania (MAT).

Observation methods coupled with memoing were also used. The general work site environment was observed for space availability in relation to client volume, comfortability, cleanliness, safety, the enthusiasm of the providers as well as the facial expression and the movements, pace and energy of the providers. The memos were translated, transcribed and analysis started on daily basis.

Data collection adhered to principles of grounded theory methodology (Glaser and Strauss, 1967).

It was necessary to use a multitude of data collection methods so as to allow for collation of the collected information. This increases reliability and validity of collected data and allows for ease of generalization of the findings.

### 3.6 Data analysis techniques

Interim data analysis was done. Data analysis was done using a thematic approach to the data and grounded theory approach was used entirely in the process. Data was collected, coded and analyzed continuously, in a cyclic way, as interviews were done until a theoretical saturation of the text was reached. Memoing was done throughout and the notes in the memo were systematically analysed following the principles of grounded theory approach. MaxQDA was used to organize the data analysis process.

All the recorded data were transcribed into word processing documents for easy analysis. All the transcribed data was then read line by line and the data divided into meaningful analytical units and coded (substantive/open coding). The coding was continuously done and modified each time new materials are obtained. The codes enabled the researcher to establish new concepts which later on were arranged into categories. The process was
done repeatedly, by going back and forth comparing data and finding meaning and relations until the growing theory is built.

Theoretical coding incorporated the growing theory by merging the various concepts into a hypothesis that establishes a theory into how the participants explain a certain occurrence.

Selective coding was done for some few core variables so as to weave with the Herzberg’s motivation-hygiene factors and to shorten the data analysis process. For all the new data theoretical sampling was done with the tentative core in mind, akin with the generation of concepts that are meaningful and are abstract of time, place and people.

The master list of codes was kept and used each time another appropriate segment of data was encountered.

The study entailed formulation of concepts and emergent theories from data and so making use of grounded theory approaches was a perfect match as it provides just an environment for that.

### 3.7 Approvals and ethical considerations

The principal investigator adhered to all scientific and ethical procedures and conduct. At first, the principal investigator submitted the proposal and resume to the Commission for Science and Technology (COSTECH) in Tanzania for review, and requested permission to conduct the study. The COSTECH ruled that the study did not require ethical clearance and so was permitted to proceed with data collection without further review by other bodies.

An informed consent was sought from all participants before they participated in the study. A designed consent form was issued to all participants and was issued for them to read before they agreed to respond to any questions. After reading the consent form and agreeing to participate in the study they were requested to sign.
The consent form ensured the subjects of confidentiality and privacy; and that the information they provide would be analyzed in relation to other information from other subjects and not individually. No any kind of pressure, compulsion or enticement was induced to participants and all willingly accepted to participate. Participants were informed of the opportunity to withdraw from participating in the study at any point during the interview.

The Principal Investigator paid proper courtesy to the local authorities and to institutional heads before starting data collection so as to ensure he gets maximum cooperation. Participants were informed that there would be no any direct benefit directed to them for being part of the study participants.

3.8 Work plan

March 1, 2007– March 20, 2007: searching and reading of the relevant literature

March 20, 2007 – April 8, 2007: writing down the research proposal and submitting it to the course director

April 8, 2007 – April 16, 2007: waiting feedback from the course director and contact with a supervisor

April 16, 2007 – April 30, 2007: data collection, analysis and report writing

Started

May 1, 2007 – June 30, 2007: report writing finalized, supervisor and student opponents comments incorporated, submission done

Done
4.0 Empirical Findings

4.1 Motivators Vs De-motivators - Findings from reviewed key documents

Strengthening human resources is an important priority for MOHSW and its partners. Significant efforts are underway to address HR shortages, including increasing the production of health worker capacity. The MOHSW led by its new performance management team, the Health Systems Strengthening Unit has begun an initiative to double the workforce training output. As part of the initiative, MOHSW is in the process of validating and updating school/campus improvement plans. Thus far, execution of the initiative has begun for the first wave of school improvements/expansions for 23 schools on 9 campuses. The aim of this initiative is to create capacity for an additional 1,480 students across these 9 campuses by September 2011.

Furthermore, the Benjamin Mkapa AIDS Foundation (BMAF) and MOHSW have worked together to implement emergency hiring initiatives to streamline the hiring process. MOHSW has also made changes to attract new health workers, including accelerating payments for new hires.

The HRH Planning Unit is refocusing efforts in the HR Management Information System. Although HRH planning has been hampered by a lack of information, this improved system, which is being rolled out to seven regions and seven referral hospitals, is encouraging. Thus far, experience has shown that the system is simple and is capable of showing trends in many aspects such as attrition, mal-distribution, age profile, etc.

4.1.1 Availability of Policies and Plans for Motivation of Healthcare Workers

The policy for the development of HRH, 1995 provides for the importance of HRH motivation. It depicts that “These workers will be adequately remunerated, supported, supplied and equipped to fulfill their tasks. In return they will take pride in their profession and care for their clients and show responsible behavior. One of the general
objectives contributing to the goals is to motivate all planners, trainers, learners, and health workers by providing them with a clear and common sense of direction.”

The Five year plan for Human Resource for Health (1996) identify the importance of having a motivated health workforce and it sets precedence for the same to be implemented. Although there is significant progress in the area of HRH, an HR crisis at all levels still exists, and low staff motivation continues to affect the ability of the health sector to cope with the heavy load. This affects the overall quality of health services. In addition to the current efforts of the MOHSW, there is a great need to enroll more students coming from rural regions/districts in pre-service training institutions, in order to improve ability to retain staff in these areas.

4.1.2 Presence of Motivators
Poor performance, low working morale and pathetic ethical standards exists among some health workers (Policy for the Development of HRH, June 1995). The main aim of the Policy for the Development of HRH is to put the Health manpower as the most critical element in the health sector. It envisages that a well planned, trained and deployed workforce will adequately cope with existing and emerging health issues. It is expected that with a good package to motivate health workers, quality of care would improve significantly.

In the Five year plan for the HRH sector in Tanzania (1996), the team found that the common approach to capacity building, using off-site meetings and seminars often leads to high absenteeism. Financial incentives given during off-site trainings, seminars, workshops, and other meetings could be used to improve quality of services as health workers consider them to be motivating; also on-the-job training and mentoring need to be utilized more often in order to use financial resources as effectively as possible. The MOHSW has a strategy in place to strengthen its Zonal Training Centers, so that mentoring and on-the-job training can be done more often.
4.1.3 Presence of Job Dissatisfiers

The proposals for health sector reforms, 1994 states that the majority of health staff is very poorly motivated. Due to the absence of coordination between programmes, many managerial decisions on staff development are fragmented. Staff promotions are administered by different authorities and rarely take into consideration individual performance. Working tools are inadequate or unavailable; housing is uncertain or of poor quality and remuneration cannot meet one’s basic needs. In order to maintain a fair geographical distribution of manpower, it is recommended to provide monetary incentives to staff who are working in areas with high work load. The incentives can be in the form of extra-work-load allowances or increased salaries. The CSD shall develop these packages in consultation with the MOHSW.

Moreover, the needs-based formula for distribution of block grant funds for health does not apply to personnel. Thus, budgetary funds for personnel are allocated based on where the health workers are, not according to need. In addition, staffing norms are identical for each health facility of the same type (hospital, health center, or dispensary), irrespective of utilization levels, resulting in very uneven workloads between facilities. The essential health package and related management activities will be ready in the near future and will clarify this issue (The HRH sector in Tanzania: A Five year plan, 1996).

4.1.4 Level of Job Commitment

The desk research found that a low level of commitment on the job results from decreased morale of health workers. Low morale of health workers is generally acknowledged in the studied documents. The various documents reports that the low level of commitment is manifested by lack of care and discipline among health care workers to their clients, and this is closely related to inadequate management, organization and remuneration. (Human Resource for Health sector in Tanzania: A five year plan, July 1996)

4.1.5 Availability of Policies and Plans to Increase Motivation of Healthcare Workers

In the technical preparatory meeting; in advance of the Joint Annual Health Sector Review, MOHSW and PMORALG, March 2006, they outlined low morale and
productivity of HWs remains to be a problem, and they further reported that, the salary increase is perceived as too small to make much difference. In their discussion this topic was described as ‘the mother of all topics’ that need ‘the mother of all champions’. One of the proposed actions was to design and secure approval for a viable and sustainable HRH retention and motivation scheme, with particular emphasis on remote postings.

The five year plan for HRH sector in Tanzania (1996) identifies the following stakeholders, in relation to the following elements of the HRH system:

1. **Motivation:** with regards to motivation the plan analyses the possibilities of offering differential incentives to health workers in underprivileged areas. It states who would benefit from this plan and what would be the possible constraints. This indicates the clear understanding of the importance of motivation to the human resource for health as envisaged by the Tanzanian government and outlines the need of the Tanzanian government to motivate health workers and the challenges anticipated.

   “Although motivating health workers will only be received positively in general terms objections may be expected when it comes to differential incentives (positive discrimination) for instance of hitherto underprivileged areas. Winners would be the public, politicians and health workers from such underprivileged areas but opposition may be expected from other individuals, politicians, health workers and population groups who may feel such differential incentives as unfair. The Civil Service Department may still favour a uniform system.”

2. **Quality:** the plan further analyses the importance of improving quality of our health workers’ performance which would come only when they are motivated. Here the plan clearly states the main barrier to employee motivation as insufficient funding – putting monetary incentives at the forefront! This is in line with Herzberg’s motivation –hygiene theory which poses the importance of ensuring the availability of extrinsic factors (hygiene factors or dissatisfiers).
3. **Performance:** the general public, patients, the MOH, members of the parliament, the donor community and all health workers would be interested in a better performing, more productive health service. All would be winners. *(from HRH sector in Tanzania: a five year plan, July 1996)*

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“Raising quality of health workers’ performance will receive general support and is not likely to be contested. However quality improvement taking into account the financial constraints is not possible without sacrifices in quantitative terms. This is likely to meet considerable resistance from those who will (or fear to) lose their jobs. Resistance is also expected from labour organizations, politicians and those in decision making positions at the Ministry of Health and the Civil Service Department who may be reluctant to take unpopular decisions.”
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In the 7th Joint Annual Health Sector Review in Tanzania, April 2006, technical experts report about the redistribution and retention of human resources to under-served areas need to be highlighted as key issues to be tackled. Participants of the expert working group felt that the proposal to have a human resources “project” with dedicated staff and resources was a good one.

### 4.2 Findings from on-site data collection

#### 4.2.1 Presence of Dissatisifiers

Employees were generally found dissatisfied since they are receiving low pay and that they are only in their current jobs because they have no other alternatives.

From the people we interviewed, the following views were obtained and are hereunder presented: -

**Salary**

The salary paid to healthcare workers in Tanzania was considered very insufficient by most participants interviewed. Salary paid could never even suffice to cater for the most basic needs for the whole single month.
“Salary is not adequate, it does not motivate me. When I budget my salary, it is not even enough to take me through the month.” [Medical Doctor, Amana Municipal Hospital]

But still many people would remain to work in their current jobs because they assert to have no any other better alternatives.

**The effect of salary increment**

Not only that salary increment is reported to be a job motivator but also it seems to have a positive effect on employees’ job performance, commitment and consequently quality. Although according to Herzberg et al, salary is a hygiene factor which is expected to be available to maintain at least a degree of no dissatisfaction at all. Health workers in Tanzania receive very little pay and this explains why would consider any increment as a motivating factor for him or her, as it will reduce economic hardships which could arise among them when they tend to struggle to meet their financial obligations by working part time in private hospitals or in their own petty businesses. Some would leave their work stations earlier than the prescribed time so as to go to their private businesses. This has significantly reduced job commitment, performance and quality.

One participant pointed out that:

“yes, it means that, I will have more time to rest, instead of using my private time to generate more income, so it will motivate me and make me concentrate more in my job.”

Monetary incentives if used appropriately could provide a policy mechanism to align health worker behavior and health workforce performance with health sector objectives. According to information from the MoHSW, the compensation framework in the public sector lacks monetary incentives that are explicitly linked to performance attributes. For example, health workers do not receive rewards for serving in hardship areas or sometimes for working overtime, and whenever they do receive it is meagre amount incomparable to the work done.

**Working conditions**
Poor working conditions have been observed to cause decreased morale among healthworkers. Generally, this is believed so by almost all stakeholders. Employees expect to receive a housing allowance of about one-thirds their salary and some cadres do receive and some do not. It has been generally reported that the amount they receive does not suffice to cover the actual cost of housing in Dar es Salaam. Most workers would live in poor houses uncommensurate their status as their entitlement provides.

Transport to and from work stations is not provided and most workers would go and live very far away from their working stations since they can't afford houses near the city center. This not only increases the cost of commuting but also consumes their time and leads to many workers living their work stations soon before rush hour so as to catch their buses hustle-free.

Also many healthworkers reported to be discouraged with lack of appropriate working equipment in the health facilities they worked with. Many facilities reportedly lacked protective gears like gloves and some lacked life saving apparati like oxygen gas reserves, masks and some essential drugs. This demoralizes many healthworkers as this nurse would say:

`...sometimes you even wonder why you are here still working while you can't even save a life when your knowledge and skills are needed the most...one day I needed an oxygen tank very badly to save a gasping patient...and I couldn't get one on time. The patient died, now I don't know whether he died because he lacked oxygen or his days had reached..`  

**Good personnel policies and procedures**

There was clearly a lack of good HRH personnel policies and procedures implemented. The government appreciates the availability of good policies and is making some efforts to improve the situation but very little direction is provided on how to motivate health workers in urban health facilities.
The following were reiterated by many interviewees as good practices which were lacking. The lack of transparency in human resource management practices (e.g. transfers, selection for training and upgrading), lack of clear job descriptions, lack of performance management system, limited opportunities to participate in decision making and poor information flow between management and staff.

**Supervision**

Proper supervision is needed for work to be done productively and effectively. Many of the interviewees reported poor supervision from their superiors.

Inadequate management and organization skills by many health facility managers is clearly observed. This lack of professional approach to leadership and management of the health system is a big problem that needs to be addressed urgently. Many facility in-charges have been appointed based on experience from their jobs and the fact that they are health professionals and the mere fact that they happen to work in that particular facility. This situation has given authority to most wrong people and hence they abuse it.

### 4.2.2 Presence of Motivators

These are intrinsic set of conditions which are expected to create some influential levels of motivation which is needed for good job performance. These factors are internal to the individual. Employees do not expect the ‘presence of satisfiers’ when they take up their jobs but if not found available they don’t result in any dissatisfaction among them. These factors include; opportunities for achievement on the job, responsibility, recognition, promotion and personal growth.

**Opportunities for Achievement on the job**

Many healthcare workers were found to be highly motivated when they treat a patient and become successful in that course. This has always been a strong factor for many to do their job well.
Sense of Appreciation

The study found that when health workers are appreciated by their clients they become highly motivated. This is one of the factors sited by many health workers as a strong ‘motivator’. They reported to feel good when their job is appreciated by their clients. It was further noted that in clinics where services for chronically ill patients are offered by the same providers over and over, some sort of friendship occurs between providers and clients (provider-patient relationship).

It was further found to be very likely that when a provider knows the patient well he will grant him preferential treatment, and this would happen when the patient is a relative, an acquaintance or someone you meet several times, which is the case with the chronically ill patients who would come to the same clinic everytime and each time meet with the same providers. Staying at the same work station for a long time creates job ownership and thus love and caring attitude for the job and clients and hence increased morale.

Appreciation by superiors for a job well done

Many healthcare workers reported to become motivated on their job if the good things they do in their job are appreciated and praised by their superiors. But they did not like negative feedback from their superiors.

“...yes it means a lot, it motivates a lot when you are recognized by doing a good job, being lamented by doing a single mistake and it shadows all the good you have done is really bad and demoralizing, so appreciation for doing a good job is good.” [A nurse at Muhimbili National Hospital]

Sense of responsibility

Decentralization of health services (from the central government) to the districts in Tanzania has given more responsibility and authority to make decisions to cadres in the lower levels. Although many staffs were found under-qualified to participate effectively
in the process of decision making especially in the planning and budgeting processes, many hailed the approach. This is so much in line with Herzberg et al although there are incidences of reluctance of higher level managers (due to fear of under-performance on the part of their subordinates) despising the contribution by lower cadres and denying delegation of responsibilities to colleagues.

**Sense of challenge**

Most health workers felt a sense of challenge on their current job only because of the difficult environments that they work in; contrary to Herzberg et al, this type of challenge on their job was found severely de-motivating.

**Professional advancement**

Professional advancement and career building is another thing that was found to be a motivator among many healthcare workers. Many remain to work in their jobs with hope that they will have an opportunity for further studies and upon graduation they would come back and get promoted, and also their pay and other worker’s benefits would increase. Many commended the government for having policies to allow health workers to advance their knowledge and skills by joining further studies; although it was not clear with regards to the selection criteria as who goes when for training. One participant said:

“My employer has put no barriers for further studies, so if you wish to go for further studies, you are free to do so, it depends on your goals…”

Short - term training programs were the most likened of all the training opportunities as attending them would mean getting per diems and this money seems to be important in complementing the gap left by low salaries. However, employees expressed their grievances as to the selection criteria for those who would go and attend these training programs. They wanted the opportunities to be equally distributed to all of them instead of the same person going each time an opportunity is available. They, however; very surprisingly, disregard the fact that some training programs are specifically targeted at
instilling certain specialized skills to a certain cadre. One nurse had the following to say regarding receiving the opportunity for training:

“It is bad if every time the same person goes for training, it makes you feel bad but if you are getting equal chances to go for training on things you do not know it helps a lot.”

The above participant addresses one of the most reiterated management ill in the health system in Tanzania. Managers put very little efforts in looking at how possibly could they motivate their subordinates and improve quality of healthcare for their clients. They go in contrary to the plain truth that the health workforce is the ‘backbone’ of the health service provision industry.

**Love for the Job**

Among the factors which motivated most study participants to stay working in their current jobs, was love for the job. It is the life that they had dreamt of and they look at no any other better or even similar alternative around. This was a driving force for many healthcare workers to choose to work and serve as health professionals. The inner need to provide service and help the needy seems to be the main factor for healthcare workers to stay on the job. Many, who are religiously inclined, morally think that what they do is sacred and has rewards in the next life.

One Medical Doctor whom we interviewed said that:

“I love this job that is why I took the pain to study it, above all I love serving patients and those in need in the society.”

**Personal growth/self development**

Since healthcare workers have needs and have to meet those needs they have to have alternative means of earning complementary income. Many were reporting having a part time job in private health facilities, although this would mean that they would spend insufficient time in their main job. Of course some would not care the least as long as
their second job pays them more than the main. And many would not leave their job with the public health facility for fear of losing their final benefits as well as the job security offered by the government employment contract.

A good proportion of study participants also reported to complement their income by doing petty trading, some small scale farming for food or for business purposes and by attending seminars, training and workshops. Another group reports to receive complementary income from their spouses who are working or doing any other type of income generating activities like trading or having a small enterprise. This was said by a nurse working in one municipal hospital in Dar es salaam: “...I continue to work on my job because I have a partner who helps me do other things, like small scale business that helps me to complement to my inadequate salary...so money does not become really an issue with me because it is what you do with yourself that counts, you could get well paid and still lead a poor life if you don’t plan well.”
5.0 Analysis

5.1 Introduction to Chapter five

Data was analysed using the principles of grounded theory, also thematic approaches were used. The data analysis process was implemented cyclically with the availability of each new material until theoretical saturation was reached.

Several factors have been considered important in motivating health workers to join the health profession and remain in the field throughout their lifetime, also those that push health workers out of their core professions and into other professions or abroad to greener pastures. Frederick Herzberg et al (1959) attempted to study the factors that motivate people to remain in their current jobs on the one hand and those that dissatisfies and thus push them away from their current jobs. This study aimed at studying the theories and principles as proposed by Herzberg et al in relation to the human resources for health in Tanzania. I hereby discuss the findings of the study in relation to the factors proposed by Herzberg.

5.2 Discussion

Pay, employees working conditions, supervision and good personnel policies and procedures were termed by Herzberg et al as dissatisfiers; they are also known as “hygiene factors” and they are considered extrinsic, and that when these conditions are not available they would cause dissatisfaction among employees. In other words they are required to maintain at least a degree of 'no dissatisfaction’. In this study we found that the presence of these factors would not cause any improved job performance.

This study found that the short supply of health workers contributes to the presence of fewer health workers which in turn results into de-motivation of the heavily burdened fewer staff. This finding is similar to what was observed by Manongi et al (2006) in their study that was also done in Tanzania.
Since the importance of having a well trained and sufficient manpower cannot be overemphasized, as also is underscored by Byrne (2006) who studied the Irish Health Sector reform, in order to provide high quality services we have to have a well trained manpower which suffices the need of the market. Unfortunately, the output from our training institutions is small and even the uptake into job positions is minimal. Bryan et al (2006) reports that 27% of doctors and 50% of nurses were unemployed.

Dambisya (2007) reports that Tanzania has fewer output of skilled HRH and despite the the low output, the employment freeze is further causing even a serious shortage of HRH in Tanzania (Bryan et al 2006). We are witnessing the tendency of having fewer and fewer young people taking science subjects, particularly health/medical training. The government and other stakeholders should put emphasis on increasing the number of young people matriculating into the health-related fields. The application should screen and rank highest those keen into joining the health related fields, should keenly look into their motivation to apply into the health-related profession. This would ensure that institutions recruit students who are committed, dedicated and are seriously interested in providing services to fellow human beings.

Poor supply has also been observed due to poor human resource planning; because non-qualified heads would not be happy as to create and plan for more qualified people than themselves for fear of losing their titles. So every year round they would report having sufficient human resource. This would increase the workload for the already contracted staff and in turn decrease morale of workers. Also having less qualified people for the job would definitely decrease motivation of healthcare workers because people are always uncomfortable doing things they are not confident about and unskilled to do.

This goes against the public service management and employment policy (1999) which requires that ‘recruitment shall be conducted by open competition through media advertising…’ The same policy states that ‘a post in the public service may only be filled if there is a funded vacancy.’ So how is there going to be new vacancies if posts are not created? Of course, there are issues of insufficient budgets in the government which
renders it difficult for the government to fill all the required manpower gaps. I am, however, inclined to think whether health should not be given first priority, or what priorities do we have as a country?

The retention of workers with valuable knowledge in their jobs is a key element in any organization’s human resource strategy. Health workers have valuable knowledge which is crucial for quality of services they provide. This important resource in public health facilities has to be retained, because the departure from their jobs means knowledge is lost (Hislop, 2002). This particular study found that the government of the URT is putting measures in place to retain health workers so that it can reap the best of their rare knowledge and skills.

There is generally a perceived phenomenon that there is better pay in the private sector as well as the international NGO labour markets compared to the public sector; also from facilities in undeserved remote areas to those in urban areas. I could not find sufficient data to substantiate this. The McKinsey report written by Brian et al (2006) reports that there is a high out-migration rate of doctors to countries in the region, mainly to Kenya, Uganda, South Africa and Botswana. The report claims that these countries are able to offer 3 to 9 times the compensation offered in Tanzania. Apparently, there is no policy to control for this and if the trend continues we would observe very few qualified health workers going into the public health facilities.

Although in this study, I could not elucidate clearly the effect of brain drain in shrinking the volume of the human resource for health in Tanzania, there is an obvious possibility that this is by large the case. There are obvious symptoms of push factors for health workers such as low salaries, poor working conditions, lack of equipments and supplies and even the unavailability of non-financial incentives; all could contribute to pushing the HRH to other countries or other sectors. And the worst of all is the fact that there is no proper manpower planning and priority for hiring in the public service management office of the government meaning that health workers compete for equal chances to be
employed with other cadres (The public service management and employment policy, 1999).

In her study, reviewing the effect of decentralisation on HRH, Kolehmainen-Aitken (2004) suggests that adequate and equitable remuneration, timely payment of salary and other benefits, and satisfactory working conditions are very important for the performance, productivity and motivation of staff. This is far agreeable to Herzberg’s motivation-hygiene theory (1966) and conforms to the findings in this study.

Since the study found out that in Tanzanian urban health facilities, pay can act as a strong motivator, there should be efforts to study in details the effect of salary increment on job motivation, and ultimately, performance. This finding is in apparent contradiction to what Herzberg et al (1959) had originally proposed. On the other hand, other researchers assert that, once employees have reached their comfort level pay becomes less important for them to become any far motivated. So pay has to be increased up to a certain level where they can fulfil their aspirations before it shows no any effect on motivation and consequently performance; and at this stage it becomes a hygiene factor in support of Herzberg’s theory.

From this therefore, other motivating factors such as a sense of ownership (that ‘I own this!’) should be inculcated among health workers. Olckers C and Du Plessis Y (2012) suggest that ownership can have a positive effect on organisational effectiveness. They went ahead into introducing a managerial construct for talent retention and increasing organisational effectiveness which they termed ‘psychological ownership’. They assert that “if organisations can create a sense of psychological ownership among employees by addressing the proposed elements in the survey construct, they should be able to enhance employees’ experience of their workplace, thus ensuring sustainable performance, especially in uncertain economic times.” Tanzania could benefit by designing strategies that would develop psychological ownership.
In studying factors more critical to performance, Intrahealth International (Fort and Voltero (2004), Munga and Mbilinyi (2008) and Dieleman et al (2003)), among others found that non-financial incentives by either provider’s employers or by the community for whom they work, were found to be the most important predictors of performance. These non-financial incentives could be in the form of recognition, in-kind contributions, community respect and assistance with services. This study also found the same. The same was also found in the United States by Timmreck (2001).

In Olckers, Duplessis et al in 2012, reviewing other studies in motivation found that ownership, not in terms of statutory ownership of shares or of materials, is very important in improving the motivation of workers. This is becoming a very important aspect of motivation studies today (West, 2001).

The public service management and employment policy (1999) requires every public service organization to perform an assessment of future human resource requirements made on the basis of future tasks the organization expects to perform them but this has not been observed. Poor human resource planning is one of the key contributing factors for increased workload among staff which in turn decreases work morale. Also results in unqualified heads leading sections or facilities. Hence lack of motivated skilled manpower is a common phenomenon.

Another very important non-financial incentive that was found to be strongly associated with health workers remaining on their job despite all the hurdles was love for their job and the Godly nature of the job and this is in line with what Manongi et al (2006) had found, that employees are willing to continue working on their current jobs because they do it for ‘God’. So morality is a very strong factor when considering the attitudes of healthcare workers in Tanzania.

Decentralization done in Tanzania has given more responsibility to lower level health managers and local committees and councils. This has increased their involvement, morale, commitment and has thus given them ownership of the plans and
implementation. This goes in hand with what Herzberg (1966) had asserted. The only weakness to this is denying them a chance at the local level to employ their staff as per their needs and priorities, thus relying on the final decisions made at higher levels. Although it has its positive benefits, Kolehmainen-Aitken (2004) argues that it poses risks of decreasing job motivation and performances; he suggests that job security among workers should not be risked, also issues of manpower planning and remuneration must be looked at, as to where they are handled and how. Also decentralization was found by Munga and Mbilinyi (2008) to have a bearing on the issue of promotion and further study, where workers are not sure as where and when to go for further studies and even when their promotions are due they would be delayed as coordination between the central government (which handles these) and the local government is not very good.

Appreciation by seniors on the job, by clients and the community was found in this study as one of the most important motivating factors. Other studies (Timmreck, 2001; Manongi et al, 2006 and Fort and Voltero, 2004) found the same. All these studies also found a sense of responsibility, ownership, achievement and recognition as important for job motivation among healthcare workers. A study by Timmreck (2001) also found that a sense of challenge on the job is very important for job motivation; the finding was in line with what I had found and conforms to the premises of Herzberg’s motivation-hygiene theory (1966). Dieleman et al (2003) further subscribes to the same assertion.

A job is meant to give a worker personal growth individually and this has to be seen happening, and further it has to give him professional as well as social development. This in itself is a factor that goes positively towards self esteem and self actualization by a worker, almost pairing up with Abraham Maslow’s (1943) assertions. It is obviously found by this study to be true.

The ‘happy worker thesis’ holds that a happy worker is a productive worker (quoted from Byrne M, 2006). Although some researchers on the subject conquer with the thesis, some say that better on-the-job performance achievement increases job satisfaction and motivation. Byrne argues that pay against performance has a potential to increase work
overload and this in turn would manifest into increasing mistakes on the job, mandatory overtime and working long shifts. This has dangers of resulting into serious dissatisfaction and lead to emotional exhaustion.

Rigoli and Dussault (2003) argues that financial incentives alone are not enough to give a person on-the-job motivation. They assert that the link between organizational objectives and personal motivation is the ‘psychological contract’ between the individual and the organization, which describes a reciprocal relationship defined by mutual expectations for a continued existence. The psychological contract for many individuals includes believes that their job will fulfill their intrinsic needs of self actualization, sense of responsibility, achievement, recognition as well as relationships with others on the job. To them this is their psychological contract. All these assertions are in line with what Herzberg has provided and conform to what I found in this study.
6.0 Conclusions and Implications

6.1 Introduction to Chapter Six

The fundamental supposition in Herzberg’s motivation-hygiene theory is to redesign and improve employee positions so as to increase motivation, involvement and performance. This study aimed at testing the applicability of what the original theorists had proposed among health workers in urban public hospitals and in a Tanzanian context. This chapter concludes by looking whether the study realized its goals and whether it managed to bring up fruitful suggestions for the improvement of the health systems in urban Tanzania. Here, I also provide some recommendations on the way forward and the future suggestions for improvements.

6.2 Conclusions

It is concluded that the following factors intrinsic to the individuals were found available: opportunities for achievement on the job, sense of appreciation, appreciation by superiors for a job well done, sense of responsibility, sense of challenge, professional advancement, love for the job and personal growth/self development; and the following factors extrinsic to the job were found available: salary, salary increment and its effect on motivation on the job, working conditions, good personnel policies and procedures, and supervision.

The Herzberg’s motivation-hygiene theory provided a proper framework for me to study HRH job motivation and associated factors among urban health workers in public hospitals in Tanzania. I further conclude that when health workers are adequately remunerated, supported, properly supplied and equipped to fulfill their tasks, they will in return take pride in their profession, love their job and extend immense care to their clients and display responsible behaviour. Although it was not sufficient to study all issues pertinent to HRH motivation using Herzberg’s theory, it suffices to say, here, that the theory provided a firm theoretical framework for the study of motivation and associated factors, that Tanzanian policy and decision makers could actually use some of the propositions in the theory in rethinking and redesigning HRH positions in the
Tanzanian health systems. Instead of focusing all their efforts on improving ‘hygiene’ factors, they could also start looking at the ‘motivators.’

It was, however, very difficult, in this particular study, to ascertain the assertion that a happy and satisfied workforce is actually more efficient and productive than the contrary. Also it was further difficult to tie the findings of Herzberg as in the motivation-hygiene theory with individual differences of workers in relation to certain individual personality traits; as assuming that all workers would respond similarly disregarding their inherent biological factors, was in my opinion a serious omission in the original design of the study by Herzberg.

It is further concluded that healthcare managers do not fully utilize the available opportunities to motivate the HRH by for instance change the way they exercise their powers and create psychological job ownership and commitment, by enhancing relationship building attitudes between staff and between HRH and the community, and by ensuring the presence of dissatisfaction-avoiders (hygiene factors).

### 6.3 Implications and Recommendations

6.3.1 Herzberg et al’s theory, although somehow inadequate in studying motivation in a developing country like Tanzania and in a study group like health workers, has proved sufficient at least in proposing that motivation is a necessary factor for if Tanzania wants to milk the best out of our HRH; also financial incentives (hygiene factors) for motivating HRH, which is a predominant practice in Tanzania, has resulted from poor skills and understanding by management.

Job enrichment should be a continuous management process undertaken by both administrators and the health workers. For the public facilities, if the government of the URT contemplates improving healthcare service delivery to acceptable levels, then it has to look at the HRH as the ‘nucleus’ of the system and henceforth it has to consider the various ways on how to motivate employees; I suggest consideration to be put to both the financial as well as non-financial incentives. For instance, the creation of a sense of
ownership for the job among health workers; this would entail re-designing the work environment to give more autonomy and responsibility to them, give more responsibility to employees who have shown to increase their abilities. The work setting could be improved to empower healthcare workers and allow them to exercise power and control over certain aspects of their work systems, decision making and enable them enjoy more autonomy and responsibility, this is expected to manifest into job motivation and increased work-related self esteem and sense of being important and useful. In turn efficiency, commitment and productivity would increase.

6.3.2 In order to attain commitment, efficiency and productivity by the HRH on their jobs, the government of the United Republic of Tanzania should develop a performance-based management system in line with the motivation system: the process should involve health workers and managers, and staff should understand clearly the impact of the performance management system on staff retention, recruitment and motivation.

6.3.3 Timely promotion of healthcare workers in urban settings would motivate them as well as providing opportunity for training. The effect of decentralization on these two should be looked at carefully.

6.4 Recommendations for further studies

- Further quantitative studies are needed to study in detail the link between HRH motivation and job performance, commitment, quality and productivity.

- It is imperative to further study the geographical imbalances perceived available between the private and public sectors, rural versus urban areas and establish the prevailing factors for the observations.

- A comparative study of the factors for motivation of HRH in rural as opposed to urban areas is also highly recommended.
• Also we need to establish the magnitude of international brain drain and elucidate the push as well as the pull factors observed.

These efforts should go in hand with plans to ameliorate the situations with new enthusiasm.
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8.0 List of Appendices

8.1 Annex 1. Interview guide

- What factors are motivating you to stay in your current job? (Probe about each of the factors that he mentions, ask if they are increased/provided/decreased will that influence his job motivation in anyway? how? - decrease or increase of motivation) If he mentions just a few of the factors ask directly the remaining ones that he has not – refer to the following list:

1. pay/salary
2. working conditions (relationship with peers/boss)
3. policies
4. good personnel policies and procedures
5. supervision
6. Security
7. sense of challenge
8. achievement
9. recognition
10. responsibility
11. advancement and
12. personal growth

- Do you think that health workers in Tanzania are motivated? Give reasons for your response?

- If they are not motivated, why?

- If all of the factors above are made favorable to you, will that influence your productivity and commitment to your job?

- What can you say about the quality of health services provided to patients? Why? (probe if it is poor, is it due to lack of motivation of health workers?)

- Are there any policies and plans for motivation of health workers? What do they say about HRH motivation? Are they functional?